AT ISSUE
A QUESTION OF CHOICE?
IVF AND THE POLITICS OF COERCION

JOCELYNNE A. SCUTT
Owen Dixon Chambers, 205 William Street, Melbourne, Victoria 3000, Australia

On May 31, 1992 in Melbourne, Australia, the *Sunday Age* ran an "exclusive": "Doctor Forced Abortion: Woman." Written by Caroline Wilson, the article described a Melbourne woman's allegation in the Supreme Court of Victoria that Australia's "largest infertility program":

> demanded that she have an abortion to cover up for "a terrible mistake" which saw her inseminated with incompatible sperm. (Wilson, 1992, p. 1)

The woman told the court that she "underwent an abortion against her will after being threatened by [a doctor] from Monash University's Infertility Medical Centre, which has been a world pioneer in in vitro fertilization [IVF]."

Caroline Wilson goes on to say that the doctor, a consultant to the Donor Insemination Service at the center, "allegedly told her patient that because of a 'mix-up with the straws' she had been inseminated with the semen of a Spanish-Egyptian of an incompatible blood type" (Wilson, 1992, p. 1). The Australian-born woman, whose husband serves in the armed forces, was allegedly told by the doctor that she "would not be allowed back on to the fertility program unless she had an abortion" (Wilson, 1992, p. 1). The woman said she was "also told that she would be refused further treatment at any fertility clinic in Australia should she take legal action over the sperm mix-up because her name would appear in every newspaper across the country" (Wilson, 1992, p. 1).

The court case is proceeding on the basis that the action can be lawfully brought, and that the doctor concerned denies insisting that the woman have an abortion. The doctor also denies that she threatened that the woman would be debarred from reentering the IVF program if she continued with the pregnancy.

The woman (who remains anonymous in consequence of a suppression order granted by the court) said that although she underwent the abortion in 1983, the doctor was unwilling to allow her back onto the program in 1985. In court, she stated: "They weren't going to let me back for a second try, and I said to [the doctor], 'I've covered up for you.'"She went on to add that the hospital had kept as a donor the man who had provided compatible sperm for insemination leading to the birth of her first child: "They stored [the sperm], and [the doctor] wasn't going to let me back on the program" (Wilson, 1992, p. 4).

The woman's claim is for damages on nine counts of medical negligence against the doctor, together with punitive damages on the basis that the doctor "showed a contumelious (insolent), arrogant and wanton disregard for the [woman] and [her] health" (Wilson, 1992, p. 4). The woman's affidavit filed in the court said, amongst other matters, that she was "informed by [the doctor] there had been a terrible mistake . . . I was told by [the doctor] to have an abortion. [The doctor] stated I would not be able to pass off as my own a Spanish-Egyptian child" (Wilson. 1992, p. 4).

The woman went on to state, in court:

> I didn't create any waves. I realised at that time when the mistake was made there was a lot of controversy, there was a lot of publicity, there were ethics committees being formed, and I guess [the doctor] knew that if I spoke out then obviously it would put the program in danger, and that was virtually what I had been threatened with. (Wilson, 1992, p. 4)

She underwent the abortion 6 weeks after her pregnancy was confirmed, and has since given birth to two sons following donor insemination at the center. Nonetheless, she says, the abortion "has continued to haunt her, and she suffered from stress and anxiety and has undergone psychiatric counselling as a result" (Wilson, 1992, p. 4).

In court, the woman referred to the doctor "virtually [telling] me that I had to have an abortion, that if I sued [the hospital] the publicity would be all over Australia, my name would be in every newspaper, and I would never get back on a program in Australia . . . " (Wilson, 1992, p. 4).

The Infertility Medical Centre running the program involved in the case is based at Epworth Hospital. The doctor concerned has been a consultant to the Donor Insemination Service at the center since 1978. According to Caroline Wilson's report, in August 1991 the woman received a letter from a man who claimed to be a Roman Catholic priest, accusing her of being "an abortionist and a murderer." This letter was followed by 10 anonymous phone calls early in 1992. Consequently, in February 1992 the woman called the doctor concerned and told her of her concern for the security of her medical file. The doctor assured her that the file was secure. However, the woman told the court, the letter and the calls "triggered off, obviously, the rebirth of the whole thing again. It has always been in the back of my mind, it's not something that ever goes away" (Wilson, 1992, p. 4).

The alleged sperm mix-up occurred in May 1983. Because it was so long ago, and outside the 6-year limitation-of-actions period, it was necessary to seek leave of the court to issue proceedings and take action under section 23A of the *Limitation of Actions Act* (1958). Under this act, an argument can be made by a prospective litigant that she can bring the action out of time, because her reasons for not doing so earlier are within the terms of the Act and can be excused.

THE POLITICS OF CONFUSION

One of the most powerful philosophies underlying IVF and other new reproductive technology programs is that the "right" child should be the outcome *of the technology*. This ignores the reality that humans, and most specifically women, are at the center of any "successful" outcome of the programs (though are not responsible for the failures of technology). It is from women that the ova come that are used on any program. Without women, there could be no programs. It is women who, by reason of their physiological capacity, nurture and give birth. Without women, there would be no births. Yet the philosophy of the "right" child imports into the programs a notion that it is the technologists, the scientists, and the doctors (and sometimes veterinarians) who "create babies" through *their* efforts. It also gives rise to a belief, on the part of the women concerned, that *they* fail if the technology does not produce a child through laboratory failure. Now the woman fails by not being implanted with the "right" embryo, not producing the "right" child.

It can hardly be surprising that, sometimes, in IVF programs or artificial insemination programs, something "goes wrong": that "something" being the injection of the "wrong" sperm into the "right" ovum. (Or, no doubt, the "right" sperm into the "wrong" ovum.) In a very real sense, an important aspect and outcome of these programs is the

creation of confusion as to precisely what is a mother? What is it *to be* a mother? What is a father? What is it *to be* a father? Arguments begin to center around the questions: Whose sperm is it? Whose ovum is it?, as if these are the central questions in the "creation" of fatherhood and motherood. While the Women's Movement works hard to develop a concept and practice of fatherhood that involves social parenting and commitment, the new reproductive technology movement works assiduously to demote the concept and practice of motherhood to the traditional notion of fatherhood: Biological relationship is all.

As the Melbourne case is currently before the courts and thus sub judice, it must be put to one side: Because it has not yet been decided, no one is entitled to speculate upon the content of the case or its possible outcome. The totality of the evidence will be revealed in due course, and cannot now be the subject of critical comment.

Yet there have been other cases, in other countries, where similar difficulties have arisen. Some years ago in the United States it was reported that a woman, a "client" of an IVF program, had given birth to a black American child. The woman was a white American, as was her husband. There had, it was reported, been an "error" in the selection of sperm for injection into the ovum that was finally transported back into her womb (Rowland, 1992, p. i).

"Image bank" is a title given to the place where receptacles store sperm waiting to be injected into an ovum. The stated aim is that the "clients" will be "matched up" to the sperm available: If the "clients" are Caucasian, then the sperm with which they are provided will be Caucasian. More specifically, if Anglo-American (or white Australian), then the sperm should be Anglo-American or white Australian. If the woman does not produce an ovum (or according to medical determination her ova are no "good" enough) and therefore an ovum donor is necessary, the idea is that an ovum (or more often, ova) will be "matched up" to the "client" couple.

"Human error" is inevitable: There can be no pretense that never will there be an incorrect "matching up"; a mistake as to which sperm is in what test tube; a "mix-up" of ovum; accidental destruction of sperm or ovum so that a substitute must be found, with attendant possibility for mistakes; wrong labeling; even deliberate "sabotaging"; or perhaps the desire to engage in experimentation, swapping and changing ovum, sperm, and "client" "receptors." But there is an additional issue here: Built in to the program is confusion. And, we need to ask, is it deliberate or unconscious confusion?

The confusion or "unknowing" of doctors and academics is illustrated clearly by two Melbourne professors, one a medical practitioner, the other an ethicist. Both take the position that, if a woman gives birth to a child following the implantation of a fertilized ovum, the ovum having been produced by another woman, the birth mother will not have a "relationship" or not as strong a "relationship" with the child as she would have had, had the originating ovum been from her own body. Professor John Leeton of Melbourne has said:

> IVF surrogacy [using the commissioning couples' sperm and ova] is superior to any other surrogacy because the child will be totally theirs genetically – her egg, his sperm – and the risk of the surrogate [sic] mother bonding to the child after that pregnancy is less . . . this is the point that everyone is missing, the vital point. (John Leeton, quoted in Monks, 1989, pp. 12-13)

Peter Singer of the Monash Bioethics Center says:

> The difference is, of course, that the surrogate who receives an IVF embryo has no genetic relationship to the child she

> carries. Attachment may still, of course, occur; but it is plausible to suppose that the lasting effects of separation will be less severe when the surrogate has no reason to think of the child as "her" child, but rather as the child "looked after" for nine months of its life. (Monk, 1989, p. 13)

Every woman has always had the certainty that the child she bears is "hers." About that, there can be no mistake. Never could any man be certain beyond doubt that a child was "his." Even in situations where women have been guarded, tied up in "chastity belts," kept together in harems and thus presumably out of the presence of men other than the husband, or isolated by other means so to be away from interaction with men other than the husband, a man has never had the same certainty as does a woman that a child is the result of the injection of an ovum by his sperm. IVF and other new reproductive technologies now make this uncertainty real for women, too.

Instead of working to create a world where "ownership" of children is not the basis for parenthood, those favoring new reproductive technologies and running the programs appear to have done more than the opposite. They have brought into use a technology, the essence of which is the creation of so-called certainty for men as to their fatherhood of a child: If the ovum is taken out of the body of their wives (or some other woman), and fertilized in vitro by sperm, then they can have control over what sperm is used. The possibility for men thus is (in theory) for as great a certainty as a woman of "parenthood" (defined in these terms). Their position is even more enhanced: Now the woman has an uncertainty she has never experienced before.

Yet, ironically, as the American example shows, any aim of scientific certainty for men in the childbirth stakes has not achieved its goal. Even the scientists and medical fraternity have no absolute control or certainty over "fatherhood" defined in this limited (biological) way. Human error in sperm storage and utilization cannot be eliminated. The end result is that men do not have a fail-safe mechanism for determining the biological origins of children to whom their wives give birth. And women have become equally uncertain of whether the ovum that is fertilized by the sperm, then replaced as an embryo back into the uterus, is indeed that self-same ovum removed from the ovaries associated with that particular womb.

If the aim of IVF programs is to enable a man to be certain about his paternity, then that goal remains elusive: Uncertainty has been created for both putative father *and* mother. If, on the contrary, the aim of IVF has been to duplicate for women as parents the uncertainty that men experience (or make women uncertain, men more certain), then on the one hand, the programs have succeeded, at least in the formal sense, while on the other, they have not. The process of developing and nurturing an embryo and fetus, and giving birth to a child, is not solely reliant on an ovum, nor on an ovum injected by sperm. This process requires nurturance, the giving of oxygen, the giving of nutrients, and the growth of the fetus for 9 months. Whether the ovum was produced by the woman in whose womb it is nurtured or not, her body, herself, is directly associated with the development of the child in an extraordinarily intimate way. For women, the confusion as to "whose ovum" is subsumed within the certainty that the ovum is nurtured and brought to term within the body of the particular woman – the childbearer. The developing embryo and fetus is herself.

To say, as does Peter Singer, that it is "plausible to suppose that the lasting effects of separation" from a child born from a "foreign" ovum will be "less severe" than when the woman gives birth to a child from her "own" ovum, is to ignore the developmental process that occurs during pregnancy. It is only more "plausible" to those who have no conception of what it is to carry a fetus to term. As

Barbara Katz Rothman points out, for a woman, "bonding" (as it is called by the so-called experts) does not begin for a woman when she holds a child in her *arms*; rather, the connection between a woman and the fetus begins when the fetus is a part of her body.

There is a parallel between IVF and developments in diagnostic technologies employed during pregnancy. Just as IVF and other reproductive technology programs import the idea that a woman can disassociate from a child she bears because it was conceived from an ovum not produced by her body, diagnostic technologies are used to affirm to a woman that the pregnancy is "real" and that the fetus is "normal": Thus a woman is taught to disassociate from the developing ovum in her body, until she gets the "okay" from a higher authority (the doctor – and his technology) that she has a fetus she can appropriately bring to term. Barbara Katz Rothman writes:

> A diagnostic technology that pronounces judgements halfway through the pregnancy makes extraordinary demands on the women to separate themselves from the fetus within. Rather than moving from complete attachment through the separation that only just begins at birth, this technology demands that we begin with separation and distancing. Only after an acceptable judgement has been declared, only after the fetus is deemed worthy of keeping, is attachment to begin.
>
> Reality has been turned on its head. The pregnancy experience, when viewed with men's eyes, goes from separation to attachment. The moment of initial separation, birth, has been declared the point of "bonding", of attachment. As the cord is cut, the most graphic separation image, we now talk of bonding . . . viewed from men's eyes, the movement of our babies from deep inside our bodies through our genitals and into our arms was called the "introduction" or "presentation" of the baby. Only when we touched our babies with the outside of our bodies were we believed to have touched them at all – using man's language we say of women who's babies died or were given away, that they "never touched the baby, never held the baby." (Katz Rothman, 1986, pp. 114–115)

Only a man could say that this is the "point that everyone is missing" (Monk, 1989, 12-13). Rather, the point that is being missed is that an embryo and fetus are a part of a woman's body until she gives birth to a child, and that an embryo and fetus grow within a woman's body, intimately touching the innermost part of her; an embryo and fetus grow as a part of her body, solely as a consequence of her nurturance, her blood supply, and her oxygen supply. The embryo and fetus are an intrinsically incorporated "being" within her own being, a part of her being.

THE POLITICS OF COERCION

What of the possibility of duress or coercion where women are IVF "clients" or "patients"? Women on IVF and other reproductive technology programs do not generally speak publicly about "coercion," "undue influence," or "pressure." Yet, as Renate Klein found in her research involving women who had *come off* these programs, such coercive factors did play a part. Speaking of the "world view" that it is the woman with the "infertility problem" rather than the man, and which precipitates women into infertility programs and, ultimately, IVF, one woman said:

> Eventually I told more and more people that it was Norm's problem because everybody assumed it was my fault and *I felt very pressured by their patronizing approach* [italics added] to me. (Klein, 1989, p. 13; see also Klein, 1988, pp. 11–13)

Another reported:

> In retrospect I realized it was a big mistake not to see a therapist before beginning IVF. I wasn't at all sure whether I had the energy to try again – and to cope again with disappointment. But *I felt everyone was pushing me into it . . . gently but steadily* [italics added]. . . . my husband, my mother, my best friend, even a girl at work whom I had told about it. *I felt really caught* [italics added]. . . . When we went to the initial counseling *there was no space to say any of this* [italics added]. We were given the impression that it was a big privilege to be accepted – and we were – so we had to be grateful. I shut up and began three years of utter misery (Klein, 1989, p. 21)

Doctors, too, are involved in coercive tactics, as one woman points out:

> When I first came with my list of questions, Dr. X patted me on my head and said, "Now don't you worry your little head off. We know what's best for you, *so if you co-operate and stop worrying you'll have a good chance* [italics added]." Later, however, he stopped being so "nice" and *once, when I complained about his assistant being too late for egg pick-up – which means that I had missed my chance that month – he commented sharply. . . . "Doctor's wives always cause trouble," and, "You want a child, don't you? If you do, then give up your job, stop being a problem and co-operate." So I felt I had to shut up or risk delay on the program* [italics added]. (Klein, 1989, p. 39)

In the law, originally "coercion" related only to actual violence or threats of violence, either directly or through an agent, to a person entering into a contract. This narrow notion of duress has been expanded to include other forms of pressure, such as economic duress (Starke, Seddon, & Ellinghaus, 1988, p. 317). Whether it will expand further to include duress of the type experienced by women who are "required" by doctors to be compliant and uncomplaining in order to remain in reproductive technology programs is a question not yet answered by the law.

For an agreement to be nullified or set aside, a person can show she (or he) has been forced unwillingly into the contract (this is coercion or duress), or that she (or he) has been "only too willing" because one party has taken unconscientious advantage of a position of dominance or ascendency (this is undue influence) (Starke et al., 1988, pp. 318, 323).

In *Universe Tankships of Monrovia v. International Transport Workers Federation* (1983, p. 614) it was said that duress in all its forms requires two elements:

- pressure amounting to compulsion of the will of the victim, and
- illegitimacy of the pressure exerted.

Compulsion means "effective lack of choice which may be evidenced by protest, by lack of independent advice or by resort to legal process, though none of these is essential to prove compulsion" (Starke et al., 1988, p. 319).

In *Union Bank of Australia Ltd v. Whitelaw* (1906, p. 720) "undue influence" was defined as "the improper use of the ascendancy acquired by one person over another for the benefit of himself or someone else, so that the acts of the person influenced are not in the fullest sense of the word his [or her] free, voluntary acts." Where a confidential relationship exists between the parties, then "the fact that the confidence is reposed in one party either endows him with exceptional authority over the other or imposes upon him the duty to give disinterested advice. The possibility that he may put his own interest uppermost is so obvious that he comes under a duty to prove that he has not abused his position" (Starke et al., 1988, p. 324).

Lena Koch's Danish research illustrates how doctors can use their position of influence to extract "agreement" from women in IVF programs. Does this fit within the legal standard of "abuse of position"? There can be no doubt that the doctor-patient relationship fits squarely within the legal concept of a confidential relationship with consequent legal implications.

Lena Koch writes of a woman who had been in an IVF program and participated in a special experiment carried out in the 1980s:

> Elizabeth is a woman who basically accepts the idea of IVF technology. But she has trouble when she considers what IVF research and experimentation implies. "I am worried about the experiments. I refuse to think that they experiment on my eggs. I know they fertilized some of my eggs and never transferred them. *I don't want to think that I might have reason to doubt them, and I believe them because of the power and authority they have* [italics added]. (Koch, 1989, p. 108)

Koch goes on to point out how Elizabeth's feelings "oscillate between faith and doubt":

> "*Once you're in the experiment, you have to have faith in them. We believed in them because we thought we were in their power. The 'girls' accepted a lot. Somehow you become dependent on them* [italics added]." These women were treated and forced to behave like children: "When I came in to have my hormone levels tested I would ask: "Have I behaved properly since yesterday?" (Koch, 1989, p. 108)

Brigitte Oberauer's example of a woman undergoing "harvesting" of egg cells in an Austrian hospital illustrates the problem of undue influence involved in a confidential relationship of doctor to "patient," and coercion or duress. She writes:

> Standing there watching, I . . . experienced the woman's humiliation. She lay with her legs apart on the chair. Dr. M. sat between her legs and introduced the vaginal scanner. At each follicle puncture he retracted the needle and then drove it in hard – a movement very similar to the act of penetration. All the other students had their eyes fixed on the woman's genitals. After the fifth follicle had been sucked out, *the woman asked him to stop, because she was in great pain. But Dr. M. would have none of that: "There are still such beautiful follicles" and so the sixth and seventh follicles were punctured against her will* [italics added]. And again she winced, again each puncture unmistakably resembled a penetration. Finally when all seven follicles were punctured, an eighth black dot appeared. *Although she implored him to stop. Dr. M. insisted on continuing. After the puncture it was found that the black bubble was a cyst which was then immediately aspirated* [italics added]. (Oberauer, 1989, p. 114)

THE POLITICS OF CHOICE

How real is a choice made by women involved in a power relationship in the situation in which they are said to exercise free will, consent, or choice? Wendy Savage acknowledges that birth and power is an issue arousing "strong emotions because birth is a profoundly moving experience for all those who participate in the drama, whether as the person who should be the central point of the whole event, the woman, or the person who should be in a supporting role, the midwife or doctor" (Savage, 1986, p. 175). She goes on:

> Birth arouses primitive and elemental feelings within us, reawakens unconscious or conscious memories in connection with our own beginnings and those of our siblings. It reminds us of death as well as

> life, and the awareness of the tragedies which do still occur is not far from the surface. (Oberauer, 1989, p. 114)

For women who are classed as "infertile," or who effectively are placed in that category as a consequence of their husband's infertility and resort to IVF and other new reproductive technology programs, the emotions and elemental feelings will be likely to be even more emphasized. Power is never absent in a situation where a woman makes the "choice" to become an IVF "patient."

The "choice" is rationalized in many ways. As Robyn Rowland points out, where a woman denies that she has maternal "feelings" for a child or children born of "surrogacy" where an ovum or ova not hers, biologically, are used, her words effectively reveal another dimension:

> A powerful example of selfless surrogacy is that of Pat Anthony, the South African grandmother who gave birth to triplets conceived using her daughter's egg and her son-in-law's sperm – although she had decided never to have any more children after the difficult birth of her son. At forty-eight, she faced considerable risks, particularly after it was discovered that she was carrying triplets, which were eventually delivered through Caesarian Section. She denied having any maternal feelings for her babies, often described as her grandchildren, saying: "I don't feel any strong maternal instincts or urges. I am doing this because my daughter, not me, was desperate for children and unhappy because of it." Ironically, while *denying maternal feeling towards the babies, she is the epitome of maternal self-sacrifice with respect to her daughter* [italics added]. (Rowland, 1992, p. 177)

Doctors and ethicists advocating IVF surrogacy with "foreign" ova may see the words of Pat Antony as supporting their position: Pat Anthony denies feelings for children she has borne, on the stated basis that they are "not hers" – because the ova were not. Yet this again limits the notion of maternal feelings to the narrow dimension often given to paternal feelings: the idea that a father will feel deeply only if he can be sure that the children are "his" (the "result" of his sperm, that is). The question to be asked is whether the mother/ grandmother would have felt no maternal feelings toward the children had they been born not from her womb but from the womb of her daughter. The answer surely is that she would be more likely than not to experience caring, compassionate feelings that we in this world describe as "maternal" or "female" toward the grandchildren born under "normal" circumstances of conception and birth. Why, then, does she state so surely that she has no maternal feelings toward them when they have been born from her own body?

The commonsense reality that a child is more than an egg is expressed by Mary Beth Whitehead, now known worldwide as the "surrogate mother" (but more properly the birth mother) of Sara Whitehead:

> I remember the inseminating doctor telling me that I was giving away an egg. I didn't give away an egg. They took a baby away from me, not an egg. That was my daughter. That was Sara they took from me. (Klein, 1989, p. 142)

> It wasn't until the day I delivered her that I finally understood that I wasn't giving Betsy Stern her baby. I was giving her my baby. (Klein, 1989, p. 140)

Similarly, Deborah Snyder of Michigan says:

> I was fine. Then I looked down at her – I went to get out of the car to give her to her

> parents and I just collapsed, sobbing uncontrollably. I don't know what did it; I wanted them to have her – I knew I couldn't raise another baby – but something hit me . . . I wanted to leave first – I didn't want to watch them drive away with her. I had a week off from work and some times during the day I would start crying for no reason . . . I'm not crying anymore – I still notice babies though and I try to imagine how big she's getting – I don't think that will ever stop . . . *I made her and I made her life* – it was worth it -but I wouldn't do it again, because I now know how hard it is. (Grossman, cited in Rowland, 1992, p. 189. footnote 84)

At the other end of the scale, making the choice not to become involved in IVF and other "treatments" for a condition classed as infertility is difficult. Alison Solomon writes:

> About a year after I'd started infertility treatment I became involved with the Women's Movement. Even there I discovered that whenever I brought up the subject of my infertility, there would be a total lack of understanding. I would be told (by women who had children, or had made a conscious decision not to have children) that it shouldn't be so central to my life. I felt that my feelings and my reality were being denied. Yet I felt that a feminist approach could be helpful to myself and other women and I began to think about the idea of a self-help group for infertile women. When I mentioned the idea to one of the women at the infertility clinic she said she had enough of her life revolving around her infertility without going to a group devoted to it. . . . (Solomon, 1989, p.175)

That feminists pose questions about "choice" in the context of new reproductive technology programs leads to charges that feminists see women only as victims, without rational will, helpless, hopeless, and unable to engage in autonomous action. Yet to recognize power differentials is not evidence of a lack of recognition of the power women do have. Nor is it outside the ken of the legal system itself.

The law recognizes many situations where people can be manipulated and unfairly dealt with as a consequence of differences in power, and as a result of existing relationships – whether familial, fiduciary, or confidential. The law of contract has developed various principles for recognizing that a person in the less powerful position may be taken advantage of, and "agree" to a contract or to contractual terms that are highly disadvantageous to her or him. "Unconscionable contract" doctrines specifically cover this situation. Statute law, passed by parliaments, has also stepped in to fill gaps where the law developed by the courts does not adequately acknowledge power differentials and the negative consequences they can have upon persons operating in the world as it is.

In Australia, for example, laws exist dealing explicitly with consumer credit transactions. These laws acknowledge that an individual consumer can be overwhelmed by the superior knowledge, financial acumen, and economic power of the finance provider – such as a bank or finance house. Consumer credit contracts can be reopened and the courts or tribunals have the jurisdiction to alter the financial arrangements, the terms of the contract, and the relative rights of the parties in any way the court or tribunal considers is necessary to make the arrangement "fair." The court or tribunal can set aside a contract or mortgage or guarantee completely, absolving the consumer from any further responsibility in relation to it. The matters that can indicate that the consumer has been unfairly dealt with include:

- o whether or not there was any material inequality in the bargaining powers of the parties;

- o whether or not it was reasonably practicable for the consumer to negotiate for the alteration of, or to reject, any of the provisions of the agreement;
- o whether or not any of the terms of the agreement impose conditions that are unreasonably difficult to comply with, or not reasonably necessary for the legitimate interests of the finance provider;
- o whether or not the consumer was reasonably able to protect his or her interests;
- o whether or not, and when, independent legal or other expert advice was obtained by the consumer;
- o the form of the agreement and the intelligibility of the language in which it is expressed;
- o whether undue influence, unfair pressure, or unfair tactics were exerted on or used against the consumer by the finance provider or any person acting or purporting or appearing to act for the finance provider or any other party to the agreement;
- o the conduct of the parties in relation to similar agreements to which any of them has been a party; and
- o the commercial or other setting, purpose, and effect of the agreement.

Anyone who might attempt to suggest that it is "wrong" for consumers to have available to them provisions of the *Credit Act* (1984) has little credibility. No one is taken seriously who asserts consumers, by reason of the existence of such laws, are being treated as perennial victims, unable to help themselves, hopeless, lacking dignity, and unable to engage in independent negotiations with others, whether individuals or large finance houses and banks. Why, then, when it comes to medical "treatment" such as IVF and its associated programs, should it be persuasive that women ought to be categorized as self-sufficient, in control, and with no right of recognition of differing authority and power?

CONCLUSION

Rather than demanding that women live up to an artificial standard that is not required of others, where questions of choice, consent, and coercion arise, it is important to recognize the social, cultural, and political underpinnings of IVF and other new reproductive technologies. Women are vulnerable to coercion and duress in many of their forms. This vulnerability does not lessen when women take on the "patient" or "client" role in an IVF clinic. It is a vulnerability experienced by all who are in a less powerful position, whether the position of lesser power is dictated by sex, race, minority ethnic background, understanding of the dominant language, class, or economics. Often the vulnerability of women is magnified by the existence of more than one of these factors; that should not be a reason for excluding women from legal recognition of the vulnerability.

Women must be wary of arguments that do not take into account the political nature of the world in which we live. We must beware of arguments that attempt to throw back on to women a responsibility that is not demanded of others. Arguments depending for their force solely on the notion that women are possessed of equal power as men, or should see ourselves in that light, are designed to disempower us further. Just as the "personal is political," women must be ever mindful of the reality that the political is personal. Autonomy for women will not come about because those who have a stake in power differentials as they are assert that women are autonomous and that the choices women make are free of coercion.

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