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## From Coitus to Commerce: Legal and Social Consequences of Noncoital Reproduction

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**FROM COITUS TO COMMERCE:  
LEGAL AND SOCIAL  
CONSEQUENCES OF NONCOITAL  
REPRODUCTION**

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Joan Heifetz Hollinger\*

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This paper owes much to discussions during 1984-85 with several colleagues, including Michael Wald and Robert Mnookin of the Stanford Law School and Emmet Lamb, Merton Bernfield, and Ernie Young of the Stanford Medical School.

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## I. INTRODUCTION

History's most famous infertile couple resorted to a surrogate mother. Many years before Abraham and Sarah were blessed with Isaac, the natural son of their old age, the "barren" Sarah had said to her frustrated husband: Abraham, take my slave girl Hagar and through her, I, Sarah, will have a family with you.<sup>1</sup> Then, as now, it was not so simple. Shortly after the surrogate mother Hagar became pregnant (through coital means, of course), she began to assert her superiority over Sarah. Is it possible to anticipate, and hence, mitigate the personal and psychological rivalry between a genetic and gestational mother and an intended rearing mother? The understanding that Sarah had reached with Abraham and Hagar could not be sustained. Sarah mistreated Hagar and Ishmael, the son Hagar bore for Abraham, and eventually drove them into the wilderness. Ishmael took with him a formidable curse: "He shall be a man like the wild ass . . . at odds with all his kinsmen," the Angel of the Lord told his mother.<sup>2</sup> Abraham's name and property would descend exclusively through the biological offspring of himself and his wife Sarah and not through Ishmael, his bastard son. Hagar's compensation was God's assurance that Ishmael, although cut off from Abraham's lineage, would become the father of a separate nation.

The Biblical cast of characters found surrogacy a problematic course, even with the benefit of the Lord's guidance. Today's participants in the various scenarios for "assisting" human reproduction and creating new family relationships face their share of problems too, but with what guidance? Our society is

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1. *Genesis*, 16-17.

2. *Id.*

uncertain about how to respond to the legal, ethical, and psychosocial consequences of artificial insemination, *in vitro* fertilization, embryo storage and transfer, and hired baby-bearers.<sup>3</sup> In relying on our technological capacity to separate the genetic from the gestational aspects of reproduction<sup>4</sup> and in paying for the use of a third person's sperm, ova, embryos, or womb in order to produce a "child of their own," should involuntarily childless couples<sup>5</sup> be left, as it were, to their own devices?

At present, there are no federal<sup>6</sup> or state laws<sup>7</sup> that prohibit research on or the use of *in vitro* fertilization and embryo transfers to relieve infertility. Nor do any federal or state laws directly encourage or provide funds for such research or treat-

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3. Hereinafter, artificial insemination will be referred to as AID, *in vitro* fertilization as IVF, embryo transfer as ET, and hired baby-bearers as surrogate gestators or uterine hostesses.

4. It is already possible for a child to have five different "parents": the woman who donated the egg, the man who donated the sperm, the woman to whose womb the fertilized embryo is transferred so she can carry it to birth, and the man and woman who will receive and presumably raise the infant. Andrews, *The Stork Market*, 6 WHITTIER L. REV. 789, 791 (1984).

5. The "involuntarily childless" characterization comes from Leon Kass and is in my view preferable to the words "infertile" or "sterile." It does not carry the potential stigma of "barrenness" implicit in those words and it is a broader and more accurate characterization of idiopathic or medically inexplicable kinds of infertility as well as of clinically diagnosed kinds. See Kass, "Making Babies" Revisited, 54 PUB. INTEREST 32 (1979). I will, however, for the sake of economy of language, use the word infertile more often than "involuntarily childless" to describe the persons most likely to resort to the new reproductive technology.

6. Although in 1979, the Report of the Ethics Advisory Board (EAB) to the Department of Health, Education and Welfare (HEW) concluded that, under certain circumstances, it would be appropriate for the federal government to support IVF research, it did not make any specific recommendation that the National Institute of Health (NIH) provide funds for such research. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ETHICS ADVISORY BOARD, REPORT AND CONCLUSIONS: HEW SUPPORT OF RESEARCH INVOLVING HUMAN IN VITRO FERTILIZATION AND EMBRYO TRANSFER, 44 Fed. Reg. 35,033 (1979) [hereinafter cited as EAB REP.] The EAB was terminated in 1980, and since then, neither HEW's successor, the Department of Health and Human Services, nor NIH has shown any interest in pushing for federal support for IVF or ET research. The best account of the political and other reasons for the persistent lack of federal involvement is Abramowitz, *A Stalemate on Test-Tube Baby Research*, 14 HASTINGS CENTER REP., Feb. 1984, at 5. The Reagan Administration is decidedly opposed to IVF or ET research. This prompted the chief of pregnancy research at NIH to resign in protest of what he called the government's failure to fulfill its responsibilities to infertile couples and "generations of unborn." *The New Origins of Life*, TIME, Sept. 10, 1984, at 46, 53.

7. Although many states have statutes restricting fetal research, these have generally been construed as not restricting IVF or ET research or procedures because they occur prior to implantation of a fertilized ovum in a woman's uterus and, therefore, prior to the creation of a fetus. A concise overview of these statutes is in Quigley & Andrews, *Human In Vitro Fertilization and the Law*, 42 FERTILITY & STERILITY 348 (1984). In contrast to the ambiguous definitions of "fetus" that are used in some of the state statutes, the federal guidelines for fetal research are more precise. A fetus is defined as "the product of conception from the time of implantation," 45 C.F.R. § 46.203(c) (1984).

ment.<sup>8</sup> The situation with regard to surrogate gestators is more ambiguous. Although state laws aimed against "baby-selling" arguably prohibit surrogacy contracts,<sup>9</sup> there are also well-established traditions of greater informality in the handling of step-parent adoptions than of adoptions between strangers,<sup>10</sup> and courts routinely enforce, indeed encourage, private agreements between biological parents concerning the custody and support of their children.<sup>11</sup> Therefore, it would be incorrect to conclude that the apparent lack of a regulatory framework means that decisions about noncoital means of reproduction are being made "autonomously," unseen and untouched by the law. Uncertainties about the legal consequences of procreative choices may unreasonably burden their exercise and in some instances may preclude altogether the making of choices subsequently believed to be vital to the well-being of parents or their children.<sup>12</sup>

This paper argues that there is an urgent need for the creation and clarification of a legal framework within which contemporary efforts to produce or procure children can take place. State legislatures should act now in order to avoid the kind of crisis that confronts Great Britain, where an infant girl, the product of a breached surrogacy contract, has been impounded by a British

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8. Whatever research is currently being done to improve IVF and ET techniques, and to learn more about their physiological consequences, is supported entirely by private funds, including some portion of the fees paid by patients.

9. *E.g.*, MICH. COMP. LAWS ANN. § 710.54 (West Supp. 1984) provides that "a person shall not offer, give, or receive any money or other consideration or thing of value in connection with [an adoption or a release of parental rights]"; CAL. PENAL CODE § 273(a) (Deering 1971) makes it a misdemeanor to offer any payments or anything of value to a parent in order to procure a consent to an adoptive placement and CAL. PENAL CODE § 181 (Deering 1971) makes it a felony to pay money or anything of value in order to have a child placed in another person's custody. Although half or more of the states have similar statutes, their scope is unclear and their enforcement irregular. CAL. PENAL CODE § 273(a) goes on to provide, for example, that it is not unlawful "to pay the maternity-connected medical or hospital and necessary living expenses of the mother . . . as an act of charity, as long as the payment is not contingent upon" the completion of the adoption. See generally, W. MEEZAN, S. KATZ & E.M. RUSSO, *ADOPTIONS WITHOUT AGENCIES* 149-210 (1978) [hereinafter cited as MEEZAN].

10. Many of these statutes are cited in MEEZAN, *supra* note 9, at 149-210. Most states dispense with the requirement of a social investigation of the adoptive parent when he or she is the child's stepparent.

11. See generally Mnookin & Kornhauser, *Bargaining in the Shadow of the Law*, 88 YALE L.J. 950 (1979).

12. For example, the absence of legal requirements to obtain and retain accurate genealogical and medical records for sperm, ova, embryo or baby-donors may make it impossible to disclose this information to the offspring of noncoital reproduction when they reach 18 even though such disclosure may, by then, be considered desirable. Such difficulties are already being encountered by AID offspring who are seeking information about their genetic fathers. See *infra* text accompanying notes 202-18.

court.<sup>13</sup> While the court ponders how to determine the legal parentage of this particular child, Parliament considers criminal penalties for those who arrange surrogacy contracts and general regulations to constrain IVF and ET research and practice.<sup>14</sup> The elements of the framework I propose derive from a principle of "supportive neutrality" similar to that set forth by David Chambers in a companion article in this Symposium.<sup>15</sup> The federal and state governments should encourage the procreative efforts of childless couples and remain neutral among couples making different choices. This neutrality implies a presumptive deference to voluntary private agreements and a reluctance to dictate their terms.

The elements of my proposed framework also derive from a commitment to minimizing the risks of specific physical and psychological harms to the children generated by noncoital reproduction, as well as to all the other participants.<sup>16</sup> Finally, these elements respond to my own belief that the opportunity to raise a child—the rearing aspects of parenting—hold much greater significance for both adults and children than do the genetic or gestational links between a child and her parents. This is not to suggest that children raised by adults to whom they are not biologically related should be cut off from knowledge of, or even contact with, their biological kindred.<sup>17</sup> But I would search for ways to make adoption both more feasible and more attrac-

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13. An account of how this infant became a temporary ward of a British court is in *Manchester Guardian Weekly*, Jan. 13, 1985, at 1.

14. A series of recommendations to criminalize surrogacy and to closely monitor and control IVF and ET in Britain are included in DEPARTMENT OF HEALTH AND SOCIAL SECURITY REPORT OF THE COMMITTEE OF INQUIRY INTO HUMAN FERTILISATION & EMBRYOLOGY (HMSO 1984) [hereinafter cited as WARNOCK REP.]. The use of noncoital methods of reproduction has recently caught other legal systems by surprise. In Australia, the furor provoked when the intended parents of a frozen embryo died without having made any provisions for the disposition of the embryo was so intense that the Victoria government asked a special commission to consider a wide range of issues posed by the technological capacity to freeze embryos, COMMITTEE TO CONSIDER THE SOCIAL, FINANCIAL AND LEGAL ISSUES ARISING FROM IN VITRO FERTILIZATION [WALLER COMM'N], REPORT ON THE DISPOSITION OF EMBRYOS PRODUCED BY IN VITRO FERTILIZATION (Aug. 1984) [hereinafter cited as WALLER REP.]. See also *N.Y. Times*, Oct. 24, 1984, at A18. In France, a court proceeding became necessary to determine whether a widow had a right to be inseminated with the frozen sperm of her deceased husband, 14 HASTINGS CENTER REP., Dec. 1984, at 20.

15. Chambers, *The "Legalization" of the Family: Toward a Policy of Supportive Neutrality*, 18 U. MICH. J.L. REF. 805 (1985).

16. My framework consists of elements that are similar to those stated by Grace Blumberg in her discussion of donor embryo transfer: "The optimal legal response is precisely tailored legislation that will give due weight to process integrity, the interests of the child and the reasonable expectations of the parties." Blumberg, *Legal Issues in Nonsurgical Human Ovum Transfer*, 251 J.A.M.A. 1178, 1180 (1984).

17. See discussion *infra*, notes 194-219 and accompanying text.

tive than it now is. Adoption should remain a prominent route by which adults can become parents and children can be assured of having parents. Before testing the elements of this framework on some of the problems presented by the new reproductive methods, I will say something about the nature of the present baby-making market, assess who stands to gain or lose by its operation, and indicate why any legal efforts to prohibit this market from operating would be unwise, whether or not unconstitutional.

## II. THE BABY-MAKING MARKET: IMPROVING TECHNOLOGY, INSISTENT PSYCHOLOGY AND INCREASING DEMAND

Baby-making by noncoital means has become a booming business. Since 1978, when the first live birth from IVF was achieved in Great Britain,<sup>18</sup> at least 1,000 babies have been born throughout the world as a consequence of *in vitro* fertilization or embryo transfer techniques.<sup>19</sup> In the United States, estimates run as high as 200-300 such babies. The first IVF clinic opened in this country at Norfolk, Virginia, in 1978 and reported its first live birth in December, 1981.<sup>20</sup> As many as 150-200 such clinics may now be in operation around the country. About fifty of these are affiliated with universities or other major medical centers; the others are being set up as adjuncts to the private practices of obstetricians and gynecologists.<sup>21</sup> Augmenting the sudden rash of IVF clinics are a rapidly growing number of private organizations, typically run by lawyers or lawyer-doctor teams, that are in the business of negotiating and arranging for the performance of contracts between childless couples and surrogate gestators. It is anyone's guess how many babies are being produced in this

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18. An announcement of the birth of Louise Brown and brief accounts of the work of British Doctors Steptoe and Edwards are in *NEWSWEEK*, Aug. 7, 1978, at 66; *TIME*, July 31, 1978, at 58; *N.Y. Times*, July 26, 1978, at A1, col. 5.

19. One thousand may be too high; some think it is only 500-600. Abramowitz, *supra* note 6.

20. Jones, *The Program for In Vitro Fertilization at Norfolk*, 38 *FERTILITY & STERILITY* 14 (1982).

21. Kolata, *In Vitro Fertilization Goes Commercial*, 221 *SCI.* 1160 (1983). According to the more conservative estimates of the American Fertility Society, fewer than fifty IVF centers have opened. Abramowitz, *supra* note 6. For an account of IVF services being offered by two doctors who share a private practice, see Sher, Knutzen, Stratton, Montalhab, Allenson, Mayville, Rubenstein, Glass & Bilach, *The Development of a Successful Non-University Based Ambulatory In Vitro Fertilization/Embryo Transfer Program: Phase I*, 41 *FERTILITY & STERILITY*, 511 (1984).

country through surrogacy arrangements.<sup>22</sup> Alongside this proliferation of treatments and services for overcoming female infertility, a robust market operates for old-fashioned artificial insemination of the wife of a sterile man with the purchased sperm of an anonymous donor (AID).<sup>23</sup> Estimates of the numbers of children who are born each year as a result of AID vary from 6,000 to 20,000.<sup>24</sup>

For those couples who seek to benefit from the new reproductive techniques, the financial costs are high. The current market cost for IVF is \$4,000-5,000 for each attempt at implantation in a woman's uterus of an eight to sixteen cell blastocyst fertilized in a petri dish from her surgically-removed ovum and the manually-expressed sperm of her husband or some other donor.<sup>25</sup> If the initial attempt fails to result in a viable pregnancy, as is most likely, subsequent attempts are less expensive, particularly if an "excess" supply of eggs has been removed during the initial surgical procedure, or laparoscopy, then fertilized and frozen for

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22. The surrogate parenting organizations that have received the most publicity are in Kentucky, New York, and California. No public authority has licensed any of them. To date, the only organization to be specifically enjoined from continuing its work is Surrogate Parenting Associates, Inc. (SPA) of Kentucky. In reversing a Circuit Court opinion permitting SPA to arrange surrogacy contracts, the Kentucky Court of Appeals held that SPA's activities violated Ky. REV. STAT. § 199.590(2) providing that no person or agency not licensed by the state may accept remuneration for the procurement of any child for adoption. *Kentucky v. SPA, Inc.*, 11 FAM. L. REP. (BNA) 1105 (Ky. Cir. Ct. 1983). The New York surrogacy organization opened by Michigan attorney Noel Keane is described in Brozan, *Surrogate Mothers: Problems and Goals*, N.Y. Times, Feb. 27, 1984 at A17. A thriving surrogacy practice in California is described in Handel, *Surrogate Parenting, In Vitro Fertilization and Embryo Transplantation*, 6 WHITTIER L. REV. 783 (1984). Needless to say, there is no central registry listing either the number of surrogacy contracts entered into or those that have been fully performed.

23. Artificial insemination using the sperm of a male donor has been an accepted medical treatment for nearly fifty years, W. FINEGOLD, *ARTIFICIAL INSEMINATION* (2d ed. 1976); Wadlington, *Artificial Conception: The Challenge for Family Law*, 69 VA. L. REV. 465, 468 (1983).

24. Curie-Cohen, Luttrell & Shapiro, *Current Practice of AID in the U.S.*, 300 NEW ENG. J. MED. 585 (1979) [hereinafter cited as Curie-Cohen]. This study estimated that there were fewer than 10,000 AID children born annually; other estimates run as high as 20,000. Wall St. J., Aug. 7, 1984, at 1. The inadequacy of the records kept by physicians who perform AID is one reason for the wide disparity in estimates of precisely how many children are conceived each year through AID.

25. The data in this and the following paragraphs is based on discussions with Dr. Emmet Lamb, Professor of Obstetrics and Gynecology and Director of the proposed IVF program at the Stanford Medical School and with Dr. Merton Bernfield, Professor of Pediatrics at the Stanford University Medical School (Oct. 8, 1984, Nov. 12, 1984, and Jan. 14, 1985) [hereinafter cited as Lamb discussions]. A good introduction to the medical technology is in Grobstein, Flower & Mendeloff, *External Human Fertilization: An Evaluation of Policy*, 222 SCI. 127 (1983) [hereinafter cited as Grobstein]. More technical discussions appear nearly every month in the professional journal, FERTILITY & STERILITY.



later implantation.<sup>26</sup> These estimates do not take into account the additional expenses incurred by such repeated efforts to achieve pregnancy and carry a baby to term, including travel, lodging, and loss of earnings. Couples typically can expect to pay around \$12,000-15,000 for medical expenses alone for a less than fifty percent chance that the wife will become pregnant and an even lower chance that she will give birth.<sup>27</sup> When other expenses are added, the average cost for a couple who end up with a healthy baby can approach \$40,000-50,000. The costs can be as high for those who end up with no child.

Somewhat less costly than *in vitro* fertilization are donor embryo transfers. These involve the *in vivo* fertilization of an ovum donor by artificial insemination with the intended father's sperm, the non-surgical removal from the donor of the fertilized ovum before she becomes technically pregnant,<sup>28</sup> and the non-surgical transfer of the donated embryo to the uterus of the intended mother, who will then presumably gestate the embryo and carry it to term. This process is described by one of its pioneers as an effort to "qualify humans as the fifteenth mammalian species in which embryo transfer is expected to produce normal young."<sup>29</sup> To date, human embryo transfer has been tried in this country only at Harbor-UCLA Medical Center and has resulted in substantially lower rates of pregnancy and birth<sup>30</sup> than the comparable success rates from *in vitro* fertilization.<sup>31</sup>

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26. A good overview of recent advances in the freezing of embryos and the advantages of this procedure for reducing the number of surgical laparoscopies a woman must undergo during IVF is Coulam, *Freezing Embryos*, 42 FERTILITY & STERILITY 184 (1984).

27. Kolata, *supra* note 21, at 1160.

28. Medically, a woman is not considered pregnant until a fertilized embryo has become implanted in her uterus. This does not occur until three to five days after the woman's ovum has been inseminated within her reproductive system. Cf. definition of "fetus" used in federal guidelines for fetal research, *supra* note 7. The embryo is removed from the donor by a process called "lavage," which is literally a flushing-out, performed with a specially designed catheter.

29. Interview with Dr. John Buster of Harbor-UCLA Medical Center (Feb. 21, 1985) [hereinafter cited as Buster interview]. See also Brotman, *Human Embryo Transplants*, N.Y. Times, Jan. 8, 1984, § 6 (Magazine) at 42, 47.

30. Bustillo, Buster, Cohen, Thorneycroft, Simon, Boyers, Marshall, Seed, Louw & Seed, *Nonsurgical Ovum Transfer as a Treatment in Infertile Women*, 251 J.A.M.A. 1171 (Mar. 2, 1984). The physicians reported a pregnancy rate of six percent of all attempts (two continuing pregnancies from 29 attempts) at *in vivo* fertilization by artificial insemination of an ovum donor. Measured as a percentage of completed embryo transfers from the ovum donor to the intended uterine mother, a rate of 16% was achieved (two pregnancies from 12 transfers). Some commentators have questioned whether the procedures described by the UCLA physicians as an acceptable "treatment" for infertility should, instead, still be regarded as highly experimental. See Annas, *Surrogate Embryo Transfer: The Perils of Parenting*, 14 HASTINGS CENTER REP., June 1984, at 25.

31. Most IVF clinics still do not report pregnancy rates of higher than 20% of all

For full surrogacy, in which a woman agrees to serve as a gestational hostess for a child whose intended rearing parents are the genetic father and his infertile wife, estimated costs are \$10,000-30,000 or higher, depending on whether legal fees as well as payments to the baby's uterine hostess are included.<sup>32</sup> Compared to these techniques for alleviating female infertility, the cost for providing an infertile man an opportunity to be the legal parent of a child borne by his wife after she has been artificially inseminated with the sperm of a third party donor is only one-tenth to one-hundredth as much.

High financial costs in exchange for low birth rates have not deterred childless couples from seeking IVF or ET treatment, nor from pursuing the medically simpler but legally more complex surrogate gestator arrangements. Waiting lists for all these services are filled and, absent an unanticipated medical catastrophe or a systematic attempt at prohibition, the demand is likely to increase substantially in coming years. Americans may be experiencing a veritable epidemic of infertility. An estimated ten to fifteen percent of all married couples are involuntarily childless: they fail to conceive after trying to do so for at least a year of not using contraceptives.<sup>33</sup> This represents a threefold in-

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implantation attempts. Wallis, *A Surrogate's Story*, TIME, Sept. 10, 1984 at 150. There are reports of pregnancy rates of 30% or higher per patient, Jones, Acosta, Andrews, Garcia, Seegar, Jones, Mayer, McDowell, Rozennaks, Sandon, Veek & Wilkes, *Three Years of IVF at Norfolk*, 42 FERTILITY & STERILITY 826 (1984). Because there are no federal or state reporting requirements, nor any standardized method for reporting the results of IVF or ET treatment, it is extremely difficult to get accurate data on just how many babies are being born as a percentage of implantation attempts or as a percentage of pregnancies. This in turn makes it extremely difficult to assess the overall costs or the costs per patient. There is little doubt, however, that IVF and ET pregnancy rates are still only about 40% that of pregnancy rates achieved through the "natural" or unassisted reproductive process. See Grobstein, *supra* note 25.

32. N. KEANE & D. BREO, *THE SURROGATE MOTHER* 17 (1981); Wallis, *supra* note 31, at 53. There are no accurate assessments of the fees being paid to surrogate gestators or to the lawyers who arrange surrogacy contracts. Some people offer as much as \$50,000 for surrogacy services. See, e.g., the classified advertisement for a "tall, trim, intelligent, and stable" surrogate aged 22-35 who, in addition to a payment of \$50,000, is offered the assurance that her child "will be reared in an outstanding environment," N. Y. REV. OF BOOKS, July 18, 1985, at 51.

33. NAT'L. CTR. FOR HEALTH STATS., VITAL & HEALTH STATS., SER. 23, NO. 11, at 13-16, 32 (Dec. 1982). There do not seem to be comparable statistics for unmarried women. *But see* the account of the increase in the past few years of sterility among married and unmarried women caused by sexually transmitted diseases. NEWSWEEK, Feb. 4, 1985, at 72-73. New data from the National Center for Health Statistics on the widespread incidence of serious impediments to conception among all women of childbearing age (15-44) are reported in the N.Y. Times, Feb. 11, 1985, at A12, col. 3. For an account of the incidence of male infertility, see Brody, *Infertility: Not Uncommon Male Problem, but Often Treatable*, N.Y. Times, Mar. 20, 1985, at C21, col. 3.

crease over childlessness rates reported twenty years ago.<sup>34</sup> In more than half of the present cases, the difficulties are attributable to the women. As many as forty to fifty percent of these women are unable to conceive because they have blocked, diseased, or otherwise damaged oviducts.<sup>35</sup> Perhaps an additional ten percent are women who have had their fallopian tubes tied as a contraceptive measure, but who now want to become pregnant.<sup>36</sup> Surgical efforts to repair damaged oviducts or to reverse tubal ligations are costly, unpleasant, and only moderately successful.<sup>37</sup> There are, then, 500,000 to 1,000,000 married women who are unable to have a child related to them, genetically or gestationally, without some kind of assisted fertilization or uterine implantation. For women whose reproductive systems are intact but who are potential transmitters of genetic diseases, IVF is not appropriate, but donor embryo transfer might be.<sup>38</sup> For women who have had hysterectomies, neither IVF nor ET is medically feasible. Resort to a surrogate gestator may be the only way for these women to raise a child who is genetically related to their spouses, although not to them. For couples whose infertility is attributable to the husband, the most efficacious noncoital reproductive techniques are traditional AID of the wife and IVF.

These data on the prevalence of involuntary childlessness and on the suitability of different methods for specific physical conditions do not by themselves account for the growing demand for access to the baby-making market. Much of this demand follows from the social and psychological importance people attach to the ideal of having children who are genetically theirs. At present, many perceive adoption as impracticable or "undesirable,"<sup>39</sup> a decided second best to having genetically-related offspring. In our culture, the desire to reproduce through blood lines, to connect to future generations through one's genes, continues to exert a powerful and pervasive influence. Evidence

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34. Reproductive endocrinologist Martin Quigley, *quoted in* TIME, Sept. 10, 1984, at 50.

35. Bigger, *In Vitro Fertilization, Embryo Culture and Embryo Transfer in Humans*, in EAB REP., *supra* note 6, Appendix, § 8 at 2.

36. Sterilization is now the most popular form of contraception, N.Y. Times, Feb. 11, 1985, at A12, col. 3. Research on women who later regret their original decision to be sterilized is summarized in Huggins & Sondheimer, *Complications of Female Sterilization: Immediate and Delayed*, 41 FERTILITY & STERILITY 337 (Mar. 1984).

37. Lauritsen, Pagel, Vangsted, Starnp, *Results of Repeated Tuboplasties*, 37 FERTILITY & STERILITY 68 (1982); Lamb discussions, *supra* note 25.

38. Jones, *Variations of a Theme*, 250 J.A.M.A. 2182 (1983).

39. "Undesirable" translates as "not enough healthy white newborns." See discussion *infra* notes 220-27 and accompanying text.

from other societies and from sub-cultures within America suggests that this desire is not "innate" nor biologically determined, but is culturally constructed.<sup>40</sup> The cultural origins and reinforcement of this desire do not minimize its importance, nor the reality of the distress infertile men and women experience by being excluded from a range of fulfilling human activities associated with childbearing and childrearing.<sup>41</sup> Women especially have been socialized with the view that their self-esteem, their deepest sense of personhood, depends on their ability to bear a child.<sup>42</sup>

The development of IVF and ET and the interest in surrogate gestation would seem, then, to herald a new chapter in the story of the striving of men and women, but especially of women, to gain full procreative autonomy. Previous chapters in this story recount how the improvement of birth control techniques, the removal of legal restrictions on their use, and the recognition of a constitutional right to abortion enabled men and women to prevent conception, and women to terminate unwanted pregnancies.<sup>43</sup> The new chapter will detail efforts to achieve freedom to conceive despite what may be an unprecedented range of impediments. This tale contains several ironies, however.

First, the dramatic increase of female infertility in recent years is in part the unfortunate concomitant of the hard won freedom to prevent conception. Pelvic inflammatory disease, blocked oviducts, uterine and cervical cancer, or ectopic pregnancies have turned out to be the devastating consequences for many women of certain birth control devices, including the Dalkon Shield and the pill.<sup>44</sup> Second, the casual and diverse sex-

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40. See, e.g., Stack, *Cultural Perspectives on Child Welfare*, 12 N.Y.U. REV. L. & SOC. CHANGE 539 (1983-84).

41. A compassionate analysis of the nature of the procreative desire is in Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405, 408-10 (1983). See also the discussion in WARNOCK REP., *supra* note 14, at ch. 2, §§ 2.1-2.4.

42. An excellent overview of contemporary feminist writing, including the analyses of Michelle Rosaldo, Sherry Ortner and others of how women have been socialized into the cult of domesticity and childbearing, is H. EISENSTEIN, *CONTEMPORARY FEMINIST THOUGHT* (1983). See also WOMEN, CULTURE & SOCIETY (1974).

43. Perhaps the best accounts of nineteenth and early twentieth century efforts to achieve freedom from conception are L. GORDON, *WOMEN'S BODY, WOMEN'S RIGHT* (1976); D. KENNEDY, *BIRTH CONTROL IN AMERICA* (1970); J. MOHR, *ABORTION IN AMERICA* (1978); and J. REED, *FROM PRIVATE VICE TO PUBLIC VIRTUE: THE BIRTH CONTROL MOVEMENT AND AMERICAN SOCIETY SINCE 1830* (1978).

44. Lamb discussions, *supra* note 25; Stevenson, *Fund is Created to Settle Claims on Birth Devices*, N.Y. Times, Apr. 3, 1985, at A1, col. 5.

ual relationships facilitated by the ability to control conception have contributed to the extraordinary increase in the incidence of sexually transmitted diseases (STD). Many of these cause sterility if not treated in their early stages; others may not even be treatable. Although the frightening spread of Acquired Immune Deficiency Syndrome (AIDS) indicates that men are not being spared the ravages of these infections, the most severe damage to reproductive capacities from STDs, especially chlamydia, gonorrhea, and genital herpes, is being visited upon women.<sup>45</sup> Third, by postponing childbearing until they have established a career for themselves, many women are discovering that it is more difficult to become pregnant as they approach forty and that there is a somewhat greater risk of giving birth to a child with Down's syndrome. By not having given birth when they were younger, they may also have made themselves more vulnerable to endometriosis or to some other condition that threatens their ability to conceive.<sup>46</sup> Having successfully separated sex from gestation, more and more people, especially women, now find that they cannot gestate with sex.

Of course, the "new" impediments to conception are due to more than the advent of birth control or the proliferation of different lifestyles. Environmental pollutants and other by-products of our technological age have done their part to render people infertile and to increase the risk of birth defects. Similarly, drugs such as diethyl stilbestrol (DES), once believed to reduce the risk of miscarriage for pregnant women, may have impaired the ability of many of these women's daughters to successfully bear children.<sup>47</sup> Hence the drive to make use of the new reproductive technologies derives not simply from the fact of infertility, nor from its apparent increase, but from the social and medical circumstances under which infertility has been sustained. The victims of infertility feel cheated: they are having to pay the unsuspected costs of innovations carried out on a broad scale in the name of several kinds of social progress. There is, then, a special intensity to the conviction on the part of many childless persons that society *owes* them a child of their own.<sup>48</sup>

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45. NEWSWEEK, Feb. 4, 1985, at 72, 72-73.

46. Lamb discussions, *supra* note 25.

47. See Tilley, *Assessment of Risks from DES: An Analysis of Research on Those Exposed During Pregnancy or In Utero*, in THE CUSTOM-MADE CHILD (1981).

48. Some especially poignant versions of the view that society has a responsibility to provide babies to those suffering from infertility are expressed by women who are sterile as a consequence of their use of Dalkon Shields. Interviews by Wendy Kaufman, *All Things Considered*, Nat'l Pub. Radio (Jan. 16, 1985).

In the context of these feelings, a number of commentators argue, not surprisingly, that the interest in procreation is of such fundamental importance that it deserves constitutional protection. The most persuasive of these is John Robertson, who contends that the constitutionally protected freedom to avoid procreation implies its converse, the freedom to procreate. Robertson defines this procreative freedom broadly enough to encompass resort to noncoital methods of reproduction and to third party reproductive "collaborators."<sup>49</sup> From the many Supreme Court decisions protecting the right of parents to rear and raise their children,<sup>50</sup> Robertson spins out an argument for according constitutional protection to efforts to bring children into the world so that they can be reared.<sup>51</sup> Single persons as well as married couples may have some claim to this "positive" procreative freedom. An individual's alleged entitlement to seek personal fulfillment through procreation should not hinge on whether he or she is married,<sup>52</sup> especially if a child's welfare is not jeopardized by having an unmarried parent.<sup>53</sup> Children raised by single parents may experience more psychological and social difficulties than children raised by two parents.<sup>54</sup> Nonetheless, it is not the particular family form in which a child lives that seems to be crucial for the child's ultimate well-being, but the nature of the personal relationships between the child and

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49. Robertson, *supra* note 41, at 415-16, and 405, n.2.

50. See, e.g., *Wisconsin v. Yoder*, 406 U.S. 205 (1972), *Stanley v. Illinois*, 405 U.S. 645 (1972), *Prince v. Massachusetts*, 321 U.S. 158 (1944), *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), *Meyer v. Nebraska*, 262 U.S. 390 (1923).

51. Robertson, *supra* note 41, at 417. See also Graham, *Surrogate Gestation and the Protection of Choice*, 22 SANTA CLARA L. REV. 291 (1982).

52. Robertson admits he is on shakier constitutional grounds when he advocates extending the argument for procreative autonomy to single persons. Robertson, *supra* note 41, at 418. Even in *Eisenstadt v. Baird*, 405 U.S. 438 (1972), only four Supreme Court Justices referred explicitly to a single person's "right" to avoid conception. The Court has not addressed directly either a married person's or a single person's alleged "right" to conceive.

53. For an argument that single persons should enjoy as much procreative freedom as married persons, see Kritchevsky, *The Unmarried Woman's Right to Artificial Insemination*, 4 HARV. WOMEN'S L. J. 1 (1981); for an argument that they should not, see Smith & Iraola, *Sexuality, Privacy and the New Biology*, 67 MARQ. L. REV. 263 (1984).

54. See, e.g., the results of an important study of children raised by single parents in Dornbusch, Carlsmith, Bushwall, Ritter, Leiderman, Hastorf, & Gross, *Single Parents, Extended Households, and the Control of Adolescents*, 56 CHILD DEV. 326 (1985). Based on a representative national sample of adolescents, the authors studied the interrelations among family structure, family decision-making, and deviant behavior among adolescents. They find that male children raised by single mothers show the greatest amount of deviant behavior, as they define "deviance." *Id.* at 329. They also find, however, that the presence of any adult in the household in addition to the mother reduces the level of the adolescent's deviant social behavior.

one or more caregivers.<sup>55</sup>

While subscribing to the general thrust of the argument for constitutional protection of procreative choices,<sup>56</sup> I have some reservations. First, the cases cited in support of this argument deal with the consequences of sexual activities. They do not address, and indeed, do not contemplate, the act of procreation through the agency of laboratory techniques or with genetic contributions from third parties.<sup>57</sup> Second, I read the cases supporting parental autonomy and the values of family life<sup>58</sup> as placing greater emphasis on the opportunity to rear a child, and on the vital social and cultural functions performed by childrearing, than on the process by which a child is acquired.<sup>59</sup> A child's

55. See generally, Sroufe, *The Coherence of Individual Development*, 39 AM. PSYCHOLOGIST 834 (1979) (a useful introduction to contemporary versions of the attachment theory of child development that originated in the work of John Bowlby); Ainsworth, Bell & Stayton, *Individual Differences in Strange Situation Behaviour of One-year-olds*, in *THE ORIGINS OF HUMAN SOCIAL RELATIONS* 17 (H. Schaeffer ed. 1971). Although they differ on a number of theoretical and practical issues, the psychological parenting theorists and the attachment theorists would agree with the assertion that children raised by single parents can turn out just as well or just as poorly as children raised by two parents. See J. GOLDSTEIN, A. FREUD & A. SOLNIT, *BEYOND THE BEST INTERESTS OF THE CHILD* (rev. ed. 1979) [hereinafter cited as GFS]; Waters & Noyes, *Psychological Parenting vs. Attachment Theory*, 12 N.Y.U. REV. L. & SOC. CHANGE 505 (1983-84).

56. It is unlikely that English courts would ever find a protected right to procreative freedom akin to what the U.S. Supreme Court might "locate." Parker, *Surrogate Mothering: An Overview*, 14 FAM. L. 140 (1984). For an articulate statement of the Christian, and particularly the Catholic theological view that "no society has ever . . . understood the methods and measures of reproduction to be a matter of private choice," see Noonan, *Christian Tradition and the Control of Human Reproduction*, J. OF CHRISTIAN JURIS. 1 (1983).

57. Despite Robertson's assertion that a right to conceive can be derived from a right to avoid conception, there is in fact no logical nexus between the two claimed "rights." Surely, the opinions that deal with the dissemination of contraceptives to teenagers or with the circumstances under which minors can have an abortion cannot be read as protecting an interest in becoming pregnant, *H.L. v. Matheson*, 450 U.S. 398 (1981); *Bellotti v. Baird*, 443 U.S. 622 (1979); *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977). Even if these and other cases, e.g., *Eisenstadt v. Baird*, 405 U.S. 438 (1972), and *Griswold v. Connecticut*, 381 U.S. 479 (1965), are read as protecting an interest in intimate association, such an interest is also distinct from an interest in resorting to third party collaborators to produce a child. See Karst, *The Freedom of Intimate Association*, 89 YALE L.J. 624 (1980). An elaboration of the distinction between protecting against unwanted pregnancies and protecting an interest in conceiving was made in the legal analysis prepared for the EAB; see Flannery, *Test Tube Babies: Legal Issues Raised by In Vitro Fertilization*, 67 GEO. L.J. 1295, 1302-04 (1979).

58. See, e.g., cases cited *supra* note 50, and *Moore v. City of East Cleveland*, 421 U.S. 494 (1977).

59. These cases assume the existence of a child within a nuclear or extended family setting. They deal with the reciprocal nature of parental rights and duties towards their children, not with the process of bringing the children into existence. For discussions of just how far removed the childrearing cases are from any claims for a broad right to procreative, as opposed to parental autonomy, see Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L. J. 920 (1973); Hafen, *The Constitutional Status of*

right to be reared and society's stake in protecting a child's need for parenting deservedly gets more attention than an adult's interest in propagating.<sup>60</sup> Third, neither the Supreme Court nor any lower federal court has accorded any constitutional protection to claims by adoptees that they have a fundamental interest in connecting with their genealogical heritage and should therefore be permitted to learn the identity of their biological parents.<sup>61</sup> Adoptees have argued that in denying them this information, states have irreparably injured their sense of "personhood."<sup>62</sup> Is it reasonable, then, to expect that an adult's claim for constitutional protection for an interest in connecting to future generations through the use of noncoital means of re-

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*Marriage, Kinship, & Sexual Privacy: Balancing the Individual and Social Interests*, 81 MICH. L. REV. 463 (1983). From a different perspective, Thomas Grey argues that the "Court has given no support to the notion that the right to privacy protects sexual freedom." Grey, *Eros, Civilization, and the Burger Court*, 43 LAW & CONTEMP. PROBS., Summer 1980, at 83, 86.

60. In recent cases that consider the circumstances under which the parental rights of biological parents may be terminated, e.g., *Santosky v. Kramer*, 455 U.S. 745 (1982); *Lassiter v. Department of Social Servs.*, 452 U.S. 18 (1981); *Smith v. Organization of Foster Families*, 431 U.S. 816 (1977), the Court has protected relational interests between parents and their children against termination procedures that do not accord with due process requirements. In recent cases that consider the interests of unwed fathers in obtaining custody of their biological offspring, or in preventing the adoption of those offspring by someone other than a blood relative, the Court has decidedly refused to grant such parental prerogatives to any father simply on the basis of his biological relationship to his child. The Court has protected the parental interests of only those unwed fathers who have entered into and attempted to sustain an actual personal and emotional relationship with their offspring, *Lehr v. Robertson*, 463 U.S. 248 (1983); *Caban v. Mohammed*, 441 U.S. 380 (1979); *Quilloin v. Walcott*, 434 U.S. 246 (1978); *Stanley v. Illinois*, 405 U.S. 645 (1972). The procreative act alone has been a basis for imposing financial responsibilities on biological parents, but it has never been the basis *by itself* for granting custodial rights or for preventing the adoption of the child by someone else. The scope of constitutional protection of the rights of unwed fathers has been much discussed and is generally beyond the scope of this paper. A useful recent analysis is in Buchanan, *The Constitutional Rights of Unwed Fathers Before and After Lehr v. Robertson*, 45 OHIO ST. L.J. 313 (1984).

61. See, e.g., *Alma Soc'y, Inc. v. Mellon*, 601 F.2d 1225 (2d Cir. 1979), cert. denied, 444 U.S. 995 (1979). State courts have been similarly unresponsive; see, e.g., *In re Roger B.*, 84 Ill.2d 323, 418 N.E.2d 751 (1981), appeal dismissed, 454 U.S. 806 (1981).

62. Although many state courts have permitted the disclosure of birth parents' identities to adoptees, they have not done so on the basis of constitutional analysis, but by construing broadly the "good cause" exceptions typically included in non-disclosure statutes. See, e.g., *Mills v. Atlantic City Dept. of Vital Statistics*, 148 N.J. Super. 302, 372 A.2d 646 (1977). Instead of pursuing their constitutional claims, those interested in opening adoption records have turned to state legislatures where they are beginning to have greater success. About 18-20 states now have some kind of procedure through which adoptees may be able to learn the identities of their birth parents. These recent statutory changes are summarized in Pierce, *Survey of State Laws & Legislation on Access to Adoption Records*, 10 FAM. L. REP. (BNA) 3035 (1984). At least two other states have created similar registry procedures since Pierce completed his survey, 11 FAM. L. REP. (BNA) 1128 (1985).



production would be taken more seriously than the adoptee's desire to be linked back in time to his or her genetic heritage? Fourth, even if the claims for procreative autonomy were to be explicitly endorsed by the Supreme Court, federal and state governments would not be obliged to subsidize IVF or ET research and treatment, nor to do more than accept the general validity of surrogacy arrangements.<sup>63</sup>

To date, there have been no sustained efforts to prohibit IVF or ET,<sup>64</sup> nor are any likely to develop so long as these procedures are used primarily for relief of infertility and not to generate embryos either for experimental purposes or to rearrange their genetic composition.<sup>65</sup> And despite some indications to the contrary, a few state courts, acting without explicit enabling legislation,<sup>66</sup> are recognizing the validity of certain aspects of surrogacy arrangements.<sup>67</sup> From a practical perspective, if not from a

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63. In the abortion context, *cf.* *Maier v. Roe*, 432 U.S. 464 (1977) (finding no public duty to provide abortion services to low-income women).

64. In 1979 Illinois enacted a statute intended to discourage physicians from offering IVF, but subsequent interpretations of the statute by the State Attorney General have narrowed its scope. Pennsylvania has taken steps to monitor the results of IVF and ET, but has not moved to prohibit these services, Andrews, *supra* note 4, at 793.

65. At hearings held before the EAB in 1978-79, opposition to research on or to "tinkering" with "extra" embryos was more vociferous than was any concern about the use of IVF and ET as infertility treatments; *see* EAB REP., *supra* note 6; Abramowitz, *supra* note 6.

66. Legislation to regulate surrogacy contracts has been introduced in more than twenty states and the District of Columbia. Most of these bills would validate at least some aspects of surrogacy arrangements, but several would attempt to ban all forms of commercial surrogacy. These bills are listed and briefly summarized in Pierce, *Survey of State Activity Regarding Surrogate Motherhood*, 11 FAM. L. REP. (B.N.A.) 3001 (1985). One court has interpreted its state legislature's failure to enact a measure explicitly legitimizing surrogacy as a "clear signal" that surrogacy violates the state's general statutory ban against baby-selling, *Kentucky v. SPA, Inc.*, 11 FAM. L. REP. (BNA) 1359 (Ky. Ct. App. 1985).

67. The Michigan Supreme Court has reversed a Court of Appeals decision that had held that the state courts lacked jurisdiction to determine the paternity of a child born to a married woman pursuant to a surrogacy agreement. *Syrkowski v. Appleyard*, 122 Mich. App. 506, 333 N.W.2d 90 (1983), *rev'd*, 420 Mich. 367, 362 N.W.2d 211 (1985). The Michigan court found that the state's Paternity Act should not bar the alleged father from having his paternity and his child support obligations established, despite the two statutory presumptions that treat the child born after the artificial insemination of the mother as the legal child of the mother and her husband. According to the court, neither presumption will operate to stop the alleged biological father from establishing his paternity, if the mother's husband will simply withhold his consent to his wife's AID. This is an awkward way of recognizing the validity of surrogacy agreements because in practice, they do not proceed unless the surrogate gestator's husband agrees to her AID. The procedure suggested by the Michigan court requires that the surrogate's husband agree in fact to his wife's AID, while "officially" withholding his consent in order to fulfill the requirements of the Paternity Act. It is preferable to create a statutory presumption that would permit the determination of paternity in accord with the intentions of the parties to the surrogacy agreement without having to pretend that what does occur did not in

constitutional one, attempts to prohibit these activities would be ill-advised. Our experience with past crusades against behavior that some people find distasteful or immoral (for example, drinking, abortion, prostitution, homosexuality) has shown the futility of legislation against morally-controversial conduct for which there is strong social support. Childless couples would no doubt take recourse to surreptitious purveyors of reproductive services. Prices would rise, noncoital baby-production would be subject to even less monitoring than it is now, and the welfare of all the participants, especially of the offspring, would be jeopardized.<sup>68</sup>

Our attention is best directed, however, not toward the uncertain future course of constitutional doctrine, but toward the unresolved legal and policy issues presented by the bustling commercial market that already exists for noncoital reproductive services. I will select a few of the issues now being discussed in professional journals and in more general publications<sup>69</sup> for closer examination. My aim is to show both how difficult and

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fact occur. See *infra* text accompanying notes 169-79. The court's decision does not address such other aspects of surrogacy agreements as the payment of a fee to the surrogate or the adoption of the child by the biological father's wife. For the moment at least, an earlier Michigan Court of Appeals decision declaring unenforceable any agreement to make payments in connection with an adoption or release of parental rights remains intact, *Doe v. Kelley*, 106 Mich. App. 169, 307 N.W.2d 438 (1981), *cert. denied*, 454 U.S. 1183 (1983). See also *Kentucky v. SPA, Inc.*, 11 F.A.M. L. REP. (BNA) 1359 (1985), where the Kentucky Court of Appeals declared unlawful "any contracts and procedures [that seek] to financially benefit from the contractual creation of human life and its subsequent transfer for what must be considered adoptive purposes." In contrast, a District of Columbia court ordered an investigation of the circumstances surrounding a surrogacy contract and suggested that if the court can be satisfied that the agreement was not fraudulently obtained, it would seek ways to construe the D.C. Paternity and Adoption Acts so as to permit the contract to be fully performed. *In re R.K.S.*, 10 F.A.M. L. REP. (BNA) 1383 (D.C. Super. Ct. Fam. Div. 1984).

68. Nevertheless, it may be worthwhile to respond to the reservations just expressed about the constitutional argument for procreative autonomy and to continue exploring the contours of that argument. The claims for constitutional protection are useful for challenging any restrictive statutes that *might* be passed, as well as for seeking a narrow construction of existing prohibitory measures and a broad reading of those statutes and regulations that could support noncoital reproductive services. Robertson, *supra* note 41, has not convinced me that a broad right to conceive can be implied from a right not to conceive, but his persistence is admirable.

69. In addition to the comprehensive discussions in Robertson, *supra* note 41, and Wadlington, *supra* note 23, and the impassioned arguments about the moral and social implications of the new reproductive possibilities in Kass, *supra* note 5, there are more than a dozen recent law review commentaries on the issues raised by noncoital reproduction, as well as countless articles in the popular press and in such medical journals as *FERTILITY & STERILITY*, *OBSTETRICS & GYNECOLOGY*, *J. OF HUM. REPROD'N*, *J.A.M.A.* and the British journals, *LANCET* and *NATURE*. Although some of these mention the issues I discuss here, most do not analyze them in much detail, nor try to develop, as I hope to do, a special focus on the interests of the offspring.

how essential it is to create a regulatory apparatus that would *not* place the government in the business of controlling human reproduction<sup>70</sup> but which would, in accord with the principles sketched above,<sup>71</sup> 1) facilitate procreative choices, 2) minimize the risk of harm to the participants, especially the children, and 3) provide some mechanism for assuring and improving the quality of the services offered by doctors, lawyers and other intermediaries.

### III. REGULATION OF THE BABY-MAKING MARKET: A FRAMEWORK FOR NEEDED PROTECTIONS

#### A. *Facilitating Choices*

To facilitate the reproductive choices of childless persons, some combination of public and private action is needed: first, to aid these persons in making an informed and voluntary decision rather than an imposed one; next, to ensure that, once made, a decision can be acted upon; and finally, to support, although not necessarily to guarantee, the fulfillment of the reasonable expectation that the end result will be a healthy child.

1. *Facilitating informed and voluntary decisions*— An informed and voluntary decision is not easily reached. The childless face a bewildering array of possibilities. Even if the costs of different alternatives were identical, which they are not, and all alternatives were equally available, which they are not, it would remain difficult to assess the appropriateness of any given alternative for particular people. For example, is the prospect of an IVF child who is related genetically to both parents sufficiently attractive to offset for a woman the physical discomfort and

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70. See, e.g., the warning of the EAB: "Where reproductive decisions are concerned, it is important to guard against unwarranted governmental intrusion into personal and marital privacy," EAB REP., *supra* note 6. Many commentators are fond of conjuring up Huxleyan and Orwellian images to remind us of the dangers inherent in public control of reproduction; see, e.g., Annas & Elias, *In Vitro Fertilization and Embryo Transfer: Medicolegal Aspects of a New Technique to Create a Family*, 17 FAM. L.Q. 199 (1983) (not as useful for its analysis as for its listing of the science fictional accounts of public control of reproduction and for its list of other articles on issues raised by IVF, ET and surrogacy). I am reminded of the Nazi government's declaration that the nation's stock of ovaries were a natural resource and the property of the German state, R.N. Proctor, *The Politics of Purity: Origins of the Ideal of Neutral Science* 501 (unpublished Ph.D. dissertation, Harvard University 1984) (copy on file with U. MICH. J.L. REF.), and of the current efforts of the Chinese government to restrict family size.

71. See *supra* text accompanying notes 15-17.

risks associated with superovulation drugs, a surgical egg-retrieval procedure under anaesthesia, a predictable number of spontaneous miscarriages of an implanted embryo, or a pregnancy that is otherwise complicated and may terminate prematurely?<sup>72</sup> Is the allure sufficient to offset for the couple the risk of possible physical harm to their offspring from the process of *in vitro* fertilization and incubation? What about an eventual psychological let down if their specially produced child fails to live up to their perhaps exaggerated expectations for her or for what her existence would do for the quality of their lives? Alternatively, for those who are potential candidates for either *in vitro* fertilization or donor embryo transfer, is a woman compensated for her lack of a genetic connection to her child by the fact that ET does not involve any surgical procedures and does offer her an opportunity to experience pregnancy? And what of the intended father's psychological reaction to the use of his sperm to artificially inseminate an anonymous egg and embryo donor? How can a couple determine whether the physical or psychological risks associated with IVF or ET are comparable to those associated with surgical or other medical procedures used to repair damaged oviducts or to otherwise improve the chances for "natural" reproduction? How can a couple who is queasy about difficult and protracted medical procedures assess whether hiring a surrogate uterine hostess constitutes a more suitable alternative for them? By turning to this medically simpler but legally and psychologically more complicated alternative, does the couple take on a different but equally imponderable set of risks to themselves, their offspring, and the surrogate? For which couples will the desire to have a child be satisfied by adopting someone not related biologically to either of them? Will the degree of this satisfaction be affected if the adopted child is one who previously suffered emotional or physical deprivation or who, without their decision to adopt him or her, might have been deprived of an opportunity to form a stable attachment to any parents?

Childless persons ought to be made cognizant of the full range of their reproductive and childrearing options, including adoption. They deserve some guidance about how to determine which alternatives are medically or physically appropriate for them. And they need some clues about how to evaluate the psychological, financial, and legal consequences of each alternative. At

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72. For a graphic description of the procedures entailed by IVF, see Yovich, *Monozygotic Twins from IVF*, 41 *FERTILITY & STERILITY* 833 (1984).

least one "consumer's guide" to the new reproductive techniques has appeared.<sup>73</sup> An artificial intelligence program to help infertile couples choose an appropriate treatment is in the works.<sup>74</sup> The media have been filled with personal "human interest" accounts of experiences with IVF, ET, and surrogacy.<sup>75</sup> More systematic and personal reproductive counseling services already are available in the private market. IVF clinics and many of the lawyers who arrange surrogacy contracts claim that they provide such counseling.<sup>76</sup> In Britain, the Warnock Commission has recommended that publicly-subsidized investigations and consultations be offered to all individuals with a potential infertility problem and that psychological counseling be routinely included in any infertility treatment.<sup>77</sup> In this country, such services might provide a valuable supplement to services available in the private sector, especially if they were to become part of an ongoing public monitoring of the quality and success of noncoital reproduction.<sup>78</sup>

Publicly-funded reproductive counseling is, of course, unlikely to be available in the United States within the foreseeable future.<sup>79</sup> Yet a special public responsibility exists to protect the welfare of children whose parentage may end up being the subject of private contracts. Because the state, rather than private individuals, ultimately confers the legal status of parent and child, the state may justifiably be concerned that persons who

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73. L.B. ANDREWS, *NEW CONCEPTIONS: A CONSUMER'S GUIDE TO THE NEWEST INFERTILITY TREATMENTS* (1984).

74. Diamond, *Student Applies Artificial Intelligence to Infertility*, Stanford Campus Report, Oct. 24, 1984, at 13.

75. *E.g.*, the Donahue show and other TV talk-shows; Markoutsas, *Women Who Have Babies for Other Women*, *GOOD HOUSEKEEPING*, Apr. 1981, at 96.

76. Lamb discussions, *supra* note 25. *See also* 41 *FERTILITY & STERILITY* (1984), and Handel, *supra* note 22. One gets the impression, however, that the activity characterized as counseling is in fact a device for physicians and lawyers to weed out "emotionally unstable" persons from consideration for a particular service or treatment.

77. WARNOCK REP., *supra* note 14, ch. 2, § 2.12.

78. For a discussion of such public monitoring, see *infra* notes 230-38 and accompanying text.

79. The United States has fewer publicly subsidized educational, counseling, and health services addressed to issues of human sexuality and reproduction than do most other advanced industrialized countries. An important recent study by the Alan Guttmacher Institute indicates that the rates of adolescent (ages 15-19) pregnancies and abortions in the United States are substantially higher than the rates in Sweden, France, the Netherlands, Canada, England, and Wales where sex education is routinely taught, and contraceptives are inexpensive or free. *N.Y. Times*, Mar. 13, 1985, at A1, col. 1. This study of teen-age sexuality is relevant to an analysis of the government's role in the new reproductive techniques because it suggests a causal connection between the public support of services pertaining to the relief of childlessness and the capacity of childless individuals to make informed and appropriate decisions about their own conduct.

separate the genetic from the gestational and nurturing aspects of parenting fully comprehend what they are doing. And the state's interest in assuring all children an opportunity to have parents calls for more sustained efforts to make adoption a feasible and attractive alternative to childless couples.<sup>80</sup> This requires something more than general dissemination of information about reproduction. This is not to suggest, however, that there "must" be publicly supported reproductive counseling, nor that public services should preempt private ones.<sup>81</sup> But the state's interest provides a reason to propose that some combination of private and public reproductive counseling be made much more widely available than is now the case.<sup>82</sup> As a policy matter, public funds would be spent better now to support such services than spent in the future to alleviate what may prove to be the unfortunate consequences of uninformed or unreflective private decisions.<sup>83</sup>

Whether reproductive counselors are privately or publicly subsidized, what would they do? In theory, reproductive counseling seems less intrusive than screening for parental "fitness."<sup>84</sup> Counselors would assist people to choose an option appropriate to their particular medical, psychological, and financial situations, rather than deny them an opportunity to make certain choices. In practice, counselors who have doubts about a couple's parenting capacity could profess neutrality, while actually attempting to dissuade them from seeking to obtain a child. Even the truly "neutral" counselor would have difficulty defining her task. Our knowledge about noncoital reproductive processes and their long run consequences is far from complete and our attitudes toward these processes are still being formed. The values we attach to parenting and to different styles of family life lack

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80. It should surely call for reluctance to eliminate what few incentives now exist for people to adopt children.

81. Recall the warnings, *supra* note 70.

82. Such counseling may be as important, if not more so, for any third party participant in noncoital reproduction: the paid contributors of sperm, eggs, embryos, or babies. The discussion here, however, considers the wisdom of providing counseling for childless persons who are trying to decide whether to pursue IVF, ET, AID, or surrogacy.

83. I do not intend to argue that reproductive counseling services deserve a higher priority than, for example, preventive social services for adults determined to be in a high risk category as potential child abusers. But I believe that a general commitment to avoid state intervention in private procreative choices is consistent with supporting occasional interventions that are likely to improve the quality of those choices, as well as protect the welfare of any offspring. See generally Professor Wald's Introduction to this Symposium, 18 U. MICH. J. L. REF. 799 (1985).

84. See *infra* notes 98-106 and accompanying text for a discussion of how such screening can be a futile and potentially harmful enterprise.

the stability they may have shown in the past. Given these uncertainties, the most salient characteristic of good reproductive counseling may be listing questions for people to ponder, rather than providing standards or guidelines for resolving them.

Counseling may also illustrate for prospective parents the difference between a thorough understanding of suitable procreative alternatives and "informed consent" to a particular medical treatment or legal procedure. The medical personnel who offer IVF, ET, or AID secure the "informed consent" of their patients primarily to protect themselves against future allegations of malpractice. They ask patients to accept the risk of legal ambiguities as well as of physical or psychological harms<sup>85</sup> and to absolve the medical professionals from responsibility for providing compensation in the event that such harms actually occur.<sup>86</sup> In the context of surrogate gestator contracts, informed consent similarly allocates risks between the uterine hostess and the intended parents, as well as between these parties and their lawyers.<sup>87</sup> In contrast, a different standard evaluates efforts to facilitate informed decisions by infertile couples. Counselors aim to get such couples to contemplate what they are prepared to endure in order to obtain a child. This includes, but is not limited to, the legal question of how many of the risks of medical and legal procedures they are willing to assume. The interests protected in the two cases are distinct: informed consent limits the liability of the professionals upon whom the adults who want to become parents must rely, while informed decision making aims to safeguard the interests of adults in pursuing what they themselves have determined to be their most appropriate route to parenting.

## 2. *Facilitating implementation of decisions*— Once childless

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85. Buster interview, *supra* note 29. See also the Information Pamphlet for Participating Couples from the Harbor-UCLA Medical Center Ovum Transfer Program. (Copy on file with U. MICH. J.L. REF.)

86. Among the more useful analyses of informed consent in the context of the patient-doctor relationship are PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP* (1982); Andrews, *Informed Consent Statutes and the Decisionmaking Process*, 5 J. LEGAL MED. 163 (1984); Schneyer, *Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices*, 1976 WISC. L. REV. 124.

87. California attorneys William Handel and Bernard Sherwyn describe, almost with glee, how they ask childless clients to consent to their performance of what might be criminal or tortious activities in the interests of completing a surrogacy arrangement, Handel, *supra* note 22; Sherwyn, *Attorney Duties in the Area of New Reproductive Technologies*, 6 WHITTIER L. REV. 799 (1984).

couples decide which parenting option they wish to pursue, how can they be assisted to act effectively upon their choice? Allocation of any scarce resource, like noncoital reproductive services, inevitably denies access to some people. The challenge is to develop selection criteria that do not unduly burden procreative autonomy. These criteria should be relevant to the characteristics of a particular service and should be applied neutrally—that is, in a manner that is neither arbitrary nor discriminatory—among those who meet the relevant criteria. A prospective parent's medical condition is surely relevant to the allocation decision. Also relevant may be a person's psychological capacity to tolerate the complex medical procedures and legal ambiguities entailed in noncoital reproduction.<sup>88</sup> The principle of neutrality would not be violated by insisting that people have certain diagnostic tests, nor, for example, by excluding from IVF a woman who has had a hysterectomy.

Where does the search for relevant criteria and neutral principles of application go once the threshold of eligibility has been established? It depends on who determines "relevance." One decisionmaker might value the goal of giving all adults an opportunity to be parents. In that event, priority might be given to those adults who have never had children or who are nearly too old to bear or raise a child. Or, for example, instead of giving a small number of people up to five chances to conceive through IVF, a larger number of persons might each be given one chance. Another decisionmaker might place uppermost the welfare of children, serving only married couples who are "fit" potential parents and refusing to serve unmarried persons. If a third decisionmaker hoped to validate a certain procedure as a legitimate treatment rather than as a mere "experiment," priority might not go to those for whom the procedure is a last resort but to younger men and women who are in excellent general health and who, although childless, have not exhausted their finances and their psyches through years of futile efforts to conceive. Still another decisionmaker might believe that procreative autonomy is so broad as to encompass efforts to select the "best" combination of genetic materials and gestational environments for producing a child. In this case, even a threshold requirement of infertility might yield to selection by lottery or, at the other

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88. Many physicians would prefer to exclude from IVF or ET those individuals whose anxiety is so pervasive that they are unlikely to achieve a viable pregnancy, no matter how many sophisticated medical procedures they undergo. It is not clear, however, that there are any reliable tests for discerning those we might call the "permanently psychosomatic infertile." Lamb discussions, *supra* note 25; Buster interview, *supra* note 29.



extreme, to selection according to who is willing to pay the highest price for a "custom-made" child.

At present, allocation decisions for IVF and ET are being made by private physicians and hospital personnel, acting for the most part in a private commercial and professional context.<sup>89</sup> It should come as no surprise that the medical professionals are selecting patients according to criteria at the more socially conservative end of the spectrum sketched above. Indeed, the word "patients," rather than "customers" or "clients," terms preferred by the private investors in IVF and ET clinics,<sup>90</sup> manifests the physicians' desire to be associated with a reputable medical endeavor. The doctors hope to garner financial support for research to improve the quality of IVF and ET procedures and to learn more about embryo development and the reproductive process. They emphatically deny any interest in "gene manipulation" and insist that IVF and ET are simply promising "infertility treatments."<sup>91</sup> Obstetricians and gynecologists already contend with large numbers of malpractice claims and pay some of the highest settlements.<sup>92</sup> Understandably risk averse, they do not wish to lose their chances for securing broad social and financial support for IVF and ET by treating "uncooperative" people,<sup>93</sup> or those with idiosyncratic life styles.<sup>94</sup> In

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89. See *supra* text accompanying notes 6-8.

90. Embryo transfer specialist, Dr. Buster, claims, for example, that he is somewhat uneasy about the commercial terminology used by the venture capitalists who have supplied the research funds for his ET program. Nonetheless, he stresses the importance of using "the best marketing and business principles" and talks of "overnight delivery networks" for speeding three- to five-day-old embryos to potential recipients who will gestate them. Buster interview, *supra* note 29. See also the accounts of the commercial prospects for ET in Brotman, *supra* note 29; Chapman, *Going for the Gold in the Baby Business*, FORTUNE, Sept. 17, 1984, at 41.

91. See, e.g., HUMAN IN VITRO FERTILIZATION AND EMBRYO TRANSFER (1984); Abramowitz, *supra* note 6; American Fertility Society, *Ethical Statement on IVF*, 41 FERTILITY & STERILITY 12 (1984) [hereinafter cited as AFS Statement].

92. In the years 1975-78, nearly 15% of total malpractice claims filed were against obstetrician-gynecologists, and 18% of the awards were paid by them or, more accurately, by their insurers. 2 NAIC MALPRACTICE CLAIMS 3 (1978). Since then, these rates have continued to rise, Malcolm, *Fear of Malpractice Suits Spurring Some Doctors to Leave Obstetrics*, N.Y. Times, Feb. 12, 1985, at A1, col. 1.

93. Dr. Buster was so eager to project the "correct" view of ET that his medical team hired a public relations consultant to supervise media coverage of their activities. Buster interview, *supra* note 29.

94. Of the licensed physicians who perform traditional AID, only 10% report that they will treat an unmarried woman, Curie-Cohen, *supra* note 24, at 595. Several sperm banks willingly serve lesbians and unmarried heterosexual women; for example, the Women's Health Center in Oakland, California. See REP. HUM. REPROD. L. R-30 (1982). The recent publication in FERTILITY AND STERILITY of an article sympathetic to the AID of single women suggests that attitudes toward unmarried AID parents may be changing. McGuire & Alexander, *Artificial Insemination of Single Women*, 43 FERTILITY & STERIL-

sum, medical professionals are less interested in treating all people who could benefit from laboratory-assisted conception than in helping those who could enhance the reputation of IVF and ET.

As a consequence of these concerns, medical personnel screen prospective candidates for IVF or ET not merely to determine if their infertility problem is amenable to these treatments. Candidates must also be married,<sup>95</sup> have the ability to pay, and be perceived by the medical staff as fit potential parents. The lawyers who facilitate surrogacy contracts are probably applying similar criteria to prospective parents. But except for the statements of a few lawyer-brokers,<sup>96</sup> who claim to be scrupulous in their search for "emotionally stable" couples and surrogates, information is scarce on the selection criteria they actually use. In some ways, access to surrogacy may be easier than access to IVF or ET, because couples are asked fewer questions about the reasons for their childlessness. But in other ways, access may be as or more limited because the number of acceptable uterine hostesses is not nearly as large as the number of prospective parenting couples, and because many couples exclude themselves after learning of the legal and psychological ambiguities that surround surrogacy. Except for a brief analysis of the commercial aspects of surrogacy,<sup>97</sup> my discussion of access to noncoital reproduction focuses on access to IVF and ET.

The search for parental fitness is not worth the effort. In addition to raising some constitutional concerns about imposing on couples who seek IVF or ET a standard that is not applied to those who engage in coital reproduction, it is not at all clear that such a search will yield reliable results. Childless couples who have spent years trying to conceive are not likely to appreciate any questioning of their capacity to be good parents. Anyone who has glanced at the case law or literature on the termination of parental rights knows that we have a hard time figuring out which people are unfit parents.<sup>98</sup> Even less consensus exists on

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ITY 182 (1985).

95. Cf. WARNOCK REP., *supra* note 14, which recommends providing treatment for "couples," meaning "heterosexual couples living together in a stable relationship, whether married or not," §§ 2.5-2.12.

96. See, e.g., Handel, *supra* note 22; Keane & Breo, *supra* note 32; Sherwyn, *supra* note 87.

97. See *infra* text accompanying notes 111-18.

98. See, e.g., Davis, *Use and Abuse of the Power to Sever Family Bonds*, 12 N.Y.U. REV. L. & SOC. CHANGE 557 (1983-84) for a thoughtful account by someone who has had to test the assumptions and purported findings of the social science literature on the issue of parental "unfitness" against her complex and troubling experience as a New

what makes for "fitness" in a parent. This is not to deny that protecting the welfare of children warrants some concern about the characteristics of the adults who will raise them. But the small number of unworthies who might be detected and weeded out by fitness screening hardly justifies the financial and social costs of trying to devise reliable tests. Nothing in the history of adoption suggests that even the elaborate investigation of potential parents by adoption agencies using socially conservative criteria, permits reliable prediction of how fit these parents will actually be. What these criteria and investigations do succeed in doing, however, is to discourage people who are concerned about their privacy, or convinced that they will not pass muster, from seeking a child through adoption agencies. Many of these people have found babies, independently, through less intrusive non-agency intermediaries.<sup>99</sup> Surrogacy arrangements may, in fact, be simply an "innovation" in the well-established market for independent adoptions. The agencies have never been able to demonstrate that those who acquired their children independently have any less parenting ability than those who acquired children through agencies.<sup>100</sup> If what the gatekeepers to noncoital reproduction really want to know is whether the couple who intend to raise a child will remain married to each other, no test will elicit such information. Funds would be better spent on counseling services to assist couples in dealing with the special problems that raising an IVF or ET child might pose than on attempting to ferret out "unsuitable" parents.

Skepticism about screening for parental fitness would be even more appropriate if the government were someday to join the

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York City Family Court judge.

99. An influential Note written 35 years ago argued persuasively that the "agencies themselves are partially to blame for the fact that three out of every four adoptions are independently arranged." Note, *Moppets on the Market: The Problem of Unregulated Adoptions*, 59 YALE L.J. 715, 736 (1950). Since then, adoption agency efforts to convince birth mothers or prospective adoptive parents to deal with them, rather than with independent doctors or lawyers, have been notably unsuccessful. MEEZAN, *supra* note 9, reports that many prospective adoptive parents perceive adoption agency procedures as inflexible and intrusive and therefore turn to the independent baby-market. Meezan's critique of agency practices has particular importance because his study was commissioned in the 1970's by the Child Welfare League of America (CWLA), a voluntary association of adoption and other child welfare agencies who have long opposed independent placements. For other accounts of how adoptive parents resent broad inquiries by agencies into their social, religious, financial, sexual, and personal behaviors, see H. KIRK, *SHARED FATE* (1964); A. SOROSKY, A. BARAN, R. PANNOR, *THE ADOPTION TRIANGLE* (1978) [hereinafter cited as *ADOPTION TRIANGLE*]; Charney, *The Rebirth of Private Adoptions*, 71 A.B.A. J., June 1985, at 53, 54.

100. There are no CWLA or other agency-sponsored studies showing that children placed independently fare less well than those placed by agencies.

private entrepreneurs and offer IVF or ET in publicly-subsidized clinics. The temptation to look for couples and gene donors who could improve the quality of our species would be great and the temptation to prevent certain people from becoming parents would be even greater.<sup>101</sup> At present, the federal and state governments are only indirectly involved with IVF or ET. Clinics associated with public hospitals or universities could face constitutional challenges if they rejected a potential patient because of marital status<sup>102</sup> or for an alleged lack of parenting skills.

Because there is no federal funding for IVF or ET research, physicians are not required to submit their research protocols to an institutional review board (IRB) for prior approval.<sup>103</sup> Even if federal funds were available, IRB approval would not be necessary if physicians claimed they were offering treatment, rather than doing research. Nonetheless, to protect themselves as well as their patients, physicians may voluntarily seek IRB approval before embarking on IVF or ET programs.<sup>104</sup> If this occurs, the selection process will be responsive to whatever criteria are deemed suitable by the IRBs, which function both as quasi-federal administrative agencies and as local review boards.<sup>105</sup> Perhaps the best that we could hope for, if public oversight of IVF and ET increases, is that rather than devising their own criteria, public review boards would simply see to it that the private decisionmakers did not turn anyone away for arbitrary or irrelevant reasons.<sup>106</sup>

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101. Some commentators have proposed a general state licensing scheme for parents. See, e.g., LaFollette, *Licensing Parents*, 9 PHIL. & PUB. AFF. 182 (1980).

102. At least one such challenge was raised by a single woman whose request for artificial insemination was denied by the sperm bank affiliated with Wayne State Medical School. She sued, claiming violation of her constitutional right to procreative autonomy, but the suit was settled before trial when Wayne agreed to treat her. For an account of the incident, see Note, *The 14th Amendment's Protection of a Woman's Right to be a Single Parent through Artificial Insemination by Donor*, 7 WOMEN'S RTS. L. REP. 251, 254 (1982).

103. IRB approval is required for any federally funded research involving human subjects, R. LEVINE, *ETHICS & REGULATION OF CLINICAL RESEARCH* (1981); Quigley & Andrews, *supra* note 7, at 350.

104. Lamb discussions, *supra* note 25.

105. Levine, *supra* note 103, at 208-12. Before its demise, the EAB, *supra* note 6, recommended that IVF or ET be limited to married couples using their own sperm and ova. IRB-determined criteria might be somewhat broader, allowing the use of third party genetic contributions, but not receptive to the prospect of treating unmarried persons. Abramowitz, *supra* note 6; Quigley & Andrews, *supra* note 7.

106. IRBs are required to see to it that the selection of human subjects for medical research is "equitable," 45 C.F.R. § 46.111(3) (1985). Cf. the recommendation in the WARNOCK REP., *supra* note 14, at § 2.13, that anyone denied access to a particular infertility treatment be given a full statement of the reasons for the denial.

The requirement that the couple have the ability to pay their physicians, as well as any third party gene contributors, actually cuts several ways. Because most insurance companies and health maintenance organizations have refused to pay for IVF or ET,<sup>107</sup> only those couples with a significant amount of money to spare can afford to enter the market.<sup>108</sup> Thus, as with other costly and considerably more sophisticated procedures (for example, heart transplants), a great many people who could benefit from IVF and ET are excluded by financial considerations. This situation could change, however, if the proponents of IVF and ET convince the insurance companies that these procedures would be more efficacious and less costly than tuboplasty or other surgical measures designed to alleviate infertility.<sup>109</sup> Among those who can afford to pay today's high rates, there are bound to be couples who resent elaborate medical or psychological screening. They may exert pressure on IVF and ET clinics to ease both medical and parental fitness requirements. Perhaps it is more accurate to suggest that the clinics with strict eligibility requirements may find themselves with fewer patients than the clinics that care less about the social characteristics of the people they treat. Another possibility is that couples who are well off will seek treatment at small private clinics that develop reputations for being emotionally supportive, rather than at large medical centers which may have a greater range of technical services, but which are perceived to be indifferent to the emotional aspects of repeated efforts to conceive a child.<sup>110</sup>

Because the clinics need fees from patients to cover their own expenses, they will be under some competitive pressure to attract childless couples and may move toward more flexible selection criteria, as well as toward lower fees. If, however, IVF procedures prove to be more successful in certain clinical settings

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107. Their rationale is that success rates are too low, the long term safety is untested, and the procedures are "not medically necessary." Lamb discussions, *supra* note 25. Several lawsuits are pending against medical insurers and health maintenance organizations (HMOs), alleging that their characterization of IVF and ET as "experimental" or "merely cosmetic" is made in bad faith to justify denial of coverage; telephone interview with Lauren Hallinan, San Francisco lawyer representing women suing Kaiser Foundation Health Plan (June 10, 1985). See also Carlsen, *Women Sue Kaiser Over In Vitro Coverage*, S.F. Chronicle, May 31, 1985, at 6. Most health insurance carriers and HMOs will pay, however, for expenses incurred during pregnancy, including diagnostic procedures such as amniocentesis or ultrasound.

108. See *supra* text accompanying notes 25-33.

109. Lamb discussions, *supra* note 25; Buster interview, *supra* note 29.

110. See, e.g., AFS Statement, *supra* note 91, which recommends that sufficient attention be given to the emotional needs of patients.

than in others, the clinics with the highest childbirth rates may impose stricter eligibility criteria and charge even higher fees. This raises yet another aspect of the present price structure that may operate either to exclude or include people who are otherwise medically eligible. Among those couples who can afford to pay, some can afford to pay a great deal more than others. Will the purveyors of IVF and ET permit those who can afford a large number of attempts at conception as many attempts as they want? Will the purveyors be willing to accept a premium price for more attempts, or will the price be the same for all? How strong are the pressures for creating highly competitive sales of the "right" to have a child? The economic and market considerations that determine the capacity of childless couples to act on their procreative choices are troublesome because symbolically, if not actually, they may commodify, and thus demean, the children who are the end-products of these transactions.

Much ink has been spilled deploring the commercial aspects of surrogacy contracts,<sup>111</sup> while very little has been devoted to questioning the legitimacy of requiring payments for the technically sophisticated IVF or ET procedures. Yet, as we have just seen, exercising any of these choices involves going to the private market and paying a fee for the production of a child. Why should surrogacy evoke such a different response about payment? IVF and ET take place in antiseptic, clinical surroundings; conception occurs in a petri dish or in the reproductive system of a carefully monitored ovum-contributor under the watchful eye of physicians and laboratory technicians. In contrast, after the artificial insemination under medical supervision of a surrogate gestator, the main task of baby-production occurs in the real world of personal and social interaction. But, in all these situations, a third person serves as the agent of a couple's reproductive efforts, and the fact that the surrogate is not subject to continuous monitoring in the laboratory should not be a reason to deny that she is performing a service that deserves compensation. If it is acceptable to pay the doctors who serve as surrogate fallopian tubes, or the men and women who contribute the genetic material in their sperm or ova, it should be equally acceptable to pay the woman who is contributing the temporary use of her womb. The payments are not to purchase a child, but to compensate for personal services.

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111. See, e.g., Annas & Elias, *supra* note 70; Krimmel, *The Case Against Surrogate Parenting*, 13 HASTINGS CENTER REP. 35 (1983); WARNOCK REP., *supra* note 14, ch. 8 and part 4.

As we move from the question of whether there should be any payment to the question of how much should be paid, the quality of the experience for the different agents of reproduction becomes relevant. The physically and emotionally complex experience of bearing a child demands much more of the surrogate than does the impersonal, detached, and more circumscribed experience of the egg, embryo, or sperm donor. Precisely because of the demanding quality of her experience, the uterine hostess deserves payment for the medical and other out-of-pocket expenses directly related to her pregnancy. In addition, she deserves compensation for the long run physical costs associated with childbearing and for the emotional costs of relinquishing the child she bears.<sup>112</sup> Once the surrogacy route is chosen, it can become exploitive not because the surrogate is paid, but because of the risk that she will be underpaid.<sup>113</sup>

Nonetheless, the commercial aspects of surrogacy are problematic because the technical distinction between buying a child and paying for personal services may obscure the fact that the transaction still involves the exchange of a live child for money. Should our principle of supporting procreative choice yield to the interest in protecting the welfare of a child, when a childless couple wants to pay not merely for "assisted" conception, as in IVF or ET, but for the right to raise another human being? The answer depends on the extent of actual "trafficking" that takes place. In my view, no trafficking is involved if the payment merely compensates for services associated with the intentional gestation of a particular child who will be genetically related to at least one of the parents who will raise her. Indeed, there are many precedents in which courts have honored "family compacts" providing for the relinquishment of parental rights to a relative in exchange for a promise to support the child, or in exchange for a fee to the surrendering parent.<sup>114</sup> The greater the

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112. See *infra* text accompanying notes 136-44 for a discussion of how the emotional complexities of surrogacy arrangements may affect their performance.

113. Cf. the recognition by those who have been critical of independent adoptions that many birth mothers prefer to place their children independently because of assurances that they will be reimbursed for their medical and other expenses. MEEZAN, *supra* note 9, at 229. The Meezan study also recognizes that the risk of exploitation of birth mothers is reduced if lists of legally reimbursable expenses are established. *Id.* at 235.

114. See, e.g., *Enders v. Enders*, 164 Pa. 266, 30 A. 129 (1894) (upholding a promise by mother to relinquish custody of her son to his paternal grandfather in exchange for payments to her and the child as an enforceable "family compact" based on motives of "blood and affection"); *Clark v. Clark*, 122 Md. 114, 89 A. 405 (Md. Ct. App. 1913) (upholding promise by mother to relinquish son to the custody of his paternal grandfather in exchange for payments to her for her life). Similar and more recent cases are cited and discussed in Rushevsky, *Legal Recognition of Surrogate Gestation*, 7 WOMEN'S RTS. L.

amount by which payments exceed the tangible and intangible costs incurred by the gestator, the less justifiable the transaction seems.

A different step toward baby-selling is taken if payments disproportionate to a birth mother's expenses are made in order to induce her to surrender a child she originally bore as the result of an unintended pregnancy, or to raise within her own family. In other words, as the payments come closer to being for the child herself rather than compensating for services actually performed by a birth mother, the potential for commodifying babies becomes more real. A similar risk would be posed by IVF and ET if "excess" embryos were routinely frozen and auctioned off to the highest bidders.<sup>115</sup> Unlike Landes and Posner,<sup>116</sup> I, along with other commentators,<sup>117</sup> find these prospects abhorrent. To diminish the danger of commodifying children, the state, or the private lawyers and physicians involved in noncoital reproduction, could establish a minimum and maximum range of financial compensation for these services. In surrogacy arrangements, it is especially important to assure that surrogates are adequately compensated and that lawyer-facilitators are not overcompensated.<sup>118</sup>

3. *Supporting reasonable expectations*— The third component of the goal of facilitating procreative autonomy requires seeking ways to assure that the reasonable expectations of the

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REP. 107 (1982). Of course, an important distinction between these custody and support cases and surrogacy arrangements is that the former deal with children who are already alive and require financial and emotional sustenance, while the latter involve payments to acquire a child for a potential family. Nonetheless, both kinds of transactions are between blood relatives of the child and presumptively benefit the child by assuring him or her enforceable support rights.

115. This is to be distinguished from having an embryo bank which would be run as most sperm banks now operate: standard prices and some choice as to the characteristics of a gene donor, but not a thoroughly competitive market for genetic materials.

116. Landes & Posner, *The Economics of the Baby Shortage*, 7 J. LEGAL STUD. 323 (1978). This is the most systematic and the most controversial defense in the current literature of the argument for creation of a commercial market for babies.

117. Perhaps the most compelling critique of Landes & Posner is Prichard, *A Market for Babies?*, 34 TORONTO L.J. 341 (1984). See also Kelman, *Consumption Theory, Production Theory and Ideology in the Coase Theorem*, 52 S. CAL. L. REV. 669, 687-88 (1979).

118. As part of its supervision of the process in which the surrogate releases her parental rights to the child's genetic father and the father's wife adopts the child, the state could require an accounting of all expenses. While less intrusive than state-imposed price ceilings, this procedure would permit the adoption court to review the expenses and disapprove excessive amounts, and would also serve to discourage those who offer surrogacy services from charging whatever price desperate childless couples are willing to pay. See *infra* text accompanying notes 169-80 for a discussion of other ways the state could protect the integrity of surrogacy arrangements.



parties to any noncoital reproductive endeavor are fulfilled. The operative presumption should be that private and public regulations will defer to and be consistent with the understandings and expectations of the parties, except in those instances where deference would cause specific and unacceptable harm to the adults or to their offspring.<sup>119</sup> The existence of *some* risk of harm should not provide a justification for preventing noncoital reproduction from occurring, but rather should permit minimal public intervention to reduce the risk of harm, while allowing the basic understandings of the parties to go forward as planned. The following discussion will focus primarily on what the law can do to support and legitimate the private agreements and medical procedures that work, those that are performed without any of the participants becoming embroiled in conflict. It will also consider why the law has been slow to resolve legal uncertainties for these "easy" cases, and what the law can do to promote the prompt resolution of the conflicts that erupt in "hard" cases.<sup>120</sup> Because the legal uncertainties surrounding IVF, ET, and traditional AID are somewhat different than those surrounding surrogacy, they will be discussed separately.

*a. Of participants in IVF, ET, and AID—*

*i. Establishing the legal status of offspring and parents—*  
The most pressing need with regard to IVF, ET, and AID is to clarify the legal status of the offspring of these procedures and of their intended parents. The allocation of parental rights and responsibilities cannot be accomplished exclusively through private contracts. In the interests of assuring that children receive a legal identity conducive to their development of a stable psychosocial identity, the state must retain the final right to determine which individuals may be legal parents. No principled reason appears for withholding the legal status of parents from those adults who hope to raise the offspring of IVF, ET, and AID. In view of the proliferation of different family forms in our society in recent years, we should not allow the newness of IVF and ET to obscure the fact that the biological and social aspects

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119. I realize that any weighing of expectations against potential harms may involve question begging; but as may become more clear in the discussion of how to minimize harms to the offspring, those harms that can be specified and anticipated can also be mitigated by a combination of public and private action. See *infra* text accompanying notes 186-219. Although the expectations of the adults may have to yield to some regulation, there are to date no known harms so great as to justify the state in trying to prevent the basic fulfillment of these expectations.

120. At present, when disagreements arise, the intended parents may end up not with a baby but with a lawyer. For the rueful comments of one such father, see *A Surrogate Mother's Story*, NEWSWEEK, Feb. 14, 1983, at 76.

of parenting are frequently separated. From the laws governing adoption, paternity, custody, and even standard AID, we have useful precedents to guide us in crafting a set of presumptions or guidelines to govern the status of the parties to noncoital reproduction.

Uncertainties about a child's legal identity are easiest to resolve in the typical IVF procedure, when the intended legal parents are the genetic father and the genetic and gestational mother. Conception may take place in a petri dish, but the child's genetic and cultural heritage remain, as it were, within one family. The state needs no special procedures or presumptions to assign parental roles. Once third party sperm, egg, or embryo donors become involved, however, it is no longer possible for the intended rearing parents to become the child's legal parents without some special procedures or presumptions. About half the states have enacted statutory presumptions to accord with the parenting goals of couples who resort to traditional AID.<sup>121</sup> These statutes conclusively presume that a man who consents to the artificial insemination of his wife with semen from an anonymous donor is the legal father of any child to whom his wife subsequently gives birth. His wife is, of course, the child's legal as well as biological mother. These laws absolve the semen donor from any legal rights or obligations with regard to the child.<sup>122</sup>

When an unmarried woman has a child after artificial insemination with sperm from a licensed sperm bank, is the anonymous donor similarly exempted from any legal relationship to the child? Although California exempts the donor whether the mother is married or not,<sup>123</sup> most states leave this question unresolved. At least one commentator suggests that in order to assure "equal protection" to the child of an unmarried mother, the child should be able to establish a legal relationship with the sperm donor and even hold him liable for child support.<sup>124</sup> No result would be more destructive of the reasonable expectations of the adult parties to artificial insemination.<sup>125</sup> If we assume

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121. These statutes are listed in REP. HUM. REPROD. L. R-119 (1984).

122. Most of the statutes have provisions similar to § 5 of the Uniform Parentage Act, 9A U.L.A. 592 (1979) [hereinafter cited as U.P.A.] which exempts the donor from any legal relationship to the child of a *married* woman.

123. CAL. CIV. CODE § 7005(b) (West 1982).

124. Comment, *Equal Protection for Illegitimate Children Conceived by Artificial Insemination*, 21 SAN DIEGO L. REV. 1061 (1984).

125. My intuitive sense that men would not donate sperm if they thought they might someday be asked to assume financial or personal responsibility for the child produced from their genetic contribution is bolstered by the findings of the Curie-Cohen survey,

that the state, for practical or even for constitutional reasons, cannot prevent unmarried women from seeking AID,<sup>126</sup> then the state should not allow the legal status of the sperm donor to depend on the marital status of the recipient. The fact that the offspring of unmarried AID mothers will not have a legal father may be a reason for the state to abjure affirmative support for the creation of such children. But, in my view, such a harm to the children is not great enough to justify imposing parental responsibilities on the sperm donor, or attempts to prevent the mother from bearing a child.<sup>127</sup>

The presumptions designed for traditional AID of a married woman are not appropriate when third parties contribute ova or fertilized embryos, rather than semen, to the intended parent. Embryo transfers, for example, are conceptually the reverse of AID. The man who provides the sperm is likely to be the man who wants to be the child's legal father. The woman who is artificially inseminated in order to subsequently permit her fertilized embryo to be transferred to the uterus of the sperm donor's wife does not want a legal relationship to any resulting child. For the first time, we face the question of who is the child's mother—the woman who contributes her genes or the woman who bears the child? The law should presumptively assign the status of legal parents to the uterine mother and her husband, if they are the intended rearing parents. The women who donate eggs or embryos should have no legal relationship to the offspring generated from their genetic contributions; nor should any other member of these women's families. Similar results should obtain if an unmarried woman receives an embryo conceived from the egg and sperm of anonymous donors. The uterine mother should be the legal mother and, as with AID of an unmarried woman, process integrity requires that the egg and sperm donors be exempt from any legal relationship to the child.<sup>128</sup>

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*supra* note 24, at 589.

126. See *supra* text accompanying notes 52-54.

127. For a discussion of whether the state has any obligation to assist the offspring of unmarried AID mothers to deal with the psychosocial consequences of not knowing their genetic father, see *infra* text accompanying notes 212-15.

128. Annas, *Redefining Parenthood and Protecting Embryos*, 14 HASTINGS CENTER REP., Feb. 1984, at 50, 50-51. Although Annas argues that the gestational mother should be the legal mother, he hedges in this article as well as in his other writings about how he thinks the law should characterize the genetic father when the gestational mother is unmarried. See, e.g., Annas, *supra* note 30. Concerned more with the child's interest in being able to claim financial support from a father than with the interest of the woman in bearing a child after AID, Annas is reluctant to allow parental status to be consistent with the expectations of sperm donors and unmarried gestational mothers. For what is in

Clarifying the legal family relationships of the participants in IVF and ET should present no great difficulties.<sup>129</sup> Why has no state done so, and why have only half the states enacted statutes to clarify the status of AID children? This unfortunate reluctance to publicly recognize or validate noncoital reproduction adversely affects the interests of the offspring. Far from implicitly deferring to the contractual allocation of parental status, the lack of statutory clarification frustrates the reasonable expectations of the parties. Adults and children alike are left in a legal limbo, not knowing precisely who they are in relation to each other. This leads to psychological complications that could be at least mitigated, if not totally averted, by stamping statutory approval on the parenting goals of those who turn to noncoital reproduction to have a child.

ii. *Establishing freedom from unnecessary physical or emotional complications*— Although the state can and should clarify the legal status of the progeny of IVF, ET, or AID, the state cannot guarantee couples that they will eventually have a child to raise, nor that the child will meet any particular specifications. All pregnancies entail risks and those begun in a laboratory are no exception. Nonetheless, the childless *do* have reason to expect that the reproductive process they choose, and for which they are willing to pay a high financial price, will not generate so many physical or emotional problems along the way that the hoped-for outcome of a child no longer seems worthwhile.<sup>130</sup> Couples may, of course, act on their own in response to difficulties that arise during the course of treatment. Women and men can decide not to go ahead with an effort to implant a fertilized egg, or can refuse to submit to physically invasive procedures. Until some point in their pregnancy, women can decide to have an abortion, or to resist efforts to diagnose or treat fetal abnormalities.<sup>131</sup>

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my view a much more compelling analysis of the importance of maintaining process integrity, see Blumberg, *supra* note 16.

129. For a discussion of the more difficult task of clarifying the legal relationship between parent and child in the surrogacy context, see *infra*, text accompanying notes 145-79.

130. For an account of some recent research on how people respond to repeated failures to achieve pregnancy, see Brozan, *The Grief of A Failed Pregnancy*, N.Y. Times, Feb. 7, 1983, at B5, col. 1.

131. Precisely how much freedom a woman continues to have with regard to her decision to abort or to resist fetal therapy remains a matter of considerable controversy. Two of the most careful analyses of the conflicts between the interests of a woman and the interests of her unborn child are Hubbard, *Legal and Policy Implications of Recent Advances in Prenatal Diagnosis and Fetal Therapy*, 7 WOMEN'S RTS. L. REP. 201 (1982) and Robertson, *supra* note 41.

These "self-help" measures are not sufficient, however, to protect the reasonable concerns about the medical procedures entailed in IVF or ET. At a minimum, the law should assure, as it does with other medical services, that the medical experts upon whom the childless rely as agents of their reproduction conform to acceptable standards of professional behavior. Malpractice claims, even though reactive rather than preventive measures, are available for couples who believe they have been harmed by negligent medical treatment. In fact, the background threat of a malpractice suit may serve to prevent physicians from acting imprudently during the course of treatment. The law should also see to it that the information disseminated about different techniques is not false or misleading. Many commentators believe that the current lack of any public oversight of IVF and ET research or treatment outcomes is detrimental to the legitimate interests of childless couples.<sup>132</sup> State or federal statutes could require that prospective donors of genetic material be adequately screened so couples could protect themselves and their offspring against physical or congenital problems. For the same reasons that we do not want the state to decide who is eligible for noncoital reproductive services, however, the state should not give the childless any legal right to choose donors with specific traits. Such choices, if they are to be exercised at all, should be made by couples and their physicians. As noted earlier,<sup>133</sup> the federal government may already be involved, at least indirectly, in supervising IVF or ET research because of the voluntary submission of research protocols to IRBs, which are then obligated to protect the interests of any human subjects involved in the procedures.

As with any complex and technically intricate course of medical treatment, however, a patient cannot reasonably expect to be in control of the process. Couples who choose to exercise their procreative autonomy through recourse to laboratory techniques must rely on the expertise of those to whom they have turned. It is a worthy goal to encourage medical professionals to give primacy to the interests of those they treat, and to encourage patients not to believe in the infallibility of "technological fixes."<sup>134</sup> But the law cannot insist that doctors be continuously accountable to patient demands for "autonomy," nor that doctors always provide unambiguous answers for those who prefer being

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132. See, e.g., Abramowitz, *supra* note 6.

133. See *supra* text accompanying notes 102-06.

134. See, e.g., the warnings in this regard in Hubbard, *supra* note 131.

more dependent on medical expertise than on their own sense of how treatment should proceed. Tensions between doctors and patients arise in the course of most complex or prolonged treatments, and IVF and ET procedures are not likely to be exceptions to this pattern.<sup>135</sup>

In sum, the law should not support the creation or attainment of unreasonable expectations by childless couples for specific outcomes from IVF, ET, or AID. But the law should be more actively involved in facilitating the attainment of their reasonable procreative expectations.

*b. Of parties to surrogacy contracts*— Supporting the reasonable expectations of the participants in noncoital reproduction presents greater difficulties for surrogacy arrangements than for IVF, ET, or AID. As illustrated by the experiences of the biblical Hagar, Sarah, and Abraham, the interests of the uterine hostess are potentially at odds with the interests of the intended father and mother. If the contract is fully performed, the childless couple's interests are served by their receipt of a child to raise and the gestator's interests are served by her receipt of the payments agreed upon and, presumably, by the altruistic feelings she experiences upon delivering the child to the father and his wife. What of the feelings of loss and sorrow that may temper the altruistic rush? Recent psychological studies have begun to confirm what had been largely anecdotal evidence, that in traditional adoptions, birth mothers who relinquish an "unwanted" child experience for many years thereafter a persistent and profound sense of loss.<sup>136</sup> This sense of loss adversely affects

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135. The dynamics of the doctor-patient relationship are themselves a fascinating subject of study, but beyond the scope of this paper. I do think, however, that we should be cautious before making assumptions that childless couples are eager to "manage" their treatment or, alternatively, are likely to be very deferential to medical professionals. An excellent general overview of the conflicts endemic to the doctor-patient relationship is in E. ROBIN, *MATTERS OF LIFE & DEATH: RISKS VS. BENEFITS OF MEDICAL CARE* (1984).

136. The first of these studies to attempt to explore the question of relinquishment loss in any depth is *ADOPTION TRIANGLE*, *supra* note 99, chs. 4 & 13. Deykin, Campbell & Patti, *The Postadoption Experience of Surrendering Parents*, 54 *AM. J. ORTHOPSYCH.* 271 (1984) and Rynearson, *Relinquishment and its Maternal Complications*, 139 *AM. J. PSYCH.* 338 (1982) both similarly report on the long term grief and sense of loss experienced by relinquishing birth mothers. The most ambitious study to date, but one which may be of limited relevance to the arguably different social circumstances surrounding adoptive placements in this country, is an account of the experience of Australian birth mothers, R. WINKLER & M. VAN KEPPEL, *RELINQUISHING MOTHERS IN ADOPTION* (1984). All of these studies, however, as well as the few others they cite, are retrospective and rely on volunteer samples, including women who respond to newspaper ads placed by the researchers, or women who belong to organizations whose goals are to search for previously relinquished children, or who are psychiatric patients.

their self-esteem and interferes with their capacity to sustain satisfying relationships with men and, if they have any, with their other children.<sup>137</sup> We do not know what will be the experience of surrogate gestators who deliberately bear a child for others to raise.<sup>138</sup> Will the ostensibly different motivation for producing and relinquishing a child protect them against or mitigate the dysfunctional effects of a long term sense of loss?<sup>139</sup> And what about the effect on the gestator's husband as he watches her bear a child for another man?<sup>140</sup> And what about her other children,<sup>141</sup> who may wonder whether they, too, will be pawned off to another set of parents? Although the payments are intended, in part, to compensate the surrogate for the emotional as well as the physical consequences of her pregnancy, she may find that no matter how firm her resolve had been when she originally agreed to be inseminated, she is reluctant to relinquish her baby at birth.<sup>142</sup>

*i. Specifying the interests of the parties—* Can the principle of supportive neutrality guide private intermediaries or state

137. These findings are reported in all the studies cited *supra* note 136, and especially in Deykin.

138. There is one published study of women who applied to be surrogate gestators, Parker, *Motivation of Surrogate Mothers: Initial Findings*, 140 AM. J. PSYCH. 1 (1983). Some of these women indicated that they wanted to serve as surrogates in order to come to terms with their own unresolved feelings of grief occasioned by an earlier relinquishment of a child for adoption.

139. WINKLER & VAN KEPPEL, *supra* note 136, at 61-69, report that it was not the sense of loss by itself that adversely affected the birth mothers they studied, but the perceived unavailability of a social support network. Those mothers who felt that they had some genuine control over their decision to relinquish and who felt supported in that decision by friends and relatives, both at the time of relinquishment and in subsequent years, reported much less difficulty in dealing with their lingering sense of loss than did those who felt pressured into giving up their babies.

140. Traditional AID also involves potential psychological complications for the birth mother's husband, including the need to come to terms with his own sterility. But at least the husband lives with his wife while she bears a child they both intend to raise.

141. Most of the lawyers who have arranged surrogacy contracts insist that the surrogate be married, have at least one child of her own, and profess a desire not to raise any more children. See, e.g., KEANE & BREO, *supra* note 32.

142. There are several reported instances of surrogates who have refused to deliver the baby to the genetic father and his wife. See, e.g., *Thrane v. Noyes*, 7 FAM. L. REP. (BNA) 2351 (Mar. 31, 1981) (permitting surrogate to retain custody of her child; denying genetic father visitation rights but placing his name on the child's birth certificate). See also the case of the British surrogate who had second thoughts about relinquishing the baby to the American couple who had paid her to bear a child for them, *supra* note 13. I know personally of one situation in which the surrogate and her husband already had several children, all girls. When, pursuant to her contract with another man, the surrogate gave birth to a boy, her husband at first tried to prevent her from relinquishing the boy to the genetic father, but later went along with her decision to abide by her contract. The surrogate and her husband have since had another child of their own—another daughter.

courts and legislatures in efforts to protect the interests of all parties to surrogacy agreements? There may be an unavoidable tilt toward according greater protection to the interests of one party rather than to those of another. Consider, for example, what is at stake in a decision about whether the surrogate and the intended parents ought to know each other's identity. Many intermediaries who have negotiated surrogacy contracts believe that fewer difficulties will arise during the course of performance if all the parties meet and maintain contact with each other. The parties allegedly come to appreciate each other's emotional needs and become highly motivated to abide by the terms of their contract. Some lawyers even recommend that the intended parents be in the delivery room when the surrogate gives birth, so that she can experience the joy of presenting the baby to them.<sup>143</sup> But there is a contrary argument that anonymity is preferable precisely because it prevents the surrogate from becoming aware of the emotions of the intended parents. Her anonymity, in this view, protects her from undue pressure to fulfill her promise to relinquish the baby soon after giving birth. When she does perform her part of the agreement, her decision to do so will be genuinely voluntary. She will have no regrets and the intended parents will get the child they crave.

This example suggests how difficult it is to determine which approach is "neutral"—that is, supportive of the integrity of the agreement without being unduly harmful to any of the parties. The answer depends upon which interests the law considers most essential to protect and upon what the law defines as "harm" to those interests. If the primary concern is to assure the *outcome* that the intended parents end up with a baby, then this interest may be harmed unless the couple has some relationship with the uterine hostess during her pregnancy. If the primary concern is to preserve the integrity of the *process* by assuring that the surrogate's consent to the original insemination and to the subsequent relinquishment is voluntary, then this interest may be harmed unless anonymity is maintained. Because, however, anonymity may in fact serve both the outcome interest and the process interest, or may in fact serve neither interest, we are unable to define it as a "harm" or as a "benefit." It is probably best for the law not to formulate any presumption with regard to anonymity, but to defer to the approach that makes the parties feel most comfortable.<sup>144</sup>

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143. Handel, *supra* note 22.

144. Research on surrogacy arrangements may eventually show that those in which



ii. *The indeterminacy of prevailing contract and family law principles*— An even more difficult test for the principle of supportive neutrality arises when the law must take sides, as, for example, when the birth mother refuses to turn the child over to the father and his wife. This situation does not involve a potential clash between an outcome concern and a process concern, but a clash between two outcomes, one initially agreed upon and the other developing as a consequence of the surrogate's experience bearing the child. Will the emotional harm now claimed by the surrogate if she is required to relinquish the child be allowed to vitiate the expectations of the intended parents? Since a decision either way will also determine who is to raise the child, how are the child's interests to be weighed as against those of the competing adults? Prevailing contract and family law principles probably could not yield predictable results in the dual effort to resolve the dispute between the adults and to protect the interests of the child.<sup>145</sup> As a consequence, time-consuming, expensive litigation would be required to resolve the matter. All participants are thus harmed by the lack of an explicit principle of support for noncoital reproduction.

Consider the numerous ways in which the intended parents' breach of contract claim against the surrogate might be resolved. The court might initially declare the contract unenforceable as a violation of state laws against baby-selling.<sup>146</sup> In this event, the infant would remain with the surrogate, but the genetic father would be unable to sue for damages or other relief, and the participants in the surrogacy arrangement, including the lawyers, might be subject to criminal penalties.<sup>147</sup> If the court did not find the contract unenforceable, it might award the father and

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the parties meet each other and have some kind of personal relationship are the ones that have the fewest conflicts about outcome or process. Even then a state legislature could justifiably be reluctant to make such contact mandatory. But it might be less hesitant to create a rebuttable presumption in favor of the parties learning each other's identity. This discussion of anonymity between surrogates and intended parents is not conclusive for, and may not even be pertinent to, an analysis of the child's interest in knowing the identity of her birth mother. For such an analysis, see *infra* text accompanying notes 218-19.

145. For the clearest analysis of how judges who decide child custody disputes must perform the dual and often inconsistent functions of settling the private dispute between the adult contestants and serving the societal interest in the welfare of the child, see Mnookin, *Child-Custody Adjudication: Judicial Functions in the Face of Indeterminacy*, 39 *LAW & CONTEMP. PROBS.* 226 (1975).

146. See, e.g., *Doe v. Kelley*, 106 Mich. App. 169, 307 N.W.2d 438 (1981), cert. denied, 454 U.S. 1183 (1983), where the Michigan Court of Appeals did declare the contract unenforceable as violating state law against baby-selling.

147. See *supra* note 9.

his wife restitution of any sums already paid to the surrogate and reimbursement of their reasonable reliance expenses. But these would-be parents want their expectancy interest: specific enforcement of the surrogate's promises to relinquish her parental rights to the father, and to consent to the child's adoption by the father's wife. The court might decline this prayer for relief, invoking the law's traditional reluctance to order specific enforcement of personal service contracts, and, instead, might permit the surrogate to retain the child, while ordering her to pay damages to the couple to compensate for the loss of their expected child. The court might also relieve the father of any obligation to support the child, especially if the surrogate's husband were willing to assume that obligation, or were deemed the child's legal father by the statutory presumption designed for AID children.<sup>148</sup> If the court felt that money could not adequately compensate the couple for the emotional damage occasioned by the loss of "their" child,<sup>149</sup> it could order the surrogate to relinquish the child in exchange for the payments originally promised her.<sup>150</sup>

Because the dispute involves the fate of a child who was not a party to the contract, the court might find it inappropriate to limit its decision to the issues posed by breach of a purely commercial transaction. Assessment of the claim for specific relief would be tempered by the concern for the child's welfare. With this in mind, the couple might recast their request in family law terms, as a claim for the permanent custody of the child based on the contractual agreement to give custody to the couple and on the alleged best interests of the child (BIC).<sup>151</sup> Specific enforcement of custody agreements is not uncommon, but courts subject the request to a review under the custody standards that would operate in a particular jurisdiction in the absence of such an agreement.<sup>152</sup> It is also possible that the surrogate would con-

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148. U.P.A., *supra* note 122, § 5.

149. *Cf.* the "unique goods" exception to the general principle of not awarding equitable relief for contract breach.

150. For alternative scenarios that might occur in the event of a dispute between the surrogate and the intended parents, see Eisenman, *Fathers, Biological and Anonymous, and Other Legal Strangers*, 45 OHIO ST. L.J. 383 (1984); Rushevsky, *supra* note 114; Comment, *Contracts to Bear a Child*, 66 CAL. L. REV. 611 (1978). My own version is not intended to consider all plausible possibilities, but merely to suggest how broad the range of possibilities is, and how difficult it is to predict in advance how our hypothetical dispute would be resolved.

151. See, e.g., UNIF. MARRIAGE AND DIVORCE ACT § 409, 9A U.L.A. 91, 211 (1979 and Supp. 1985) [hereinafter cited as U.M.D.A.].

152. In many cases, such a review is pro forma, or the challenger bears a heavy burden of persuasion that such enforcement would be detrimental to the child. However, in

vince the court that the critical issue is not enforcing the original contract, but dealing with her request for "modification" based on the alleged "change of circumstances"—the profound changes in her feelings about the child during the course of her pregnancy.<sup>153</sup> Under either characterization of the issue—contract enforcement or modification—the court is likely to apply some version of the typical BIC standard.

Under the BIC, neither the genetic mother nor the genetic father is obviously "best" as a potential nurturing parent. If the court felt that the mother's "moral fitness" was tainted by her refusal to perform the contract,<sup>154</sup> the BIC standard might help the couple. Even then, the surrogate could respond by noting first, that her conduct in commercial transactions is not relevant to her fitness as a parent, and second, that she broke the contract for the sake of the infant, in order to assure the infant an opportunity to be raised by a mother in whom the genetic, gestational and rearing roles were united. If the court applied a tender years<sup>155</sup> or primary caretaker<sup>156</sup> presumption, the surrogate would prevail. The surrogate might similarly have an edge if the Goldstein, Freud, and Solnit (GFS) standards were invoked,<sup>157</sup> because her experience as child-bearer may establish her as the only contestant with at least an incipient psychological parenting relationship with the child. If the mother continued to care for the child after birth during the pendency of the dispute, her GFS-based argument would be stronger.

If the court looked for the parent more likely to encourage "frequent and continuing contact" between the child and the non-custodial parent,<sup>158</sup> neither one would be appropriate. If the

unusual circumstances like the ones presented by our hypothetical, the court is more likely to perform an independent assessment under the jurisdiction's general custody standards; *see, e.g.*, *Gruber v. Gruber*, 87 A.D.2d 246, 451 N.Y.S.2d 117 (1982) (ordering a father to abide by an agreement to keep his children in a religious school through the 12th grade after he failed to show that following the "crystal clear" terms of the marital separation agreement would be detrimental to his children).

153. This requires some stretching of the meaning of "modification," which usually requires that there be a pre-existing custody decree; *see, e.g.*, U.M.D.A., *supra* note 151, § 409.

154. *See, e.g.*, MICH. COMP. LAWS § 722.23(3)(f) (1979).

155. *See generally*, Klaff, *The Tender Years Doctrine: A Defense*, 70 CALIF. L. REV. 335 (1982).

156. *See, e.g.*, *Garska v. McCoy*, 278 S.E.2d 357 (W. Va. 1981).

157. GFS, *supra* note 55, at 97-101.

158. For example, California is one of a growing number of states to give preference to the so-called "friendlier parent," the one more likely to allow the maintenance of a continuing relationship with the non-custodial parent, in the event that the primary statutory preference for joint custody cannot be applied. CAL. CIV. CODE § 4600(b) (*Deering* 1983). I have not even considered the possibility of using the fashionable preference for

court were required to give weight to the commitment of the parties to parenting,<sup>159</sup> the father's prospective loss of his opportunity to raise his child might weigh heavily against the court's reluctance to award custody of a newborn to anyone other than the birth mother. Similarly, if the court viewed the father's wife as sharing his strong reliance interest in parenting, then it might conclude that fairness dictated an award of custody to the father and his wife, even though the wife would normally not be able to prevail in a dispute against a biological parent.<sup>160</sup> In sum, even though in a number of jurisdictions the financial or custodial provisions of the contract might be presumptively valid, the court might or might not conclude, after reviewing the evidence, that the child's interests would be threatened by specific enforcement.<sup>161</sup> And if the court had initially determined that the surrogacy contract was unenforceable, the custody dispute would be resolved with even less attention to the parties' original expectations.

Regardless of how the custody determination turned out, the court would still have to decide whether to enforce the surrogate's promise to consent to the child's adoption by the father's wife. Here, the solicitude that courts and legislatures have shown to the right of birth mothers to withhold or revoke their consent to adoption<sup>162</sup> would have to be balanced against the

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joint custody, since our hypothetical is clearly not conducive to the harmonious sharing of custodial responsibilities. One of the best analyses, to date, of joint legal and physical custody is Scott & Deryn, *Rethinking Joint Custody*, 45 OHIO ST. L.J. 455 (1984).

159. Under current family law principles, courts are typically not required to do this, although many judges implicitly take the interests of the adults into account in applying a BIC standard. For an interesting argument that courts *should* take into account the interests and expectations of the adults, see Chambers, *Rethinking the Substantive Rules for Child Custody Disputes in Divorce*, 83 MICH. L. REV. 477 (1984).

160. This is because of the typical statutory requirement that in a dispute between a parent and a third party, the BIC of the child is served by awarding custody to the parent, "unless the contrary is established by clear and convincing evidence," MICH. COMP. LAWS § 722.25.5 (1979); or unless the third party can show that an award to the parent "would be detrimental" to the child and an award to the third party is "required" to serve the BIC, CAL. CIV. CODE § 4600(c) (Deering 1983).

161. If the court decided that the couple should get custody, it would probably characterize the decision as a "custody award" and not as "specific relief," in order to avoid the appearance—symbolically—of ordering the surrogate to perform an objectionable personal act. Whatever the terminology, the result would in fact be that the father and his wife would end up with the child.

162. See, e.g., *Scarpetta v. Spence-Chapin Adoption Serv.*, 28 N.Y.2d 185, 321 N.Y.S.2d 65, 269 N.E.2d 787 (1971), in which a birth mother who claimed that she was pressured into consenting to her daughter's adoption was allowed to revoke her consent even though the child had already been placed with prospective adoptive parents. The birth mother did not regain her child, however, because the adoptive parents fled to Florida where a local court later denied the birth mother's request for habeas corpus. *Foster, Adoption and Child Custody*, 22 BUFFALO L. REV. 1, 8-9 (1972). See also, *Sims v.*

claims of the father and his wife that the child's best interests necessitated enforcement of the gestator's promise.<sup>163</sup> Because consent was given even before the child was conceived,<sup>164</sup> and because the birth mother probably would revoke it while the infant remained in her possession,<sup>165</sup> the court would have to be very strongly committed to serving the parenting interests of the prospective adoptive mother before it would seriously entertain her request for specific enforcement of the adoption promise.

If the adoption does not take place, the genetic father and his wife could end up with custody of the child, but subject to visitation by the surrogate gestator. If the surrogate prevailed on the custody dispute, she could end up with custody of the child, but subject to visitation by the genetic father and his wife. Conflicts over child support would persist. The arrangement would take on the characteristics of many of the blended families that now come into existence when divorced parents, who share legal and physical custody of their child, each remarry. The child's stepparents, who may in fact give the child both emotional and financial sustenance, acquire at most an ambiguous legal relationship to the child.<sup>166</sup> Parents who choose to divorce have considerable control over the consequences of that decision for their children as well as for themselves. This is because the law, albeit indeterminate on many issues if the parties disagree, generally

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Sims, 30 Ill. App. 3d 406, 332 N.E.2d 36 (1975). The range of different statutory consent provisions is summarized in MEEZAN, *supra* note 9, at 154-64. Most states impose some kind of time limit within which a revocation must be made. *Id.*

163. A handful of states have incorporated the BIC question into their consent to adoption statutes. This includes New York where, subsequent to *Scarpetta v. Spence-Chapin Adoption Serv.*, 28 N.Y.2d 185, 321 N.Y.S.2d 65, 269 N.E.2d 787 (1971), the legislature enacted a provision which in some circumstances makes it easier for prospective adoptive parents to invoke the BIC standard to enforce a birth mother's consent to relinquish her child. N.Y. DOM. REL. LAW § 115-b(3)(d)(ii),(iii),(iv). For a persuasive criticism of this statutory change as being insufficiently protective of the interests of birth mothers in traditional adoptions, see Note, *The Constitutional Rights of Natural Parents Under New York's Adoption Statutes*, 12 N.Y.U. REV. L. & SOC. CHANGE 617 (1983-84). Although a number of states seem to have case law precedents for refusing to allow birth mothers to revoke adoption consents, the variation in the standards is so great that I find it impossible to extrapolate a general rule.

164. Many statutes provide that a consent to adoption signed before birth cannot become irrevocable until some time after the child is actually born or, alternatively, that no matter when a consent is given, it can be withdrawn at any time prior to placement with the adoptive parents or prior to the entry of the adoption decree. See MEEZAN, *supra* note 9, at 154-64.

165. This, of course, makes it difficult for the prospective adoptive mother to argue that she rather than the birth mother has established an emotional bond with the infant.

166. See generally, Mahoney, *Support and Custody Aspects of the Stepparent-Child Relationship*, 70 CORNELL L. REV. 38 (1984).

supports and enforces their private agreements.<sup>167</sup> Parties who choose to enter surrogacy agreements have considerably less control over the consequences of their decision. The law is not only indeterminate when a dispute arises, as we have just seen,<sup>168</sup> it is also indeterminate when the parties agree. Surely the law owes at least as much protection to the private understandings of those who hope to create families as to those who are breaking them apart. Unguided by an explicit principle of support for this kind of procreative choice, courts and legislatures are preventing childless couples from making reasonable plans for child rearing, and subjecting children to persistently unresolved questions about who is responsible for raising them.

*iii. Justifying a presumption for enforcing surrogacy contracts*— To avoid these harms, contract and family law principles should be combined into a strong statutory presumption in favor of enforcing the terms of the private surrogacy contract, including the provisions governing the relinquishment of the child to the father and the consent to the adoption of the child by the father's wife. Any party who challenged the agreement should have to show by clear and convincing evidence either that the agreement was not freely and knowingly entered into,<sup>169</sup> or that full and specific enforcement would be detrimental to the child. The presumption would thus favor the intended parents' interests in the event of a breach by the surrogate, and the surrogate's interests in the event of a breach by the genetic father.

A strong presumption in favor of enforcement is warranted for a number of reasons. First, because there is no way to anticipate whether a child will be better off being raised by his birth mother and her husband or by his genetic father and his wife, the child is not harmed by a presumptive allocation to the father in accord with the basic intention of the surrogacy contract. Second, placing a burden on those who would challenge the enforcement of rights and responsibilities allocated voluntarily, rather than on those who desire such enforcement, conforms with our general social, if not full constitutional, support for privately de-

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167. Mnookin & Kornhauser, *supra* note 11; Mnookin, *Divorce Bargaining: The Limits on Private Ordering*, 18 U. MICH. J.L. REF. 1015 (1985).

168. Our discussion of what might occur if the law has to take sides when a surrogate decides that she does not want to relinquish the child suggests only a few of the legal uncertainties surrounding these reproductive choices. Many others would become manifest if we were to explore the consequences of a genetic father's breach of the contract terms, by refusing, for example, to accept the child or by refusing to make the promised payments.

169. This would serve the process concern of protecting the surrogate against undue pressure to enter the agreement in the first instance.

terminated reproductive choices. Third, this presumption would make it considerably easier than it now is for the parties to a surrogacy arrangement that goes smoothly to obtain legal and public validation of their private conduct. Those who understand what they are doing, and do it without harming either each other or their offspring, should not have to go to court to fight for a sympathetic interpretation of their activities. Fourth, the existence of this presumption would encourage people to reflect carefully upon the consequences of a surrogacy contract before entering into one, and discourage them from initiating litigation to set aside such agreements once performance has begun. Given the special importance of avoiding the harms to children occasioned by protracted custody litigation,<sup>170</sup> there is much to be said for a presumption designed to narrow the boundaries within which legal indeterminacy exists. For the sake of the child who is bound to be harmed by not having a clear location in which to experience her infancy, we should not wait for the majesty of the law to gradually and inconsistently manifest itself through a series of ad hoc decisions. Legislative action is needed now.<sup>171</sup>

Legislation designed to presume and facilitate enforcement of surrogacy contracts must, of course, ensure that both the negotiation and the performance of the contract conform to at least minimal standards of fairness. The state should require, for example, that the agreement be in writing, that the surrogate and the intended parents offer evidence of the knowing and voluntary nature of their consent, such as being represented by separate counsel,<sup>172</sup> and that any party be permitted to cancel the agreement without penalty prior to the insemination of the surrogate.

The state should also insist that specific terms be included to enhance the possibility that the parties will end up with the outcome they desire. Contracts routinely should provide for medical and genetic screening of the surrogate and the intended father to protect the surrogate against infections transmitted by the father's sperm and the child against inheritable illnesses or other congenital disabilities. The surrogate should agree to abide by explicit instructions from her physician to refrain from regular

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170. GFS, *supra* note 55, ch.3.

171. See *supra* text accompanying notes 121-29 for the similar argument for clarifying the legal relationship among the parties to IVF, ET, and traditional AID.

172. See, e.g., the recommendation of the Committee on Judicial Ethics of the New York City Bar Association with regard to separate attorneys for the surrogate and the couple, 8 FAM. L. REF. (BNA) 4069 (1982).

sexual intercourse while trying to achieve a pregnancy through artificial insemination. Contracts also should call for blood tests to determine paternity after the surrogate gives birth.<sup>173</sup> Escrow accounts or insurance policies<sup>174</sup> are needed to guarantee that the promised payments are made, including, for example, partial payment to the surrogate if she miscarries or if other unanticipated medical complications prevent her from carrying the baby to term.<sup>175</sup>

Additional legislation may be needed to facilitate, first, the acknowledgment of the genetic father's paternity, second, the relinquishment of the surrogate's parental rights to the genetic father, and third, the adoption of the child by the father's wife. Some might argue that the surrogate's relinquishing of parental rights to the child's father is the equivalent of her consent to the child's adoption by another woman. I think the integrity of the entire process is better served by separating the relinquishing of parental rights, which might be interpreted in some jurisdictions as not being broad enough to encompass a general consent to adoption, from the surrogate's consent to the specific adoption by the father's wife. Alternatively, this could be accomplished in one judicial proceeding in which the surrogate submitted her written consent relinquishing all parental rights to the father, including the right to place the child for adoption.<sup>176</sup> At this pro-

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173. As many commentators have noted, such requirements could have averted the Malahoff-Stiver fiasco in which the fate of the microcephalic child borne by the surrogate remained uncertain because of a dispute over his genetic parentage. Blood test results, read on the Donahue show, eventually indicated that the child was the son of the surrogate and her own husband. See, Annas & Elias, *supra* note 70, at 217.

174. The parties will probably agree to have such accounts or policies in order to support the child in the event that the father dies or refuses to accept custody. But since the state does not require that the children generated by coital means be similarly protected in the event one or both parents die or abandon them, I do not believe such a requirement can be mandated in the surrogacy context.

175. She should not get paid, however, if she decides to have an abortion, unless she does so with the consent of the genetic father after learning, for example, from amniocentesis, that the fetus is not developing normally. She should also not get paid if her own negligence results in the loss of the fetus. Frankly, I am undecided as to whether the state should by statute limit the father's recovery against the surrogate to return of his payments, in the event that her provable negligence results either in the loss of or physical harm to the baby. Perhaps this question, as well as the question of specific enforcement of any promises made by the surrogate with regard to prenatal care, ought to be resolved by the courts in what I hope will be very few such cases.

176. I am not addressing here the possibility that the father's wife will refuse to adopt the child, or that the father will refuse to give his consent to the adoption because, for example, he and his wife are estranged. Would the surrogate be held to her relinquishment of parental rights to the father even if the adoption does not take place? I would stand by my proposed presumption of enforceability of the promise to relinquish, in part because it is by no means clear that the child would be harmed if raised exclusively by his or her father.



ceeding, the court could scrutinize the consent to be sure it conformed to the proposed standard of being informed and voluntary,<sup>177</sup> and could ask for an accounting of all moneys paid to the surrogate and to the attorneys.

Legislation should recognize the legitimacy of the payments discussed earlier,<sup>178</sup> and should specifically exempt the kind of surrogacy agreement described here from state statutes prohibiting "baby-selling." As a final protection of the integrity of the process, the state could insist on a minimal social investigation of the adoptive mother, analogous to what might be done in a routine stepparent adoption.<sup>179</sup> The scope of this inquiry should be carefully limited to any characteristics that might threaten the child's welfare, and should *not* include any futile attempt to determine if the adoptive mother is the "best" possible parent for the child. Indeed, counseling services for the father and the adoptive mother, to assist them with any problems they anticipate in raising the child, would be more consistent with the procedures outlined here than would any general investigation of the suitability of either one of them as parents. But I doubt that any state would be willing to allow its courts to approve the adoption without some inquiry into the setting in which the child will probably be raised. At the end of this process, the surrogate gestator would have no legal rights or responsibilities to the child, who would then reside with her legal parents—her genetic father and his wife.

My aim, in outlining some of these procedural and legislative measures, has been to show that my proposed presumption in favor of enforcing surrogacy contracts can be achieved without creating an elaborate administrative or supervisory structure. I explicitly disagree, for example, with Walter Wadlington's suggestion that the model of traditional adoption with its "networks of child placement agencies operated or regulated by the states,"<sup>180</sup> is an appropriate model for supervising surrogacy contracts. As my proposals indicate, I do recognize that some public oversight is necessary. But the goal of any public regulation must always be to protect the interests of all parties by allowing,

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177. If the parties had previously determined that they wished to retain anonymity among themselves, see *supra* notes 143-44 and accompanying text, this desire could be honored by having the court question the birth mother separately, or by waiving any requirement that she appear in person.

178. See *supra* text accompanying notes 111-18.

179. The interest in protecting the child's welfare does not, in my view, require an elaborate investigation of the intended parents any earlier in the process. For my skepticism about screening for parental fitness, see *supra* text accompanying notes 98-106.

180. Wadlington, *supra* note 23, at 512.

to the greatest extent possible, the parties to define those interests for themselves.

The social and psychological complexities of surrogacy,<sup>181</sup> in addition to its legal ambiguities and commercial aspects, may present good reasons for people not to choose this procreative option. These concerns certainly account for the hostility toward surrogacy expressed by the medical profession and by most associations of adoption and child welfare agencies.<sup>182</sup> The current efforts in Britain and Australia to criminalize commercial surrogacy are similarly responsive to these concerns.<sup>183</sup> Surrogacy is also distasteful to those feminists who are eager to eliminate the perception and use of women exclusively as child bearers. Those sharing this perspective see the childless man exercising a form of "patriarchal genetics" over the woman whose gestational services he hires,<sup>184</sup> as well as over his wife, who, if the typical pattern holds, is more likely than he to assume the major responsibility for the infant's care. For other feminists, however, who glorify the role of woman as child bearer and nurturer,<sup>185</sup> surrogacy may be the apotheosis of the ethos of care among women. My own position on surrogacy is, as suggested throughout this discussion, that it is extremely difficult to make an informed and knowing decision to pursue a procreative choice that has so many indeterminate psychological consequences. Nonetheless, in the absence of a showing of specific and substantial harm to the offspring, I do not believe the law should stand in the way of those who determine that this is the most appropriate choice for them.

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181. See *supra* text accompanying notes 136-44.

182. See, e.g., the critical statement of the American College of Obstetricians and Gynecologists (ACOG) (May 1983), reprinted in 13 HASTINGS CENTER REP. 31 (1983). See also the AMA Resolution criticizing surrogacy arrangements as not serving societal interests, reported in REP. HUM. REPROD. L. R-114 (1984); and the recommendation by the Child Welfare League of America and the National Committee for Adoption (NCFA) that adoption agencies refuse to cooperate with any surrogacy arrangements and that legislation be enacted to outlaw these arrangements, reported in Pierce, *supra* note 66, at 3002.

183. WARNOCK REP., *supra* note 14, §§ 8.17-8.18: "That people should treat others as a means to their own ends, however desirable the consequences, must always be liable to moral objections. . . . [T]here is a serious risk of commercial exploitation of surrogacy . . . that . . . would be difficult to prevent without the assistance of the criminal law." See also WALLER REP., *supra* note 14, part 4.

184. See, e.g., Blakely, *Surrogate Mothers: For Whom Are they Working*, Ms., Mar. 1983, at 18.

185. From his interviews of women who wished to be surrogates, Parker, *supra* note 138, reported that many of these women experienced a strong emotional desire to bestow "the gift of life" on childless women.

### B. *Minimizing Harm, Especially to the Children*

What about the children who are the end product of the new conception techniques? To remain consistent with the principle of supportive neutrality, the state's policies for facilitating procreative choice must yield at some point to the newborn's interest in avoiding harm.<sup>186</sup> In defining the parameters of the child's interest, three questions need to be addressed. Should special attention be afforded the products of assisted fertilization? Can the kinds of harms that might befall these children be anticipated? What might be done to minimize the likelihood that these harms will occur?

No one stands at the bedside of the couple who are attempting to conceive a child through coital means to ask whether they have taken appropriate steps to protect their offspring against physical or emotional harms. Why should the children produced by noncoital means receive special treatment? With other children, we defer to parental autonomy until some actual danger looms against which the parents are by themselves unable to shield their children, or for which the parents themselves are responsible. Why should it be different here? The grounds for some early "protection" are clear. As discussed earlier, the absence of some state action identifying the legal parents may leave children vulnerable to harm resulting from being the object of litigation, as well as from the lack of stability that inheres in not knowing precisely who one's parents are.<sup>187</sup> The very process by which these children are created may be more physically harmful or dangerous than conventional conception and birth. Finally, the specific psychosocial harms that may reasonably be anticipated to threaten these children over the course of their lives might actually be averted or mitigated by supplementing the self-interested actions of the adult participants in noncoital reproduction with some publicly-imposed preventive measures.

1. *Threats to physical well-being*— Is there any evidence that the new reproductive techniques jeopardize the physical well-being of the offspring? The artificial *in vivo* insemination of a surrogate gestator with the sperm of the intended father presents no more chance that the child will be born with physical or congenital disabilities than what would be anticipated from the usual process of conception and gestation.<sup>188</sup> The

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186. See *supra* text accompanying notes 15-17.

187. See *supra* text accompanying notes 121-29 and 145-68.

188. Artificial insemination is a simple procedure, requiring no surgery and no medi-

chances may even be lower because the medical and genetic histories of both the sperm-provider and the uterine hostess would presumably be thoroughly reviewed and "approved" before the artificial insemination takes place.<sup>189</sup> Also, the promise of payment upon her delivery of a newborn may encourage the surrogate to give the child especially attentive prenatal care.

In contrast to the surrogacy situation, the risks of physical harm to a child from being fertilized in a petri dish may be somewhat higher, or at least of a different kind. Although many medical groups are convinced that IVF is safe,<sup>190</sup> questions remain about the unknown and still unknowable long term consequences of being conceived outside a womb. Biomedical research has taught us a great deal about the growth and development of embryos. Nonetheless, we still lack complete understanding of this extraordinarily complex process. Similarly, our knowledge of what accounts for the successful implantation of a fertilized embryo within a woman's uterus remains incomplete. Many inter-related processes occur at the same time. If anything goes awry, the consequences could occur at once and the embryo could abort itself, as indeed happens in many "natural" conceptions. But the difficulties could also appear years later in unexpected and catastrophic ways.<sup>191</sup>

There is a somewhat greater than average likelihood of multiple births after IVF, along with their predictable concomitants: premature labor, low birth weights, and caesarean delivery. This is not due to the *in vitro* fertilization itself, but to the currently

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cation, that can be performed in a doctor's office or in an outpatient hospital clinic, FINEGOLD, *supra* note 23. We are assuming that the AID of surrogates will be performed by licensed physicians and not, as of course can be done, by the parties themselves.

189. See *supra* text accompanying notes 132-33 for the suggestion that the state require the routine use of the most up-to-date diagnostic and genetic screening tests for the surrogate and the genetic father prior to the insemination. This is not intended to prevent the surrogacy agreement from going forward if the tests indicated some heightened degree of risk to the child, but to make the information available to inform whatever decisions the adults make. For example, if the tests reveal that the child is likely to have cystic fibrosis, the state cannot prevent the adults from proceeding as planned, but they themselves might decide not to proceed.

190. AFS Statement, *supra* note 91. Much of the information, as well as the questions raised, in this and the following paragraph are drawn from recent articles in FERTILITY & STERILITY or J.A.M.A., from IN VITRO FERTILIZATION AND EMBRYO TRANSFER, *supra* note 91, and from my discussions with members of the Stanford Medical School faculty.

191. Much of this would also apply to donor embryo transfer. Although fertilization in the ET procedure takes place *in vivo*, our knowledge about the consequences of transferring an embryo from one reproductive environment to another is still derived largely from cattle and other animal breeding. Brotman, *supra* note 29; Buster interview, *supra* note 29.

preferred procedures of giving the uterine mother superovulation drugs prior to retrieving her eggs, and then implanting several fertilized embryos simultaneously to improve the chances of at least one successful implantation. No one has suggested that a high occurrence of multiple births is an unacceptable "harm"; indeed, some would say it is a benefit both to the parents who get an unbargained-for windfall and to the children who get siblings they might not otherwise have. Similarly, no one has claimed that any of the children born thus far as a consequence of IVF show signs of unusual physical or mental disabilities. Nonetheless, the oldest of the test tube babies is only seven-and-one-half-years-old. How long should we wait before we can feel comfortable about saying that the risks to children from IVF are no more or less than the risks from normal conception?<sup>192</sup>

More importantly, how substantial would the risks from IVF have to be before we would feel comfortable arguing for its prohibition? And who are "we": prospective parents choosing between having no child and having a child who, however "damaged," is genetically related to at least one of us; doctors deciding whether it is worth our time to attempt to improve IVF outcomes or to explore other infertility treatments; or the federal or state governments choosing between commitment to procreative autonomy for adults and responsibility to protect the welfare of children? In other words, "we" might include everyone except the child, who is not in existence and therefore cannot tell us whether he or she would prefer some life to no life at all. The law must of necessity entrust the fate of the unborn child to others. Perhaps equally inescapable is the difficulty of preventing the interests of adults from always getting primacy over the interests of children.

2. *Threats to psychological well-being*— This last observation may be of even greater relevance for an analysis of potential psychosocial harms to the children produced by noncoital means

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192. Our experience with other medical procedures or treatments that have resulted in unanticipated and severe physical harm certainly argues for some caution when the creation of human life is involved. Consider such examples as the doubling of the incidence of uterine cancer in the 1970's, which has now been attributed to the widespread use in the previous decade of estrogen therapy for post-menopausal women; the inaccurate diagnoses of pulmonary embolism resulting from the use of inadequately tested lung scanners; past epidemics of blindness among premature newborns resulting from excessively high exposure to oxygen while in neonatal intensive care units; the second thoughts now beginning to emerge about the superiority of radical mastectomy for women with breast cancer as opposed to the less physically invasive and disfiguring approach of limited lumpectomy. These and other examples of medical practices which became routine without adequate studies to test their efficacy and safety are discussed in E. ROBIN, *supra* note 135, at ch. 8.

than for a discussion of physical harms. Consider what would happen if IVF or ET offspring were suddenly to manifest serious physical problems; being born, for example, with some fatal disease. This would probably not result in a clash between childless couples and a paternalistic legislature or court. Instead, all parties would quickly come to a consensus to abandon these procedures.<sup>193</sup>

In contrast, conflicts between the interests of children and the interests of adults might well arise once attention shifts to the much more elusive realm of psychosocial harms. The state may then have to be enlisted to act on behalf of the children. Although more difficult to specify than physical harms, psychosocial harms are no less real. Those harms most likely to threaten the offspring of noncoital reproduction resemble the genealogical bewilderment that many adopted children experience: confusion about the circumstances of their birth, difficulties with identity formation, and desires to be reconnected to their apparently lost genetic heritage.<sup>194</sup> It is not abnormal to be curious about one's origins; indeed, such curiosity is generally recognized as a healthy and predictable part of growing up. In recent years, adoptees who seek information about their biological parents have been treated more sympathetically; they are no longer seen as obsessive or weird.<sup>195</sup> Erikson and Lifton are among those who argue that identity formation *does* require some awareness of one's biological and historical past.<sup>196</sup>

a. *Whether to reveal the child's origins*— Secrecy has been

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193. I doubt whether even those who believe that it is better to be born with handicaps than not to be born at all would argue that it is better to be born in order to die an early and painful death than not to be born at all, especially if other less dangerous routes to conception could be devised. But for an argument that comes close to the position that any life, no matter what its quality, is better than no life at all, see Robertson, *In Vitro Conception and Harm to the Unborn*, 8 HASTINGS CENTER REP., Oct. 1979, at 13.

194. For a general overview of the psychological problems adopted children confront, see American Academy of Pediatrics, Committee on Adoptions, *Identity Development in Adopted Children*, 47 PEDIATRICS 948 (1971); Schwam & Tuskan, *The Adopted Child*, in 1 BASIC HANDBOOK OF CHILD PSYCHIATRY 342 (J. Noshpitz ed. 1979). For useful bibliographies of the many published and unpublished papers on this subject see ADOPTION TRIANGLE, *supra* note 99; W. FEIGELMAN & A. SILVERMAN, CHOSEN CHILDREN (1983)[hereinafter cited as CHOSEN CHILDREN].

195. The research on searching and on reunions between adoptees and birth parents reported in ADOPTION TRIANGLE, *supra* note 99, has had a lot to do with changing attitudes toward adoptees who manifest curiosity about their biological roots. See also CHOSEN CHILDREN, *supra* note 194, at ch. 8; JONES, THE SEALED ADOPTION RECORD CONTROVERSY: A SURVEY OF AGENCY POLICY, PRACTICE AND OPINIONS (1976).

196. E. ERIKSON, LIFE HISTORY AND THE HISTORICAL MOMENT (1975); R. LIPTON, THE LIFE OF THE SELF: TOWARD NEW PSYCHOLOGY (1976).

an element in adoption since the 1920's,<sup>197</sup> but it need not be carried over into other child rearing arrangements that involve a separation of biological from social parenting. Even in the case of adoption, informed opinion during the last several decades has overwhelmingly favored sharing with the child the fact that he or she has been adopted.<sup>198</sup> The offspring of noncoital reproduction ought to be told the circumstances of their birth. Even if the parents do not display a bronzed petri dish on their mantle, it is difficult to imagine that the circumstances of artificial conception could be kept from a child forever. Children are bound to experience more distress if they learn about these circumstances inadvertently than if their parents tell them. Adoptees who feel the greatest need to search for their biological parents, and who often experience other kinds of psychological stress, are those who learn of their status when they are older or who are told, not by their adoptive parents, but by others.<sup>199</sup> Nothing is gained by non-disclosure. The energies that go into maintaining the "family secret" undermine the long term development of a trusting relationship between the child and the parents who raise her.<sup>200</sup> There are reasons to believe, then, that similar distress and intra-family difficulties will afflict the offspring of IVF, ET, AID, and surrogacy if they are kept in the dark about the nature of their conception.

Assuming that it is better to tell than not to tell, can disclo-

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197. *E.g.*, New York State explicitly recognized in 1924 that the judge who granted an adoption had the discretionary power to seal the records of an adoption proceeding. 1924 New York Laws ch. 323, § 113. But New York, like most other states, did not mandate the sealing of adoption records until at least the mid-1930's. *See* 1935 New York Laws ch. 860, § 113. *See generally* Hollinger, *The Search for the Ideal Home: Adoption in America, 1900-1935* (paper prepared for University of Wisconsin Legal History Project, summer 1984; copy on file with the U. MICH. J.L. REF.).

198. CHOSEN CHILDREN, *supra* note 194; CHILD WELFARE LEAGUE OF AMERICA, STANDARDS FOR ADOPTION SERVICE § 4.20 (rev. ed 1978) [hereinafter cited as CWLA STANDARDS]. *See also* Dukette, *Value Issues in Present-Day Adoption*, 63 CHILD WELFARE 233 (1984).

199. *See generally* ADOPTION TRIANGLE, *supra* note 99, and CHOSEN CHILDREN, *supra* note 194.

200. Sands & Rothenberg, *Adoption in 1976: Unresolved Problems, Unrealized Goals, New Perspectives* (paper read at American Association of Psychiatric Services for Children, Annual Meeting, San Francisco, (1976)). This influential paper is the work of two psychiatrists who earlier had the view that no harm would come from keeping the fact of a child's adoption secret. *See* ADOPTION TRIANGLE, *supra* note 99, ch. 3. I can find nothing in the child development literature of the past decade arguing that any good can come from failing to disclose to a child the circumstances of her birth, except for an article by one psychoanalyst. On the basis of limited clinical experience, Wieder conjectures that for some adoptees, the psychological disturbances that result from knowing that they were adopted may prove too difficult to handle; *see* Wieder, *On Being Told of Adoption*, 46 PSYCHOANALYTIC QUARTERLY 1 (1977).

sure be "enforced" and its character prescribed? Surely not. Deference to parental autonomy and faith in parental good sense remain preferable to having the state send children a certificate of IVF conception on their eighteenth birthdays. Doctors could make a promise to disclose a condition of the parents' receiving IVF treatment, but would there be a follow-up? And what sanctions could be imposed for failing to disclose? The child's "right" to know is strong, but not so strong as to circumvent the decision of the child's parents about when and how to disclose.<sup>201</sup>

b. *Whether to reveal non-identifying information*— What about information concerning the medical and genetic make-up of those who contributed to the children's conception? The offspring deserve, as do the adults who raise them, all the available information.<sup>202</sup> This should include not only the information about the donor of sperm, egg, embryo, or baby at the time of conception, but also up-dated accounts throughout the donor's life. The parents are themselves likely to encourage their child's genealogical curiosity. After all, it was their own desire to be genetically linked to their offspring that led to their efforts to conceive through some combination of their own and third party genetic materials. But as the experience over the past several decades with AID reveals, the relevant information is all too rarely available. Without a state-imposed requirement that genetic and medical profiles of sperm, egg, embryo, and baby donors be made initially, and then periodically up-dated and made available to the legal parents or to the children upon attaining age eighteen, such procedures may never become routine.<sup>203</sup> In

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201. CWLA STANDARDS, *supra* note 198, suggest that counseling services be provided for parents of adoptive children who desire assistance in planning how to tell their children about the circumstances of their birth and adoption. Such counseling might also be a useful adjunct to IVF, ET, and surrogacy services, but the state should not get into the business of monitoring the intimate details of the parent-child relationship.

202. My reading of the "search for roots" literature on adoptees, including ADOPTION TRIANGLE, *supra* note 99, CHOSEN CHILDREN, *supra* note 99, and many of the articles they cite, suggests that the genealogical bewilderment discussed here may be eased for many children by simply sharing with them whatever is known about their biological parents, short of identifying information. It is not so much a question of whether the adoptees would like more than non-identifying information, but whether any psychological stress they experience as a consequence of not having identifying information can be at least partially reduced by the disclosure of non-identifying information.

203. Curie-Cohen, *supra* note 24. This study of AID procedures revealed a shocking lack of attention to pre-insemination screening as well as to maintaining up-dated information about sperm donors. The AID experience, then, is far from encouraging about the ability of the private market to see to it that such records are maintained. Even among the 25 states that have AID legislation, few require recordkeeping. As a consequence, the choice has been made for an entire generation of AID children: no information about



addition to the parents' and children's legitimate interest in having access to non-identifying medical and genetic information, society also has a general interest in monitoring the incidence of heritable and genetic diseases and conditions. The medical professionals who are now devising standard protocols for IVF and ET acknowledge the importance of acquiring and maintaining complete background information about donors.<sup>204</sup> A statutory requirement should bolster this resolve. As an innocent participant in her own conception, the child should not be burdened in the future by the discovery that her perfectly legitimate curiosity about the characteristics of her biological forebears cannot be satisfied because records of those characteristics were not maintained.

Providing non-identifying information, the wisdom of which is at last becoming self-evident, does not resolve the more controversial question of whether to divulge the identity of a third party donor. Parents may be quite willing to have the donor's genetic profile and medical history known to their child, yet prefer that the donor's identity remain undisclosed. The parents' feelings may depend on whether they themselves know the donor's identity. These feelings may also depend on whether they fear that providing such knowledge to their child would threaten their own relationship with him or her. Our recent experience with the open-records debate in the context of traditional adoption shows how difficult is the question of whether to disclose the identity of third parties to the child's conception.<sup>205</sup> It may be possible, however, to approach an answer if we begin with the simpler of the noncoital situations—IVF, ET, and AID—and subsequently move to the more complicated circumstances of surrogacy.

*c. Whether to reveal the identity of IVF, ET, and AID donors*— Until the child is eighteen, the decision concerning the identity of the IVF, ET, or AID donor should be left to the child's parents. But once the child is herself an adult, the interests of her legal parents should no longer be able to stand in the way of her learning what is known about the genetic and medi-

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their genetic fathers.

204. Buster interview, *supra* note 29, Lamb discussions, *supra* note 25, AFS STATEMENT, *supra* note 91. For similar recommendations in the context of traditional adoptions, see CWLA STANDARDS, *supra* note 198, at 4.26.

205. See generally ADOPTION TRIANGLE, *supra* note 99, and CHOSEN CHILDREN, *supra* note 194. In my view, because of the limited and self-selected nature of the research samples, none of the studies is as conclusive about the psychological benefits of disclosure as many of the researchers would like us to believe.

cal histories of those who contributed to her conception. Nor should her parents' wishes stand in the way of her learning the identity of those contributors if she desires to do so. Even as an adult, however, she may encounter other legitimate barriers to her desire to obtain identifying information. The most formidable of these are the past assurances given to sperm, egg, embryo, or baby donors that their anonymity would be preserved. The donor's reliance interest in continued anonymity cannot be brushed aside easily. But it can be reassessed through some kind of registry process<sup>206</sup> in which donors are contacted by neutral intermediaries on behalf of the IVF, ET, or surrogate gestator's adult child, and asked if they would object to the disclosure of their identity.<sup>207</sup>

As a matter of general policy, is it advisable to establish a presumption that the identity of the donor shall eventually be made known to the child? The answer determines whether doctors performing IVF, ET, or AID should seek donors who are willing to have their identities disclosed. If the law tilts toward the view that the child has an absolute "existential right" to such disclosure, or even that the child has some legitimate interest in such disclosure, then doctors should indeed seek donors who will not ask for anonymity. If, however, the law's preferred policy is assuring the continued availability of noncoital reproduction—a circumstance that might become less likely if promises of non-disclosure were no longer offered—then the law ought to move cautiously in deciding to discontinue any guarantee of anonymity. Sperm donors are not routinely asked if they want such a guarantee. They are invariably given one on the assumption that they would demand one if asked.<sup>208</sup> We have had too little experience with egg donors to predict their feelings about anonymity.<sup>209</sup> As I argued above, it is advisable to assure donors that they will never have any financial or legal liability for a child produced from their eggs or sperm.<sup>210</sup> But the prohibition of lia-

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206. See *supra* note 62. Upon attaining her majority, the child may communicate with the surrogate gestator or egg, embryo, or sperm donor and ask if the donor is willing to change his or her original desire for anonymity.

207. Although, as the above discussion indicates, we are beginning to get studies of the effects of non-disclosure on adoptees, no one has studied the psychological effects of being told "no" in response to a request for identifying information made 18 years or more after the child's birth.

208. Curie-Cohen, *supra* note 24.

209. Dr. Buster does have anecdotal evidence that some potential donors said they would prefer not to have their identities disclosed, but others said they would be curious about any child produced from their genetic contribution and assumed that such child would be curious about them. Buster interview, *supra* note 29.

210. See *supra* text accompanying notes 121-28.

bility differs from the assurance of anonymity.

Because our thinking about the disclosure of the donor's identity has been so bound up with ideas about the disclosure of the identity of the biological parents of adopted children, it is essential to attend to a basic difference between the two kinds of non-rearing parents. The difference gains importance in the present context because it strengthens the argument for a presumption against disclosure of the identity of sperm, egg, or embryo donors.<sup>211</sup> The donor assists in a planned, much-desired pregnancy; he or she is not shedding an unwanted child. Thus, the child conceived in part with the assistance of a donor's genetic material can be told that she was very much desired by all parties to her conception. She was not an "accident" or a "mistake." The donor stands in a very different relation to the child than does the biological parent to the adoptive child: the donor's contribution is impersonal, indeed mechanical. Donors facilitate the gestational, birthing, and rearing experiences of others. The donor is less akin to a biological parent in an adoptive relationship than to a contributor of blood to a needed and wanted transfusion. Hence the donor does not present, for the child, the potential problems presented for an adopted child by having an unknown, biological parent.

Nonetheless, recent research has begun to raise some basic questions about the appropriateness of assuring sperm, egg, or embryo donors that their identities will remain confidential. Nearly all of a large group of sperm donors interviewed ten to twenty-five years after their donations<sup>212</sup> indicate that they are curious about their genetic offspring, have felt some regret about their earlier requests for anonymity, and are concerned about the possibility that the children may experience psychological distress as a consequence of being unable to have any contact with their genetic father's families.<sup>213</sup> The parents who raise AID

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211. For an argument in favor of the reverse presumption when full surrogate gestation is involved, see *infra* text accompanying notes 218-19.

212. The questionnaires were administered by Pannor and Baran, two of the authors of *ADOPTION TRIANGLE*, *supra* note 99. Their research will be reported in a forthcoming book by Pannor and Baran, both psychiatric social workers affiliated with Vista Del Mar Child Care Services in Los Angeles, California. The information presented here is based on a telephone interview with Mr. Pannor, Apr. 9, 1985 [hereinafter cited as Pannor interview].

213. Pannor interview, *supra* note 212. Some anecdotal support for the Pannor and Baran research appeared in a television interview of male sperm donors whose sperm has been used to inseminate unmarried women at an Oakland, California sperm bank. These men spoke of their own surprise at discovering, years after their donation, that they were persistently troubled by a desire to know more about the children they helped produce, Newscenter 4, (K.R.O.N. T.V., NBC Network Affiliate), San Francisco, California, Apr.

children report considerable tension within their families, especially in the event of a divorce, over the issue of discussing with their child the nature of his or her conception. The offspring, most of whom are eighteen and older, report strong desires to know the identity of their genetic fathers. These children are not impressed by the argument set forth above,<sup>214</sup> that the special circumstances under which the sperm was contributed result in their experiencing less urgency to know their actual genetic father. These AID children believe that their relationships with the parents who raised them would be considerably improved if they were able to learn the identity of the sperm donors.

But are these findings, based on a limited number of AID donors and offspring, sufficient to overcome the arguments for preserving the anonymity of sperm and egg donors? Probably not. The evidence from traditional adoptions is mixed; it is far from clear that psychological distress always follows from lack of knowledge about the identity of a biological parent;<sup>215</sup> nor is it clear that the only or best way to relieve that distress is by divulging the parent's identity. It may be that disclosing the identity of the birth parents—the proposed “cure”—creates additional problems for the children, in relating to both their adoptive and biological families, that will prove just as intractable as the initial psychological distress of not knowing who the birth parents are.<sup>216</sup> Perhaps counseling or other efforts directed at alleviating the children's felt distress, or at enabling adoptive parents to understand and respond to the concerns of their children, would be of equal or greater value. The limited research to date on the children of divorced parents offers even less direct support for a presumption favoring disclosure. The finding that the children of divorce do better psychologically when they

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2, 1985.

214. Pannor interview, *supra* note 212. These children are, of course, not the only children whose fathers are perpetually “absent” or unknown. It will take some time before the significance of any other research on the psychological role played in a child's life by unknown fathers is assessed in relation to the findings of Pannor and Baran.

215. See, e.g., the strong dissent from the argument of ADOPTION TRIANGLE, *supra* note 99, in Aumend & Barrett, *Self-Concept and Attitudes Toward Adoption: A Comparison of Searching and Nonsearching Adult Adoptees*, 63 CHILD WELFARE 251 (1984). Although working with a small sample, these researchers find that the desire for knowledge of birth parents is not especially widespread and that the effects on self-esteem and identity conflicts among those adoptees who learn the identity of birth parents is not substantial; cf. CHOSEN CHILDREN, *supra* note 194, at 224, whose authors found widespread genealogical curiosity but much less prevalent searching behavior than they had anticipated.

216. See, e.g., the note of caution in Dukette, *supra* note 198.

maintain contact with both parents<sup>217</sup> appears superficially consistent with an argument that knowledge of genetic parentage is essential for children. But the post-divorce research explores the arguments for continuing an established and existing personal relationship, one that may not always have been happy, but one that has involved continuous emotional interaction. These research results may not be pertinent to the question of whether to facilitate the creation of a personal relationship when the only prior link between a donor and the offspring was an impersonal, genetic one.

The AID, adoption, and post-divorce research does not present a compelling argument for disclosure; nor does it present a compelling case for anonymity. I would err on the side of facilitating the possibility of disclosure in the event that the felt need for such information does in fact become more widespread, and in the event that future research substantiates the still tentative claim that disclosure makes a positive difference for AID, IVF, or ET children. At the very least, the states should create a registry procedure to preserve the opportunity of the child, once he or she reaches the age of eighteen, to initiate an inquiry. At this point the issue is between the gene donor and the offspring, not between the intended parenting couple and the child.

*d. Whether to reveal the identity of surrogate gestators*— I have been addressing the problem of disclosure as it applies to IVF, ET, and AID; it takes on a different texture in the context of full surrogacy. The genetic and gestational mother has had a relationship with the child that the donor of eggs, sperm, or fertilized embryos has not had. Instead of an exclusively genetic connection, hers has included sustaining the unborn fetus within her uterine environment for nine months<sup>218</sup> and may also have included some time caring for the child after birth. The years the child will spend with her rearing parents are of much more importance to the child's overall social and psychological development than these nine months, but we should not therefore deny the importance to the child of having access not merely to information about, but to the actual identity of, her birth mother. Traditional arguments developed in the standard adop-

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217. See generally J. WALLERSTEIN & J. KELLY, *SURVIVING THE BREAKUP* (1980); Hetherington, Cox & Cox, *The Effects of Divorce on Parents and Children*, in *NONTRADITIONAL FAMILIES* 233 (M. Lamb ed. 1982).

218. For a discussion of the possibility of emotional bonding between a mother and an infant during the course of pregnancy itself, see KLAUS & KENNEL, *MATERNAL-INFANT BONDING: THE IMPACT OF EARLY SEPARATION OR LOSS ON FAMILY DEVELOPMENT* 45-46 (1976).

tion context for protecting the anonymity of the birth mother do not apply: the birth mother does not need anonymity to protect her against the shame or embarrassment of an unwanted pregnancy. The surrogate deliberately chooses to become pregnant and to bear a child for others. She is likely to be proud of what she has done. Even if she later has regrets, her stake in confidentiality is not sufficient to outweigh what may be the importance to the child's psychological well-being of learning her identity. This is especially so if the birth mother receives no assurance of permanent anonymity in the first place and therefore, in contrast to birth mothers in traditional adoptions, has no reliance interest to protect. Nor is anonymity needed to protect the child against the stigma of illegitimacy. If the contract is performed, the child will not be illegitimate and will suffer no legal or social stigmas as a consequence of the circumstances of her birth. The one traditional argument for anonymity that continues to have some viability in the context of surrogacy is the need to protect the autonomy of the legal parents to raise the child as they prefer without any interference by the birth mother. This interest can be served by insuring that the legal parents retain the right to decide whether to divulge the identity of the surrogate to the child until the child becomes an adult and can decide for herself whether or not to seek this information.

Should the decision about whether and when to disclose the identity of the birth mother to the child be left exclusively to the terms of the private agreement between the surrogate gestator and the child's intended parents? Not altogether. If the parties agree to disclosure, their agreement should be enforced. If they attempt instead to grant permanent anonymity to the surrogate, they ought to be told that such a guarantee cannot be made. As with sperm, egg, or embryo donors, states should establish a registry procedure to enable the question of disclosure to be raised between the child and the birth mother at some later point in the child's life.<sup>219</sup>

I have been arguing that the potential psychological harm to children resulting from not having complete information about those who contributed to their creation warrants specific legal procedures to facilitate access to such information. But I remain unpersuaded by arguments for mandatory disclosures of the

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219. My intuitive sense is that the number of women willing to serve as surrogates would not decrease if potential surrogates were told that even if they preferred anonymity, the state might determine that the welfare of the child required leaving open the possibility of disclosing their identity at some future date.

identities of surrogate gestators or the donors of genetic material. Consider how many children raised by their genetic parents may not be told every detail of their parents' background. Parents may choose to omit some information about their own lives or about the lives of close relatives. Most people grow up with knowledge about themselves and their families that is incomplete or distorted. No public authority exists ready to disseminate to the child-turned-adult his or her own Book of Genealogy. The alleged severity and persistence of psychological distress and of intra-family conflicts resulting from such incomplete knowledge remains elusive and speculative, despite the research findings discussed above. I believe, however, that the history of traditional adoptions teaches us that we should not attempt to irrevocably impose secrecy, and that the psychological, social, and financial advantages to children of being reared by adoptive parents can be attained without inflexible policies on confidentiality. As we attempt to shape the law to provide for the welfare of the offspring of noncoital reproduction, we should at least preserve, rather than foreclose, options. Although the jury will of necessity be out for an indefinite time on the question of potential harm to the offspring, we do not have to be paralyzed, unable to take steps to minimize or avoid the harms that might occur. The state should act even though we may never know in our own lifetimes whether these alleged harms would in fact have occurred if we had not acted to forestall them. The state should make available to the offspring of IVF, ET, AID, or surrogacy certain procedures whereby they may learn no less than the rest of us ever learn about our forebears. But there should be no obligation to see to it that they learn more.

3. *A different kind of harm to children*— The offspring of noncoital reproduction are not the only children who are placed at risk by the striving of men and women for procreative autonomy. There remains an altogether different category of potential harm: the risk of indifference to the many thousands of children, indeed, to the hundreds of thousands,<sup>220</sup> who are already born but in desperate need of parents to raise them. Those who pursue IVF, ET, AID, or surrogacy do so in part because of the belief that they have no reasonable alternatives for obtaining a

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220. The Children's Defense Fund estimated in 1978 that 500,000 American children, many of them infants but most of them pre-adolescents and adolescents, were without permanent homes and were being raised in foster homes or in some kind of institutional setting. CHILDREN'S DEFENSE FUND, CHILDREN WITHOUT HOMES 1-2 (1978).

child; that, for example, there are not enough infants available for adoption.<sup>221</sup> While it is certainly true that most adoption agencies do not have healthy white infants<sup>222</sup> to offer to the childless,<sup>223</sup> it is not true that a supply of adoptable children is generally lacking. Aside from older children with mental or physical handicaps, who indeed may pose special problems for prospective parents, many thousands of healthy white and non-white American as well as foreign-born children remain, who would probably do quite well even if raised by parents of a different racial or ethnic background.<sup>224</sup> Many more women and adolescents than is commonly supposed, who give birth out of wedlock, would consider relinquishing their children for adoption if they were treated in a more humane and sensitive manner than has been characteristic of many adoption agencies in the past.<sup>225</sup> These mothers want to be reimbursed for their pregnancy-related expenses and they want to have some role in the

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221. The only published survey, to date, of the characteristics and attitudes of couples applying for IVF treatment indicates that more than two-thirds of the 200 couples interviewed were positive or neutral toward adoption. About one-third would continue to consider adoption or fostering if their IVF efforts were unsuccessful. Freeman, Boxer, Rickels, Tureck & Mastroianni, *Psychological Evaluation and Support in a Program of in Vitro Fertilization and Embryo Transfer*, 43 FERTILITY & STERILITY 48 (1985) [hereinafter cited as Freeman] (describing a study of 200 couples applying for IVF treatment at the University of Pennsylvania Hospital between Jan. 1983 and Mar. 1984). Anecdotal evidence from couples pursuing surrogacy also suggests that many of these couples would have adopted an infant if one had been available. See, e.g., KEANE & BREO, *supra* note 32, at ch. 1.

222. Nearly all the couples seeking IVF or ET are white. Freeman, *supra* note 222 (96% of couples applying to University of Pennsylvania IVF Clinic are white); Lamb discussions, *supra* note 25; Buster interview, *supra* note 29.

223. In the 1970's, agency placements fell from about 70,000 per year to less than 25,000. Wadlington, *supra* note 23, at 467. National data on adoptive placements has not been available since 1971. CWLA STANDARDS, *supra* note 198, at 6. No one doubts, however, that adoption agencies have been placing very few newborns and that the average wait for an adoptable infant from an agency is 5 to 7 years. Interview with David Keene Leavitt, member Adoption Committee, A.B.A. Family Law Section, and Adoption Committee of California State Bar, Apr. 11, 1985 [hereinafter cited as Leavitt interview].

224. CHOSEN CHILDREN, *supra* note 194, at 4-6, for an account of the special difficulties, and distinctive successes, of transracial and transcultural adoptions. Additional substantiation of the claim that "whatever problems may be generated by transracial adoption, the benefits to the child outweigh the costs," is reported in the follow-up study to CHOSEN CHILDREN, Feigelman & Silverman, *The Long-Term Effects of Transracial Adoption*, 58 Soc. SERV. REV. 588, 600-01 (1984); this article contains a useful bibliography, at 601-02, for exploring some of the controversial aspects of transracial adoptions. The National Association of Black Social Workers remains opposed to transracial adoption, as do other black professional organizations, on the ground that "Black children in white families are cut off from a healthy development of themselves as Black people," quoted in R.J. SIMON & H. ALSTEIN, *TRANSRACIAL ADOPTION* 45 (1977).

225. MEEZAN, *supra* note 9, at 228-32; Charney, *supra* note 99; Leavitt interview, *supra* note 223.



selection of the adoptive parents for their child.

In addition to the many adults eager for children to raise, there are, then, many children who need parents. What we lack is a sustained public commitment to bringing the two together. The state's interest in assuring all children an opportunity to have parents, which I have argued deserves more fundamental protection than the interests of adults in procreating,<sup>226</sup> calls for more legislative and financial efforts to avoid the harms noted here.<sup>227</sup> Without such a commitment, the worlds of adoption and of noncoital reproduction will grow farther and farther apart, and those who resort to the laboratory to conceive a child will be symbolically, if not actually, diminishing the role of adoption in our society.

#### IV. CONCLUSION: IMPROVING THE QUALITY OF RESEARCH AND SERVICES

In exploring this new chapter in the striving of women and men for full procreative autonomy,<sup>228</sup> I have shown how modern medical technology has created choices where previously none had existed, and have argued that actors in the new reproductive drama deserve from the law certain supports that are now insufficiently in place. I have sought to specify these supports, and to distinguish what they can and cannot reasonably be expected to achieve on behalf of the various parties affected by noncoital reproduction. It remains to underscore the extent to which this historic drama is being played out on a stage designed and managed by professionals whose relation to the public interest constitutes an enduring controversy in our society. If Jehovah sought to manage, in a fashion, the drama centering around Ishmael, today's Ishmaels and Hagars, and Sarahs and Abrahams, must rely instead on doctors and lawyers responsive both to the dynamics of their own professions and to the competitive and commercial aspects of the private market for

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226. See *supra* text accompanying notes 58-60 and 80-83.

227. Adoption or "permanency planning" is, of course, not the only, and not always the best response to the plight of homeless children. In my view, efforts should first be directed at sustaining a viable existence for the child within the context of his or her biological family. See generally K. KENISTON, *ALL OUR CHILDREN* ch. 9 (1977); Davis, *supra* note 98; Garrison, *Why Terminate Parental Rights?*, 35 *STAN. L. REV.* 423 (1983). Nonetheless, the contemporary focus on the rights of birth parents and on the potential of IVF, ET, or surrogacy for obtaining biologically-related offspring may serve to obscure the benefits of adoption for both children and adults.

228. See *supra* text accompanying note 43.

baby-making.<sup>229</sup>

This reliance calls for further scrutiny and reflection in at least two areas. The first involves the circumstances surrounding research on the efficacy, safety, and long term psychosocial and physical consequences of noncoital reproduction. The second involves the competence and accountability of those who provide IVF, ET, or surrogacy services. A basic question must be raised about both areas: to what extent can the law encourage greater responsiveness by the private providers to the interests of the childless and their hoped-for offspring? All I can do here is to indicate why this question is so difficult to answer.

In marked contrast to the substantial federal funding for most other biomedical research in this country, funds for basic and applied research in noncoital reproduction still derive entirely from private sources.<sup>230</sup> In addition to relatively small sums from nonprofit medical centers and foundations, support comes from venture capital companies<sup>231</sup> and perhaps even from a portion of the fees paid by childless patients.<sup>232</sup> Privately funded research may yield useful practical results, but it is scarcely reasonable to expect research carried out under the auspices of profit-conscious venture capitalists to be directed toward reducing patient fees or toward advancing our understanding of underlying physiological and genetic processes. If the moratorium on federal

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229. Perhaps the most comprehensive history and analysis of the emergence of a corporate ethos in the medical profession is in P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982). No comparable contemporary analysis exists for the legal profession, although Willard Hurst's work still provides a fascinating introduction to this subject, W. Hurst, *The Bar*, in *THE GROWTH OF AMERICAN LAW* (1950); there is at least one excellent recent case study, in J.P. HEINZ & E.O. LAUMANN, *CHICAGO LAWYERS: THE SOCIAL STRUCTURE OF THE BAR* (1982).

230. See *supra* notes 6-8 and accompanying text; see also, Pear, *Grants for Medical Research to be Cut by Administration*, N.Y. Times, Jan. 21, 1985 at A1, col. 2. NIH funds may be used to support research on some of the psychosocial consequences of noncoital reproduction. See, e.g., the results of an NIH-funded project reported in McGuire & Alexander, *supra* note 94. But because of the moratorium in effect since the late 1970's on federal funding of IVF and ET, NIH funds are not available for basic research on the efficacy or safety of IVF and ET techniques or for studying externally fertilized embryos for information about the structure of genes, the development of malignancies, the "natural" loss of embryos, etc.

231. For example, the work on donor embryo transfers by Dr. John Buster and other researchers at Harbor-UCLA Medical Center was funded by a \$500,000 grant from Fertility & Genetics Research, Inc., a Chicago-based venture capital firm, *supra* notes 29-30 and accompanying text. Medical research and health care are among the "new hot spots for venture capital investing," according to Eckhouse, *Plight of Venture Capitalists*, S.F. Chronicle, Feb. 1, 1985, at 33.

232. I have not found any direct evidence that patient fees are being used to subsidize research on IVF or ET procedures, but the suggestion that they are is not implausible. See Abramowitz, *supra* note 6, at 9.

funding were lifted, the prospects might improve for creating both a more broadly defined agenda for research and a more neutral and comprehensive system for evaluating and disseminating its results.<sup>233</sup> The introduction of federal guidelines might inspire greater confidence among the childless when certain procedures are designated as "acceptable treatments" and others as "merely experimental." It might also assure that participants in genuine research projects were neither paid to "volunteer" nor expected to pay for any services rendered to them.<sup>234</sup>

It would be naive to expect, however, that any transition to increased public support for research would guarantee that commercial principles would give way to those of "disinterested" scientific inquiry. Federal funding or monitoring would no doubt be accompanied by political, ethical, and cultural conflicts about the appropriateness of specific research endeavors. Approval for research proposals would be sought amid public debates about the definition of "life," the consequences of experimentation on human embryos, the use of donated genetic materials, the disposition of unused embryos, and the appropriateness of allowing unmarried persons to be among the potential beneficiaries of noncoital reproduction. Moreover, a shift to federal funding would raise the question of research priorities. Is noncoital reproduction so important a need in our society that federal funds should be allocated to its development rather than, for example, to research on the causes of infertility, or on how to prevent the ravages of sexually transmitted diseases,<sup>235</sup> or on how to reduce the infant mortality rate?<sup>236</sup> Finally, regardless of what combination of private and public funds eventually prevails,<sup>237</sup> the find-

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233. These points were among those made before Representative Albert Gore's Subcommittee on Investigations and Oversight, Committee on Science and Technology, United States House of Representatives, Aug. 8, 1984, cited in Annas, *Redefining Parenthood and Protecting Embryos*, 14 HASTINGS CENTER REP., Oct. 5, 1984, at 50.

234. For a discussion of federal requirements that human subjects in federally sponsored research projects not be offered any "undue" inducements to participate, see Schwartz, *Institutional Review of Medical Research*, 4 J. LEGAL MED. 143, 148 (1983).

235. See, e.g., the pleas of Leon Kass that federal funds should be spent on preventive measures rather than on what he characterizes as "our thoughtless preference for expensive, high-technology, therapy-oriented approaches to disease and dysfunctions." Kass, *supra* note 5, at 54; a similar plea is made, albeit from a more avowedly feminist perspective, in Hubbard, *supra* note 131.

236. Recent data indicate not only a nationwide slowing of the rate of decline in infant mortality, but also an ominous increase in some states in the mortality rate of babies after the newborn stage. Pear, "Cause for Concern" on Infant Mortality Seen by U.S. Agency, N.Y. Times, May 5, 1985, at A1.

237. Any discussion of funding sources for research on noncoital reproduction must take account of the more general contemporary debate about the goals and methods of research in biotechnology. A useful introduction to this debate is the editorial, *How*

ings of research on noncoital reproduction are likely to be less definitive than its proponents desire<sup>238</sup> and to require interpretation within a matrix of conflicting personal and social values.

As for the competence and accountability of those offering noncoital reproductive services to the childless, the medical and legal professionals have a number of incentives to regulate themselves. Among these are concerns about malpractice liability, eagerness to match, and indeed to surpass, the achievements of rival professional communities in Britain and Australia, and competition among medical schools to offer specialized training in reproductive endocrinology.<sup>239</sup> Lawyers who are intermediaries in surrogacy arrangements are sensitive about the relatively low prestige of family law practice<sup>240</sup> and want to insulate themselves against allegations of "baby-selling."<sup>241</sup> Further, many doctors and lawyers are genuinely committed to assuring safe, efficient, and humane service to their patients and clients. Responding to these incentives, medical groups have begun to devise standard protocols for IVF and ET clinicians.<sup>242</sup> There are also indications that the psychological aspects of infertility treatments are not being ignored.<sup>243</sup>

Nevertheless, wherever profit motives and professional rivalries are strong, we have reason to look for ways in which the law can supplement efforts at self-regulation. Because the capital investment needed to equip an IVF, ET, or AID-surrogate gestator clinic is very low (compared, for example, to the costs of equipment for performing heart transplants), it is easy to enter the business of selling noncoital reproductive services. The public interest in assuring the competence of the purveyors of these

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*Much Research Is Enough?*, N.Y. Times, Jan. 28, 1985, at A14, col. 1, and one of the many responding letters to the editor, Cape & Perpich, *How We Can Stay Ahead in Biotechnology*, N.Y. Times, Apr. 23, 1985, at A26, col. 3.

238. For an interesting general discussion of why "[d]iscovering what works and what does not is something the medical professional is not very good at," see Bunker, *When Doctors Disagree*, N.Y. Rev. of Books, Apr. 25, 1985, at 7.

239. These concerns were frequently expressed in the Lamb discussions, *supra* note 25, and in the Buster interview, *supra* note 29. They are also manifest in the professional medical journals cited throughout this article.

240. One of the best contemporary analyses of how family law practitioners are regarded by other lawyers, as well as by their clients and the general public, is in HEINZ & LAUMANN, *supra* note 229, at Part III.

241. See generally Handel, *supra* note 22; Keane & Breo, *supra* note 32; Sherwyn, *supra* note 87.

242. See, e.g., AFS Statement, *supra* note 91, and the influential article, Dandekar & Quigley, *Laboratory Set Up for Human in Vitro Fertilization*, 42 FERTILITY & STERILITY 1 (1984).

243. See, e.g., Mahlstadt, *The Psychosocial Component of Infertility*, 43 FERTILITY & STERILITY 335 (1985); Freeman, *supra* note 221.

services might, therefore, be well-served by the imposition of some statutory licensing requirements.<sup>244</sup> But the government should not indirectly support the creation of private monopoly control over entry into the market by granting patent protection to specific noncoital reproductive techniques.<sup>245</sup> Beyond that, it is easier to identify the appropriate limits to federal regulation than it is to outline a program for exactly how a combination of private and public regulation can best guarantee services of the highest possible quality. And the law can probably do even less to ensure that the childless actually exercise their procreative choices to achieve their *own* goals—not the goals of the doctors and lawyers upon whom they must depend.<sup>246</sup>

In our search for ways to reap the benefits and to resolve the problems raised by the new reproductive technologies, a certain skepticism about “hypergenetic” activity is in order. We would do well to remember the power of society and culture to transfer and to transform what we are from one generation to the next. Control of our genes does not, after all, provide us with very much control over the kinds of people who will carry these genes. Genes are of course relevant, but we achieve our most intimate and abiding identities as the children of the parents who raise us. As we enlist the support of the law in behalf of procreative autonomy, we should not forget that the reproduction of self that so many hope to achieve through their children is more evident in the long term relationships of rearing and nurturance than in the single act of genetic procreation.

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244. I have in mind something similar to the statutory licensing authority recommended in Britain by the WARNOCK REPORT, *supra* note 14. Unlike the Warnock recommendation, however, such licensing would not be denied to those offering surrogacy services.

245. A sharp controversy has erupted within the medical profession about the propriety of the application of Fertility & Genetics Research, Inc., *supra* note 231, for patent protection for the donor embryo transfer procedure developed by Dr. Buster and his colleagues with investment funds from Fertility & Genetics Research, Inc. Although patent protection for drugs and medical devices is commonplace, such protection for a medical *process* is virtually unprecedented and, if enforceable, would enable the patent holder to exercise considerable control over who could or could not perform the protected medical procedures. See Annas, *supra* note 30, and Chapman, *supra* note 90.

246. An excellent analysis of how authoritarian patterns of interaction continue to define most doctor-patient relationships can be found in J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).