The following are excerpts from the testimony of Lynne Millican RN, March 27, 2003, to Congress concerning the lack of informed consent to risks of fertility treatment. Full document and citations can be found on ‘Documents’ page:

“ … In February 1995 I noticed a surrogate ad running in a college newspaper, offering $17,000 plus expenses to carry the gift of life for an infertile couple, and I called the ad. A Dr. Radecki answered the phone, and I heard all about the wonders of IVF and “there were no long-lasting risks” and “no one ever suffered serious harm from the drugs.” On March 21, 1995, I was surprised to see CBS Evening News interviewing this Dr. Radecki - and became even more surprised to learn that Dr. Radecki was not a fertility doctor - he was a psychiatrist who had lost his license for sexually abusing his patients. By the end of March 1995, Dr. Radecki had closed shop - the telephone number for the surrogate ads was disconnected, the ads were gone, and he was under siege for misrepresentation.

A TAP advertisement in a fertility journal gives a glimpse into the sly canvas upon which the industry paints its picture: This TAP Lupron ad read: “Remote Control: Your patient with endometriosis doesn’t have to remember her daily therapy - Lupron Depot 3.75 mg remembers it for her. ... She only needs to remember six monthly visits.” (Ad, 1992). Nowhere does the consumer learn that memory loss has been known to be “a commonly observed” side effect to Lupron, or that patient noncompliance with daily Lupron could likely have been related to a memory disorder (listed as a known adverse event to Lupron), or that clinical trials conducted for Lupron depot approval utilized methodologically flawed study design that was conducive to subjects forgetting adverse events (surveyed every 30 days). …

A recent Popular Science article unintentionally highlights the issue of consent: in the March 2003 series, the McNamara’s were featured as they had undergone experimental fertility treatment using cow uterus to grow their embryos. This Popular Science piece examined the risks of ART, and the McNamara’s conclusion at the end of this article was “Yeah, there is [a possibility of long-term effects] ... But ... we would still have done it.” (Skloot, 2003). However, Popular Science held a Popular Science Infertility Chat on America Online, and, in fact, the McNamara’s stated in the chat - after they had read the article - that “I think it’s important to point out that the information in the article wasn’t available when we made our decisions. .... Honestly, if it was presented in a way that it would cause trauma to our offspring, we probably wouldn’t have done it.” (Chat, 2003)

(2) Dead Women Don’t Talk:

Not until long after my fertility treatment did I learn that, before my treatment, there were questions raised and warning given regarding the fertility industry’s use of lack of informed consent, deceptive advertising and manipulated statistics. The first survey in the world of IVF clinics was done by two journalist/authors, Gena Corea and Susan Ince, and this survey revealed that while half of responding clinics had claimed high success rates, they had, in fact, produced not one baby (Corea, 1987). In 1992 I had begun legal action against my fertility treatment providers, and in 1997, Gena Corea (see also Corea, 1985) provided a statement to me intended for inclusion into the Offer of Proof for my medical malpractice tribunal (Millican v. Harvard Community Health Plan, Boston IVF, Natalie Schultz M.D., Brian Walsh M.D., Mahmood Niaraki M.D., Selwyn Oskowitz M.D., Michael Alper M.D.) The following 5 paragraphs are from that statement:

“... A lack of informed consent to IVF has been a constant and continuing problem with IVF from its earliest days when Lesley Brown, pregnant with the first IVF baby, Louise, was under the misapprehension that hundreds of such babies had already been born. She had no idea that she was in such an experimental program. ...”

“ ... The exact number of women who have died in in vitro fertilization programs is not known. However I have information on the deaths of ten women: in Germany, Brazil, Israel, Spain, and Martinique (in all these countries, I have tape-recorded interviews with the physicians and/or relatives of the dead women), and in Australia, New Zealand and Canada. Women entering IVF programs do not know of these deaths. Even physicians practicing IVF do not know of most of the deaths or their causes. With the exception of the Israelis, the IVF teams involved are not writing reports on the deaths for their professional publications nor are they delivering papers on the deaths at international meetings ... No professional or governmental organization is recording the deaths in a data bank.”

“Some Brazilians know of the first death -- of a woman named Zenaide Maria Bernardo, whose daughter and physician I interviewed in, respectively, Araraquara and Sao Paulo, Brazil. They know of her death because it occurred during a course on IVF for physicians and the course was a huge media event, covered by Globo, a national television station and the fourth largest in the world. The death could hardly be covered up when the television cameras were rolling. But aside from these Brazilian citizens, few in the public know of any IVF deaths.”

“To date, IVF deaths are known to have occurred due to hyperstimulation of the ovaries through the administration of hormones; anesthesia for laparoscopy; infection following laparoscopy; bleeding following laparoscopy; bleeding following ultrasonically-guided puncture of egg follicles; and ectopic pregnancy.”

“Physicians and the public relations firms hired by the IVF industry often give women the impression that IVF is a low-risk procedure. How do they know it is low-risk? I have interviewed physicians around the world on IVF deaths and without exception, I have known of, and had documentation on, more IVF deaths than any of them claimed to. Why is that? If scientists doing IVF do not know of the deaths their programs are causing, why don’t they? What are the mechanisms by which this information has been obscured? Through their journals and conferences, physicians share information on every slight change in drug protocol for inducing artificial ovulation. Shouldn’t information on deaths, injuries, psychotic breaks, lengthy recoveries also be shared? It’s not. ...” …

“Inclusion of patients with a poor response to GnRHa therapy has not always occurred in outcome analysis in the published medical literature.” (Redwine, 1994). Conflicts of interest are extensive, troubling, and have far reaching consequences upon standards of care and the state of science. Two cases in point: Another lead Lupron investigator alleged in a study that reduced bone mass was associated with endometriosis (Comite, 1989), yet another investigator with contrasting findings reported that “One explanation for the difference between the results of this study and those of Comite et al. is that they included women who previously had been treated with GnRH agonists and these agonists are associated with bone loss.” (Dochi, 1994). (See www.lupronvictims.com, ‘Endometriosis’ for further elaboration on these studies). Claims of the disease endometriosis being associated with bone loss, while deliberately omitting patient’s prior use of GnRHa (which is known to causes bone loss), is a perilous concept of manipulating iatrogenic, adverse, drug effects into a disease-related non-tort phenomenon - and deserves attention.

A 2002 Human Reproduction article, ‘High rates of autoimmune and endocrine disorders, fibromyalgia, chronic fatigue syndrome and atopic diseases among women with endometriosis: a survey analysis’, co-authored by the President of the Endometriosis Association, failed to mention GnRHa’s within the article (Sinaii, 2002). The survey upon which the article is based, which was sponsored by Zeneca (1998), does contain reference to GnRHa use in survey participants. Despite the presence of a National Lupron Victims Network, with many women complaining of autoimmune and endocrine disorders, fibromyalgia, chronic fatigue syndrome, etc. post-Lupron, this article makes no mention of these adverse advents. … To date there have been a number of renowned reproductive physicians/surgeons who have been found to have fabricated and/or falsified data: Dr. Andrew J. Friedman, a lead investigator for Lupron, recipient of many TAP grants to study Lupron, and director of Brigham & Women’s IVF Program (where this writer was mandated to use Lupron), was found to have falsified and fabricated approximately 80% of the data in 2 published, and 2 unpublished Lupron journal articles (Federal Register, 1996). Is it any wonder that during the time Dr. Friedman was director of Brigham & Women’s IVF Program, the criteria for the administration of Lupron with IVF changed from “Lupron is only used in certain diagnoses” to “Lupron is widely prescribed”? Where is the data to justify such widespread application of a hazardous, reproductive and developmental toxicant? …

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The father of GIFT, gamete intrafallopian transfer, Dr. Cecil Jackobson, rounded off his accomplishments with 52 convictions of perjury and fraud. He had been substituting his own sperm for that of some 75 women’s husbands’ sperm resulting in these women (initially) unknowingly giving birth to children fathered by this ‘expert’. To quote USA Today, “... His case taught a valuable lesson about the fertility industry: Self-regulation is not enough. ... Many of his most offensive acts were legal - like donating his own sperm. The only way Jacobson was stopped was on federal wire, mail fraud and perjury charges. ...” (USA Today, 1992).

The “Dyno Gyno”, Dr. Niels Lauersen (and a cohort) were convicted of billing fraud, “falsif[ying] bills to get $2.5 million in payments from insurers for a variety of fertility procedures” (Barrett, January 2001), and Dr. Lauersen was “jailed as flight risk” (Barrett, March 2001). Dyno Gyno loyalists attempted to assign this fraudulent billing as nothing but ‘an attempt to provide otherwise denied procedures’, causing “prosecutors [to] fume that the case is not about health-care policy, but a thief with a medical degree and a lab coat.” (Barrett, 2000). Of note is an aside mentioned in the latter article, which relates one loyal Lauersen patient’s position that women’s health issues don’t get enough insurance coverage. The aside is a description of this patient, “whose three children all needed special attention from the doctor due to different complications at birth.” (Ibid). No further elaboration is made on these “birth complications”, and the implications of such “complications” appear to be unrecognized.

And the story of Dr. Asch, et al. is well known: Dr. Asch, who was overdosing women in superovulation to steal their eggs and then sell them to researchers and other unsuspecting women, reportedly often left his office with a briefcase stuffed with thousands of dollars in cash - while he was also preaching and publishing on the psychological effect of egg donation on women (Lessor, 1993). ….

A renowned group of fertility experts published a study, a report of “the first case of human germline genetic modification resulting in normal healthy children” (Barritt, 2001), however the expert group “failed to disclose that along with 15 healthy babies it produced two foetuses with a rare genetic disorder. Experts are horrified because the fault can be passed to future generations” (Hill, 2001). The fertility clinic and fertility experts report published claims of healthy children from their procedure ... yet the Washington Post reported “[i]nternal documents from Saint Barnabas explicitly acknowledge that the novel technique may be causing the problem ...” (Weiss, 2001). The ‘Birth Defects Research for Children’ points out that “the two cases of Turner’s syndrome should have been mentioned in the report so that doctors and others would be aware of all the facts” (Birth Defects, 2001). The group would later report that the “children born after IVF with cytoplasmic transfer have been carefully evaluated and one 18-month-old child was recently diagnosed with a pervasive development disorder ... a broad spectrum of disorders with mixed prognosis. .... Because the procedure is experimental, protocols have been supervised and re-evaluated in 1999 and 2001 ... However, this research has been suspended since early July 2001, pending clarification of new requirements suggested by the federal Food and Drug Administration.” (Institute, 2001). Six years prior, in an abstract published by one of this group, 4 abnormal embryos were implanted into women - and this act brought little, if any, attention from anyone or anywhere. (Munne, 1995). At St. Barnabas’ webpage on egg donation (in which Lupron is used), the question of “What are the risks of being an egg donor” is answered ... “Donors may risk psychological distress if they are rejected from the program ...” (St. Barnabas, 2001).

The following are excerpts from the testimony of Lynne Millican RN on April 6, 1994 to the Massachusetts House of Representatives’ Health Care Committee concerning the risks of fertility treatment. (Full testimony and citations can be found on ‘Documents’ page ):

“ … But historically, fertility doctors have shown a poor track record in maintaining records; DES being one example. This can be further illustrated by another past fertility drug "misadventure" practiced by the U.S. (as well as in other countries). Human pituitary gland hormone (hGH), derived from cadavers, was administered beginning in 1963 as a fertility drug to infertile women and as a growth hormone to children with pituitary insufficiency. But in 1985, after two deaths in the U.S., investigation yielded the discovery that a fatal neurological disorder, Creutzfeldt-Jakob Disease (CJD), was associated with human pituitary gland hormone.

Quoting 'Overdue Acknowledgement? The Legacy of CJD for Australian Women Treated With Human Pituitary Gland Hormone for Infertility' from Lynette Dumble, Senior Research Fellow, the University of Melbourne, Parkville, 3052, Australia, and Renate Klein, School of Social Inquiry, Geelong, 2317, Australia (1992), (Synopsis also found in The Lancet, October 3, 1992): "It was suggested in 1985 that the first of the hGH-associated CJD deaths might represent the beginning of an iatrogenic epidemic, but by 1988, despite the emergence of further cases of CJD (in the U.S., U.K., and Australia), the basis for an international silence was established." "In the United States, where hGH use was abandoned in 1985, monitoring, surveillance and counseling of subjects at risk commenced immediately after the first CJD death in 1985 under the auspices of the FDA, CDC, NIH, and the Institutions who were responsible for hGH administration".

"More recent reviews of the U.S.A. and U.K. experiences have reported that CJD continues to occur in their respective hGH-treated populations and that they must remain under long-term review. The U.S.A. review points out that only 10% of their 6,284 recipients had been followed-up for the 15 year average incubation interval from midpoint of hGH treatment to the onset of CJD symptoms. As a result the great majority of potentially exposed patients have not yet attained the requisite incubation period for expression of CJD."

Therefore, as women in this country take approved fertility drugs that have never been properly tested, with evidence pointing to carcinogenic and teratogenic effects, and with no monitoring ... women (and children) exposed to a former, now-recognized-as-deadly fertility drug remain unsurveilled and presently are at risk for death. That this is disturbing is an understatement.

Given that the U.S. abandoned the use of the human pituitary gland hormone after two deaths, it would appear that two deaths from a fertility drug are the requisite red flag for intervention. I offer Gilda Radner and Barbara Mays as a tragic pair of deaths arising from current, approved, never properly tested, readily available, fertility drugs. Both took currently used fertility drugs and both died of ovarian cancer. (Was this why Barbara May's baby was "switched at birth"? Could someone have feared a relationship might be established with Barbara Mays use of fertility drugs and her offspring's congenital heart defect? Mother and child may well be victims from these drugs [fertility-drug conceived child died at age 9]). While their names are high profile, how many other unknowns are there out there? Without data tracking, we'll never know.

The number of women and children in the world who were exposed to the human pituitary gland hormone associated with CJD are estimated at 13,000 to 30,000; exact figures are unknown. As of 1988, 1.9 million women were estimated to have taken currently approved fertility drugs - and again, exact numbers are unknown. Clearly data tracking is in order here. …

Massachusetts currently has an epidemic of breast cancer, and has awarded millions of dollars in grants to study breast cancer. Though there has been a number of case reports of developing breast cancer following ovulation induction (bilaterally in several instances), not one grant in this high concentration of fertility clinics chose to examine this issue.

Ovarian cancer is the fourth leading killer cancer of women. Despite the lack of knowledge on the effects of superovulation on infertile women, now fertile women are being groomed for taking these drugs; to serve as either egg donors or gestational carriers, to undergo IVF for their infertile partners, for purposes of preimplantation diagnosis, or for menopausal pregnancies.

It is reported that there is a shortage of egg donors, yet there are an estimated 200,000-plus frozen embryos worldwide. Infertility and treatment options are prevalent and hyped in this country, yet the disasters of excess fertility are of paramount concern in the Third World and measures of sterilization and birth control reign. Fertility drugs are touted as safe, yet have never been tested. These deductions and concepts are baffling.

Equally baffling is the widespread use of lupron, a Category X drug, as an ovulatory adjunct in assisted reproductive procedures. Quoting the 1993 PDR under 'warnings', 'contraindications', and 'precautions': "Safe use of lupron in pregnancy has not been established clinically. Before starting treatment with lupron, pregnancy must be excluded" ... "Lupron is contraindicated in women who are or may become pregnant while receiving the drug. Lupron may cause fetal harm when administered to a pregnant woman. Major fetal abnormalities were observed in rabbits but not in rats. There was increased fetal mortality and decreased fetal weights in rats and rabbits. The effects on fetal mortality are expected consequences of the alterations in hormonal levels brought about by the drug. If this drug is used during pregnancy or if the patient becomes pregnant while taking this drug, she should be apprised of the potential hazard to the fetus" ... "safe use of the drug in pregnancy has not been established clinically. Therefore, a nonhormonal method of contraception should be used during pregnancy.”

As mentioned in my 1993 testimony "the routine use of GnRH-a (lupron) for all patients undergoing IVF has practical but no significant medical advantages ... there have been very few prospective randomized studies comparing the use of GnRH-a with conventional stimulation regimens" - citing 'Fertility and Sterility' April 1992 in 'The routine use of GnRH-a for all patients undergoing IVF. Is there any medical advantage?" The 'practical advantage' referenced is the fact that the clinic can schedule the woman for an 8:00 A.M. retrieval, thereby avoiding the disruption a 2:30 A.M. wake¬up would create. But what dangers does this chemical compound pose to the woman (either alone or synergistically with the fertility drug), how long does the chemical remain in her system, and what effect might it have on an embryo and/or offspring? Again, without data, these questions cannot be answered ... but they must be asked.

The following excerpts are from testimony of Lynne Millican RN on November 13, 1999 to the Massachusetts House Ways and Means Committee. The full testimony can be found on ‘Documents’ page:

“ … There are many terms used by the fertility industry to define "extra" human eggs or oocytes used in research. A read of reproductive medical journals has revealed that there are so many synonyms for these research oocytes that some of my notes are lost, but a partial list is as follows: "surplus" oocytes, "abnormal" oocytes, "left-over" oocytes, "discarded" oocytes, "spare" oocytes, "fertilized" oocytes, "unfertilized" oocytes, "suboptimal" oocytes, "nonviable" oocytes, "aspirated" oocytes. In a random 20 page examination of how many "extra" oocytes were being "shared" with fertility labs, I plucked the March 1995 Supplement to the Journal of Assisted Reproduction and Genetics [Vol. 12(3)] off the shelf and opened to page 123 S. I then counted 7,845 oocytes and 266 embryos used in research within a 20 page span. This is just 20 pages -from one journal, from one month, from one symposium, from one year, at one library. The Commonwealth's medical library stacks are full of reproductive journals, and the Commonwealth's fertility clinics are full of women. Women are full of oocytes, and the labs are full of gametes and genetic materials. Yet there is a lack of informed consent, lack of passage of House 3477, and the unconscionable lack of medicolegal advocacy.

The following are Excerpts from Lynne Millican’s 12-2-96 read/review of OurBodies OurSelves’ update to their ‘New Reproductive Technologies’ chapter. Full read and citations can be found on ‘Documents’ page:

“ … Since 1992, many issues and a growing number of different procedures have evolved in the field of reproductive technologies. Even though "present scientific evidence does not support the use of IVF for indications other than tubal blockage" (Buitendijk, 1995, p.901), and despite the lack of safety and efficacy data ... the indications for IVF and it's variants have exponentiated (endometriosis, subfertility, polycystic ovarian disease, unexplained infertility, male factor infertility, egg donation, surrogacy, preimplantation diagnosis, postmenopausal pregnancies, or simply to verify that fertilization takes place). There is a dizzying array of acronyms for the ever-expanding procedures: there's IVF, GIFT, ZIFT (zygote intrafallopian transfer), TET (tubal embryo transfer), FET (frozen embryo transfer), ICSI (intracytoplasmic sperm injection), SUZI (subzonal insertion), DIPI (direct intraperitoneal insemination), ICI (intracervical insemination), ITI (intratubal insemination), IUI (intrauterine insemination), SFR (selective fetal reduction).

Just in the last four years, for the first time in history: There have been virgin births; abnormal human embryos have been transferred into women undergoing IVF (Munne et al., 1995); fertility drugs are bought and sold over the internet (without benefit of prescription); fertility clinic solicitation of egg donors has become commonplace; human embryos have been cloned; and the possibility to transplant aborted fetuses' ovaries into women has emerged. One could bear one's own brother, or be the offspring of an unborn non-person. Human embryos are being grown in human ovarian-cancer cells (Ben-Chetrit,.et al., 1996), among other substances, for research, and embryonic kidney cells have been used to make recombinant DNA fertility drugs. The 1994 National Institutes of Health's Human Embryo Research Panel Hearings stated that there is much profit to be made in embryo research: "Therapeutic agents, vaccines, hormones, proteins, stem cells, gene therapy, cell lines, chimeras, patents" - all are potential products of embryo research (which cannot begin without eggs). A current goal is to mature oocytes in vitro, controlling in the lab the very development of eggs - rendering the woman dispensible to this process.

But while the many procedures, drugs, devices, and tests have been increasingly used on women, there has been a lack of informed consent provided to the women regarding the risks. "(E)vidence exists that there has been less adherence to appropriate disclosure of information by practitioners of assisted reproduction than is ethically required" (Macklin, 1995, p.486), and "at some centers, incomplete and misleading information is given to women" (Baird, 1995, p.494). "Physicians and the pharmaceutical industry are making huge profits treating infertility, and hyperstimulation drugs are central to their limited success in producing healthy infants. A powerful incentive exists to overlook or downplay any bad news." (Napoli, 1994, p.6).

While there appears to be a lack of informed consent regarding the risks of fertility drugs and treatment, these risks were openly discussed at the 1994 National Institutes of Health Human Embryo Research Panel Hearings. Dr. Van Blerkom, reporting the 'State of the Science of Human Embryo Research: "To IVF methodologies and techniques ... there are procedures done that I think a lot of you would consider experiment that are in clinical use. They have received no oversight, they have received no real evaluation. They're just done. This field is based on methodologies being introduced into clinical practice based on a few papers, based on a few studies, based on exchanges of information at meetings, without a thorough evaluation." ( Van Blerkom, 1994; p. 77). Panel member and Doctor of Philosophy, Carol A. Tauer: "I think we need to say something about the detrimental things that have occurred in the last 15 years, the fact that clinical work has gone on without the basic science to underlie it... I think the fact that research enterprise has gone on out there without peer review and without the appropriate safeguards is something very bad that has happened." (Tauer, 1994, p.54).

Women should pay particular attention to the issue of egg donation. As many as 91 eggs at one time were taken from one woman who was undergoing superovulation! While that number is extreme, the goal is to get as many as possible ... and women should be asking why is there such a demand for so many eggs. The fertility journals are rife with article after article using 'donor eggs' in research - if there is such a shortage, how is it that so many tens of thousands are available for 'research' ... and how would the healthy women who donates eggs "to give the infertile couple the child of their dreams" feel if her eggs were destined only for a lab?

Fertility clinics frequently target the young, healthy, fertile women for egg donation through college and parenting newspapers, and pay the woman up to $2000 and more for one round of hormonal stimulation and egg retrieval. The woman usually undergoes some form of psychological testing, in contrast to sperm donors who require no such psychological testing. One Boston fertility clinic advertises that it is located on the train line - an enticement for the economically disadvantaged women without means of transportation. There has been an estimated 200,000 frozen embryos in the world, while the demand for eggs is high and growing. There have been scandals of eggs stolen - at the University of California, Irvine, the inventors of the GIFT procedure, Drs. Asch and Balmaceda, have been charged with covertly using the eggs of women without their permission, and selling them to women as donor eggs (Kelleher et al., 1995). In a Rhode Island hospital fertility clinic, it is likewise charged that eggs were stolen and either sold to unsuspecting women or used in research. The inventor of amniocentisis, Dr. Cecil Jacobson, was found guilty of substituting his own sperm for that of the woman's partner, and fathered over 75 children. (And a Dutch couple undergoing IVF gave birth to twins, one black and one white - because the clinic had reused a pipette from a previous cycle, introducing two man's sperm to this woman's egg.).

"Current evidence indicates that most patients who donated oocytes during their own cycle of IVF treatment did not conceive" (Shenker, 1995, p.501). …

John A. Robertson states: "As more personnel become involved in handling gametes and embryos, the number of embryos lost because of negligent handling or accidents in the laboratory may increase. Often couples may not learn of these mishaps, but be told that "oocytes did not fertilize," that zygotes "did not cleave," or that "your embryos were not viable". ... Internal pressures to cover up errors should also be resisted." (Robertson, 1996).

Ovarian, breast, and endometrial cancers, visceral and vascular injuries, adverse neurological symptoms, memory complaints, bone loss, infections, and death are but a few of the known risks associated with fertility treatment and/or fertility drugs. Bacterial contamination following egg retrieval (transvaginal aspiration) "appears to occur commonly" (Saltes, 1995, p.658). Transvaginal oocyte aspiration is associated with varying degrees of bleeding and the risks of infections, visceral trauma, and risk of injury to blood vessels; and the trauma of puncturing follicles may interfere with the formation of functioning corpus lutea - one potential cause of the low pregnancy rates (Bequaert Holmes, 1988). Studies in mice who were administered superovulatory hormones developed malformations which was "transmittable to subsequent generations", and in human IVF embryos, a "higher than expected number of structural chromosomal anomalies" have been noted. (Kola, 1988, p146). "That superovulation is a problem that results in many abnormal embryos in universally recognized in animal breeding." (Moor, etal., 1985, p171)

Ovarian hyperstimulation syndrome (OHSS), in some degree, occurs in all women undergoing treatment with hMG/hCG (Golan, et al., 1989; Forman, et al., 1990) …

It has been noted that during GnRH agonist treatment, "ovarian cyst formation occurs ... the consequences of which are unclear" (Deidrich et al., 1991). "In humans, few experiments have been conducted on the biological action of GnRH agonists, with contradictory results." (Guerrero, et al., 1993). … "Identification of GnRH binding sites in tissues outside of the reproductive tract suggest that leuprolide [lupron] may have actions previously unsuspected. ... further investigation of GnRH agonists mechanisms of action are essential in view of the increasing clinical uses." (Blacker, et. al., 1991, p587). "... (A) substantial majority of the patients [72%] showed difficulty with memory while on leuprolide acetate" (Varney, et al., 1993; p.57) ... and "memory disruption may be a more common side effect of GnRH-a treatment than currently is recognized." (Newton, et. al., 1996, p.1253). …

There is a multitude of various sera that the embryo is cultured in - from fetal calf serum, to cancer cells, antibiotics, and hormones ... few studies have been done to assess the individual co-culture, never mind the synergistic effect of all the different variants that the egg and/or sperm has been exposed to.

Regarding the risk of ovarian cancer in fertility treatment, the International Federation of Fertility Societies (IFFS) stated during the 1995 International Consensus on Assisted Procreation: "Doctors ... must inform the patients and keep detailed files for further retrospective studies." In the United States, neither the government, research institutions, or drug companies have conducted long term studies on the effects of fertility drugs on the women or their offspring (Herman, 1994), and the long term health impacts of 'reprotech' are unknown (Ibid; Costigan, 1993; Napoli, 1994).