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Assisted Reproductive Technology and the Family

by

JOHN A. ROBERTSON*

More than one in eight married couples in the United States suffer from infertility (defined as a lack of pregnancy after a year of unprotected intercourse). Although some couples adopt or choose to remain childless, many turn to physicians for help in forming families. The list of assisted reproductive techniques (ARTs) available for treating infertility now includes intrauterine insemination (IUI), ovulation induction, in vitro fertilization (IVF), intracytoplasmic sperm injection, sperm donation, egg donation, embryo donation, and gestational surrogacy.

The growth of the contemporary infertility industry has been largely spurred by the development of IVF. The first American birth resulting from in vitro fertilization occurred in 1981. By 1988, 15,000 stimulated IVF cycles occurred in more than 100 clinics. In 1994, more than 300 clinics performed more than 35,000 cycles, resulting in more than 6,000 births. More than 200 programs now provide donor eggs, and thousands of obstetricians and gynecologists provide IUI, donor sperm, and ovulation induction in office settings. Twenty to

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thirty thousand children are born each year as a result of these techniques, with the vast majority of them produced by artificial insemination with partner or donor sperm.\(^4\)

Assisted reproductive techniques—the focus of this paper—have become available on a widespread basis in the last decade. Other reproductive technologies include preconception screening for carriers of autosomal recessive genetic disease, and prenatal screening of embryos and fetuses to prevent the birth of handicapped or diseased offspring. Technologies are also available to identify and treat problems in fetuses in utero, enabling offspring to be born reasonably healthy. In the future, genetic selection for sex or other characteristics, and even preimplantation genetic enhancement of offspring traits, may be possible.\(^5\)

The use of assisted reproductive techniques by infertile couples is a family-centered act, reflecting couples' desire to form families with biologically related offspring. Although adoption and foster parenting can provide parenting experiences, only ARTs enable one or both partners to have some biologic tie, either genetic or gestational, to their children. While some critics of ARTs disapprove of the emphasis these technologies place on genetic ties, our culture, our law, and our social and psychological understandings of reproduction and parenting define parental and offspring roles largely though not exclusively in genetic or biologic terms. In this context, the development of safe and effective ARTs appears to be positive: it reduces the suffering of childless couples by making it possible for them to realize their procreative goals.

Yet many people have doubts about ARTs and the industry that has grown up around them. Some of these doubts concern the morality and consequences of interfering with nature or manipulating the earliest stages of life. Others focus on the consequences for offspring, for participants (including the couples directly involved and the collaborating donors and surrogates), and for women and families generally.\(^6\) Some have criticized the industry's emphasis on profits and its lack of regulation—which has recently received considerable attention

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\(^4\) The number of IVF deliveries in 1993 for IVF, GIFT (gamete intrafallopian transfer), ZIFT (zygote intrafallopian transfer), and frozen embryo transfers was 7,456. Egg donation added another 716 births. Society for Assisted Reproduction, supra note 3, at 1121. There are no figures on the number of children born by IUI or ovulation induction.


because of allegations of the theft of eggs and embryos by leading doctors at a California fertility center.\(^7\)

This paper will address policy issues arising from the use of ARTs to help infertile couples form families. My basic premise is that ARTs support the traditional notion of the family, even though they depart from the conventional method of producing children through coital conception. Despite the differences in the method of conception, the goal of an ART is a child biologically related to one or both rearing parents—a goal similar to that sought through coital conception. The family project in each case should be treated equally. The use of gamete donors and surrogates, however, requires special attention because of the potential problems that the resulting disaggregation of the genetic, gestational, and social aspects of procreation pose for participants and offspring.

Rather than prohibit or discourage their use, the main thrust of public policy toward ARTs should be to assure that they are used with care and attention to the needs and interests of all parties. Such a strategy typically arises after some experience with an emerging technology. To be successful, it requires a close, contextual understanding of the field, so that problems can be identified and corrected. As discussed below, the main policy issues with ARTs revolve around medical efficacy, access to ART services, legal infrastructure, and regulation. I will focus on issues of legal infrastructure and regulation, and discuss how the growing use of ARTs may or may not alter conceptions of the family as we approach the dawn of a new century.

I. ARTs, Freedom, and the Family

Before addressing current policy issues, it is useful to consider briefly the connection between the use of ARTs and personal and procreative liberty. Critics of ARTs have often called for prohibition or regulation without realizing the impact such restrictions would have on procreative freedom, a freedom that is highly valued in other contexts.\(^8\) Yet the right of infertile couples to use these techniques is as important as their right to conceive coitally or to avoid reproduction once pregnancy has occurred. The argument in support of the rights

\(^7\) Diane M. Gianelli, *Fertility Scandal Raises Call for Regulation*, AM. MED. NEWS, Sept. 11, 1995, at 1.

\(^8\) In questioning the lengths to which some persons go to have offspring, critics do not usually distinguish carefully among techniques, nor reconcile their willingness to restrict some ARTs with their strong defense of freedom with regard to coital reproduction, contraception, and abortion.
of infertile couples to use ARTs to form families can be briefly stated.\(^9\)

Although it is not mentioned explicitly in the Constitution, courts would no doubt recognize as fundamental the right of a married couple to reproduce coitally, because of the traditional association of reproduction and childrearing with marriage, and the independent importance of reproduction in people's lives. Since an infertile couple or individual has the same interest in bearing and rearing offspring as a fertile couples does, their right to use noncoital techniques to treat infertility should have equivalent respect. This is clearest when the couple's own gametes will be involved, such as IUI and IVF, but it should also be recognized when one partner does not contribute genetically or gestationally to reproduction.\(^10\) Thus laws that restrict or prohibit access to ARTs should be judged under the same exacting standard that would apply to direct restrictions on coital reproduction—the need to show a compelling state interest not achievable by less restrictive means.\(^11\) Under this standard, most objections to ARTs are insufficient to justify banning or unduly burdening their use, though there is considerable room for reasonable regulation designed to assure that consumers fully understand and freely choose the particular ART at issue.\(^12\)

Although few direct restrictions on the use of ARTs currently exist,\(^13\) vigilance in maintaining the protected status of noncoital and collaborative means of forming families is important for two reasons.


\(^10\) The right involved may also be articulated as an instance of the right of intimate association. Just as gays and lesbians have a legitimate claim to marry and rear offspring under theories of family privacy and intimacy of association, Baehr v. Lewin, 852 P.2d 44 (Haw. 1993), so should individuals and couples have the right to collaborate with each other and their physicians to create new forms of intimate association that produce offspring.


\(^12\) The liberty claim is a claim of a negative right against interference by government or others. See McRae v. Harris, 448 U.S. 297, 314-18 (1980); Maher v. Roe, 432 U.S. 464, 473-74 (1977). The question of the extent to which such an important negative right should be funded or supported by the state is an important one, but beyond the scope of this article. See Dan Brock, *Funding New Reproductive Technologies: Should They Be Included in a Basic Benefit Package?*, in *New Ways of Making Babies: The Case of Egg Donation* (Cynthia Cohen ed., forthcoming 1996).

\(^13\) The exception is surrogacy. New York, for example, makes it a crime to pay a woman to be a surrogate or an agent who arranges surrogacy. N.Y. DOM. REL. LAW § 123(1) (McKinney Supp. 1995).
First, we should be mindful of the personal importance of the interests that are at stake for couples using ARTs, and the need to be prudent and moderate with regulation. The infertile couple's quest for children is normal and natural, and their resort to medical assistance is a reasonable response in a technologically oriented culture. Second, legal, policy, or professional restrictions should be imposed only for good reason, as they may prevent couples from obtaining such services. As long as the ARTs in question are not causing tangible harm to others, medical professionals should be free to provide them.

However, the liberty to procreate is only presumptive, and thus can be limited when it causes great harm. Fundamental rights are not absolute, but a heavy burden of justification is placed upon those who would restrict them. Although the protected status of ARTs greatly limits the state's power to ban a technique, it leaves room for regulatory measures that guide and discourage, rather than coerce and prohibit. There is, for example, room for regulatory efforts that aim to enhance and protect autonomy, rather than to restrict it totally. The liberal state does not lack the power to instill virtue—it need only respect rights in doing so.

In a regime of reproductive rights, there is room for both state and private actors to express their own moral views about reproductive choice or to take steps to minimize perceived harm. Doctors can choose not to perform these procedures, or to perform them only in a pro-life way, as illustrated by the Christian gynecologist who prays with his patients before both egg retrieval and embryo transfer. They can personally set limits on which procedures they are willing to perform; for example, refusing to transfer more than three embryos, to discard embryos, or to use donor gametes. The state may choose not to fund ART procedures, even though there are sound arguments for increasing access. Although the absence of legal guidance may cause problems for couples using these procedures, the state could also refuse to provide the legal infrastructure that is required for the efficient use of these procedures. At the very least, the state could ensure autonomy for participants, ratify and authorize the agreements made with donors and surrogates, gather statistics, and certify and license laboratories and providers.

14. The classic statement of this position is found in Griswold, 381 U.S. at 485.
16. See generally Brock, supra note 12.
17. See Robertson, supra note 9, at 261–62.
The key policy and regulatory issues are: What practices are unethical or undesirable, and what actions should be taken to stop them? These issues will vary with the type of medical assistance sought, and may change over time as patients become better informed, as medical technology progresses, and as ethical standards of care emerge. Different issues will arise depending on whether the couple provides the gametes and gestation, or seeks the assistance of a gamete donor or surrogate.

Although ARTs that use the couple's gametes avoid conflicts over rearing rights and duties, they still present issues concerning intrusions into the body, high costs, and the manipulation, transfer, and destruction of embryos. The main policy concerns for this category of ARTs will focus on ensuring that the services are provided in an honest, safe, and effective manner, and that the couple's dispositional control over their gametes and embryos is respected.

ARTs that use gamete or embryo donors or gestational carriers raise additional issues because they include a third party in the effort to reproduce. Because these practices pose risks for both donors and surrogates, they require clear legal understandings of rearing rights and duties. They also raise questions about whether and in what manner the children they produce should be informed about the nature of their conception. As discussed in the concluding section, the implications of such practices for altering conceptions of family are less radical than they might first appear to be.

II. Policy Issues with IVF

The use of IVF to treat infertility raises policy issues that can be categorized under the headings of efficacy, access, legal infrastructure, and regulation. Questions of medical efficacy concern how to improve laboratory and medical procedures so that more women have successful outcomes—questions that are beyond the scope of this paper. Questions of access raise important issues of social justice in the allocation of medical resources and reproductive opportunities,

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18. Several issues exist here: stimulated verses nonstimulated or gently stimulated cycles; limits on the number of embryos to transfer, except in older women; selective reduction and attempts to stop it; high rate of multiplets; etc. See generally John A. Collins, Reproductive Technology—The Price of Progress, 331 NEW ENG. J. MED. 270, 270–71 (1994).
and are also beyond the scope of this essay. I will focus instead on issues of legal infrastructure and regulation.

A. Legal Infrastructure

A workable system of assisted reproduction through IVF requires a clear legal system of rules and laws for disposition of gametes and embryos acquired or created in the IVF process. Although only a few cases have directly confronted the issue, a legal presumption has emerged that the persons providing the gametes for the embryos created through IVF have dispositional control over, or "own," the resulting embryos. This rule has given rise to two kinds of legal issues concerning ownership of embryos:

One issue involves disputes over disposition of embryos between the parties who provided the gametes from which the embryos were formed. Although they are joint owners and have joint dispositional control over embryos vis-à-vis the IVF center's physicians and staff, difficult questions arise when they disagree over the use or disposition of embryos. Such situations arise most frequently when couples divorce or separate, and cannot agree whether to use or discard their stored embryos. In these situations, one party's interest in avoiding procreation may clash with the other party's interest in using the embryos to procreate.

To minimize such conflicts couples should specify in advance their wishes concerning disposition of embryos in case of divorce, separation, unavailability, or inability to agree at a later time about disposition. Indeed, it is customary for IVF programs to request that couples state their wishes concerning disposition prior to freezing. Jointly agreed-upon written directions for disposition of embryos are likely to be legally recognized, even if one party later changes his or her mind and wishes a different disposition.

Difficult questions arise in disputes over the disposition of embryos and gametes when no advance agreement exists. In each of the two reported cases that confront this issue, the wife wanted to save

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embryos, and the husband wanted them destroyed. In one of them, *Davis v. Davis*,22 the Tennessee Supreme Court ruled that the party wanting to avoid reproduction should control disposition of the embryos, unless the other party has no other reasonable way of reproducing without the embryos in question. In the other case, *Kass v. Kass*,23 a New York state trial court analogized the situation to a woman's right to control the product of in vivo conception, and held for the woman.

At one level it may not matter what the default rule is, as long as it is clear and the parties are given advance notice of it. A rule that says that embryos must be saved whenever the woman so insists can be justified in terms of the greater burdens undergone by the woman to produce the embryos. On the other hand, a rule that says that embryos should not be transferred to either party unless both parties agree is also reasonable, since such a transfer could lead to unwanted parenthood for the dissenting party. Clear notice of the applicable rule will inform couples of the consequences of freezing embryos, and permit them to negotiate an alternative solution.

Another legal issue about control of embryos can arise between the couple and the IVF program. Here the issue is not the recognition of the couple's ownership and dispositional authority, but rather how to devise remedies for interference with that ownership. Consider the case, for example, in which the couple's embryos are negligently destroyed or inadvertently given to another couple. The owners have lost or been deprived of valuable property, and should be compensated. But what value should be assigned to embryos in those circumstances? The cost of production allocated equally among the number of embryos produced? Would this be enough to support a suit to recover damages? Would it adequately cover the loss sustained? Should liquidated damages be agreed upon? What about cases in which a program has failed to hear from the owners of the frozen embryos for five years or more, has no way of contacting them, and discards the embryos?

In addition to the question of compensation, questions of criminal liability for the intentional misappropriation of gametes or embryos may also arise. The scandal involving fertility doctors at the University of California at Irvine (UCI) shows that this concern is not merely theoretical. Dr. Ricardo Asch and colleagues who ran the IVF

22. 842 S.W.2d at 604.
program at UCI were alleged to have intentionally taken the eggs and embryos of women and couples without their consent, and used them to initiate pregnancy with other couples. While most of the attention has focused on UCI's alleged dereliction in allowing this situation to continue, and on compensation for the injured couples, the question of criminal liability for theft of eggs and embryos is also relevant.

Since eggs and embryos would appear to be things of value, there is no barrier in principle to applying theft and larceny laws to their misappropriation. The district attorney, however, has refused to prosecute because of uncertainty whether the value of the stolen eggs and embryos meets the $1,000 threshold requirement for a felony theft prosecution. Statutes making intentional misappropriation or misrepresentation of gametes and embryos a felony could avoid this problem, and should be an essential part of the legal infrastructure for conducting IVF.

B. Regulation

A major current policy issue in the provision of IVF is whether greater public regulation is needed. IVF services are now regulated like other medical procedures—there is little regulation other than medical licensure, malpractice, and specialty certification. Just as any licensed doctor is legally permitted to perform any medical procedure, any doctor can also provide infertility services without any specific certification if he or she attracts patients and has access to surgical suites for egg retrieval.

In the late 1980s, the practice of some IVF programs of exaggerating their success rates led to Federal Trade Commission actions against them for false advertising. Such practices also spawned congressional hearings, and eventually led to the passage of the Fertility Clinic Success Rate and Certification Act of 1992. The purpose of the Act was to have the Centers for Disease Control collect data concerning clinic-specific success rates, which would then be made available to patients for selecting clinics. It was also hoped that by certifying laboratory procedures and practices (on which much of the efficacy of IVF depends), pregnancy rates would improve.

25. Id.
Although the federal government has yet to fund implementation of the 1992 Act, considerable progress has been made by the profession itself. The American Society for Reproductive Medicine (ASRM), together with the Society for Assisted Reproductive Technology (SART), have operated a registry of data concerning success rates for many years.28 ASRM, together with the College of American Pathology (CAP), have also conducted voluntary laboratory certification procedures, as the 1992 law envisages.29

The publicity surrounding the allegations of stolen eggs and embryos at UCI has spurred further talk about regulation. Many commentators have reacted to the scandal by focusing on the unregulated nature of the IVF system, implying that more regulation could have prevented such actions. Some critics have recommended that the United States adopt the British regulatory system, in which a national Human Fertilisation and Embryology Authority (HFEA) licenses and inspects every IVF program on an annual basis.30 Indeed, the ASRM has announced that it is amenable to such an approach.31

I am skeptical about the need for a British-style regulatory agency for IVF or for assisted reproduction generally. A generation of law and economics study has reminded us how costly and inefficient "throwing an agency" at a problem can be. Among other problems, regulatory agencies can have protectionist effects that make the entry of competitors more difficult. In any event, the antigovernment bias prevalent in contemporary national politics and the tight budgets prevailing in Washington make the creation of a new federal agency to regulate IVF extremely unlikely. Nor are states equipped to take on the job, although one or two might attempt it. Additional private efforts might occur, or a consortium of university programs might devise standards, as has occurred in California.32

My skepticism about the likelihood that an IVF regulatory agency will be created is based on a prediction that the costs of such an approach are likely to outweigh the benefits. There is no guarantee, for example, that annual inspections and licensure will increase the efficacy of IVF overall, or even in specific programs (it may be

28. See sources cited supra note 3.
that the number of patients treated by a particular program is the key factor). Nor will annual inspections necessarily prevent unscrupulous practitioners from stealing gametes and embryos or defrauding patients. Yet such a system would be costly, and the costs would ultimately be passed on to patients. Ironically, regulation intended to protect patients could end up making the procedure too costly for many patients to obtain.

Many of the desired protections could be provided without a costly new regulatory system. The current system of malpractice law, medical licensure, and professional standards, despite its defects, already provides some incentives to assure good, quality care, and it can easily be modified to provide more. For example, the existing ASRM-SART registry of clinic-specific outcomes already gives patients considerable information about the programs available. Malpractice, property, and informed consent law already protects against gross abuse. Various groups, from the ASRM to the National Advisory Board for Ethics in Reproduction, have devised ethical guidelines for doctors delivering these services. As patients become better informed about the chances of success and the differences among programs, the case for a new regulatory system weakens further. Indeed, it is hard to argue for a special regulatory system for IVF and assisted reproduction when procedures that present a much greater threat of harm to patients, such as laparoscopic cholecystectomy, radial keratotomy, and autologous bone marrow transplant, go unregulated.

In sum, the current system of IVF is highly supportive of the family because it provides infertile couples with a means to have biologic offspring who would not otherwise be born. An important concern for couples undergoing IVF is obtaining safe and effective treatments and accurate information about their prospects. Public policies that enhance access and efficacy, create legal infrastructure, and regulate appropriately are supportive of the family interests that IVF serves.

### III. Donors and Surrogates

Assisted reproductive techniques involving donors and surrogates raise additional issues because of the complications engendered by third-party contributors to family formation. Although issues of efficacy and access arise here as well, I will again focus only on legal infrastructure and regulation.33

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33. With regard to efficacy, egg donation has a higher success rate than basic IVF for persons who need it, due to the generally better quality of eggs provided by donors. Mark April 1996] ASSISTED REPRODUCTIVE TECHNOLOGY 921
A. Legal Infrastructure

The main issue with donors and surrogates is the need for a legal infrastructure that clarifies the legal effects of participation in such practices. Such an infrastructure now exists with donor sperm. More than thirty states have statutes that give legal recognition to the parties' intent that the recipient couple will take responsibility for all rearing rights and duties, and that the donor will relinquish them. Although there is less legal certainty for sperm donations to single women and lesbian couples, there is enough precedent to give them at least some guidance.

(1) Egg and Embryo Donation

Legal infrastructure for egg and embryo donation is an entirely different matter. Although more than 150 IVF programs now provide egg donation, resulting in 500 births annually, only six states have statutes recognizing the intended legal effects of the transaction. Embryo donation is currently practiced on a much smaller scale than sperm donation, but it could grow in the future. Only two states now give explicit legal recognition to the parties' intent in embryo donation to have the recipient couple acquire all rearing rights and duties.

Sauer & Richard Paulson, Understanding the Current Status of Oocyte Donation in the United States: What's Really Going On Out There?, 58 Fertility & Sterility 16, 17 (1992). Access is a more difficult issue, because the use of an egg donor or gestational carrier increases the costs of a cycle of treatment significantly. However, if one believes that infertility treatments should be covered as part of basic health insurance, then one could argue that donor and surrogate assistance in reproduction should be covered as well.

34. OFFICE OF TECHNOLOGY ASSESSMENT, supra note 1, at 242-48.

35. See, e.g., People v. Sorenson, 437 P.2d 495 (Cal. Ct. App. 1968) (husband who consents to donor insemination of wife is liable for child support); K.S. v. G.S., 440 A.2d 64 (N.J. Super. Ct. Ch. Div. 1981) (stating that a husband who consents to artificial insemination takes on the obligation to support the child); Gursky v. Gursky, 242 N.Y.S.2d 406 (Sup. Ct. 1963) (holding that a child conceived through artificial insemination of the wife through the use, with the husband's consent, of semen contributed by a donor other than the husband was not the legitimate issue of the husband, but that the husband was liable for the support of the child); In re Baby Doe, 353 S.E.2d 877, 878 (S.C. 1987) (holding that the father of a child conceived through artificial insemination is responsible for supporting that child, regardless whether the father gave written consent to the procedure).


Couples and donors involved in egg and embryo donation thus face legal uncertainty over whether their intentions and agreements concerning rearing rights and duties will be enforced. If custody or child support disputes arise, it is likely that the courts will apply the underlying principle of their own state’s donor sperm statutes, or existing egg and embryo donation statutes, and give legal effect to the intent of the donor to relinquish, and the couple's intent to take on, all rearing rights and duties. However, it would serve the interests of all parties if legislation explicitly recognized the intent of the collaborating parties.

(2) Gestational Surrogacy

Surrogacy first came to public attention with the much publicized Baby M case in New Jersey in 1988. In that case, the New Jersey Supreme Court held that full surrogacy contracts (under which the surrogate provides both the egg and the gestation) are unenforceable because they conflict with sound public policy and existing adoption laws that prohibit enforcement of preconception or prenatal agreements concerning the rearing of children. The Court also suggested that any payments to the surrogate beyond actual medical expenses violated state baby-selling statutes.

The California Supreme Court in Johnson v. Calvert reached a very different result in a case of partial or gestational surrogacy (in which the surrogate carries the embryo of the couple). In Calvert, the Court explicitly recognized the preconception intention of the parties as the deciding factor in determining whether the genetic or gestational mother would have rearing rights and duties. Its decision excluded the surrogate from any rearing role.

38. See Robertson, supra note 6, at 128–29.
40. Id. at 1240–50.
41. Id. at 1240–42.
43. 851 P.2d at 782.
44. The court reached this conclusion because the Uniform Parentage Act adopted by California permitted motherhood to be determined on genetic or gestational grounds. Id. As between the gestational and the genetic mother, the court found the that the preconception intention of the parties should control. Id. at 782–83. It rejected the claim that the rules for adoption should control the outcome, and found inadequate, or better left to the legislature, various public policy considerations put forward as reasons for discouraging gestational surrogacy (dehumanization of women, commodification of children, etc.). Id. at 784–85.
Calvert has firmed up the legal support for gestational surrogacy and encouraged its growth.\textsuperscript{45} Gestational surrogacy is increasingly viewed as a valid assisted reproductive modality, and is now reported to the ASRM-SART registry. However, many legal uncertainties remain. The most common legislative response to surrogacy has been the creation of laws that prohibit the enforcement of preconception agreements.\textsuperscript{46} States without surrogacy legislation could reach the same result through judicial interpretation of laws that prohibit the enforcement of contracts for adoption or payments beyond medical expenses to a birth mother to relinquish a child for adoption. Despite the important differences between full and partial surrogacy, none of the existing surrogacy statutes (much less state adoption laws that could be interpreted to apply to surrogacy) distinguish the two forms of surrogacy. As a result, couples in need of a gestational carrier have strong incentives to seek the procedure in California, Pennsylvania, or other states whose laws seem more hospitable to gestational carriers.

A few states are beginning to deal with the realities of surrogacy by specifying preconception procedures for creating both types of surrogate contracts. In a few states, such as New Hampshire and Virginia, the parties to a surrogate arrangement must come to court prior to conception, explain their intentions and understandings, and, if they are found fit and able, they are authorized to proceed.\textsuperscript{47} In such cases, the surrogate will be prevented from claiming the child after the birth has occurred.

Given this mixed legal picture, in many states couples using gestational carriers face uncertainty about who will have parenting rights and duties. Since these reproductive practices will continue to occur regardless of the existence of a statute, the best solution would be to give formal legal recognition to the preconception understandings and intentions of the parties. However, many people might oppose the creation of a legal infrastructure recognizing gestational surrogacy as too encouraging or facilitative of a method of family formation which they find objectionable. Proponents of surrogacy, on the other hand,

\textsuperscript{45} Couples using gestational surrogacy usually involve women who have functioning ovaries but lack a uterus or for other reasons cannot carry a pregnancy to term.


would argue that the benefits of prior legal certainty outweigh any imprimatur effect that such legal recognition carries.

B. Regulation

With regard to donors and surrogates, the main purpose of regulation, beyond the legal recognition of the intent of the parties, is to assure that third-party collaborators are informed and protected in the process. Although this does not require a new regulatory agency or system, it does require that attention be paid to the interests of donors and surrogates. I want to call attention to several issues that will have to be faced as the use of these practices increases.¹⁴⁸

(1) Egg Donation

Most egg donors are young women recruited by advertisements or word of mouth and paid $1,500–$2,500 for undergoing screening, ovarian stimulation, and egg retrieval. In some cases friends or relatives of the egg recipient also donate. A major ethical and policy issue in egg donation is the protection of the donor from injury. Two kinds of concerns arise here.

Psychologically, the donor needs to be aware that she will be reproducing genetically, but may never have any contact with, or even knowledge of, the resulting offspring. It may be that female genetic reproduction without gestation—the hallmark of egg donation—will not be as significant as when both are combined in the same woman. However, given the importance of genes in our culture, it is likely that the female genetic connection, though divorced from gestation, will still carry great psychological significance for donors, recipients, and offspring. Donors need to be counseled about the loss of future connections with their genetic offspring, and informed about the legal rights they are relinquishing. Furthermore, donors should be counseled by someone other than the doctor or the person recruiting them, such as an experienced and disinterested mental health professional, so that they are not unduly influenced to participate.

Donors also need to be protected against any physical injury that might result from the donation. Although the risks of ovarian stimulation and egg retrieval are tolerable, there is always the possibility that something could go wrong and that the donor could be injured.⁴⁹ Provisions should be made to ensure that the donor is fully informed

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¹⁴⁸ See Robertson, supra note 6, at 139–42.
⁴⁹ Hyperstimulation syndrome and anesthetic error are two risks of the egg donation procedure.
of these risks, and to cover the medical expenses resulting from any injury. The standard approach is to have the recipient couple promise to pay for medical expenses attributable to the donation. One problem with such a promise is that it might be difficult to enforce, and could leave the donor without recourse for serious injury.\textsuperscript{50} At the same time, such an agreement opens the recipient couple to potentially large financial obligations that could arise in the rare event of major complications. A better approach would be to have the clinics that offer egg donation arrange for the recipient to purchase a health insurance policy for the donor, to assure that the donor's medical expenses are paid.\textsuperscript{51} In addition, couples and donors might agree to pay for lost wages, though this is not now the custom.

(2) \textit{Gestational Carriers}

The concerns about full information, voluntary choice, and protection from injury that arise with egg donation are even more pressing with surrogate gestational carriers, because of their greater physical and psychological involvement. At the very least, surrogate carriers need to be fully informed and counseled about the physical, psychological, and social risks of their arrangement. They also need independent legal representation in negotiating the surrogacy contract. As discussed above in connection with egg donation, gestational carriers should also be assured of compensation in the event of injury. Regulations to achieve these goals would seem desirable. In designing a regulatory system, a major decision will be whether the actual bargains and understandings of the parties will be recognized, or whether some preconception or preimplantation screening or ratifying mechanisms for assessing consent, such as those now existing in New Hampshire and Virginia, should be enacted. Until there is more evidence that such mechanisms work effectively, the need for judicial screening of surrogacy agreements remains unclear.

If the growth in gestational surrogacy continues, disputes over prenatal testing and continuation of the pregnancy may arise between the couple providing the embryo and the gestational carrier. Most commentators and critics of surrogacy have argued that the surrogate

\textsuperscript{50} In an anonymous donation, the donor might never learn the identity of the recipient couple in order to obtain payment from them. Even if the recipients are known, there is no guarantee that they will be willing or able to pay.

\textsuperscript{51} In current practice, some clinics might recruit only women who have health insurance coverage of their own as donors.
must be free to abort or not abort during pregnancy, as she chooses.52 Presumably, she should also be free to have or not have amniocentesis or other prenatal tests.

But recognizing the legal right of a pregnant woman to abort or not abort might not always be a fair solution to the problem presented. Although the commissioning couple may not be legally able to prevent her from aborting, they do have an important interest at stake if she aborts contrary to their wishes. After all, they have entrusted her, based on her promise, with their embryo(s), and will suffer some damage if she aborts contrary to the agreement. Rules for such situations, even if only contract-based, need to be developed.

Similarly, if a surrogate carrier refuses to undergo prenatal diagnostic procedure, such as amniocentesis, or if she refuses to terminate a pregnancy in which the results of prenatal testing have been positive, the consequences for the parties should be specified in advance. One solution would be for the hiring couple (the embryo source) to relinquish all rearing rights and duties in the resulting offspring to the carrier, effectively transforming what was initially intended as a gestational surrogacy into an embryo donation. Early attention to such issues by persons recruiting and using surrogate carriers should prevent lawsuits, or at least help to resolve them in a fair way. Although it may not be appropriate to require legally that children be informed that their birth resulted from a surrogate carrier, this is another important issue that couples using these techniques must face.

IV. The Challenge to Conceptions of Family

This article has focused to this point on ways in which the provision of ART services can be improved so that the family interests they serve can be realized in a safe and effective way. Indeed, the central policy issue with ARTs is the improvement of efficacy so that the pregnancies and deliveries so fervently desired can occur in a manner consistent with the ethical and legal norms of consent and informed choice. Policies that improve safety and efficacy, increase access, create a legal infrastructure, and regulate to protect the parties will thus make the infertility journey less perilous and more efficient.

Will the increasing use of ARTs to form families change the shape or conception of the family? Rather than undermining or alter-

52. For an interesting discussion of this point, see Lori Andrews, Beyond Doctrinal Boundaries: A Legal Framework for Surrogate Motherhood, 81 VA. L. REV. 2343, 2372–74 (1995).
ing traditional conceptions of the family, the demand for ARTs com-
pports with the prevailing family paradigm of couples having and
rearing biologically related offspring. Despite their differences from
coital conception, ARTs support traditional notions of family by en-
abling a (usually married) couple to have and rear children who have
a genetic or gestational tie to one or both of the rearing partners. The
need for reproductive assistance may increase the costs of procreation
and may even require new legal infrastructure and regulation, but it
has little impact on the structure, shape, or meaning of the family as it
is traditionally understood.53

The aspect of ARTs that seems most threatening or challenging
to traditional conceptions of the family is the use of donors and surro-
gates to obtain children for rearing. The absence of legal infrastruc-
ture and regulation may well affect the family experiences that
infertile couples and collaborators using these techniques have. But it
is much less clear that the use of donors and surrogates, even when
done with respect for the rights and needs of all parties, will affect or
change our conception of family.

My impression is that these practices, though they result in fami-
lies in which a gamete source or even a gestating mother is absent,
pose little threat to the traditional understanding of the family. This
lack of impact should not be surprising for two reasons. One is that
couples use these techniques to replicate the coitally conceived family
as closely as possible. The second is that all of the techniques resem-
ble coital conception more closely than adoption does. Yet adoption
occurs much more frequently and has long been assimilated into our
understandings of the family.

ARTs using donors and surrogates differ importantly from adop-
tion in that they enable a biologic tie to exist between the infertile
couple and resulting child. In gestational surrogacy, for example, both
rearing partners provide genes to offspring, but lack the female gesta-
tional relation. In egg donation, both partners have a biologic rela-
tion, with only the female genetic connection missing. In embryo
donation, the rearing woman gestates but neither she nor her partner
have a genetic connection with the offspring. In sperm donation, the
woman both gestates and provides genes, and her partner has no bio-
logic connection at all.

53. This is not to deny that a new source of power is created in persons who control
this process as gatekeepers and providers of services, nor that new questions of social jus-
tice in the distribution of reproductive opportunities arise.
I do not mean to trivialize the challenges that ARTs using donors and surrogates pose for families. The donor or surrogate needs protection from exploitation and injury. Rearing rights and duties must be clarified. The question of informing children of the details of their conception or birth must also be faced. In short, a new set of reproductive roles and relationships will arise, with unique demands, problems, and stresses that need attention.

Yet the overall effect on the shape and conception of family is likely to be small. Although of crucial importance for the participants, the number of children born through gamete donation and surrogacy will always be small. Moreover, the intention of the parties will be, in almost all cases, to replicate the rearing relations of the coitally conceived model of family, with the donor or surrogate usually excluded from any rearing role or acknowledgment. The variations on family that ARTS make possible are simply incorporated into the dominant model of the family that pervades our culture.

Some persons, however, might argue that the freedom to create and define families in the novel ways made possible by ARTs will lead to other ways of creating families that will ultimately hurt traditional notions of family. In considering the possible effect that the freedom to use donors and surrogates to form families could have on conceptions of the family, three kinds of freedom in fashioning families should be distinguished. One form of such freedom is the previously discussed use of a donor or surrogate to provide a missing genetic or gestational component, with the collaborator having no rearing role at all—the model that most persons using donors and surrogates now adopt. As noted, the use of a third party raises issues of identity, rearing rights and duties, and protection of collaborators. But the freedom to create a family in this way presents no threat to traditional notions of family, because these actions occur within the prevailing paradigm of the family as a couple raising offspring together. The third-party collaborator is physically absent, and his or her existence may not even be disclosed to the child.

54. It is unlikely that more than 35,000 of the two million children born in the United States each year are born as a result of medical assistance. Of those born with medical assistance, donor sperm probably accounts for most of them, estimated to be 20,000–30,000 a year. IVF, frozen embryos, donor egg, donor embryo, and gestational surrogacy probably account for 5,000–6,000 births at most. See Society for Assisted Reproduction, supra note 3.

55. Depending on the technique used, the child may or may not be the actual “offspring” of the rearing couple.
A second kind of freedom in forming families would arise if the parties using collaborative ARTs agreed among themselves to share rearing in an ongoing way, thus constituting a new, extended form of family. For example, suppose the sperm or egg donor, the embryo donors, or the gestational carrier agreed with the recipients that all would play an active rearing or visitation role with the child. Imagine a new grouping or type of family that involves open cohabitation or open rearing by all participants in collaborative reproduction. Would not such arrangements challenge the norms of reproduction, parenthood, and family as we now understand them?

In fact, very few persons using donors and surrogates opt for such an arrangement. While donor sperm is usually used anonymously, the use of donor eggs and gestational surrogacy often includes a meeting between the couple and the donor and surrogate beforehand. In some instances there has been ongoing contact with the donor or surrogate. Indeed, in some cases the same donor or surrogate has collaborated in producing a second child with the same couple.

But even when the parties are open about collaborator identity and allow ongoing contact with the child, their practice is still far short of a joint living or rearing arrangement. Even when the donor or surrogate is a sibling or parent, the recipient couple is still usually the primary custodian and cohabitant of the child. It seems unlikely that this pattern will change in the next few decades, even though claims of reproductive and associational freedom would support enforcing such alternative agreements. Although some couples and collaborators might embark on joint living or rearing arrangements, their number is likely to be so small that their impact on traditional understandings or conceptions of the family would be negligible. At worst, such arrangements would present an alternate but rarely used way in which persons could group together to produce or rear offspring—a high-tech variation on a communal pattern of creating and rearing offspring.

The most radical effect that the freedom to use donors and surrogates could have on traditional understandings of the family would result from a reevaluation of the law of adoption. Consider, for exam-

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56. I have argued that such agreements should be enforced. See ROBERTSON, supra note 6, at 132–34. As Alta Charo has pointed out, just as you can never be too thin or too rich, you can never have too many parents. Alta Charo, And Baby Makes Three . . . or Four, or Five: Defining the Family after the Reprotech Revolution, TEX. J. WOMEN & L., Spring 1994, at 265, 306.

57. Such arrangements would be a very small part of an already minor part of annual reproduction. See supra note 54.
ple, how the use of donors and surrogates to form biologically related families could extend to situations in which there is no biologic connection between the rearing parents and the offspring. For example, imagine a couple who very much want to have a child to rear, but are unconcerned about having, or are unable to have, a genetic or gestational connection. As a result of the shortage of babies for adoption, the couple hires a woman who is impregnated with donor sperm (a case of full surrogacy exists if the male partner provides the sperm), or alternatively, they hire a woman to gestate a donated embryo or an embryo created from separate egg and sperm donations, and the woman agrees to relinquish the child at birth.58

Since such arrangements amount to agreements to conceive or carry a child who will then be relinquished to the commissioning party, they present a direct challenge to the current system of nonenforcement of preconception or prenatal agreements to adopt. The theory of procreative liberty that undergirds the use of ARTs would not directly protect such arrangements, because the commissioning party is not procreating, and indeed, has no biologic connection at all with the child provided to them for rearing.59 This would be true even if the commissioning couple or individual orchestrated the entire production, and thus was a but-for cause of the child's birth.

Could one not argue, however, that the interest in rearing children is as important as the protected interest in reproduction? Indeed, recognition of the right to use donors and surrogates devalues to some extent the need for all rearing partners to have a biologic tie with the child, and thus supports the use of the parties' preconception intent as the determining factor in any later legal dispute. If so, the ideal of procreative liberty would then loop back to affect our law and understandings of adoption, and greatly affect the existing regulatory schemes for adoption. The effect would be that the state could regulate the process of entering into and implementing such arrangements, but could not ban them altogether. Under this approach a single person could gather together the gametic and gestational factors necessary to produce the child that he or she would then rear alone.60

58. This analysis tracks a discussion in Children of Choice, Chapter 6, entitled "The Loop Back to Adoption." See Robertson, supra note 6, at 142-44.
59. Actions and agreements to obtain a child for rearing are not themselves procreative, even though they serve interests that might have their own independent importance. See id. at 22-23.
Whether the loop back to adoption occurs will depend upon emerging understandings and valuations of the importance of rearing children per se, and the relative weight given to genetic and nonbiologic ties in the production and rearing of offspring. While I am doubtful that the law will quickly move that far, if it does, it would not necessarily have a major effect on the shape or understanding of family.

The main effect would be to expand the number of adoptions by leading to a group of women (not unlike full surrogates) who are paid to play that partial reproductive role. It would also lead to children being raised by parents with whom they have no biologic tie, as now occurs with traditional adoption. Special psychological problems might arise for such children (who, strictly speaking, are not harmed because they have no other way to be born but into such arrangements), and protection for the women who bear these children would be needed. Yet it is difficult to see how such arrangements would have any greater effect on the traditional conceptions of the family than adoption does. Unless these arrangements led to joint living or rearing situations among all the participants, they would simply be another way to create an adoptive family. Such arrangements would have little effect on the concept of family beyond that which now exists with adoption.

Although ARTs are unlikely to affect or change prevailing notions of family, they can nevertheless be seen as part of a larger set of developments affecting the autonomy of individuals to shape families and childrearing units to their needs. ARTs are part of a growing array of social practices that redefine and restructure traditional families, as do blended families, stepparent adoptions, and similar practices. The resulting families are defined both by biology and by intentional interactions. The question of the extent to which society should permit, encourage, discourage, or recognize these new forms of intimacy or family, some of which become childrearing units, is a major ongoing social issue now being played out on many fronts.

Although ARTs do not directly affect the shape or meaning of the traditional family, they do remind us of the importance to individuals and couples of having a sphere of intimacy and privacy in such matters. Questions about ARTs help us see the importance of intimate concerns, and show us that biology is less important than we may have realized (though paradoxically ARTs use and rely on biologic connection for their popularity). Freedom to use these techniques
thus implicitly supports the freedom of same-sex couples to marry and to have and rear offspring.

If the principle of autonomy that underlies the use of ARTs is applied to other situations of associational intimacy, the rights of gays and lesbians to marry and to have and rear children should also be recognized. Both involve individual choices about fundamental human relations that define and give meaning to life. The right to create and express intimate associations reflected in assisted reproduction provides grounds for supporting same-sex marriage in addition to the equal protection grounds in \textit{Baehr v. Lewin},\textsuperscript{61} the Hawaii same-sex marriage case. It also provides grounds for recognizing the intent of the parties in gay partnerships concerning the birth and rearing of offspring. The New York Court of Appeals achieved this result when it held in \textit{In re Jacob}\textsuperscript{62} that the statute specifying who may adopt included the same-sex partner of a biologic mother, thus removing the barrier to same-sex rearing that its earlier decision in \textit{Alison D. v. Virginia M.}\textsuperscript{63} had created. Extending to same-sex reproduction and child-rearing the principle of intentionality that drives our system of gamete donation and gestational surrogacy would have reached the same result more directly.

In sum, although ARTs pose no revolutionary threat to the shape or understanding of family, they do remind us of how important family is to human flourishing, and hence the need for tolerance of different ways of forming or defining families. Opponents of same-sex marriage should reexamine their position in light of ART practices, for the respect for intimacy and meaning reflected in social acceptance of ARTs should extend to gay marriages as well. At the same time, ARTs proponents should listen to the concerns of critics, so they may improve the provision of assisted reproductive services.\textsuperscript{64}

\textsuperscript{61} 852 P.2d 44, 63–68 (Haw. 1993).
\textsuperscript{62} 660 N.E.2d 397, 398 (N.Y. 1995).
\textsuperscript{63} \textit{In re Jacob}, 660 N.E.2d at 399–400 (citing \textit{Alison D. v. Virginia M.}, 572 N.E.2d 27, 29 (N.Y. 1991)). Chief Judge Judith Kaye, who dissented in \textit{Alison D.}, 572 N.E.2d at 30, wrote the majority opinion in \textit{Jacob}.
\textsuperscript{64} Regulatory attention to how men and women actually use and experience ARTs connects with insights and arguments that feminism has brought to bear on the debate. Although liberal, cultural, radical, and socialist feminists disagree about the desirability of ARTs, they all focus attention on the actual experience of women undergoing these procedures by asking how these practices affect the actual lives and experiences of women. Asking "the woman question" about ARTs has thus helped focus attention on the problems ARTs pose for donors, surrogates, couples, and offspring in practice.