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Giving in to Baby Markets: Regulation Without Prohibition

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GIVING IN TO BABY MARKETS: REGULATION WITHOUT PROHIBITION†

*Sonia M. Suter**

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INTRODUCTION

Baby making has become big business. With delays in childbearing, a concomitant rise in infertility, and ever-improving techniques to overcome that infertility, the demand for assisted reproductive technologies

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(ART) is increasing. ART, once viewed with suspicion and skepticism, has become a \$3 billion industry.¹ In vitro fertilization (IVF), one form of ART, “is now a popular, revenue-generating procedure, with individual clinics grossing as much as \$20 million annually.”² Indeed, in the United States alone, such forms of ART have created at least a \$1.7 billion market.³ But IVF clinics are not alone in profiting from the demand for ART. Women are selling eggs at ever-increasing prices, ranging from a few thousand dollars to as much as \$50,000–100,000.⁴ One need not look far for ads soliciting the purchase of ova from college students fitting a particular profile.⁵ Sperm donation (or, more correctly, sperm sale) has been ongoing for some time, though at considerably lower prices.⁶

ART has transformed from a new technology used by only a few to a burgeoning market so strong that niche markets have emerged to fulfill the particular needs and desires of certain consumers.⁷ Some sperm

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1. See NAOMI R. CAHN, TEST TUBE FAMILIES: WHY THE FERTILITY MARKET NEEDS LEGAL REGULATION 1 (2009) [hereinafter CAHN, TEST TUBE FAMILIES].
 2. Michele Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 J. GENDER RACE & JUST. 1, 22 (2005) (“[O]ver the past ten years . . . the number of children born through ART techniques quadrupled.”).
 3. Debora Spar & Anna M. Harrington, *Building a Better Baby Business*, 10 MINN. J. L. SCI. & TECH. 41, 47 (2009).
 4. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 148; June Carbone & Paige Gottheim, *Markets, Subsidies, Regulation and Trust: Building Ethical Understandings into the Market for Fertility Services*, 9 J. GENDER RACE & JUST. 509, 515 (2006); *Couple Seeks Eggs for \$100,000*, VERO BEACH PRESS J. (Fla.), Feb. 9, 2000, at A16. Most payments to egg donors are no more than \$5000, Peggy Orenstein, *Your Gamete, Myself*, N.Y. TIMES MAG., Jul. 15, 2007, at 40, but some have been paid as much as \$15,000, *id.*, or even \$100,000, DEBRA SPAR, THE BABY BUSINESS 46 (2006).
 5. An advertisement in a number of Ivy League colleges read, “‘Egg Donor Needed,’ adding, ‘Large Financial Incentive.’ The advertisements called for a 5-foot-10, athletic woman who had scored at least 1400 on her Scholastic Achievement Test and who had no major family medical problems. In return for providing eggs, she would receive \$50,000.” Gina Kolata, *\$50,000 Offered to Tall, Smart Egg Donor*, N.Y. TIMES, Mar. 3, 1999, at A10, available at <http://www.nytimes.com/1999/03/03/us/50000-offered-to-tall-smart-egg-donor.html>.
 6. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 148 (“The price of a sperm vial ranges, but it may cost hundreds of dollars.”).
 7. The gamete market has created “potential consumer preferences for certain (bordering on the eugenic) characteristics of their gamete providers, characteristics that go beyond basic gamete safety and the desire to become a parent but turn on the nature of identity.” *Id.* at 150; see, e.g., Pacific Reproductive Services, <https://www.pacrepro.com/index.php> (last visited Feb. 2, 2009) (a sperm bank that is run by and targeted toward the lesbian population); see also Richard F. Storrow, *Quests for Conception: Fertility Tourists, Globalization, and Feminist Legal Theory*, 57 HASTINGS L.J. 295, 326–27 (2005) (describing fertility tourism marketing itself as a romantic holiday for couples seeking to get pregnant).

banks offer “specialty” sperm from donors with particular qualities, such as high IQ.⁸ Others cater to the lesbian and gay community.⁹ Egg brokers seek out ova sellers who have the physical and intellectual qualities that match their customers’ preferences.¹⁰ Women sell gestational surrogacy services, carrying an embryo created by the gametes of others or using their own eggs for insemination.¹¹ One can even now purchase a made-to-order embryo.¹²

The commodification of reproductive materials and services has created veritable baby markets¹³ nationally and internationally. To a large extent these baby markets, particularly with respect to gametes, are free and unfettered. The infertility industry fits well within America’s capitalistic norms, evolving to meet consumer desires and needs—almost always for a buck.

The commodification of reproductive material evokes different responses. Some argue that the sale of reproductive material should be prohibited.¹⁴ Others argue in favor of unfettered baby markets on principle or to achieve broad-scale access to reproductive technologies.¹⁵ In this Article, I respond to the emergence of baby markets with great skepticism,

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8. For instance, the California based sperm bank, Cryobank, allows prospective recipients to search for their perfect sperm match according to fields such as occupation, education level, and areas of study of the donor. California Cryobank, Inc. Advanced Search, <http://www.cryobank.com/Donor-Search/Advanced-Search/> (last visited Feb. 2, 2009).
 9. For instance, Pacific Reproductive Services markets itself as “a sperm bank that is fully supportive and understanding of [a woman’s] unique needs [making] the insemination process easier.” Pacific Reproductive Services About Us, https://www.pacrepro.com/index.php?main_page=about_us (last visited Feb. 2, 2009).
 10. Dov Fox, *Silver Spoons and Golden Genes: Genetic Engineering and the Egalitarian Ethos*, 33 AM. J.L. & MED. 567, 621 (2007) (“For-profit egg and sperm banks routinely cater to consumer preferences donor characteristics such as educational, professional, and athletic achievements.”).
 11. See SPAR, *supra* note 4, at 69–96 (describing the evolution of the surrogacy market).
 12. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 149 (describing the growing market for embryos in which recipients may chose from “donor profiles” that the embryo bank had already “manufactured.”). Recently, a British couple paid £9,000 to purchase a made-to-order embryo based on particular traits and qualities. Daniel Martin, *Couple Pay £9,000 to Have the First British Web Baby*, DAILY MAIL (London), Jan. 18, 2007, at 7.
 13. In most of this Article, I primarily refer to the buying and selling of gametes and embryos, although I make some references to surrogacy services as well.
 14. Some countries have prohibited the sale of gametes. See Carbone & Gottheim, *supra* note 4, at 538 (noting that Australia and Sweden prohibit the sale of gametes); John McMillian & Tony Hope, *Gametes, Money, and Egg Sharing*, 362 LANCET 584, 584 (2003) (noting that “countries such as Israel, Australia, Denmark, France, Spain, the United Kingdom, and Denmark” prohibit payment to gamete donors).
 15. Martha M. Ertman, *What’s Wrong with a Parenthood Market? A New and Improved Theory of Commodification*, 82 N.C. L. REV. 1, 16 (2003).

but reluctant acceptance. Drawing on a relational conception of autonomy and self-definition, I argue that commodification of reproductive material is intrinsically harmful. Moreover, such commodification poses a number of consequential harms. Nevertheless, in spite of these concerns, I “give in” to baby markets, which is to say I do not argue for the prohibition of these markets, but instead for their regulation and oversight. I give in to baby markets in part because of the great impracticality of prohibiting markets given how well entrenched they are; people have been buying and selling reproductive material for some time. In addition, as I shall suggest, although there are risks of markets, the risk-benefit calculus calls for allowing markets to exist, provided there is careful and serious regulation of such markets. In other words, I am not willing to accept completely free and unfettered markets.

In Part I, I use a relational theory of personhood to suggest that reproductive material can be relationally self-defining, depending on our intentions and actions. The more self-defining such material is, the more intrinsically harmful it is to buy and sell it. I emphasize, however, that baby markets do not exist in a world where all things are equal. Therefore, we must also consider the effects (both positive and negative) of these markets in an imperfect world. In Part II, before describing the consequential effects of baby markets in detail, I explain why I give in to baby markets. In short, I take a pragmatic approach that suggests we should (reluctantly) accept baby markets as long as we offer measures to counteract the negative effects of commodification. To be sure, intrinsic harms cannot be completely avoided. But given the impracticalities of prohibiting markets, our focus should be on making baby markets work equitably, safely, and in a way that protects the interests of all involved: seller, buyer, and future child. In a country with limited regulation of the reproductive industry, this may be a tall order.

Part III addresses the first and, in some ways, most pressing consequential effects of baby markets: the coercion, distorted decision making, and power imbalances that arise when money drives the exchange of reproductive materials and services, particularly in an unregulated industry. This Part offers proposals for reforming informed consent to enhance decision making and for regulating the industry to try to eliminate some of the conflicts of interest and power imbalances that can distort decision making and threaten the safety of buyers, sellers, and future children.

Part IV returns in more detail to the problem of relational autonomy, but this time from the perspective of the children born of ART who have no ability to express market preferences since they are not buyers or sellers in these markets. I argue that market preferences have

avored provisions ensuring the anonymity of sellers of reproductive material, which threaten the child's relational autonomy in learning about her biological heritage. Recognizing that these interests may conflict with the interests of sellers and buyers, I offer reasons for resolving this conflict in favor of the child.

In Part V, I respond to the arguments that unfettered baby markets increase access to ART. While they may increase supply and theoretically prevent discriminatory practices, I argue that the barriers of cost, minority status, and marital status cannot be overcome simply by the presence of unrestricted markets. Instead, public mechanisms may be necessary to bridge some of the gaps in access. In short, once again, I argue for the acceptance of baby markets, but not without prophylactic regulations.

Finally, in Part VI, I address the way in which market preferences raise eugenic concerns. My discussion is brief here, building on arguments I have made previously about how we should evaluate criticisms that certain reproductive choices are eugenic.¹⁶ In essence, I argue that the market can exacerbate underlying prejudices and heighten social inequity. As a result, I suggest we set price limits on reproductive material to minimize these market effects.

Ultimately, I am most troubled by the consequential harms of baby markets, some of which can be remedied through regulation, some of which can only be tempered. I am also concerned about the potential for intrinsic harms, which as I shall suggest in the next section cannot be overcome through regulation. As we shall see, however, the degree of intrinsic harm varies depending on one's relationship with and expectations for one's reproductive material. I turn now to the problem of intrinsic harms.

I. COMMODIFICATION AND PERSONHOOD INTERESTS

The concern that baby markets are intrinsically harmful builds on the theory that market valuation is inherently corruptive if we treat certain goods as reducible to monetary measures of value.¹⁷ Whether commodification poses intrinsic harms or degrading effects depends on the "character of the particular good in question" and "the ideals at

16. Sonia M. Suter, *A Brave New World of Designer Babies?*, 22 BERKELEY TECH. L.J. 897 (2007) [hereinafter Suter, *Brave New World*].

17. Michael J. Sandel, *What Money Can't Buy: The Moral Limits of Markets*, Lecture at Brasenose College, Oxford (May 11–12, 1998), in THE TANNER LECTURES ON HUMAN VALUES 89, 94–95 (1998), available at <http://www.tannerlectures.utah.edu/lectures/documents/sandel00.pdf>.

stake.”¹⁸ We potentially do harm to ourselves and to human flourishing if we treat something integral to ourselves as a commodity, i.e., as separate and fungible.¹⁹ Whether and to what degree commodification is problematic therefore depends on whether and to what degree the putative “commodity” is integral to the self.

I contend that because embryos and gametes are severable and separable from us, they are not per se integral to us. But the possibility of severability and separation is not sufficient to assess whether something is essential to human flourishing. Some things that are severable and separable, such as employment, can sometimes be deeply integral to the self.²⁰ To assess how integral something is to the self, we must consider other factors such as our intentions and actions regarding the commodified item, that is, whether we want to separate from it or whether we see it as integral to us.²¹ Equally important is the nature of our relationship to the commodified item, not just as defined by us, but as understood culturally, legally, and biologically.²²

What makes embryos, and to a lesser extent gametes, integral to personhood interests is their centrality to decisions about reproduction and the creation of families.²³ They occupy a unique place in the world of “things” because of their reproductive potential.²⁴ As one court and many ethicists have recognized, embryos are neither property nor persons, but tissues that deserve special respect because they implicate people’s procreative interests.²⁵ Gametes do not, in and of themselves, have the same capacity, but they are of course essential to the reproductive process in a way that ordinary cells are not.

18. *Id.* at 104.

19. Margaret Radin has been influential in this discussion and I draw to a large extent on her analysis in such works as MARGARET J. RADIN, *CONTESTED COMMODITIES* (1996), and Margaret J. Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849 (1987) [hereinafter Radin, *Market-Inalienability*].

20. Similarly, personal information, which is not severable, can be quite integral to us.

21. Radin, *Market-Inalienability*, *supra* note 19, at 1880–81.

22. *Cf. id.* (Although Radin does not discuss this point specifically, she discusses the way in which our relationship to the commodified item is in part understood culturally. I believe that our cultural attitudes toward these relationships are influenced by biological connections and what they mean culturally; and that our legal conceptions are influenced by our cultural views of certain relationships).

23. Cf. Radhika Rao, *Property, Privacy, and the Human Body*, 80 B.U. L. REV. 359, 458 (2000).

24. *See id.* (“Although embryos themselves are not full-fledged persons, they differ from other body parts because of their potential to develop into a person.”).

25. *Davis v. Davis*, 842 S.W.2d 588, 592–97 (Tenn. 1992) (describing this view among commentators).

The nature of our relationship with gametes and embryos and their role in self-definition depend a great deal on context and our intentions regarding them, specifically the procreative decisions we make and the relationships that we choose or do not choose to form with the people they may become. But their role in self-definition also depends on the biological, social, and cultural importance of our intergenerational relationships to them. This assessment is rooted in a notion of selfhood that is relational, where self-discovery unfolds “in relation to others with whom we confront our thoughts against their thoughts,” where “my life is always embedded in the story of those communities from which I derive my identity,” as opposed to an “atomistic conception of self-definition, in which the individual shapes herself without reference to others.”²⁶ This relational understanding of the self looks to a broad range of communities of which one is a part. As philosopher Alasdair MacIntyre has noted,

What I am . . . is in key part what I inherit, a specific past that is present to some degree in my present. . . . I inherit from the past of my family, my city, my tribe, my nation, a variety of debts, inheritances, rightful expectations and obligations. . . . This is in part what gives my life its own moral particularity.²⁷

Under this relational notion of self-definition, the extent to which embryos and gametes are self-defining depends on whether they will become people who form part of the community from which we derive our identity. Embryos and gametes may be the origins of families and intimate relationships. Even when genetic relatedness is absent—as in the case of a couple or individual who obtains an embryo for implantation—the embryo, which will become their child, defines them in very real and deep ways, and thus is integral to the self. Alternatively, embryos or gametes may be something from which we intentionally separate (whether or not for money) with little or no possibility of future connection: We might donate them to unknown infertile couples or researchers, or we might request that extra reproductive material be destroyed.²⁸ The fact that we treat these embryos as separable from us diminishes the extent to which they are integral to us. How much

26. Sonia M. Suter, *Disentangling Privacy from Property: Toward a Deeper Understanding of Genetic Privacy*, 72 GEO. WASH. L. REV. 737, 772, 773 n.174 (2004) [hereinafter Suter, *Disentangling*] (quoting ALASDAIR MACINTYRE, *AFTER VIRTUE: A STUDY IN MORAL THEORY* 221 (1981)).

27. MACINTYRE, *supra* note 26, at 205.

28. See NAT'L RESEARCH COUNCIL & INST. OF MED., *GUIDELINES FOR HUMAN EMBRYONIC STEM CELL RESEARCH* 81 (2005) [hereinafter NAS GUIDELINES].

depends on why we choose to separate from them. If just profit motivates this separation, we are treating them “as essentially fungible and interchangeable,”²⁹ and our personhood interests are lessened. But if altruism prompts us to separate from embryos (whether or not we are paid) to help infertile couples³⁰ or promote research,³¹ then these decisions are more relationally self-defining because such decisions are based on our membership in and commitment to the community writ large. In cases where we donate gametes or embryos to friends or family as part of our commitment to these relationships, an even more significant relational interest would exist.³² In all of these cases, however, separability is the main intention, and therefore these actions are not as self-defining as decisions to use embryos or gametes to become a parent to the future child.³³

A recent case involving “a colossal mix-up” of sperm at a fertility clinic demonstrates how intent and actions regarding gametes can implicate strong personhood interests.³⁴ In this case, the clinic accidentally used a man’s sperm to inseminate, not his girlfriend as intended, but a woman who had arranged for artificial insemination by an anonymous

29. Rao, *supra* note 23, at 458–59 (“As a result . . . relationships with the embryos merit only the same legal protection afforded to other object relationships.”).

30. Ethics Comm. of the Am. Soc’y for Reproductive Med., *Financial Incentives in Recruitment of Oocyte Donors*, 74 FERTILITY & STERILITY 216, 218 (2000) [hereinafter Ethics Committee] (surveying ova donors and finding that for most donors a significant factor in selling eggs was to help infertile people); Lori B. Andrews, *Beyond Doctrinal Boundaries: A Legal Framework for Surrogate Motherhood*, 81 VA. L. REV. 2343, 2353 (1995) (describing the altruistic motives of surrogate mothers).

31. NAS GUIDELINES, *supra* note 28, at 81.

32. In these cases, financial exchanges are also less likely.

33. See Rao, *supra* note 23, at 364. The line of cases that protect decisional privacy in reproduction, marriage, and child rearing are consistent with the view that decisions regarding whether and how to create certain relationships enhance and foster self-definition. See *Planned Parenthood v. Casey*, 505 U.S. 833, 923 (1992) (“These matters [involve] the most intimate and personal choices a person may make in a lifetime . . .”). One might respond that this very line of cases undercuts my claim that our degree of personhood interests in embryos or gametes varies to some degree based on our intentions and actions regarding them. One might say, for example, that if reproductive decisions, including decisions *not* to procreate, implicate privacy and personhood interests, then shouldn’t all decisions regarding embryos and gametes equally implicate the kinds of personhood interests that commodification threatens? The difference is that the reproductive privacy cases address decisions *about* whether to procreate or not, but they do not address our relationship to gametes and embryos and their role in self-definition. Deciding to sell one’s gametes or embryos is a procreational decision in one sense, but it is a decision that reduces our self-defining, relational interests in those entities. In contrast, deciding to procreate to create a family maximizes our self-defining, relational interests in them.

34. Angela Valdez, *The Wrong Egg*, SALON.COM, Nov. 16, 2006, http://www.salon.com/mwt/feature/2006/11/16/fertility_mix_up/index.html.

donor.³⁵ The man's goal was to use his gametes to create his own family, not to help an unknown woman conceive.³⁶ His is not a case where the sperm donor considers his sperm severable and separable. In fact "[w]hen asked about the common assumption that men regard their sperm as expendable, he begins to cry."³⁷ In short, he had strong personhood and relational interests in his gametes. As a result, he went to court to ask to be declared the legal father if a child was born and turned out to be his.³⁸

Since the choices we make with respect to gametes and embryos influence the degree of personhood and relational interests,³⁹ the extent to which baby markets threaten human flourishing turns, in part, on intent and actions. Thus when someone chooses to sell gametes or embryos, the intrinsic harms of commodification are far less (although as Parts III–VI suggest, consequential harms are still present). When someone intends to use them to create a family, commodification is particularly threatening to human flourishing. The famous case *In re Baby M*⁴⁰ raises these kinds of concerns. In that case, an infertile couple, William and Elizabeth Stern, entered into a contract with Mary Beth Whitehead, a gestational surrogate who agreed to conceive a child through artificial insemination with the husband's sperm, to carry the child to term, and to relinquish her parental rights so the couple could adopt the child.⁴¹ In exchange she was to be paid.⁴² Originally Mrs. Whitehead's personhood interests in the fetus were minimal: she

35. *Id.* For purposes of ease and space, I, like many others, refer to sellers of eggs and gametes as donors, a misnomer to be sure. Technically, when they receive money for this reproductive material they are sellers. See Bonnie Steinbock, *Payment for Egg Donation and Surrogacy*, 71 MOUNT SINAI J. OF MED. 255, 255–56 (2004) (noting that the term, "donation," is the accepted usage, even though it refers to a "commercial enterprise").

36. *Id.*

37. *Id.*; see also *In re K.M.H.*, 169 P.3d 1025, 1040 (Kan. 2007) (discussing a sperm donor's unsuccessful petition to be treated as the legal father of twins conceived through the artificial insemination of his friend, in part, on grounds that it violated his due process rights "to care, custody, and control of his children").

38. Valdez, *supra* note 34. While sperm donors typically sign away their rights to custody, he had not intended to be an anonymous sperm donor. Instead, he planned to use his sperm to create his own child, and therefore never signed away parental rights.

39. Cf. Rao, *supra* note 23, at 458 ("In the absence of a relationship between the person and the embryo, . . . the embryo may be addressed as an object of ownership governed by the law of property. For example, individuals who seek to sell their spare embryos . . . treat the embryos as essentially fungible and interchangeable, much like other objects of ownership.").

40. *In re Baby M*, 537 A.2d 1227, 1234–35 (N.J. 1988).

41. *Baby M*, 537 A.2d at 1235.

42. *Baby M*, 537 A.2d at 1235.

intended and contracted to separate from the future child.⁴³ But in the course of the pregnancy, she formed the kind of relational attachment that implicates personhood interests and that led her to change her mind.⁴⁴ Of course the Sterns, who desperately wanted a family,⁴⁵ also had strong, relationally self-defining interests in the future child. They had entered into the contract and agreed to pay money with the specific goal of bringing a child into the world whom they intended to raise.⁴⁶

Among the concerns that led the *Baby M* court to invalidate the contract was the exchange of money.⁴⁷ The court reasoned that commodification was harmful to all involved: the future child, the gestational surrogate, the natural father, and the adoptive mother.⁴⁸ It concluded that “[t]here are, in a civilized society some things that money cannot buy.”⁴⁹ In so doing, the court drew upon the kind of discomfort many feel regarding certain financial exchanges, such as paying a spouse for sex, paying for a baby, or paying for a mail-order bride.⁵⁰

43. *Baby M*, 537 A.2d at 1235.

44. *Baby M*, 537 A.2d at 1236–37. Indeed, a psychologist from the Infertility Center, who evaluated Mrs. Whitehead found that she “demonstrated certain traits that might make surrender of the child difficult and that there should be further inquiry into this issue in connection with her surrogacy.” *Id.* at 1247–48. Apparently, these findings were not shared with the Sterns or Mrs. Whitehead. *Id.* at 1248.

45. *Baby M*, 537 A.2d at 1235–36.

46. *Baby M*, 537 A.2d at 1235–36. One might question whether the purchasers of the embryo have a self-defining relationship with the embryo before the transaction is actually completed. A couple or individual who purchased an embryo or gamete to create a family, however, would rightly argue that the act of purchasing the gamete or embryo to create a family is itself self-defining because it is the first-step in a process intended to bring about a child.

47. The irrevocability of the gestational surrogate’s agreement to terminate her parental rights prior to conception was equally problematic to the court. *Baby M*, 537 A.2d at 1250. The court found that the irrevocability prevented Mrs. Whitehead from making an informed, voluntary decision.

Under the contract, the natural mother is irrevocably committed before she knows the strength of her bond with her child. She never makes a totally voluntary, informed decision, for quite clearly any decision prior to the baby’s birth is, in the most important sense, uninformed, and any decision after that, compelled by a pre-existing contractual commitment, the threat of a lawsuit, and the inducement of a \$ 10,000 payment, is less than totally voluntary.

Id. at 1248.

48. *Baby M*, 537 A.2d at 1250.

49. *Baby M*, 537 A.2d at 1249.

50. *Baby M*, 537 A.2d at 1241–42 (discussing the “evils inherent in baby-bartering”); see also Donna R. Lee, *Mail Fantasy: Global Sexual Exploitation in the Mail-Order Bride Industry and Proposed Legal Solutions*, 5 *ASIAN L.J.* 139, 140 (equating the mail order bride business to prostitution and involuntary servitude); William B. Turner, *Putting the Contract into Contractions: Reproductive Rights and the Founding of the Republic*,

Baby M was, we hope, the rare case where the ultimate intention of one of the contracting parties changes.⁵¹ Assuming sellers do not change their minds, their actions and intentions with respect to the embryos, gametes, or future child is usually severability and separation. As a result, in most instances, although the sellers of the embryo, gamete, or surrogacy service⁵² will have a relational interest in the gametes or embryos, their interest will be less than that of buyers who intend to establish a life-long relationship as parents of the future child.

Although choice and intention are highly important in establishing the degree to which embryos and gametes are integral to the person, this evaluation should not be purely subjective. Self-definition based on relationships is shaped not only by our choices regarding which relationships to embrace, but also by objective factors. We are defined, in part, by relationships that have social, cultural, and intergenerational importance, even if we do not have the subjective experience of being related.⁵³ For example, a woman may give birth to a child and ultimately choose not to have a relationship with that child. But until the child has been legally adopted, we recognize that child as the woman's, even if her intention is to part with it.⁵⁴ Even afterwards, we think of the child as

2005 WIS. L. REV. 1535, 1560–61 (2005) (stating that agreements between husbands and wives with sex as consideration are not valid contracts). *Cf. infra* note 65. As one commentator queries, given that there are no laws prohibiting the payment for gametes and embryos, why do we insist on the euphemism of “donation” unless “to mask the pervasiveness of the literal market transactions that occur surrounding something we connect to a deep sense of personhood[?]” Suzanne Holland, *Contested Commodities at Both Ends of Life: Buying and Selling Gametes, Embryos, and Body Tissues*, 11 KENNEDY INST. ETHICS J. 263, 272 (2001). Perhaps this need to mask the commodification reveals our great discomfort with this reality. *Id.* at 274.

51. *Cf. Andrews, supra* note 30, at 2351 (“Apparently fewer than one percent of surrogates . . . change their mind and make an effort to keep the child, which is in keeping with data about the women who change their mind about sterilization or abortion.”).
52. Surrogacy is tougher because of the fact that the fetus is not severable from the individual in the way that an embryo is. Thus, while the surrogate may ultimately decide to separate from the child at birth, a relationship is potentially unfolding within her body, making any change of heart all the more compelling from a personhood context. However, Lori Andrews discovered from interviews with surrogates that they “did not refer to the fetus as ‘my baby,’ . . . but as the intended parents’ baby.” Andrews, *supra* note 30, at 2352. Nevertheless, one study found that twenty-two percent of surrogates considered separating from the baby to be the most emotionally troubling part of the arrangement, while twenty-five percent considered it to be separating from the intended parents. *Id.* at 2353. This suggests that the relational interests for surrogates exist, but are less than those for the intended parents.
53. *See supra* text accompanying note 27.
54. For instance, the biological mother's rights do not terminate until she has given her consent to adoption. *See, e.g.,* ALA. CODE § 26-10A-7(a)(2) (LexisNexis 2008); CAL. FAM. CODE § 8605 (2008). In some states, the biological mother's parental rights are

hers biologically.⁵⁵ We would not misspeak, in one sense, if we described the adopted child as her child. Biological parents themselves may still feel like parents in one sense, even if they intend to relinquish parental rights.⁵⁶

Unless the biological relationships are complex (e.g., when intended parents use in vitro fertilization, donor gametes, and/or a gestational surrogate to bring a child into the world),⁵⁷ we have long established cultural and legal understandings that a parent-child relationship exists given certain biological connections.⁵⁸ Of course, these understandings are not set in stone, and our society and laws recognize the importance of allowing people to redefine these relationships through adoption.⁵⁹ The fact, however, that this redefinition requires legal recognition and does not occur solely because of one's intentions and experiences attests to the fact that a relationship of sorts exists given certain biological connections between two individuals. The relationship may ultimately change legally, socially, and emotionally from the presumed parent-child relationship, but it nonetheless remains a self-defining relationship given the cultural respect and recognition of this biological connection.

Lest I be misunderstood, let me be clear that I am not suggesting that the biological connection is greater or more significant than the relationship between the adopted child and adoptive parents or between the child born through gamete donation and the intended parents. Clearly the adoptive parents or the parents who used donor gametes to

so strong that she may revoke her consent to an adoption within a given time period. *See, e.g.*, WASH. REV. CODE ANN. § 26.33.160(2) (LexisNexis 2008) (allowing the revocation of consent to adoption any time before the consent is approved by the court); N.Y. DOM. REL. § 115-b(3) (McKinney 2008) (allowing the revocation of consent within forty-five days of the execution of the consent so long as the consent is not executed or acknowledged before a judge or surrogate).

55. Naomi Cahn & Jana Singer, *Adoption, Identity, and the Constitution: The Case for Opening Closed Records*, 2 U. PA. J. CONST. L. 150, 176 (1999).

56. *Id.* (“For the biological parents, their identity as ‘parents’ remains, regardless of when they relinquished their child. Quite commonly, biological parents still feel that they are parents . . .”); *id.* at 177 (“[M]any birth mothers still feel a closeness to the children that they relinquished for adoption.”).

57. *See, e.g.*, *In re Marriage of Buzzanca*, 61 Cal. App. 4th 1410, 1412 (1998) (addressing the question of who the legal parents are when a couple (the intended parents) arranged to have “an embryo genetically unrelated to either of them implanted in a woman—a surrogate—who would carry and give birth to the child for them”).

58. June Carbone & Naomi Cahn, *Which Ties Bind? Redefining the Parent-Child Relationship in an Age of Genetic Certainty*, 11 WM. & MARY BILL RTS. J. 1011, 1015 (2003) (“[C]ourts most often assume that the word ‘parent’ refers [sic] a child’s biological progenitors.”).

59. *Id.* at 1024 (discussing societal exceptions to the general rule that a child’s parent is dependent on a biological connection).

bring a child into existence form a more significant and self-defining relationship than the individual who is merely genetically related to the child.⁶⁰ My point is that the fact of being genetically related to another, whether by giving birth to a child or by being an egg or sperm donor, is nevertheless self-defining. Thus, those who are genetically related to embryos and gametes (i.e., the gamete donors) as well as the intended parents are defined by the relationships that exist between them and the people who will develop from those embryos or gametes. For the intended parents who embrace these relationships, which are often legally and socially recognized, the gametes or embryos are especially self-defining.⁶¹ For the gamete or embryo donors, the relationship can be purely genetic (assuming there is no plan for contact with the resulting child).⁶² As a result, the embryos or gametes are integral to the self, but less so than in the former instance.

Because embryos and gametes are integral to the self, albeit to differing degrees depending on intention, actions, and objective recognition of certain relationships, commodification of this reproductive material is intrinsically harmful. As others have noted, we threaten human flourishing when we treat something integral to us as a commodity.⁶³ This claim, however, presumes a world in which the only variable at issue is whether or not money should change hands in exchange for an embryo, gamete, or surrogacy service. It presumes no other threats to human flourishing such as unequal bargaining power, unequal access to reproductive options, or limited availability of gametes and embryos.⁶⁴ In this theoretical world, widely divergent from the real world, it seems particularly unsettling and improper to engage in financial transactions with respect to the relationally, self-defining decisions associated with baby markets.⁶⁵

60. See *supra* text accompanying note 28.

61. See *supra* text accompanying note 28.

62. See Ellen Waldman, *The Parent Trap: Uncovering the Myth of "Coerced Parenthood" in Frozen Embryo Disputes*, 53 AM. U. L. REV. 1021, 1049–52 (2004). But see NAS GUIDELINES, *supra* note 28, at 67 (discussing varying attitudes of gamete donors toward their donations from medical byproducts to parental concern).

63. See *supra* notes 17–19 and accompanying text.

64. Cf. Sandel, *supra* note 17, at 94–95 (distinguishing objections to commodification based on its devaluation from objections based on "coercion," where inequality can push some to sell more readily than others); Radin, *Market-Inalienability*, *supra* note 19, at 1915 ("But we are situated in a nonideal world of ignorance, greed, and violence; of poverty, racism, and sexism."). See also *infra* Part III.

65. This is consistent with the fact that the law resists certain kinds of economic exchanges between individuals based on the nature of the relationship and the degree of intimacy. For example, to preserve and protect certain kinds of intimacy, the law does not condone certain financial exchanges, particularly those that help define the level

To demonstrate fully the kind and extent of harm to human flourishing that baby markets present would require a well-developed normative vision of human flourishing that is beyond the scope of this Article.⁶⁶ I do not offer such a vision beyond my claims about the concerns regarding relational, personhood interests for a few reasons. First, the notion that some things are so central to personhood and human flourishing that they would be corrupted by markets challenges the market-oriented view that all goods are commensurable. But as Sandel has pointed out, “[i]t does not seem . . . possible, in general, to prove or refute the thesis of commensurability, which is one of the reasons that arguments by analogy play such an important role in debates about commodification.”⁶⁷

Second, and more important, all things are not equal. Commodification here, as in any other context, occurs against the backdrop of many factors that influence the conditions of the exchange. If these background conditions meant, for example, that such markets enhanced the ability or opportunities for individuals to create families,⁶⁸ prohibit-

of intimacy. Jill Elaine Hasday, *Intimacy and Economic Exchange*, 119 HARV. L. REV. 491, 493 (2005) (“The law’s regulation of economic exchange between intimates, which restricts but does not bar economic transfers, helps to define and construct the legal understanding of intimacy, and to mark the dignity and specialness of intimate relations.”); *id.* at 507 (“The law governing nonmarital sexual relationships also devotes enormous energy to differentiating between relationships . . . [and] operates on the assumption that a critical way to establish the worth and dignity of an intimate relation is to stress the relation’s detachment from the market and to prohibit some forms of economic exchange between intimates.”); *id.* at 511 (“The law of parenthood seeks to promote the specialness and dignity of the parent-child relation by stressing its removal from the market and refusing to enforce certain economic transactions,” such as the buying and selling of children).

66. Even Margaret Radin, in developing her theory of personhood and property, relies on a “pragmatically conceived” vision that draws on “particular values that are said to be shared or are implicit in our society, rather than on some transcendent, abstract theory of what is right.” Stephen J. Schnably, *Property and Pragmatism: A Critique of Radin’s Theory of Property and Personhood*, 45 STAN. L. REV. 347, 351, 353 (1993) (noting the appeal of her pragmatic approach but also pointing out its reliance on consensus, which may not be as easy to establish on these points and both “obscures the exercise of power . . . [and] tends to treat power as irresistible”).

67. Sandel, *supra* note 17, at 104.

68. For example, they may increase the supply of reproductive material, and theoretically reduce prices. *See, e.g.*, Carbone & Gottheim, *supra* note 4, at 522 (“The supply of gametes, like any other commodity, is a function of the available price and the relative demand.”); Ethics Committee, *supra* note 30, at 218 (“[P]roviding financial incentives increases the number of oocyte donors”). *But see* Gregory Stock, *Eggs for Sale: How Much Is Too Much?*, AM. J. BIOETHICS, Dec. 2001, at 26, 27 (“[T]here is no shortage of donors in general, just a shortage of donors with certain profiles of intelligence, beauty, education, religion, and other factors.”). *Cf.* Michele Goodwin, *Altruism’s Limits: Law, Capacity, and Organ Commodification*, 56 RUTGERS L. REV.

ing such markets would be damaging to human flourishing. In those cases, being unable to engage in such commerce would be much more degrading than commodification itself.

Markets might enhance options for buyers and/or sellers, but they might also negatively affect them. This raises empirical questions as to whether and when being able to buy or sell embryos, gametes, or surrogacy services increases opportunities for relationally self-defining actions on the part of both buyers and sellers. So although we may worry about the damaging effects of baby markets on human flourishing, we cannot evaluate baby markets as if the only issue is the intrinsic harm of commodification. It is impossible to separate out completely the intrinsic harms of commodification from the consequential effects (positive or negative) of commodification that turn on “background conditions within which market exchanges take place.”⁶⁹

My final reason for not offering a fully developed theory of human flourishing is that the consequential harms of baby markets are equally, and in some cases even more, troubling than the intrinsic harms. As I argue in Parts III–VI, existing inequities, power imbalances, discrimination, the psychological aspects of infertility, an unregulated ART industry, and unequal access to ART all potentially impact the self-defining choices associated with baby markets even more than the mere fact of commodification. Market preferences that favor anonymity and prevent the child from learning her genetic heritage also threaten the child’s relational autonomy.⁷⁰ Market preferences may also exacerbate the tendencies to use ART for “eugenic” ends.⁷¹ Finally, even if baby markets increase access to gametes and embryos, they cannot alone overcome the various barriers to ART that its proponents imagine.⁷²

As a result, the consequential effects of commodification can be especially threatening. Yet, as the title of this Article suggests, in spite of these many concerns about intrinsic and consequential harms, I reluctantly accept baby markets. Because I aim to remedy the consequential harms of baby markets, I first explain my pragmatic response to baby markets in Part II before I turn to the consequential effects of baby markets in more detail in Parts III through VI. In short, I explain why I “give in” to baby markets.

305 (2004) (suggesting that legitimate organ markets can increase the supply of organs). Some argue that baby markets allow certain marginalized individuals to access reproductive materials they would otherwise be barred from obtaining. *See* Ertman, *supra* note 15, at 1.

69. Sandel, *supra* note 17, at 95.

70. *See infra* Part IV.

71. *See infra* Part VI.

72. *See infra* Part V.

II. GIVING IN TO BABY MARKETS

Despite my unease regarding markets, the reality is that markets (black or otherwise) do exist in embryos, gametes, surrogacy services, and other aspects of assisted reproductive technologies.⁷³ Such markets are in fact proliferating here and in other countries.⁷⁴ Prohibiting these markets may limit choice, which can also threaten human flourishing.⁷⁵ Moreover, approaches that try to theorize out the market are insufficiently attentive to real problems that must be dealt with given the presence of these markets and are likely doomed to failure.⁷⁶ This may be a case where “[p]rohibition . . . carr[ies] moral and practical costs that outweigh the good of preventing the practice.”⁷⁷

In addition, the elimination of commodification of gametes, embryos, surrogacy services, and other aspects of ART is highly impractical. Instead of having a price system to allocate rights and distributions of these biological materials and services, they would have to be “gratuitously transferred at every stage of distribution, with the forces of generosity (or a governmental entity) guiding tissue from its original human source to its ultimate consumer.”⁷⁸ Because the distribution of reproductive materials and services for ART involves so many actors, the chain of gratuitous transfers “can only succeed if none of the participants acts to capture the available economic surplus by selling tissue, and if the parties involved are able to solve the formidable logistical

73. Julia D. Mahoney, *The Market for Human Tissue*, 86 VA. L. REV. 163 (2002); see also Carbone & Gottheim, *supra* note 4, at 520 (“Purchasing of organs in the international market is widespread.”); Ertman, *supra* note 15, at 7–26; Goodwin, *supra* note 68, at 358–65; CAHN, TEST TUBE FAMILIES, *supra* note 1, at 153.

74. Raekha Prasad, *The Fertility Tourists*, GUARDIAN, July 30, 2008, at 6 (describing the global market in gametes and fertility tourism). In the United States, there is no federal legislation prohibiting the sale of gametes, and only a few states even address the issue. Radhika Rao, *Coercion, Commercialization, and Commodification: The Ethics of Compensation for Egg Donors in Stem Cell Research*, 21 BERKELEY TECH. L.J. 1055, 1057 (2006) (“Louisiana is the only state that explicitly prohibits the sale of human oocytes while Virginia is the only state that explicitly authorizes the sale of human oocytes.”).

75. Holland, *supra* note 50, at 275–77 (arguing that incomplete commodification—which lies between the extremes of “full commodification, in which everything is bought and sold,” and “complete noncommodification”—“offers regulation of the market as a way of fostering vitally important aspects of our flourishing, such as contextuality, identity, and freedom.”).

76. Cf. Holland, *supra* note 50, at 276 (“[I]ncomplete commodification affords us a more accurate reflection of the realities of our human transactions: we value both market efficiency and the fullness of our personhood.”).

77. Sandel, *supra* note 17, at 96.

78. Mahoney, *supra* note 73, at 197.

problems of coordinating benevolent behavior.”⁷⁹ At best this is likely to be impractical, at worst, unworkable.⁸⁰ In addition, there is the risk that the biological materials and services would be provided with greater levels of waste and inefficiency.⁸¹

Recognizing the costs⁸² and impracticalities of prohibiting markets, how entrenched baby markets are, and the possible benefits they offer, I give in to baby markets. That is to say, I reluctantly resist the prohibition of markets in spite of the many consequential harms of markets such as (1) coercion, distorted decision making, and power imbalances made worse by an unregulated infertility industry motivated by profit, (2) market preferences that promote anonymity of sellers at the expense of the future child’s relational interests in learning about these sellers, (3) barriers to accessing baby markets, and (4) eugenic-like effects of baby markets. Instead, I argue strongly in favor of mechanisms to address these threats, offering various approaches to minimize each of the consequential harms. I recognize that some of my suggested fixes are more easily achieved than others. In short, I recognize that “ideal theory. . . may have to give way to nonideal theory.”⁸³ If baby markets are inevitable, better that we allow them, but not that we accept them warts and all.

My goal in advocating the regulation of markets is to bring the world as close to ideal as possible. Of course, some of the intrinsic concerns I raised will still exist. But given both the impracticalities and costs of prohibiting markets, as well as the fact that certain background conditions that can affect human flourishing will not disappear simply by banning markets, this may be the price we have to pay. Since my response to baby markets is not grounded in “ideal theory” but practical realities, we should not let the best be the enemy of the good. As a result, we must choose the next best approach—one where we tend to the

79. *Id.* at 197–98.

80. *Id.* at 198 (“The number of human actors necessary to convert the recovered human components into useful scientific and medical materials, combined with the fact that many of these actors are unable or unwilling to forego financial compensation, means that distribution systems based on gratuitous transfers are likely to prove unworkable.”).

81. *Id.* at 199 (“The achievement of a genuine regime of noncommodification would mean that “[p]rofit-making and profit-seeking firms would withdraw, leaving the field to governmental entities and to nonprofit firms that agreed not to take part in bargained-for exchanges involving human biological materials,” which “might cause goods and services to be provided with greater levels of waste and inefficiency.”).

82. See *infra* text accompanying notes 116–125.

83. Margaret Jane Radin & Madhavi Sunder, *Introduction: The Subject and Object of Commodification*, in *RETHINKING COMMODIFICATION: CASES AND READINGS IN LAW AND CULTURE* 8, 14 (Martha M. Ertman & Joan C. Williams eds., 2005).

many consequential harms as well as we can, recognizing that our solutions will not be perfect. Prohibiting commodification, as I shall show below, will not alleviate many of the background conditions that raise the consequential harms. Instead, it may increase the vulnerability of the disempowered because we will have washed our hands of markets, effects and all.

As Parts III through VI will show, the consequential harms of baby markets, in particular unfettered baby markets—driven by consumer preferences and free of government regulation—can threaten the well-being and sometimes even human flourishing of the various participants in baby markets: sellers, buyers, and future children. In addressing the consequential harms, I distinguish between commodification of reproductive materials and completely free, unregulated baby markets. Many defenders of baby markets advocate the latter, arguing against government regulation, sometimes for very different reasons such as libertarian impulses⁸⁴ or to prevent majoritarian values from infringing on minority choices.⁸⁵

As I suggest in my exploration of each consequential harm, my reluctant willingness to allow a market in reproductive material is premised on the promise of regulatory measures to address the dangers of unfettered markets and to ensure that the choices of participants in these markets are most likely to enhance human flourishing. It is a compromise that accepts the reality and sometimes even value of markets, but which distrusts the ability of markets alone to avoid the consequential harms, particularly because markets can exacerbate harmful tendencies and sometimes even create them. After describing each consequential harm, therefore, I offer my suggested regulatory fix. It is quite unabashedly a compromise of sorts to address the messy problems of a messy world.

III. COERCION, DISTORTED DECISION MAKING, AND POWER IMBALANCES

I begin with one of the biggest consequential effects of markets: their potential to distort decision making unduly through coercion and power imbalances. As is true of all of the consequential harms, it is not context-specific in the way that claims of intrinsic harms are.⁸⁶ In other

84. See, e.g., Elisabeth M. Landes & Richard A. Posner, *The Economics of the Baby Shortage*, 7 J. LEGAL STUD. 323, 342–46 (1978).

85. See Ertman, *supra* note 15, at 22.

86. See Sandel, *supra* note 17, at 94–95.

words, this harm does not depend entirely on the moral importance of the good being sold, but rather on the ways in which markets can influence behavior.⁸⁷ The concern is that commodification may lead people to make choices they might not otherwise make—in particular, choices that are not in their best interests.⁸⁸ Such coercion may be further exacerbated in the face of underlying inequities, where those who are neediest may make choices they would not otherwise make because of a need for money.⁸⁹ Such a result would aggravate existing inequities by increasing the flourishing of the advantaged at the expense of the disadvantaged.⁹⁰

Concerns regarding coercion are heightened when the reproductive choices are tied to one's sense of self. We might worry, for example, about the surrogate who originally intended to part with the baby she has carried for nine months and now has a change of heart. Would financial necessity, in some cases, drive her to relinquish her parental rights in spite of bonding with the fetus and wanting to raise the child? The harm would be especially serious. Not only would money have influenced a choice, but it would have done so with respect to a choice that strongly implicates relational autonomy and that is deeply integral to the self.⁹¹

Coercion is troubling even if lesser personhood interests are at stake. The woman who wants to sell her ova may not have as deep a relational connection to the ova. Nevertheless, she might not have otherwise chosen to endure the burdensome process of taking hormones, undergoing anesthesia, and facing possible long-term health risks to retrieve the ova⁹² had she not needed the money.

An additional concern with markets here (and in other areas of commodification) is their potential to exacerbate power imbalances,

87. *See id.* (comparing intrinsic harms of commodification with ones that depend on background conditions).

88. *Id.* (describing the risks of coercion); *cf.* Steinbock, *supra* note 35, at 262 (suggesting that in most cases offers of large sums of money will not literally be coercive, but may instead constitute “undue inducements”).

89. *Id.*; *see also* JULIA DEREK, *CONFESSIONS OF A SERIAL EGG DONOR* 164 (2004) (describing money challenges as the primary motivation in her and her friends' decisions to sell eggs); Holland, *supra* note 50, at 272; Steinbock, *supra* note 35, at 258 (“[M]ost women would not be egg donors for strangers without financial compensation.”).

90. Radin, *Market-Inalienability*, *supra* note 19, at 1916.

91. *See supra* text accompanying notes 40–44.

92. *See infra* text accompanying notes 130–137; *Cf.* CAHN, *TEST TUBE FAMILIES*, *supra* note 1, at 156 (“If we prohibit the sale of gametes, it must be [in part] because of . . . a fear of economic exploitation of people who need money and are willing to sell ANYTHING . . .”).

which can distort decision making. Sellers in baby markets are, by and large, more economically disadvantaged than buyers.⁹³ Women with plenty of economic resources, for example, are far less likely to go through the physically arduous process of producing ova for sale or carrying a child for another couple, whereas women in need of money may find this a reasonable tradeoff.⁹⁴ Socioeconomic differences as well as the circumstances of negotiating some of these sales may lead to further power imbalances. For example, in the negotiation of surrogacy contracts, the intended parents and their agents pay many of the relevant expenses and control many aspects of the process.⁹⁵ The buyers therefore are in a position to “exert undue influence on the potential surrogate.”⁹⁶ In short, “the party who holds the most resources is the party who has the greatest ability to manipulate the situation.”⁹⁷

But the power relationships in baby markets are complicated. As Martha Ertman has described, the alternative insemination market inverts feminist concerns about gender power imbalances, when men are sellers of gametes and the buyers include gay women.⁹⁸ Moreover, the kinds of structural imbalances that often arise in other contexts, where

93. See, e.g., Ethics Committee, *supra* note 30, at 217 (“[C]ollege students and other women may agree to provide oocytes in response to financial need.”); Paula M. Barbaruolo, *The Public Policy Considerations of Surrogate Motherhood Contracts: An Analysis of Three Jurisdictions*, 3 ALB. L.J. SCI. & TECH. 39, 46 (1993) (“Data have shown that the majority of women who apply to become surrogate mothers are from low income brackets.”); Carson Strong, *How Should IVF Programs Handle Initial Disclosure of Information to Prospective Ovum Donors?*, AM. J. BIOETHICS, Dec. 2001, at 23, 23 (“[A]ds that recruit donors are targeted toward groups likely to have economic need, such as college students, which means that payments will often be a significant incentive.”). Of course this won’t always be true. As the court noted in *In re Baby M*, in spite of its concerns about coercion, “the Sterns [the intended parents] are not rich and the Whiteheads [the surrogate and her spouse] not poor.” *In re Baby M*, 537 A.2d 1227, 1249 (N.J. 1988). See also Andrews, *supra* note 30, at 2365 (“Few surrogates are financially needy.”); *id.* at 2349–50 (describing how Andrews interviewed surrogates, “looking for evidence that the women had been exploited,” and was “frustrated when the first surrogate mother [she] interviewed, an intensive care nurse, had a higher income level than [her]”). Nevertheless, the court speculated “that it is unlikely that surrogate mothers will be as proportionately numerous among those women in the top twenty percent income bracket as among those in the bottom twenty percent. Put differently, we doubt that infertile couples in the low-income bracket will find upper income surrogates.” *Baby M.*, 537 A.2d at 1249.

94. See DEREK, *supra* note 89, at 164 (describing money challenges as the primary motivation in her and her friends’ decisions to sell eggs).

95. Molly J. Walker Wilson, *Precommitment in Free-Market Procreation: Surrogacy, Commissioned Adoption, and Limits on Decision Making Capacity*, 31 J. LEGIS. 329, 341 (2005).

96. *Id.*

97. *Id.*

98. Ertman, *supra* note 15, at 41.

the buyers are institutions or corporations and the sellers are individuals, are not always present here.⁹⁹ The end-point buyers and sellers in baby markets are usually individuals.¹⁰⁰

Buyers in baby markets, however, are also vulnerable participants. The desire for a child can be overwhelming precisely because of the deep personhood and relational autonomy interests at stake.¹⁰¹ Many buyers in baby markets are willing to go to great lengths and pay huge sums to have a baby.¹⁰² For this reason, they may arguably be even more invested in the sale of reproductive material than the seller, which can tip the

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99. With respect to genetic information, for example, individuals are much more likely to be sellers than buyers because their information has economic value to those who may use it for research, pharmaceutical development, underwriting, etc., whereas the genetic information of others does not usually have the same economic value to individuals. See N.I.H.-DEPT. OF ENERGY TASKFORCE ON GENETIC INFO. & HEALTH INS., GENETIC INFORMATION AND HEALTH INSURANCE 5 (1993) (describing the use of genetic information in the insurance industry to underwrite risk); Christopher P. Austin & Jack L. Tribble, *Gene Patents and Drug Development: The Perspective From Merck*, in HUMAN DNA: LAW AND POLICY 379 (Barbara Maria Knoppers ed. 1997) (discussing the use of genetic information within the pharmaceutical industry for drug development). Some aspects of genetic information, however, may be of *personal* value to individuals, who might want to know, for example, about health risks to their future partners. See Nat'l Acad. of Scis., *Social, Legal, and Ethical Implications of Genetic Testing*, in ETHICAL ISSUES IN BIOTECHNOLOGY 375, 393–94 (Richard Sherlock & John D. Morrey eds., 2002) (discussing the disclosure of genetic information to spouses). Of course, once the individual parts with his or her genetic information, buyers and sellers who are similarly situated—researchers, companies, etc.—may buy and sell valuable genetic information from one another, much like the doctrines of first sale and exhaustion. See *Quanta Computer, Inc. v. LG Electronics, Inc.*, 128 S. Ct. 2109, 2122 (2008) (“[A]uthorized sale of an article that substantially embodies a patent exhausts the patent holder’s rights and prevents the patent holder from invoking patent law to control postsale use of the article.”); see also 18 AM. JUR. 2D *Copyright and Literary Property* § 100 (2009) (discussing the first sale doctrine).
100. See SPAR, *supra* note 4, at 35–46 (providing an overview of the fertility market). Of course, agents may become involved in the transactions, complicating the power balances. See *infra* note 103.
101. *Id.* at 46.
102. *Id.* at 4 (describing the vulnerability of infertile couples who “will frequently pay whatever they can. They will mortgage their houses, sell their cars, deplete family savings” because they are “desperate” to have a child); SPAR & Harrington, *supra* note 3 at 44. Recently, the news has described examples of women trying to have children at significantly advanced ages, in spite of the medical risks that their ages present. See Patrick White, *Woman, 60, Gives Birth to Twins—and Ethics Debate*, GLOBE & MAIL, Feb. 6, 2009, at A1 (describing women giving birth at ages sixty to seventy years old). Even more notorious is the much published case of Nadya Suleman, a woman who was so desperate to overcome infertility, that she was willing to have six embryos implanted, Kimi Yoshino et al., *Before the Octuplets*, L.A. TIMES, Feb. 6, 2009, at A1 (describing Suleman’s extreme, even desperate, desire for a biological child), in spite of the fact that the national average number of embryos implanted is 2.3, see Alan Zarembo et al., *Octuplet Doctor’s Record Dubious*, L.A. TIMES, Feb. 10, 2009, at A1.

power balance in favor of the seller. Obviously, this power imbalance is less likely to occur when buyers are not the end-point individual purchasers, but are instead sophisticated brokers, whose only stake in the transaction is profit.¹⁰³

Buyers in baby markets are also dependent on the sellers of infertility services to disclose the risks and limitations of the procedures generally and at the particular facility.¹⁰⁴ Many are willing to undergo infertility treatments, even in the face of low (and often uncertain) chances of success and uncertainty regarding long-term safety.¹⁰⁵ The profit incentives in an unregulated infertility industry¹⁰⁶ create conflicts of interest that can exacerbate this problem. Despite legal duties to disclose the risks associated with fertility treatment or limited success rates, the desire to remain competitive may lead some providers or fertility clinics to minimize the risks of fertility drugs or to overstate the prospects of success with fertility treatments.¹⁰⁷ It may also, as seems to have occurred in the Baby M case, discourage fertility clinics from disclosing information about participants' vulnerabilities that might make them poor candidates for participating in the buying and selling of fertility services or products.¹⁰⁸ Profit motives can even prevent some buyers

103. DEREK, *supra* note 89 (describing personal experiences of selling eggs and working solely with an egg broker).

104. See Fertility Clinic Success Rate and Certification Act of 1992, 42 U.S.C. § 263a-1 (1992) (requiring fertility clinics to report their success rate to the Secretary of Health and Human Services); see also ANGELA RODDEY HOLDER, LEGAL ISSUES IN PEDIATRIC AND ADOLESCENT MEDICINE 11-14 (1985) (discussing the requirement of informed consent for the removal, donation, and implantation of ovum); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 53-54 (noting that the Fertility Clinic Success Rate and Certification Act was the first federal legislation that "applied explicitly to the reproductive technology industry"). But in spite of federal reporting requirements, the only sanction for failing to report success rates is to be listed "as a non-reporting reporting clinic in the CDC's annual report." Alicia Ouellette et al., *Lessons From Across the Pond: Assisted Reproductive Technology in the United Kingdom and the United States*, 31 AM. J. L. & MED. 419, 427 (2005). See also CAHN, TEST TUBE FAMILIES, *supra* note 1 at 54.

105. Goodwin, *supra* note 2, at 21 ("Notwithstanding technological advancements and that some pregnancies will result, ART's failure rate is estimated to be between 65% and 80%.").

106. See CAHN, TEST TUBE FAMILIES *supra* note 1, at 43-72 (describing how thin the regulation is of the infertility industry). See generally Ouellette et al., *supra* note 104 (comparing America's lack of centralized, effectual regulation of the infertility industry with England's comprehensive regulatory system).

107. Goodwin, *supra* note 2, at 22 ("[S]ome doctors make exaggerated claims that they can help 95% of patients conceive.").

108. A psychologist from the fertility clinic screened Mary Beth Whitehead before she signed the surrogacy contract, but the *Baby M* court was deeply skeptical that this was for her benefit. As the court points out,

from accessing fertility services when clinics “striving for high ‘success’ rates tend to refuse to take complicated fertility cases, thereby decreasing the risks of a ‘low’ success rate or, conversely, increasing their statistical pregnancy ‘success’ rates.”¹⁰⁹ In the context of infertility services, the power clearly resides with the sellers.

The sellers of reproductive material such as ova may also fall prey to power imbalances vis-à-vis providers of fertility services. Although physicians owe them the same obligation they owe any patient to promote their best interests,¹¹⁰ the fact that the women are not being treated for a condition and that they offer the prospect of financial benefit to the fertility clinics can create a conflict of interest.¹¹¹ This conflict of interest may reduce the extent to which physicians promote these women’s best interests in general. Clinics that profit from ovum donors may minimize

The Sterns regarded the evaluation as important, particularly in connection with the question of whether she would change her mind. Yet they never asked to see it, and were content with the assumption that the Infertility Center had made an evaluation and had concluded that there was no danger that the surrogate mother would change her mind.

In re Baby M, 537 A.2d 1227, 1247 (N.J. 1988). All Mrs. Whitehead was told was that “she had passed.” *Id.* (internal quotation marks omitted). As a result, it was

apparent that the profit motive got the better of the Infertility Center. Although the evaluation was made, it was not put to any use, and understandably so, for the psychologist warned that Mrs. Whitehead demonstrated certain traits that might make surrender of the child difficult and that there should be further inquiry into this issue in connection with her surrogacy. To inquire further, however, might have jeopardized the Infertility Center’s fee.

Id. at 1247–48.

109. Goodwin, *supra* note 2, at 23.

110. Ethics Committee, *supra* note 30, at 219; Mark V. Sauer, *Egg Donor Solicitation: Problems Exist, But Do Abuses?*, AM. J. BIOETHICS, Dec. 2001, at 1, 2 (“Donors are as much our patients as the recipients we so eagerly serve. They too need our best efforts and professional talents to safely guide them through a complicated and potentially dangerous therapy.”).

111. Andrea L. Kalfoglou, *Navigating Conflict of Interest in Oocyte Donation*, AM. J. BIOETHICS, Dec. 2001, at 1a, 1a (2001) (“The nature of the relationship between an oocyte donor and physician is difficult to characterize, but it is clearly not a typical doctor-patient relationship.”). This may depend on whether the recruiters are “ART programs that recruit donors for use by recipients in the practice or . . . agencies that recruit donors independently for practices and/or individuals.” Robert G. Brzyski, *Putting Risk in Perspective*, AM. J. BIOETHICS, Dec. 2001, at 25, 25. In the latter case, the financial conflict of interest is likely to be quite great. In the former, however, donor egg cycles constitute “a small proportion of cycles in any given program. Rather than being the source of easy money for ART programs, donor egg programs are burdensome to administrate.” *Id.* (finding in one study the “total cost to bring a single donor into their program was approximately \$1,869”).

or even fail to disclose certain risks associated with ovum donation.¹¹² For example, one clinic has been reported to include information about potential links to cancer in consent forms for IVF patients, while leaving such information out of consent forms for oocyte donors.¹¹³ In addition, donors might be pressured to undergo procedures that maximize the number of eggs retrieved, which can potentially increase the side effects of the procedure.¹¹⁴ Finally, some clinics try to maximize compliance from donors by holding them legally responsible for the buyers' expenses if the women do not complete the donation process.¹¹⁵

A. Arguments Against Prohibition

Given underlying inequities, various power imbalances between the participants in baby markets, conflicts of interest, and the potentially coercive influence of money, we should be concerned about commodification of embryos and gametes in transactions that implicate varying degrees of relational, personhood interests. We might prohibit baby markets for fear that coercive influences make consent inherently invalid and market exchanges de facto involuntary. But, while women driven by economic necessity to sell eggs might not have made such a choice if everything else were equal, they might well prefer selling eggs over taking a job that pays poorly and offers few rewards.¹¹⁶ Similarly, while infertile couples desperate to have a child might not have purchased reproductive material if they could have a child naturally, they might well prefer being buyers in this market over having limited reproductive op-

112. See Maggie Jones, *Donating Your Eggs*, GLAMOUR, July 1996, at 168, 170 ("After all they want donors to participate in their programs. And the more these clinics convince themselves that there's a horrible shortage of egg donors, the more likely they will cut corners and recruit women faster than they should.") (quoting George Annas); see also Jennifer Knox, *Egg Sale Ends*, SHEPHERD EXPRESS (Univ. of Wis.-Milwaukee), July 9, 1998, at 8 (quoting a prospective ovum donor who asked an oocyte donor coordinator about the safety of fertility drugs and was handed "a photocopied article entitled, 'Fertility Drugs Are Safe,' which supposedly ran in some magazine [she'd] never heard of").

113. Jones, *supra* note 112, at 170.

114. Kalfoglou, *supra* note 111, at 2 (noting that twenty-seven percent of the thirty-three ovum donors interviewed experienced side effects strong enough to keep them in bed or from otherwise going about their daily lives, which researchers attributed to hyperstimulation syndrome, since the women had all donated more than twenty oocytes despite being told that the usual retrieval amount is ten or twelve); Steinbock, *supra* note 35, at 263 (describing how "it was not uncommon for clinics to 'flatter' donors" about their super-fertility "to get them to be repeat donors").

115. Kalfoglou, *supra* note 111, at 2 (describing reports of such arrangements by donors).

116. Cf. Radin, *Market-Inalienability*, *supra* note 19, at 1916.

tions.¹¹⁷ These psychological and economic pressures create a “double bind.” Circumstances may make otherwise undesirable choices compelling, but prohibiting commodification does not overcome those circumstances.¹¹⁸ Prohibition of baby markets would merely limit the options for dealing with economic need or infertility.¹¹⁹ It would limit choices integral to the self, which can also threaten human flourishing.

Such a double bind of course exists with respect to the sale of other things that we prohibit, such as prostitution.¹²⁰ While I do not want to discuss the relative merits and demerits of banning prostitution, I raise this point to emphasize that the mere fact that bad circumstances can make an otherwise undesirable choice (like prostitution) compelling is not in and of itself sufficient reason to legalize such choices. Much of what motivates legislatures to ban prostitution concerns the kinds of intrinsic personhood harms of selling something integral to oneself, in this case one’s body.¹²¹ As I suggested in Part I, personhood interests are at stake with respect to the sale of reproductive material as well. But here the gametes and embryos are less integral to oneself than one’s entire body.¹²² As a result, the intrinsic harms associated with selling one’s sexual services seem greater than those associated with selling one’s gametes.

Even more important, the sale of gametes or embryos furthers an important aspect of human flourishing, allowing individuals who are otherwise unable to create families to do so. While healthy sexual encounters can also contribute to human flourishing, a sexual encounter based solely on the exchange of money is unlikely to and in fact may be damaging to both the buyers’ and sellers’ sense of self.¹²³ Given that “baby markets” may actually make it easier for some to achieve the goal of creating a family,¹²⁴ such markets can potentially enhance human

117. *Cf. supra* text accompanying notes 101–102.

118. Radin, *Market-Inalienability*, *supra* note 19, at 1915–16. Indeed, as one commentator notes, “preventing excessive risktaking by banning payments, instead of through the regulation of collection procedures and required disclosures of relevant hazards, is a curious strategy.” Mahoney *supra* note 73, at 213. Normally if it is found that people are being exploited and exposed to unreasonable risk the response is to regulate the actual procedure instead of forbidding payment for assumption of the risk. By merely outlawing payment, the government is still allowing altruistic persons to be exposed to the risk. *Id.*

119. *Cf. id.* (noting that if we deny the neediest the option of becoming sellers in baby or organ markets, without offering them other alternatives for dealing with economic hardship, we have not done much to help them).

120. *See id.*

121. *See id.* at 1879–81; Sandel, *supra* note 17, at 95.

122. *Cf. supra* text accompanying notes 28–33.

123. Radin, *Market-Inalienability*, *supra* note 19, at 1879–81; Sandel, *supra* note 17, at 95.

124. *See infra* text accompanying notes 336–340.

flourishing, especially for buyers.¹²⁵ Thus, in spite of the troubling aspects of commodifying gametes and embryos, several things argue in favor of allowing these markets, including the “double bind” problem, the attendant costs and impracticalities of prohibiting baby markets,¹²⁶ and the way that markets can further self-defining goals.¹²⁷

Rather than prohibit markets, we should bolster informed consent law and impose certain safeguards to minimize the power balances and distorted decision making that can arise in baby markets. Of course, regulation cannot solve all problems. The potentially coercive influence of financial necessity or desperation in baby markets cannot be entirely overcome through regulation. We cannot realistically level the economic playing field to remove the economic pressures that may influence decisions to sell eggs or surrogacy services.¹²⁸ And we cannot regulate away deep and strong desires to have biologically related children. Some buyers and sellers will necessarily participate in baby markets in the face of such economic and/or emotional pressures.¹²⁹ We are left then with the next-best approach in a world of imperfection, where we do all we can to enhance the decision making process so that consent is grounded in a full understanding of the risks, benefits, and implications of participating in these markets, and where markets are regulated to minimize the threat of conflicts of interest and power imbalances.

B. Informed Consent

This section addresses that next-best approach by focusing primarily on the goal of helping participants in baby markets make self-defining choices based on full awareness and understanding of the implications of these choices. The kind of information essential to truly informed consent for buyers of fertility services and sellers of ova, for example, would of course include the physical risks associated with the procedures, such as ovarian hyperstimulation syndrome,¹³⁰ bleeding and

125. See Kenneth Baum, *Golden Eggs: Towards the Rational Regulation of Oocyte Donation*, 2001 BYU L. REV. 107, 136 (2001).

126. See *supra* text accompanying note 78–81.

127. See *supra* text accompanying note 68 and *infra* text accompanying notes 336–340.

128. See *infra* Part V.A.

129. See *supra* text accompanying notes 101–102, 116–119.

130. This condition is the result of fertility drugs and “can require hospitalization and may be life-threatening. Severe cases occur in about 1 percent of women who have their ovaries stimulated.” Cook, *supra* note 114, at A18. “An additional 10–20% of donors develop moderately severe ovarian hyperstimulation syndrome, which, although not life threatening, is certainly unpleasant and at times debilitating.” Sauer, *supra* note 110, at 1–2.

infection,¹³¹ stroke,¹³² and “very rarely, death.”¹³³ In addition, they should know about the “controversial risk of ovarian cancer”¹³⁴ as well as the fact that many long-term risks are unknown.¹³⁵ Ova sellers also need to know about the risks of unintentional pregnancy¹³⁶ and the potential for secondary infertility.¹³⁷

But physical risks are not all that is material. To make a truly informed decision to participate in these markets, individuals must also understand the known or possible *psychological* risks.¹³⁸ This is an area that has not been adequately researched.¹³⁹ One study of ovum donors found that eight percent of those who were later unable to conceive experienced some distress, knowing that someone else was possibly raising a child genetically related to them.¹⁴⁰ Research of anonymous sperm donors or people who relinquished their children for adoption suggests that the psychological impact of selling or donating ova might lead to “experiences of dislocation from genetic offspring, [as well as] desires to learn about these children [and] to meet these children.”¹⁴¹ Selling gametes might affect future relationships where having children is contemplated.¹⁴² In

131. Luigi Mastroianni, Jr., *Risk Evaluation and Informed Consent for Ovum Donation: A Clinical Perspective*, AM. J. BIOETHICS, Dec. 2001, at 28.

132. Holland, *supra* note 50, at 270.

133. Michelle A. Mullen, *What Oocyte Donors Aren't Told?*, AM. J. BIOETHICS, Dec. 2001, at 1c, 1c.

134. Andrea D. Gurmankin, *Risk Information Provided to Prospective Oocyte Donors in a Preliminary Phone Call*, AM. J. BIOETHICS, Dec. 2001, at 3, 3; Kalfoglou, *supra* note 111, at 1a.

135. Cook, *supra* note 114, at A18 (“The [fertility] drugs have not been studied well enough, and so there is no way to adequately inform women of the risks they face.”).

136. Ethics Committee, *supra* note 30, at 217 (noting that donors undergoing egg retrieval must discontinue hormonal contraceptives).

137. Kalfoglou, *supra* note 111, at 1a; Mastroianni, *supra* note 131, at 28 (Fertility drugs present “the potential for a subtle, long-term effect on fallopian tube functions, with consequent infertility.”).

138. See Ethics Committee, *supra* note 30, at 218 (stating that the psychological risks of ovum donation should be discussed when obtaining informed consent from donors).

139. Mullen, *supra* note 133, at 1c (“[T]here is little empirical data to describe the long-term psychosocial effects, if any,” associated with ovum donation).

140. Ethics Committee, *supra* note 30, at 217.

141. Mullen, *supra* note 133, at 1c. This claim, of course, extrapolates from the data on two groups (biological parents who place their children for adoption and anonymous sperm donors) to reach conclusions about the potential effects of donating ova. While there are differences among the three groups, in all cases these individuals are genetically connected to a child they will not raise or have a relationship with. One could imagine that the sense of genetic dislocation in the first two groups would likely arise in the third group.

142. *Id.*; Ethics Committee, *supra* note 30, at 218 (describing the risks associated with ovum donation as including future “desires to establish contact with genetically related children, desires that may be difficult or impossible to satisfy because of legal or

addition, because these market transactions are intended to create families, they have important legal implications regarding parental rights, the enforceability of contracts, and the amount of information and contact allowed between the various parties: intended parents, donors, and future child.¹⁴³

To ensure that both buyers and sellers can consent to these transactions as meaningfully as possible, we need mechanisms to promote deliberative decision making and to bolster the narrow protections of informed consent. When buyers and sellers in baby markets interact with the medical profession, they are protected by the legal requirements of informed consent.¹⁴⁴ But existing informed consent law cannot achieve the goals of full informed consent in this context for two reasons: (1) it only requires the disclosure of a limited range of information and (2) it goes only so far in ensuring full *comprehension* of risks and benefits.

First, the law of informed consent only requires the disclosure of a narrow range of information, excluding certain types of information that would be crucial to a truly informed decision in baby markets. Ordinarily physicians are required to disclose information relevant to medical interests, but not non-medical information.¹⁴⁵ Thus, while physicians must disclose material medical risks associated with ovum retrieval, for example, they may not be legally bound to discuss the legal implications of selling or buying a gamete or embryo.

In addition, it is not clear whether physicians are legally required to disclose the psychological consequences or risks associated with donating an egg or embryo, acting as a surrogate, or undergoing implantation of another's embryo. The law has had very little to say about whether

other barriers"). Some have also speculated as to the "serious potential 'risk'" of the "emotional impact of subsequent infertility" in donors "even when the infertility is completely unrelated to the earlier ovum donation procedures." Mastroianni, *supra* note 131, at 28.

143. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 73–129.

144. The requirements of informed consent exist in all physician-patient relationships regardless of the specific medical procedures. See BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 230–88 (6th ed. 2008).

145. In *Arato v. Avedon*, 858 P.2d 598, 600 (Cal. 1993), for example, the California Supreme Court rejected the lower court's ruling that "under the doctrine of informed consent, a physician is under a duty to disclose information material to the patient's *nonmedical* interests." The court emphasized that the informed consent doctrine is premised on the right to control one's body and "presuppose[s] a *therapeutic* focus" and "does not mean that [the doctor] is under a duty . . . to disclose every contingency that might affect the patient's *nonmedical* rights and interests." *Id.* at 608–09.

psychological risks should be disclosed to obtain informed consent.¹⁴⁶ Depending on the jurisdiction, the standard of disclosure is based on either what would be material to the reasonable patient or what reasonable professionals would disclose (the standard of care).¹⁴⁷ In jurisdictions that use the reasonable-patient standard, a jury might be persuaded that reasonable patients would consider this information material. To my knowledge, however, no published case has so held. If instead, the scope of disclosure is based on the professional standard, much will depend on whether such disclosure has become the standard

146. See Karen H. Rothenberg, *Breast Cancer, the Genetic "Quick Fix," and the Jewish Community: Ethical, Legal and Social Challenges*, 7 HEALTH MATRIX 97, 106 (Psychosocial risks "are not the traditional risks associated with an invasive, medical intervention [S]ocial and psychological risks . . . typically have not been the major focus of the informed consent process"). Virtually all of the case law addressing informed consent and psychological risks examines a different issue: the constitutionality of state laws that mandate the disclosure of psychological risks associated with abortion. See, e.g., *Planned Parenthood Minn. v. Rounds*, 467 F.3d 716 (8th Cir. 2006) *vacated and remanded* 530 F.3d 724 (8th Cir. 2008) (upholding the district court's grant of a temporary injunction of a South Dakota law because the record supported the finding that the mandatory disclosure requirements violated First Amendment rights); *Karlin v. Foust*, 188 F.3d 446, 472 (7th Cir. 1999) (finding that a Wisconsin statute requiring physicians to disclose specific information to a woman undergoing an abortion, including the risks of "psychological trauma," does not impose an undue burden on a woman's liberty interest in undergoing an abortion). Arguably, the Supreme Court has treated informed consent with respect to abortion differently from informed consent in other areas. See Rebecca Dresser, *From Double Standard to Double Bind: Informed Choice in Abortion Law*, 76 GEO. WASH. L. REV. 1599, 1617 (2008) (noting that the Court has shifted from requiring abortion disclosure laws to "conform to the general requirements of the common law informed consent doctrine," to the "double standard" in which "states could emphasize risks of and alternatives to abortion as a means of encouraging women to refuse abortion," and then to the "double bind" in which "neither the traditional disclosure standard nor a heightened one offer[s] an adequate means of protecting women's interests"). Even the ABA's recent Model Act, which includes elaborate informed consent regarding ART, does not discuss a need for disclosure of possible psychological risks associated with the procedure. MODEL ACT GOV'G ASSISTED REPROD. TECH. § 201(2)(a) (2008) [hereinafter ABA Model Act].

147. "A slight majority of courts has adopted the professional disclosure standard [over the reasonable-patient standard], measuring the duty to disclose by the standard of the reasonable medical practitioner similarly situated." FURROW ET AL., *supra* note 144, at 240. Of the courts that use a patient-based standard, the vast majority of courts use an *objective* test. Only a few courts apply a subjective patient-based standard, and even then "the courts tend to leave room for deference to physicians." Jamie S. King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Decision-Making*, 32 AM. J. L. & MED. 429, 444 (2006). Oklahoma and Oregon seem to be the only two jurisdictions that apply a true subjective patient-based standard. Most courts reject the subjective test because it is "too abstract," leaves physicians "vulnerable to patient bitterness" and to "patient hindsight." *Id.* Some even worry it "might preclude recovery . . . if the patient died as a result of undisclosed risks." *Id.*

of care, and whether courts would consider psychological risks to be the sort of information physicians should legally be obligated to disclose.¹⁴⁸ In spite of the fact that some commentators and professional organizations call for such disclosure,¹⁴⁹ the lack of oversight makes it difficult to determine how frequently this information is included as part of the disclosure process.¹⁵⁰ Nevertheless, evidence suggests that informed consent is lacking in this area generally.¹⁵¹

To promote deliberative decision making, we should focus not only on the information that participants in these markets consider at the moment they give consent, but also what information they receive (or

148. Because the professional standard examines what a “reasonably prudent practitioner” would disclose, it essentially bases disclosure on the standard of care. King & Moulton, *supra* note 147, at 441.

149. See Ethics Committee, *supra* note 30, at 218; Practice Comm. of the Am. Soc’y for Reproductive Med. & the Practice Comm. of the Soc’y for Assisted Reproductive Tech., *Elements to be Considered in Obtaining Informed Consent for ART*, 86 FERTILITY & STERILITY S272–73 (2006) [hereinafter Practice Committees] (describing the spectrum of information to be disclosed to individuals undergoing assisted reproductive technologies including “psychological issues” associated with ovum donation). *But see* ABA Model Act, *supra* note 146 (failing to discuss a need to disclose the possible psychological risks associated with ART). In other contexts, commentators have similarly argued that psychological risks associated with various procedures or diagnostic testing must be disclosed in order to make informed consent meaningful. See, e.g., Gail Geller et al., *Consensus Statement, Genetic Testing for Susceptibility to Adult-Onset Cancer: The Process and Content of Informed Consent*, 277 JAMA 1467, 1471 (1997) (arguing that people who undergo genetic testing for genes associated with adult-onset cancer “should be informed of potential adverse responses in those found to be mutation carriers such as anxiety, depression, anger, and feelings of vulnerability” as well as guilt, survivor guilt, and regrets regarding prior life decisions); Nichola Rumsey, *Psychological Aspects of Face Transplantation: Read the Small Print Carefully*, AM. J. BIOETHICS, Summer 2004, at 22, 23 (describing the various “psychosocial stressors, challenges and adaptive demands” associated with face transplants that “must be conveyed and weighed-up if truly informed consent is to be achieved”).

150. Sauer, *supra* note 110, at 1 (“[I]t remains unclear whether physicians heed such tenets, because policing is nonexistent and sanctions have never been levied against violators.”). The fact, however, that a professional organization like the American Society for Reproductive Medicine believes that such information should be disclosed could persuade a jury that this is the standard of care even if many physicians do not in fact disclose such information.

151. Sauer, *supra* note 110, at 2 (describing his suspicion that physicians are not “receiving proper informed consent” based on his membership on the Medical Advisory Board to the New York State Task Force on Life and Law, which reviewed IVF programs in New York and found “improvements were needed in executing informed consent,” among other things); see also Kalfoglou, *supra* note 111, at 1c (describing interviews with 33 oocyte donors and finding examples that “call into question whether the information provided was complete,” although noting that even “three years later, most of the women could recite a long list of potential physical complications, and others discussed the psychological risks”).

do not receive) even before they step into a clinic. Ads soliciting ovum donors, for example, encourage egg donation, but “never portray the real-life activity” and its risks.¹⁵² One study of nineteen oocyte-donation programs found serious inadequacies in the disclosure process during the initial phone interviews with prospective donors, including failure to volunteer information, provision of inaccurate information, reluctance to answer questions, and failure to send written information to prospective donors.¹⁵³ These initial encounters may influence the decision making process in ways that lead donors to minimize the risks.¹⁵⁴

Finally, in addressing the problems of coercion and decision making in baby markets, we must also focus on helping participants *comprehend* the information they receive. Deciding what should be disclosed is far easier than ensuring that patients fully understand what has been disclosed. It is no surprise, therefore, that the law has focused primarily on the latter. Physicians are not required to confirm that patients *understand* the risks associated with a procedure, merely that physicians *disclose* the relevant risks.¹⁵⁵ As many have noted, the legal protections

152. Sauer, *supra* note 110, at 1.

153. Gurmankin, *supra* note 134, at 4. The authors of the study warn that we should “regard the results with caution,” given that it was based only on a preliminary phone call, the sample was “small and potentially biased” and the coding scheme was subjective. *Id.* at 10; *see also* Sauer, *supra* note 110, at 1.

154. Gurmankin, *supra* note 134, at 11–12. Studies have shown that people who are not told about negative information until they agree to something are much more likely to comply, than people who make judgments based on initial information, since the latter “fail to adjust [their decisions] sufficiently for other information.” In addition, “potential kidney donors [make] their decisions about donating prior to and independent of the disclosure process.” *Id.* *But see* Brzyski, *supra* note 111, at 26 (noting the irony that Gurmankin relies in part on evidence that shows that “information provided during the consent process only occasionally influences medical decision making”). These data raise important questions about how preliminary risk information should be presented, both in terms of content and manner of disclosure. *See* Rebecca Dresser, *Donation, Disclosure, and Deception*, *AM. J. BIOETHICS*, Dec. 2001, at 15, 15; Sauer, *supra* note 110, at 1 (arguing that he “would discourage nonmedical personnel, who are usually the recipients of such calls, from engaging in such discussions, if for no other reason than to lessen the likelihood of misinformation being disseminated”).

155. *Canterbury v. Spence*, 464 F.2d 772, 780 n.15 (D.C. Cir. 1972) (“In duty-to-disclose cases, the focus of attention is more properly upon the nature and content of the physician’s divulgence than the patient’s understanding or consent. . . . [T]he physician discharges the duty when he makes a reasonable effort to convey sufficient information although the patient, without fault of the physician, may not fully grasp it. . . . [T]he fact-finding process on performance of the duty ultimately reaches back to what the physician actually said or failed to say.”).

have led to a thin process of obtaining consent that does little justice to the underlying goals of informed consent.¹⁵⁶

All of these problems require some retooling of informed consent law in baby markets. First, we should ensure that the obligations of disclosure are sufficiently broad to encompass the kind of information that is central to these decisions. Statutes might require the disclosure of certain kinds of information. For example, buyers and sellers should be told of the known short- and long- term risks, the potential physical risks, and the possible psychological implications of selling or buying reproductive material, as well as the legal implications of these decisions, including instances where the law is unclear about such things as parental status and the enforceability of certain arrangements.¹⁵⁷

In addition, we need mechanisms to minimize the potential coerciveness of recruitment efforts. One solution is to prohibit ads and other solicitations from trying to entice prospective ova sellers or infertility patients by describing, respectively, only the financial benefits or the success rates of infertility treatment.¹⁵⁸ They must also disclose the risks.¹⁵⁹ Similarly, we should require clinics to provide prospective ova, sperm, or embryo donors with standardized information regarding the physical, emotional, and legal consequences of such decisions even before they step into a clinic.¹⁶⁰ New York, for example, developed a guidebook for egg donors, entitled *Thinking about Becoming an Egg Donor: Get the Facts Before You Decide*.¹⁶¹ Requiring all egg donors to receive such a document before attending a clinic would enhance the decision making process.

156. See, e.g., Jay Katz, *Informed Consent: Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 77–81 (1993) (describing informed consent in practice as little more than a legal formality that does not honor the true goals of the doctrine).

157. See Andrews, *supra* note 30, at 2358 (noting that “the uncertain status of the law” presents the biggest risk to children in the surrogacy context); ABA MODEL ACT, *supra* note 146, at § 201(2)(c). In the context of genetic testing, some states mandate the disclosure of specific information to ensure that consent to genetic testing is informed. See 16 Del. C. § 1220(4) (2009); MCLS § 333.17020 (2009); R.R.S. Neb. § 71-551 (2009); N.Y. C.L.S. Civ. R. § 79-1; S.D. Codified Laws § 34-14-22 (2009).

158. See Ethics Committee, *supra* note 30, at 219.

159. See *id.* (“If financial or other benefits are noted in advertisements, the existence of risks and burdens should also be acknowledged.”).

160. Gurmankin, *supra* note 134, at 12; Stock, *supra* note 68, at 27.

161. N.Y. STATE TASK FORCE ON LIFE & THE LAW, THINKING OF BECOMING AN EGG DONOR? GET THE FACTS BEFORE YOU DECIDE! (2002) http://www.health.state.ny.us/community/reproductive_health/infertility/docs/1127.pdf (noting that the guidebook was created in response to research that revealed that “egg donors frequently are not adequately informed about the process”); see also Sauer, *supra* note 110, at 2 (describing this effort as one of the only ones in the country).

Legally mandating the scope of material information to be disclosed is only the first step. In addition, we must consider mechanisms to make the *process* of informed decision making as meaningful as possible and to promote *deliberative* informed consent.¹⁶² New York again offers a useful model. A task force drafted model consent forms to ensure some uniformity in the informed consent process among fertility clinics.¹⁶³ Unfortunately, not many other states have followed suit.¹⁶⁴ These model consent forms are helpful in creating professional norms and educating providers. But, in the context of a largely unregulated infertility industry, mere guidelines may not adequately protect patients.¹⁶⁵ We need some teeth associated with the guidelines.

If we want decision making to be even more deliberative here, however, the system must not rely solely on physicians, particularly given their potential conflicts of interest and the fact that some of the material information is not just medical. For example, the legal implications of these financial transactions extend beyond the medical sphere. We cannot expect physicians to understand, let alone adequately disclose, the full legal implications of the decisions that buyers and sellers are making in baby markets. Thus, we should consider requiring consultation with attorneys so that participants in these markets can better understand the legal implications.

Psychologists are appropriate participants as well. Professional guidelines require psychological screening of ovum donors, for example.¹⁶⁶ Ideally, however, psychologists would do more than just screen potential donors.¹⁶⁷ As a psychologist from a major IVF clinic described

162. Barbara Atwell, *The Modern Age of Informed Consent*, 40 U. RICH. L. REV. 591, 597 (2006) (noting the inadequacy of the process of informed consent).

163. Sauer, *supra* note 110, at 2 (describing New York State's drafting of guidelines and "model consents").

164. *Id.*

165. *Id.* (noting that such efforts are rare in the United States and generally go "unrecognized" without "the authority of a mandate"); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 193 ("Finally, the professional organizations who are currently advancing the state of regulation by proffering guidelines lack 'established mechanisms to police compliance with these guidelines.' Membership and compliance are both strictly voluntary.").

166. Practice Committees, *supra* note 149, at S272; *See also* ABA MODEL ACT, *supra* note 146, at § 301(1) (requiring "[a]ll participants known to the ART provider [to] undergo a mental health consultation in accordance with the most recently published standards of the ASRM and SART prior to the ART procedure."); *id.* at § 302(2) (requiring that participants are offered additional counseling from a mental-health profession).

167. *See supra* note 108 and accompanying text, for a discussion of the ways in which the mere screening of buyers or sellers is inadequate to protect the goals of informed consent.

it, given the financial conflicts of interest inherent in ovum donation, “[m]y job is to talk donors out of it. That’s not because we don’t need them, but we want to sleep at night.”¹⁶⁸ Psychologists should help donors understand their motivations in participating in this process. Are they doing it for altruistic reasons, financial, and/or other reasons? Have they considered the possibility that they may want to have contact with the future child or that the future child might or might not want contact with or information about them?¹⁶⁹ What would it mean for them if they couldn’t? How would they feel if their fertility were affected by the process? We might borrow from the field of genetic counseling, which sees its role as not only providing information, but helping individuals make decisions consistent with their values and life plans.¹⁷⁰ In addition, information gleaned from such a psychological evaluation that is relevant to the donor’s ability to cope with the decision must be disclosed to the donor.¹⁷¹ Finally, we might also (or alternatively) rely on patient advocates to raise similar questions while also focusing on elements that are not overtly psychological.¹⁷² They might, for example, ask women to consider other potential sources of income if financial motives are driving their decisions.¹⁷³

My suggestions for enhancing consent will not satisfy everyone. Some have suggested that informed consent in this context is highly problematic. The *Baby M* court reasoned, for example, that the surrogate’s consent was “irrelevant”—that a surrogate can never make a totally informed decision prior to the child’s birth.¹⁷⁴ Whether one can

168. Jan Hoffman, *Egg Donations Meet a Need and Raise Ethical Questions*, N.Y. TIMES, Jan. 8, 1996, at A1, available at <http://www.nytimes.com/1996/01/08/us/egg-donations-meet-a-need-and-raise-ethical-questions.html>.

169. See *infra* Part IV.

170. See Anne L. Matthews, *Genetic Counseling*, in ENCYCLOPEDIA OF ETHICAL, LEGAL, AND POLICY ISSUES IN BIOTECHNOLOGY 349–50 (Thomas H. Murray & Maxwell J. Mehlman eds., 2000); Sonia Mateu Suter, *The Routinization of Prenatal Testing*, 28 AM. J. L. & MED. 233, 243 (2002).

171. ABA MODEL ACT, *supra* note 146, at § 203(4); see *supra* note 108 and accompanying text.

172. Atwell, *supra* note 162, at 608 (suggesting that patient advocates could be an important safeguard in ensuring that “emerging adults” contemplating procedures like selling ova, offer truly deliberative consent to the procedure); Mastroianni, *supra* note 131, at 29 (arguing for patient advocates “who could better assess and review in objective terms the risks associated with the procedure and who would be less subject to the pressures to provide as many oocytes as possible”).

173. Atwell, *supra* note 162, at 609.

174. *In re Baby M*, 537 A.2d 1227, 1249 (N.J. 1988); see also Wilson, *supra* note 95, at 330 (arguing that “women who enter surrogacy contracts can never truly give informed consent because there is no way that they can know before conceiving the child how they will feel about giving up the child once the time comes”).

ever make such life altering, irrevocable changes before experiencing the realities of one's choice is a very difficult problem. Yet it is not unique to exchanges in baby markets. End-of-life decision making is fraught with such dilemmas and yet the law has widely supported the notion of advanced directives. A now-competent individual can make legally enforceable decisions with respect to life-sustaining treatment in the event one's future self becomes incompetent, even if such determinations result in the end of one's life.¹⁷⁵ Even non-medical decisions raise similar problems. My decision to become a mother was not fully informed, nor could it have been. I did not and could not understand completely the physical and emotional challenges and sheer hard work of parenting. But even less could I grasp the utter depth of love and fulfillment I would experience, which, even now, I find difficult to comprehend.

Many, indeed most, important and difficult decisions require us to take a leap of faith. We never fully understand what we are getting into, yet we make such decisions all the time and the law enforces such decisions.¹⁷⁶ This does not mean, however, that we should give up on efforts to try to understand our choices as fully as possible. We are better equipped to make such important decisions if we are aware of their possible implications and if we have thought about what motivates us.¹⁷⁷ Again, we should not let the best be the enemy of the good. We may never be able to comprehend perfectly what it means to make these choices in advance of them, but we can come closer to that goal by being informed, deliberative, and self-aware.

Although I believe informed consent is an important element in overcoming some of the coercive effects of baby markets, it is not sufficient. As I suggest in the next section, an enormous contributing factor to coercion, distorted decision making, and power imbalances in baby markets is the fact that the infertility industry in America is motivated by profit and essentially unregulated.¹⁷⁸ Creating enforceable reporting requirements and oversight of experimental approaches in the ART industry would go far in enhancing the decision-making process of buyers and sellers in these markets. As I suggest below, greater regulation may also offer much needed protections against risky procedures or approaches.

175. See ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE* 7–20 (3d ed. 2004) (describing the legal acceptance of advanced directives).

176. See Andrews, *supra* note 30, at 2363.

177. See Amanda Ratliff et al., *What is a Good Decision?*, 2 *EFFECTIVE CLINICAL PRAC.* 185, 187 (1999) (stating that good decisions “should be well informed”).

178. See *supra* note 106 and accompanying text.

C. An Unregulated Infertility Industry

An additional background factor that we must consider in the debate about baby markets is the fact that the ART industry in this country is a \$3 billion industry,¹⁷⁹ which is highly privatized, motivated largely by profit¹⁸⁰ and, more important, lacking in “consistent oversight.”¹⁸¹ Unlike England, for example, which has a comprehensive, authoritative and centralized regulatory body—the Human Fertilisation and Embryology Authority (HFEA)—the United States has “no comprehensive policy [that] governs ART.”¹⁸² Instead we have just “a patchwork of . . . state and federal regulation that essentially leave the U.S. fertility industry unregulated.”¹⁸³ We have no enforceable reporting requirement¹⁸⁴ and no licensing or accreditation requirements for ART.¹⁸⁵ Moreover, at the federal level, we lack any regulation regarding sensitive issues concerning ART, and at the state level, “regulations of ART lack consistency and are rarely well developed in any particular state.”¹⁸⁶ The closest things we have to any kind

179. Valdez, *supra* note 34, at 1; CAHN, TEST TUBE FAMILIES, *supra* note 1, at 1.

180. Ouellette et al., *supra* note 104, at 430 (describing the United States reproductive technology industry as “driven by commercial success and consumer behavior”).

181. *Id.* at 419 (noting that to the extent the ART industry is regulated, it is in a piecemeal way, often without any enforcement mechanism to ensure compliance); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 44–45 (noting the limited internal and external regulation of ART).

182. Ouellette et al., *supra* note 104, at 435 (describing our system as a “patchwork” and “essentially . . . unregulated” system).

183. *Id.*; CAHN, TEST TUBE FAMILIES, *supra* note 1, at 52, 59–62 (noting the void at both the federal and state level, and noting that although some state laws require screening of egg and sperm donors, no regulations exist for the number of implantations doctors may perform for an IVF cycle, or the number of donations per donor).

184. Ouellette et al., *supra* note 104, at 423–28 (noting that although U.S. law requires fertility clinics to provide data on success rates to the Centers for Disease Control, the CDC has no authority to enforce this requirement); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 54. In contrast, the British HFEA oversees comprehensive data collection regarding infertility clinics. Ouellette et al., *supra* note 104, at 423 (describing the HFEA registry as “the largest of its type in the world”).

185. Ouellette et al., *supra* note 104, at 429 (“[N]o U.S. law requires licensing or accreditation of ART programs or embryo laboratories.”); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 54 (describing the Model Program for the Certification of Embryo Laboratories, which was released in 1999, and yet “it does not appear that any state has actually adopted it”). In contrast, the HFEA licenses fertility clinics and laboratories that use gametes and embryos for research and has the authority to enforce licensing requirements. Ouellette et al., *supra* note 104, at 428 (describing the HFEA’s authority to license in three areas: fertility treatment, embryo storage, and research on human embryos or gametes).

186. Ouellette et al., *supra* note 104, at 432–33.

of oversight are the guidelines regarding specific issues related to fertility services published by the American Society of Reproductive Medicine.¹⁸⁷ Our “private capitalistic health care system”¹⁸⁸ and the infertility industry’s strong efforts to self-regulate have contributed to this lack of regulation.¹⁸⁹

When profit drives the industry, the lack of regulation is particularly problematic in several ways. First, it limits the collection and analysis of important data regarding reproductive technologies. Without enforceable regulations, incentives are few for providers of fertility treatment or brokers for ovum donors to report or fully record their experiences with ART.¹⁹⁰ Inadequate data regarding the risks, effects, and success rates of infertility treatments generally, and specifically with respect to individual providers and fertility clinics, is problematic to buyers and sellers in this market. It reduces their ability to make truly informed decisions because they do not know the full spectrum of risks, benefits, or the (often limited) success rates of these procedures, generally, or at a particular clinic.¹⁹¹

In addition, without adequate oversight and regulation of the fertility industry, profit motives may drive self-interested and unethical providers toward practices that are unsafe or unethical or may prevent them from providing honest or accurate accounts of the risks or

187. Carbone & Gottheim, *supra* note 4, at 538; CAHN, TEST TUBE FAMILIES, *supra* note 1, at 62–64 (describing the industry’s self-regulation).

188. Ouellette et al., *supra* note 104, at 433.

189. Sandra Carson, Chief, Baylor Coll. Assisted Reproductive Tech. Program, & President, Am. Soc’y. for Reproductive Med., Remarks at Meeting of the President’s Council on Bioethics, Session 5: Biotechnology and Public Policy: Professional Self-Regulation (Mar. 7, 2003), <http://www.bioethics.gov/transcripts/march03/mar7full.html>.

190. See Ouellette et al., *supra* note 104; CAHN, TEST TUBE FAMILIES, *supra* note 1, at 54 (noting how implementation of the reporting requirements “has not been particularly speedy or protective of consumers”). Some of the most well-known infertility clinics have been the biggest offenders of failing to report. Numerous factors may influence the decision not to report success rates such as “the lack of solid criteria to correctly identify the etiology of infertility, an imprecise separation of clinical indications, and the inherent bias in the reporting structure toward pregnancy rates as the sole arbiter of a clinic’s success.” Ouellette et al., *supra* note 104, at 427. Surprisingly, however, the physician involved in the highly controversial implantation of six embryos, which resulted in Nadya Suleman’s delivery of octuplets, did report his success rates, even though they were “one of the worst success rates of any fertility clinic in the country.” Zarembo, *supra* note 102, at A1.

191. In addition, as noted, the conflict of interest gives sellers of infertility services and egg brokers little incentive to focus on risks that may dissuade potential consumers of infertility services or donors of ova (or sperm) or surrogates. See *supra* text accompanying notes 106–113.

success rates of their practices.¹⁹² In fact some clinics have misled couples about ART success rates by using “criteria such as the number of eggs retrieved, number of eggs fertilized, or number of embryo transfers to tout success, rather than the number of live births.”¹⁹³ Further, as noted earlier, financial interests may lead providers to pressure egg sellers to do things to maximize egg-retrieval such as undergoing numerous cycles of egg-retrieval or taking high doses of hormones.¹⁹⁴ Similarly, as evidenced by the recent birth of octuplets to a woman who had had six embryos implanted at once, providers may be tempted to implant large numbers of embryos to maximize the chances of successful ART treatment, even if this may pose health hazards to some patients.¹⁹⁵ And, as noted earlier, providers may use threats of legal or financial liability to induce donors to complete the donation process.¹⁹⁶ In short, our system allows the “unscrupulous practices of unethical providers who have made headlines and eroded confidence in the U.S. system.”¹⁹⁷

An additional concern with limited regulation is that assisted reproductive technologies are ever advancing and physicians may experiment with new procedures or approaches, which some call

192. See Goodwin, *supra* note 2, at 3 (stating that research has largely ignored the consequences of financial conflicts of interest experienced by doctors); Ann Bindu Thomas, *Avoiding Embryos “R” Us: Toward a Regulated Fertility Industry*, 7 WASH. U. J.L. & POL’Y 247, 270 (2008) (proposing that fertility facilities be required to be nonprofit entities to discourage clinics from taking advantage of the vulnerable). Cf. *supra* text accompanying notes 111–115.

193. Judith F. Daar, *ART and the Search for Perfectionism: On Selecting Gender, Genes, and Gametes*, 9 J. GENDER, RACE & JUST. 241, 254–55 n.34 (2005) (describing testimony from witnesses who testified at hearings on the bill that became the Fertility Clinic Success Rate and Certification Act of 1992).

194. See *supra* text accompanying note 114.

195. See Zarembo, *supra* note 102; see also B. Jason Erb, *Deconstructing the Human Egg: The FDA’s Regulation of Scientifically Created Babies*, 5 ROGER WILLIAMS U. L. REV. 273, 288–89 (1999) (stating that fertility doctors do not follow medical guidelines to avoid having to reimburse patients in accordance with clinics’ money-back guarantee); Cheryl Erwin, *Utopian Dreams and Harsh Realities: Who Is in Control of Assisted Reproductive Technologies in a High-Tech World?*, 9 J. GENDER RACE & JUST. 621, 630–31 (2006) (discussing clinics’ incentive to implant large numbers of embryos to increase their success rate); Stacey Pinchuk, *A Difficult Choice in a Different Voice: Multiple Births, Selective Reduction and Abortion*, 7 DUKE J. GENDER L. & POL’Y 29, 51–52 (2000) (discussing fertility clinics’ incentive to implant large numbers of embryos as created by money-back guarantees); cf. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 61 (noting that “[n]o regulations govern the number of implantations an infertility clinic may perform per IVF cycle”).

196. See *supra* text accompanying note 115.

197. Ouellette et al., *supra* note 104, at 435; see Zarembo, *supra* note 102.

“clinical innovation.”¹⁹⁸ Physicians often view this as treatment.¹⁹⁹ Indeed, technically it is not research as defined under the federal regulations protecting human subjects.²⁰⁰ The law does require physicians to inform patients that they are “participating in an experimental procedure” and to discuss the associated uncertainties regarding risk and success.²⁰¹ If, however, they view the procedures as treatment, rather than research, physicians may choose not to discuss the experimental aspects of the procedure. If patients participate in experimental treatments without consenting, we have done serious harm to their autonomy interests.²⁰²

Finally, the lack of regulation in a profit-driven industry also raises concerns about safety issues when individuals undergo experimental fertility procedures. If infertility clinics engage in experimentation

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198. See FURROW ET AL., *supra* note 144, at 386–90 (describing how the term “clinical innovation” originated in the context of medical malpractice litigation as a defense to a claim that the doctor’s treatment deviated from the standard of care); Jesse A. Goldner, *An Overview of Legal Controls on Experimentation and the Regulatory Implications of Taking Professor Katz Seriously*, 38 ST. LOUIS U. L.J. 63, 66 (1993) (describing this as “innovative treatment [which] is a deviation from standard practice, the efficacy or safety of which has not yet been validated”).
199. See Nancy M.P. King, *The Line Between Clinical Innovation and Human Experimentation*, 32 SETON HALL L. REV. 573, 573 (2002) (“[D]rawing a line between human experimentation and medical treatment is surprisingly difficult, not only for patients but also for physicians.”).
200. 45 C.F.R. § 46.102(d) (2008) (defining research as “a systematic investigation . . . designed to develop or contribute to generalizable knowledge”).
201. Goldner, *supra* note 198, at 88 (“[E]ven if what is being done with the patient is not part of a formal experimental design, the patient is entitled to know that the drug or procedure has not been accepted as standard, to be informed of whatever known risks may be involved, and that other risks may not be known.”). *But see* Karp v. Cooley, 493 F.2d 408, 420–24 (5th Cir. 1974), in which a family of a patient, who had a heart transplant and allegedly was not told that the device in question was “completely experimental,” sued the physician for failure to obtain informed consent. The Court of Appeals affirmed the dismissal because the physician had disclosed sufficient information regarding the nature of the procedure and there was “no evidence that Mr. Karp’s treatment was other than therapeutic.” *Id.* at 423. As a result, it concluded that “in this context an action for experimentation must be measured by traditional malpractice evidentiary standards.” *Id.* at 423–24.
202. NAT’L COMM’N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMED. & BEHAVIORAL RESEARCH, THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH § B.1 (1979), available at <http://ohsr.od.nih.gov/guidelines/belmont.html>. Of course, the patient is not without potential recourse and could bring a cause of action against the physician for failure to obtain consent. See FURROW ET AL., *supra* note 144, at 232 (discussing the legal basis of informed consent actions); Goldner, *supra* note 198, at 80–87 (describing actions brought against physicians for failure to obtain informed consent for “therapeutic” clinical research”).

(whether it is clinical innovation or systematic research) and do not rely on federal funds for research, they are not bound by the federal protections of human research—also known as the Common Rule.²⁰³ Thus, end-point buyers, sellers, and the future children will not benefit from the federally mandated oversight process, which requires not only adequate informed consent from research participants, but also an adequate scientific basis for the research, an appropriate balance of risks and benefits, minimization of risks, and, when necessary, monitoring to ensure the safety of the research participants.²⁰⁴

All of these concerns demonstrate the ways in which unregulated baby markets impose costs on society, not all of which buyers internalize. Inadequate information about the long-term effects and efficacy of ART procedures means that the price of gametes, embryos, and the medical procedures accompanying ART may not accurately reflect the risks and benefits to both buyers and sellers.²⁰⁵ Latent, and perhaps unknown, health risks associated with the procedures used to obtain gametes²⁰⁶ impose costs (both in terms of future medical costs and lost

203. The federal regulations apply only to research performed or funded by the United States government or subject to “regulation by any federal department or agency,” as defined in § 46.102. 45 C.F.R. §§ 46.101–02 (2008) (“[T]his policy applies to all research involving human subjects conducted, supported or otherwise subject to regulation by any federal department or agency which takes appropriate administrative action to make the policy applicable to such research. . . . It also includes research conducted, supported, or otherwise subject to regulation by the federal government outside the United States.”).

204. 45 C.F.R. § 46.111 (2008) (describing the criteria for approval of research, including that “risks to subjects are minimized . . . [b]y using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk,” that “[r]isks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result,” that “[i]nformed consent will be sought from each prospective subject or the subject’s legally authorized representative,” and that “[w]hen appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects . . . [,] to protect the privacy of subjects and to maintain the confidentiality of data.”).

205. One argument against leaving certain activities solely to market forces is that these activities “involve costs that cannot be reduced to money and hence cannot be the basis of a free market choice.” GUIDO CALABRESI, *THE COSTS OF ACCIDENTS* 97 (1970). Even if the marketplace could make the efficient choice among acts and activities, such a valuation is impossible because many “costs . . . cannot be measured in purely monetary terms.” *Id.* In addition, market forces may not allocate resources efficiently if individuals are not “able to estimate accurately the risk” associated with an activity before the risk manifests. *Id.* at 103.

206. See generally INST. OF MED. & NAT’L RESEARCH COUNCIL OF THE NAT’L ACADS., *ASSESSING THE MEDICAL RISK OF HUMAN OOCYTE DONATION FOR STEM CELL RESEARCH* (2007), available at http://www.nap.edu/catalog?record_id=11832 (discussing medical and psychological risks associated with egg donation). See also Helen Pearson, *Health*

productivity) that buyers externalize. For example, ART imposes costs on society that are rarely acknowledged such as “higher labor and delivery costs . . . , higher neonatal costs, . . . and possibly even higher educational costs as children who were born prematurely or at below-normal weights enter the public schools system.”²⁰⁷ In addition, unregulated baby markets impose potential costs on the future children, both in terms of potential long-term health problems and, as I shall discuss in more detail in Part IV, anonymity provisions that prohibit the future child from learning about the donors of the gametes or embryos. Buyers externalize these costs as well.

A clear solution to most of these concerns is better public oversight of the fertility industry. England’s system of broad oversight and comprehensive regulation achieves that goal.²⁰⁸ Indeed, many commentators have argued for implementing a regulatory system in the United States much like England’s.²⁰⁹ I would strongly advocate such a model, which shifts the focus from a privatized, profit-driven industry to more of a public-health model. But there is some reason to be skeptical about the ability to implement such a regulatory scheme given the politics and culture of America. England’s comprehensive regulation of assisted reproductive technology fits easily within its centralized and heavily

Effects of Egg Donation May Take Decades to Emerge, 442 NATURE 607, 607–08 (2006) (discussing the lack of conclusive information about the health effects of egg donation).

207. Spar & Harrington, *supra* note 3, at 59.

208. See Marsha Garrison, *Regulating Reproduction*, 76 GEO. WASH. L. REV. 1623, 1623–24 (2008) (discussing the United Kingdom’s “comprehensive regulatory scheme” for regulating Assisted Reproductive Technology); Ouellette et al., *supra* note 104, at 422–34 (comparing the regulation of Assisted Reproductive Technology in the United Kingdom and the United States).

209. See, e.g., PRESIDENT’S COUNCIL ON BIOETHICS, REPRODUCTION & RESPONSIBILITY, THE REGULATION OF NEW TECHNOLOGIES 9–10 (2004), http://www.bioethics.gov/reports/reproductionandresponsibility/_pcbe_final_reproduction_and_responsibility.pdf (recommending monitoring and oversight of ART in this country to replace the patchwork regulation we currently have); James F. Childress, *An Ethical Defense of Federal Funding for Human Embryonic Stem Cell Research*, 2 YALE J. HEALTH POL’Y L. & ETHICS 157, 163 (2001) (suggesting that the United States might need a regulatory body liked that of the U.K. to oversee embryonic stem cell research); Weldon E. Havins & James J. Dalessio, *The Ever-Widening Gap Between the Science of Artificial Reproductive Technology and the Laws Which Govern that Technology*, 48 DEPAUL L. REV. 825 (1999); Robert L. Stenger, *The Law and Assisted Reproduction in the United Kingdom and the United States*, 9 J. L. & HEALTH 135, 159 (1994–95) (arguing that the UK’s HFEA can guide U.S. efforts to address assisted reproductive technology); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 236 (arguing for a system like England’s mandatory reporting of ART procedures which children have access to upon reaching the age of majority); *Id.* at 196 (arguing for limits on the number of embryos that may be transferred, as in England).

regulated healthcare industry.²¹⁰ In contrast, the United States' healthcare system has long resisted such an approach, not just with respect to infertility, but with respect to healthcare generally.²¹¹

Because of the concerns regarding coercion and distorted decision making, one of the primary goals in regulating baby markets should be a mandate to collect and analyze relevant data regarding the risks and success rates of assisted reproductive technologies.²¹² Ideally, the data would address not only short- and long-term physical risks associated with the various procedures but also the psychosocial issues. In addition, the focus of the research must be on the sellers (of ova, sperm, embryos, and gestational surrogacy services), the buyers (the recipients of these reproductive materials and/or services), and of course the resulting children.

Although American law requires infertility clinics to report data on their procedures, these requirements are virtually unenforceable.²¹³ Making such requirements enforceable would be a starting point. To give teeth to otherwise meaningless requirements, we might impose penalties for reporting violations. Liability schemes too might create some level of incentive. This approach, however, would require patients to pursue such claims and to demonstrate failures within the system, which might be difficult and burdensome for them. Alternatively, we might consider a market-driven, carrot rather than stick, approach. Financial incentives such as tax credits might encourage clinics to collect and report the relevant data and even to participate in large-scale research about the effects of and success rates of various treatments.²¹⁴ Such incentives would go

210. Ouellette et al., *supra* note 104, at 422–34. “The [English ART regulation] is successful in the U.K. in part because of the tradition of national control over health care, which is viewed as a public, not a private commodity. Patients and providers in the U.K. accept government regulation of virtually every kind of health care issue.” *Id.* at 444. See also CAHN, TEST TUBE FAMILIES, *supra* note 1, at 20 (“Although there is much more oversight of the industry in other countries, many of them (England, Australia, and France) have government-provided medical care, so the population may be more accustomed to government regulation of its health care” than the population in the United States, where “individual states, rather than the federal government, are primarily responsible for regulating the medical profession and the family law issues posed by ART.”).

211. See Ouellette et al., *supra* note 104, at 434–42.

212. See Spar & Harrington, *supra* note 3, at 65.

213. See *supra* note 184 and accompanying text.

214. The use of tax credits to incentivize behavior is well known in medicine. Such a strategy has been employed to change behavior ranging from the individual purchase of health insurance to private research and development. See Belinda L. Heath, *The Importance of Research and Development Tax Incentives in the World Market*, 11 MICH. ST. U.-DETROIT C.L. J. INT'L L. 351, 352 (2002) (discussing the use of tax credits to encourage research and development of pharmaceutical products); Alec G. Karakatsanis, *Health Insurance in America: Providing Substance to America's Values*, 11

much further than the current one: to avoid “being listed as a non-reporting clinic in the CDC’s annual report.”²¹⁵ Whether through direct regulation or indirect incentives, a crucial remedy to some of the harms of baby markets would be to bring the much overdue centralized analysis of data to the American infertility industry, something markets alone have not achieved.²¹⁶

In addition, we should expand the federal regulations of human subject research to cover experimental treatments conducted in the private sector.²¹⁷ Again the British model offers some guidelines for greater oversight: the regulatory body must approve the implementation of new techniques.²¹⁸ Whether we expand the scope of the entities regulated by the Common Rule or make specific requirements for oversight of research in this area, we must demand greater protections for those who are patients and research subjects in this industry.

Additional regulations should address the health risks associated with buying and selling reproductive materials in baby markets. For example, regulations might set limits on the dosages of fertility drugs to decrease the possibility of side effects like hyperstimulation syndrome.²¹⁹ Similarly, if data suggest that the health risks associated with ovum retrieval are cumulative, it may be appropriate to limit the number of lifetime ovum donations that a woman may undergo.²²⁰ Again, the

MICH. ST. U. J. MED. & L. 337, 361–62 (2007) (discussing the use of tax credits to encourage the purchase of private health insurance).

215. Ouellette et al., *supra* note 104, at 427; *see also* note 104.

216. In essence, I am suggesting that the existing social norms of self-regulation have not adequately achieved these goals.

217. DANIEL D. FEDERMAN ET AL., RESPONSIBLE RESEARCH: A SYSTEMS APPROACH TO PROTECTING RESEARCH PARTICIPANTS 47 (2003) (recommending that “every organization sponsoring or conducting research with humans” should be subject to federal regulations protecting human research participants); NAT’L BIOETHICS ADVISORY COMM’N, ETHICAL AND POLICY ISSUES IN RESEARCH INVOLVING HUMAN PARTICIPANTS 40 (2001) (“Federal policy should cover research involving human participants that entails systematic collection or analysis of data with the intent to generate new knowledge.”).

218. The UK regulatory system requires programs that apply for licenses from the HFEA to comply with the Act and the Code of Practice, which describes acceptable and unacceptable practices for the treatment of infertility and embryo research. *See* HUMAN FERTILISATION & EMBRYOLOGY AUTH., CODE OF PRACTICE 1.3 (7th ed. 2008), *available at* http://cop.hfea.gov.uk/cop/pdf/CodeOfPracticeVR_4.pdf; Human Fertilisation and Embryology Act, 1990, c. 37, § 3(1) (Eng.), *available at* <http://www.opsi.gov.uk/acts/acts1990.htm>.

219. *See* Cook, *supra* note 114, at A18 (noting that Harvard’s protocol for obtaining ova from women for stem cell research requires estrogen levels to “be kept fairly low” to minimize the risk of hyperstimulation syndrome).

220. *Cf.* CAHN, TEST TUBE FAMILIES, *supra* note 1, at 61 (noting that there is no regulation limiting the number of donations per donor). Based on her personal experiences

British model is compelling for its ability to analyze data on health risks and then to draw upon experts to regulate or prohibit certain actions.²²¹ Moreover, because sellers in baby markets do not personally benefit from the medical procedures they undergo, they, like research subjects, should have the ability to withdraw from the gamete retrieval process without financial or legal penalties,²²² which would reduce some of the power imbalances at work in these markets.

While my suggestions are potentially difficult to implement in an industry loathe to be regulated and in a country skeptical of the government's presence in such personal matters, healthcare has historically been regulated by the state to protect the well-being of its citizens.²²³ With so many participants potentially vulnerable to the forces of baby markets, we have an obligation to ensure their ability to participate with full understanding of the risks involved, as well as to be protected from the power imbalances and coercive influences of the market.

IV. RELATIONAL AUTONOMY AND ANONYMITY OF DONORS

Baby markets not only threaten the well-being of buyers and sellers, but also potentially the well-being of children born through assisted reproductive technology. First, if profit motives in an unregulated industry drive some to engage in practices that are potentially physically risky to future children, this alone is a significant concern.²²⁴ A more indirect

as a "serial egg donor," Julia Derek has argued for an age cut-off of 25 for ovum donors, which would have the effect of limiting how many eggs they could donate. Personal communications with Julie Derek, Nov. 2006, roundtable, *Baby Markets: Money, Morals, and the Neopolitics of Choice* at DePaul University.

221. See Ouellette et al., *supra* note 104, at 442–43 (discussing how the United Kingdom used the scientific work of health experts regarding the risks of multiple births to limit the number of embryos that could legally be implanted).

222. See *supra* text accompanying notes 115, 115, 196; ABA MODEL ACT, *supra* note 146, at § 201(2)(a) (suggesting that informed consent requires a "statement that the patient retains the right to withhold or withdraw consent at any time prior to transfer of gametes or embryos without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled.").

223. See William D. White, *Market Forces, Competitive Strategies, and Health Care Regulation*, 2004 U. ILL. L. REV. 137, 141–46 (discussing the history of the healthcare industry and its regulation by government).

224. Just as we may worry that financial conflicts of interest could reduce the extent to which some physicians promote their patients' best interests, we might also worry that such conflicts of interest could push some physicians to take undue risks with respect to the future children. Some studies describe the potential health risks to children born of IVF. See Gina Kolata, *Picture Emerging on Genetic Risks of IVF*, N.Y. TIMES, Feb. 17, 2009, at D1 (describing "a paper reporting that babies conceived

harm is to the personhood and relational self-definition of the future children when markets indirectly deprive them of the opportunity to learn important information about their genetic heritage. In this country, baby markets reflect the preferences of the buyers and sellers, which has created a presumption in favor of the anonymity of those who sell reproductive material.²²⁵ The markets have not, however, captured the interests of the children since they are not participants in these transactions. Regulation of baby markets is necessary to address the conflicting interests between the participants in these markets and the resulting children. Moreover, in addition to being the right thing to do, attending to this problem addresses the fact that the costs of anonymity to the resulting children are often externalized in the existing unregulated market.²²⁶

Although “there is no legislation, at either federal or state level, that either prohibits or enforces anonymous gamete donation,”²²⁷ the market favors anonymity. From the inception of artificial insemination, anonymity and secrecy have been the norm.²²⁸ The majority of individuals who use gametes to conceive do not disclose this fact to their children,²²⁹

with IVF, or with a technique in which sperm are injected directly into eggs, have a slightly increased risk of several birth defects, including a hole between the two chambers of the heart, a cleft lip or palate, an improperly developed esophagus and a malformed rectum”); Sonia M. Suter, *The “Repugnance” Lens of Gonzales v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1523 (2008). Unfortunately, we know little about “the effects on children born through collaborative reproduction . . . because so few studies have addressed the topic.” Helen M. Alvaré, *The Case for Regulating Collaborative Reproduction: A Children’s Rights Perspective*, 40 HARV. J. ON LEGIS. 1, 43–44 (2003). We would not want profit incentives to encourage physicians to push the technology in directions that could pose even greater risks to children.

225. See *infra* text accompanying notes 228–233.

226. See *supra* text accompanying notes 208.

227. Lucy Frith, *Gamete Donation and Anonymity: The Ethical and Legal Debate*, 16 HUM. REPROD. 818, 819 (2001).

228. Carbone & Gottheim, *supra* note 4, at 514; see also A. McWhinnie, *Gamete Donation and Anonymity: Should Offspring from Donated Gametes Continue to be Denied Knowledge of Their Origins and Antecedents?*, 16 HUM. REPROD. 807, 807 (2001) (“Donors were anonymous, assured of confidentiality. Recipients were encouraged to keep AID secret and not to tell the child.”); *id.* at 811 (describing “the extreme secrecy over the 60 years of” the practice of artificial insemination by donor).

229. Glenn McGee et al., *Gamete Donation and Anonymity: Disclosure to Children Conceived with Donor Gametes Should Not Be Optional*, 16 HUM. REPROD. 2033, 2033 (2001) (noting that one study found that “86.5% had not told the child and did not plan to tell and 40% had told no one at all”) (citing Susan C. Klock & Donald Maier, *Psychological Factors Related to Donor Insemination*, 56 FERTILITY & STERILITY 489, 491–92 (1991)). The interest in secrecy, however, varies depending on whether ART occurs in the context of a heterosexual or homosexual couple. While heterosexual couples strongly favored secrecy so they could “mimic the natural family . . .

often to avoid revealing their infertility.²³⁰ In addition, professional societies recommend that gamete donors remain anonymous,²³¹ sperm bank contracts “routinely provide” for anonymity,²³² and internationally, “the vast majority of countries endorse anonymous gamete donation.”²³³

These practices, however, are not uniform and seem to be evolving, especially outside the United States. Some clinics offer “an exclusively known service” and others offer the choice of anonymous or non-anonymous sperm donation.²³⁴ Such choices are commonly used in oocyte donor programs in the United States.²³⁵ Internationally, there is “a

most homosexual couples were planning to tell the child [and] 40% of these couples would like the identity of the donor to be registered.” Frith, *supra* note 227, at 822 (citing A. Brewaeys et al., *Children from Anonymous Donors: An Inquiry into Homosexual and Heterosexual Parents Attitudes*, 14 J. PSYCHOSOMATIC OBSTETRICS & GYNAECOL. (SPECIAL ISSUE) 23 (1993)).

230. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 122 (“Nonetheless, the overwhelming majority of parents who have used either donor sperm or donor eggs do not disclose to their children that they were created through donor gametes.”); see also Naomi Cahn, *Children’s Interests and Information Disclosure: Who Provided the Egg and Sperm? Or Mommy, Where (and Whom) Do I Come From?*, 2 GEO. J. GENDER & L. 1, 16 (2000) [hereinafter Cahn, *Children’s*] (“In a recent study of parents who conceived children through gamete donation, more than one-half of the parents surveyed did not intend to disclose this information to their children, while slightly more than one-third expected to do so.”); McWhinnie, *supra* note 228, at 810–11 (describing how strongly many families adhere to such secrecy, even avoiding discussions of the fact of gamete donors among couples).
231. Frith, *supra* note 227, at 819 (citing guidelines from the American Society for Reproductive Medicine and the American Association of Tissue Banks); see also McWhinnie, *supra* note 228, at 807 (noting that the “established medical practice in assisted reproductive technology [] where donated gametes are used, is to favour anonymity of donors, to stress confidentiality and the privacy of the infertile adults”); ABA MODEL ACT, *supra* note 146, at § 1002(1)(a) (requiring that “[d]onor and collaborative reproduction registries (or equivalent) created for the purpose of maintaining contact, medical, and psychological information about donors, gestational carriers, and children born as a result of ART . . . [e]stablish procedures to allow the disclosure of non-identifying information, while protecting the anonymity of donors”).
232. Cahn, *Children’s*, *supra* note 230, at 8 (noting that “donors are often promised anonymity by the sperm bank, clinic, or under state statute”); *id.* at 9 (observing that even though “the identity of egg providers was often well-known in early cases, there is now more anonymity and secrecy attached to this process as well”); Ertman, *supra* note 15, at 20–21 (describing California Cryobank’s contract, which provides that recipients of the sperm agree that they “shall not now, or at anytime [sic] require nor expect [the bank] to obtain or divulge to Client the name of any Donor, nor any other identifying information contained in the files of [the bank]”).
233. Frith, *supra* note 227, at 818.
234. *Id.* at 821.
235. McWhinnie, *supra* note 228, at 814 (noting that it was introduced “because of the difficulty of attracting oocyte donors” and that it treats the choice as “a matter of preference rather than of ‘moral rightness’”).

discernible trend” towards openness, even with respect to identifying information about gamete donors.²³⁶ In Australia, for example, legislation was proposed to allow children of artificial insemination by donor to learn of the identity of the donors when the children are older.²³⁷ The United Kingdom, Sweden, Austria, Western Australia, and the Netherlands have prohibited anonymous donations.²³⁸ Perhaps, we will begin to see a shift in American attitudes that reflects the movement in other countries toward greater openness. But until that happens, American baby markets will tend to favor the interests of donors and intended parents in restricting access to donor information over the interests of children in learning about the donors.

Others have debated the virtues of anonymity and secrecy surrounding ART.²³⁹ Many of the arguments in favor of anonymity are consistent with preserving the personhood and relational autonomy interests of buyers and sellers in baby markets. Anonymity can preserve

236. Frith, *supra* note 227, at 819 (describing the actual or contemplated removal of anonymity of gamete donors in Sweden, Austria, Switzerland, Australia, New Zealand, and Holland); *see also* Carbone & Gottheim, *supra* note 4, at 516 (noting that some countries “require the disclosure of non-identifying medical or genetic information, and other jurisdictions . . . require the disclosure of donor identity when the child comes of age”); McWhinnie, *supra* note 228, at 815 (describing that “a movement towards much greater openness about origins and antecedents is part of a growing perception . . . in Europe, in Australia and in Canada that donor offspring’s rights and needs have to be given recognition and not denied or ignored”). One poll in England found that 83% of those surveyed believe that medical and health records of sperm donors should be disclosed. *Call to End Sperm Donor Anonymity*, BBC NEWS, June 26, 2002, <http://news.bbc.co.uk/1/hi/health/2065329.stm>. *Cf.* McGee et al., *supra* note 229, at 2034 (noting that the same shift towards openness with respect to the fact of having been adopted is developing with respect to disclosure to “children conceived using donor gametes”). Medical practitioners are also gradually becoming more supportive of general openness in this context and of telling children that they were brought about through assisted reproductive technologies. Some even advise parents to tell their children. McWhinnie, *supra* note 228, at 811; Ethics Committee of the American Society for Reproductive Medicine, *Informing Offspring of Their Conception by Gamete Donation*, 81 FERTILITY & STERILITY 527 (2004) (supporting disclosure from parents about the use of donor gametes in their conception).

237. *See, e.g.*, Cahn, *Children’s*, *supra* note 230, at 25; Carbone & Gottheim, *supra* note 4, at 509, 541 (Ultimately, “the change came not through new legislation . . . but through the adoption of new Ethical Guidelines by the National Health and Medical Research Council.”).

238. Carbone & Gottheim, *supra* note 4, at 542; Olga van den Akker, *A Review of Family Donor Constructs: Current Research and Future Directions*, 12 HUMAN REPROD. UPDATE 91, 93 (2006); Kate M. Godman et al., *Potential Sperm Donors’, Recipients’ and Their Partners’ Opinions Toward the Release of Identifying Information in Western Australia*, 21 HUMAN REPROD. 3022, 3022 (2006).

239. McWhinnie, *supra* note 228, at 813; CAHN, TEST TUBE FAMILIES, *supra* note 1, at 117–29 (discussing the arguments in favor of anonymity).

the parent's right to privacy with respect to reproduction.²⁴⁰ In addition, anonymity potentially expands the choices of individuals who want to create families by maximizing the supply of donors²⁴¹ and possibly ensuring better quality gametes.²⁴² Many defend anonymity as a way to protect and enhance the formation of families, which goes directly to relational concerns.²⁴³ Some suggest it also strengthens the child's bonds with the "social" parent,²⁴⁴ discouraging donors who want to be overly involved in the children's life.²⁴⁵

Of course donors have a stake in anonymity as well. Given that their choice to sell gametes often reflects a desire to sever connections with and separate from the future child, gamete donors might value anonymity to avoid unwanted contact with the future child or the newly

240. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 220 ("A second critical argument against information disclosure centers on the privacy rights of everyone involved: the social/legal parents, the gamete providers, and the child."); Cahn, *Children's*, *supra* note 230, at 20–24 ("Some advocates for birth parents and civil libertarians, have analogized the adoption/gamete provision decision to that made by women choosing to undergo an abortion, claiming that the right to privacy regarding abortion should also protect adoption."); Frith, *supra* note 227, at 822 (noting that for many couples anonymity helps hide the stigmatizing fact of the underlying infertility); Jennifer A. Baines, Note, *Gamete Donors and Mistaken Identities: The Importance of Genetic Awareness and Proposals Favoring Donor Identity Disclosure for Children Born From Gamete Donation in the United States*, 45 FAM. CT. REV. 116, 119 (2007) (noting that anonymity protects parents against being subject to the stigma of infertility).

241. Carbone & Gottheim, *supra* note 4, at 545; Frith, *supra* note 227, at 823 (noting that in "Sweden there was a drop in both the number of donors and the demand for AID after the 1984 legislation that removed donor anonymity, although this decline has been reversed. . . . A similar trend in declining donor numbers has been noted in Victoria after the passage of their legislation to remove anonymity."); Robert Winston, *This Foolish Threat to the Gift of Life: As Ministers Plan to End Anonymity for Sperm Donors Britain's Leading Fertility Expert Issues a Warning*, DAILY MAIL (London), July 26, 1999, at 10.

242. In countries that no longer preserve anonymity, donors tend to be older, which theoretically could reduce the quality of the gametes. Frith, *supra* note 227, at 823.

243. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 217 ("Mandating identity disclosure may suggest that genetic origins are superior to socially and legally created parenting relationships and thereby contribute to the danger of over-emphasizing one's biological composition."); Cahn, *Children's*, *supra* note 230, at 15 ("Anonymity is a tool that protects the social and psychological construct of the family resulting from gamete donation." (quoting a physician)); Carbone & Gottheim, *supra* note 4, at 516 (noting that "anonymity . . . protect[s] recipients from demands for visitation or parental recognition"); Ertman, *supra* note 15, at 21 (noting that anonymity facilitates "the formation of family units based on intent, rather than biology alone"); Baines, *supra* note 240, at 120.

244. McGee et al., *supra* note 229, at 2034.

245. Guido Pennings, *The Double Track Policy for Donor Anonymity*, 12 HUM. REPROD. 2839, 2843 (1997).

created family.²⁴⁶ Even more, they may want to avoid being responsible for child support.²⁴⁷

In my earlier discussion concerning the personhood and relational interests in gametes and embryos, I addressed the self-defining aspects of reproductive decisions to buyers and sellers in baby markets.²⁴⁸ However, I did not discuss issues of human flourishing and self-definition for the future child. Individuals may decide that they want to separate from their gametes or genetically-related embryos, but these are not decisions that affect only them. If we are concerned with one's self-definition in relation to others, we must think not only of the buyers' and sellers' interests, but also of the interests of children born through ART.²⁴⁹

While some suggest anonymity avoids upsetting children about the facts of their origins²⁵⁰ and that their self-esteem should depend on "the emotional environment created by being a wanted child," not genealogy and genetic origins,²⁵¹ the evidence suggests that donor anonymity threatens the personhood and relational autonomy interests of the resulting children. It prevents them not only from knowing one or both of their biological parents,²⁵² it can prevent them from learning important facts about these biological parents as well as information about their genetic heritage.²⁵³ Children born via ART may be curious about the

246. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 119 (quoting a doctor stating "I can't think of one that said, 'Boy, I just look forward to meeting my child when they reach the age of 18,' not one").

247. Carbone & Gottheim, *supra* note 4, at 516.

248. See *supra* Part I.

249. See Alvaré, *supra* note 224, at 43 ("[T]he interests of children conceived by means of collaborative reproduction should form a significant part of any analysis of the rights of parents to undertake collaborative reproduction processes").

250. See Frith, *supra* note 227, at 822 (noting that some actually believe that it is not in the child's best interest to know his or her origins in this context); McGee et al., *supra* note 229, at 2034.

251. McWhinnie, *supra* note 228, at 813; see Lori B. Andrews & Nanette Elster, *Adoption, Reproductive Technologies, and Genetic Information*, 8 HEALTH MATRIX 125, 150-51 (1998) (Anonymity is helpful to "prevent a genetically deterministic view of people as nothing more than a packet of unfolding genes.").

252. Ertman, *supra* note 15, at 21.

253. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 126 ("Like adoptees, children of donated gametes may feel a sense of 'genealogical bewilderment,' a feeling that they are confused about their identity and different from other children."); Cahn, *Children's*, *supra* note 230, at 5 ("While non-disclosure recognizes that one's parents are the individuals who function as parents, it denies these children may be interested in other adults who contributed to their creation."); Spar & Harrington, *supra* note 3, at 66 ("Individuals want to know from whom they came. They may not want to maintain any kind of emotional relationship with their birth mother, with their sperm donor, or with the woman who provided the egg from which they sprang, but they want to know . . . that information."); China R. Rosas, Comment, *A Necessary*

source of their inherited traits, such as eye and hair color, or certain talents and predispositions.²⁵⁴ As genetics becomes more important in medical diagnosis and treatment, knowledge of one's genetic history will become ever more important.²⁵⁵ Such information may be a prerequisite to providing genetic testing for certain late-onset conditions, preventive care, or prenatal testing once the child reaches reproductive age.²⁵⁶ Individuals conceived in this manner may also have strong desires to discover more than just medical information about the donor. Understanding their genetic origins or lineage may be important to their self-identity and self-understanding, precisely the kinds of concerns that go to relational autonomy.²⁵⁷

These claims are not merely speculative, as the experiences with adoption suggest.²⁵⁸ Adoptees often "feel a need to understand their 'heritage' and to integrate the circumstances surrounding their birth into

Compromise: Recognizing the Rights of a Donated Generation to Tame the Wild Wild West of California's Sperm Banking Industry, 37 SW. U. L. REV. 393, 416 (2008) (On Maslow's hierarchy of needs, "a donor offspring's need for identifying biological information is akin to an 'esteem' need, since donor offspring lacking such information often experience psychological problems."); Baines, *supra* note 240, at 118 (citing arguments against anonymity, including: "identifying information is considered essential to human well-being, both physical and mental" and "people have the right to know the truth of their origins").

254. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 127 ("Children want to know why they have a certain eye color, where their musical talent comes from, whose sense of humor they have, and they want to know their medical histories.").
255. Lorie M. Vandebusch, *Integrating Genetics into Primary Care: Family History is Key*, TOPICS IN ADVANCE PRACTICE NURSING EJOURNAL, June 18, 2008, <http://www.medscape.com/viewarticle/575481>; Rosas, *supra* note 253, at 416 (On Maslow's hierarchy of needs, "[a] donor offspring's need for medical information is akin to a 'safety' need, since donor offspring cannot be secure in their health without such information.").
256. McGee et al., *supra* note 229, at 2034–35 (describing the importance of genetic information for construction of genetic pedigrees for genetic counseling).
257. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 126 ("Nonetheless, several studies have examined whether donor offspring experience identity problems that are similar to those of adopted children, and although the studies often conflict, they do indicate that at least some donor children experience a sense of loss for not having information about their biological pasts or being able to establish a relationship with their gamete providers."); Cahn & Singer, *supra* note 55, at 173 ("There is substantial, albeit controversial, evidence that, for some adult adoptees, access to information about their biological origins may be central to their construction of identity.").
258. See Cahn, *Children's*, *supra* note 230, at 9 (noting the similar desire to learn about one's genetic parents in adoptees and children born through gamete donations); Frith, *supra* note 227, at 821 (noting that some support these claims by turning to research in the adoption context).

their overall sense of self.”²⁵⁹ For many, information about their biological parents is crucial to their identity and self-definition.²⁶⁰ Of course, we cannot rely entirely on adoption data given notable distinctions between adoptees and children born of ART. Biological parents of adoptees had parental rights, which they relinquished; whereas gamete donors simply provided genetic material.²⁶¹ Consequently, the ART child may struggle far less with a sense of abandonment, especially when they are biologically related to one of their legal parents.²⁶² This might suggest that knowledge of one’s genetic parents could be less central to the ART child than the adoptee,²⁶³ especially when the fact of adoption can be so self-defining for an adoptee.²⁶⁴

Even so, evidence suggests that a similar drive for knowledge of one’s genetic heritage can exist in the ART context. Although no systematic studies have examined these issues in individuals born of artificial insemination by donor, a few small studies capture the experiences of roughly 80–90 of such adults.²⁶⁵ All of them, who only learned late in life about their origins, reported “problems of personal

259. Cahn & Singer, *supra* note 55, at 173; *see also* CAHN, TEST TUBE FAMILIES, *supra* note 1, at 127 (noting that children “believe that finding the donor will help them to learn more about who they are”); *Id.* at 218 (“Knowing the identity of a biological progenitor may help the child in her identity development, but it is certainly not the only factor in that development.”); Naomi Cahn, *Birthing Relationships*, 17 *WIS. WOMEN’S L.J.* 163, 190 (2002) (observing that many adoptees want to know their birth parents “to fill in missing parts of their identity”).

260. *See* CAHN, TEST TUBE FAMILIES, *supra* note 1, at 127 (“There is substantial evidence that, for some gamete children, access to information about their biological origins may be important to their own construction of identity.”); Cahn, *Children’s*, *supra* note 230, at 5 (“Adoptees generally seek access to their original birth certificates, which include the names of their biological mother and perhaps, their biological father.”); *see also* Cahn & Singer, *supra* note 55, at 173 (observing that there is “substantial, albeit controversial evidence that, for some adult adoptees, access to information about their biological origins may be central to their construction of identity”); *id.* at 175 (identifying medical reasons and self-identity concerns as arguments adoptees have offered in litigation to explain why they sought access to their birth records); *id.* at 172 n.102 (noting that even minor adoptees may “need information about their biological origins, especially as they mature”).

261. Cahn, *Children’s*, *supra* note 230, at 6.

262. *See* Cahn, *Children’s*, *supra* note 230, at 10; Frith, *supra* note 227, at 821 (“Donor offspring are in a very different position to adoptive children within the family, they have not been abandoned by their genetic parents and they are often biologically related to one member of the couple.”). *But see* McGee et al., *supra* note 229, at 2035 (arguing that the differences between adoption and this context are not differences that “are relevant for the disclosure debate”).

263. Cahn, *Children’s*, *supra* note 230, at 10.

264. Cahn & Singer, *supra* note 55, at 173.

265. *See* McWhinnie, *supra* note 228, at 811.

identity”²⁶⁶ as well as “anger, resentment at the lies and deceit, loss of a sense of self and of their identity.”²⁶⁷ Not only did they wish they had known sooner about the fact that they were born via donor insemination, they wanted information about the donor:

what he looked like, what he was like as a person, his education and interests and especially details about his health and family health record. Some want to meet him, at least once. It is a source of great frustration and anger that this will never be available to them. For some, the quest for information about their donor father preoccupies them. . . . A recurring comment about their anger and frustration is that no one thought them important enough to keep records about their donor father and that the system was set up intentionally to deceive them and to make it impossible for them ever to know.²⁶⁸

Admittedly, there are methodological problems in relying on small studies of individuals born through artificial insemination by donor.²⁶⁹ Indeed, it is “by no means certain that not knowing . . . the identity of one’s donor can cause psychological problems.”²⁷⁰ But we need not show that anonymity leads to psychological problems to make claims about the importance of donor information to the child. At a minimum, these studies suggest that some individuals born via gamete donation will find this information of great consequence, not just for medical reasons, but for their sense of identity and self-definition.

Anecdotal reports certainly confirm the suggestions from these studies. Oprah Winfrey recently interviewed sperm donors and individuals born through artificial insemination by donor to explore their

266. See Cahn, *Children’s*, *supra* note 230, at 10.

267. McWhinnie, *supra* note 228, at 812 (noting that it did not matter whether they learned about their origins after family disagreements or divorce, a significant event (i.e., medical event that required such disclosure), or asking about their origins because they were puzzled about something in the family relationship.) Similar feelings of resentment, betrayal, and distrust have been found in adopted children who learned of their adoption late in life or through third parties. McGee et al., *supra* note 229, at 2034.

268. McWhinnie, *supra* note 228, at 812.

269. Selection bias may be present in these studies given that respondents were members of support groups, who might have had greater problems with these issues than those who did not participate in such groups. *Id.*

270. Frith, *supra* note 227, at 821 (noting also that because “anonymity has been the dominant model it has been difficult to conduct comprehensive studies on the effects of disclosure and identification of the donor”).

reactions to the process.²⁷¹ Understandably reactions differed.²⁷² But some children experienced great sadness and frustration in not being able to learn who their donor father was.²⁷³ Among the interviewees were a mother and her donor-conceived son, who had started a Donor Sibling Registry because of her son's "curiosity . . . about his genetic origins."²⁷⁴ Frustrated that "no public outlet exists for mutual consent contact between people born from anonymous sperm donation," they created the registry to help those who are genetically-related through sperm donation make contact with one another, including "their own or their child's half-siblings, their own or their child's sperm or egg donor, or their own genetic offspring."²⁷⁵ In the piece, Oprah's show profiled the moving encounter between two half-siblings who found each other through the registry.²⁷⁶ Finding a heretofore unknown genetically related half sibling filled a personal gap that each had felt due to being cut off from half of their genetic identity.²⁷⁷

While there is a danger in believing that our genetic identity is our complete identity, and while our society may increasingly overstate the value of genetic information in self-definition,²⁷⁸ we should not reject the value and interest in genetic identity. It is not merely a social construct that should be discouraged;²⁷⁹ it is a way to connect to one's "biological past."²⁸⁰ An interest in one's biological parents is not always based solely on a desire for medically relevant information. The desire to know one's genetic heritage is part of a complex discovery of identity, understood in relation to the many who shape us: intimates, family, and

271. The Oprah Winfrey Show: *The Ultimate Reunion: When Dad is a Sperm Donor* (NBC television broadcast Feb. 8, 2008), available at http://www.oprah.com/dated/oprahshow/oprahshow_20080208.

272. *Id.*

273. *Id.*

274. See *id.*; Donor Sibling Registry, <http://www.donorsiblingregistry.com/> (last visited Mar. 11, 2009).

275. Donor Sibling Registry, *supra* note 274. The site "has helped connect more than 6300 half-siblings (and/or donors) with each other. . . ." *Id.*

276. Oprah Winfrey Show, *supra* note 271.

277. *Id.*

278. Cahn, *Children's*, *supra* note 230, at 17 ("Genetic information, while potentially helpful, does not reveal everything about a person's identity."); Mary L. Shanley, *Collaboration and Commodification in Assisted Procreation: Reflections on an Open Market and Anonymous Donation in Human Sperm and Eggs*, 36 LAW & SOC'Y REV. 257, 269 (2002) (rejecting genetics essentialism while advocating an end to donor anonymity); Sonia M. Suter, *The Allure and Peril of Genetics Exceptionalism: Do We Need Special Genetics Legislation?*, 79 WASH. U. L.Q. 669, 674-75 (2001) (describing and challenging the views that genes are all or nearly all determining).

279. See Shanley, *supra* note 278, at 268-69.

280. Cahn, *Children's*, *supra* note 230, at 17.

community.²⁸¹ “The information provides additional background to [the children’s] full identities—genetic, emotional, and even cultural.”²⁸² Our environment and social relationships are clearly central to self-definition, but so is our genetic information.²⁸³ Both pieces of the nature/nurture puzzle are important in self-understanding and self-definition, especially if we understand the self in relational terms.²⁸⁴

As I suggested in Part I, self-identity, understood relationally, depends not only on our intentions with respect to relationships, but on the existence of relationships that have social, cultural, and intergenerational importance.²⁸⁵ Just as one’s gametes, even when sold, are to some degree self-defining by virtue of the intergenerational connection between the gamete donor and the child who will result,²⁸⁶ so too can knowledge about the gamete or embryo donor be self-defining to the ART child. The very fact that so many people pursue ART in order to have a child who is genetically related speaks volumes to the importance of genetic connections to self-definition.²⁸⁷ “Why . . . not see biological connectedness to the past as an equally vital part of the identity of children?”²⁸⁸

Unfortunately, a potential conflict arises between the relational autonomy interests of the parents and donors and the relational autonomy interests of the child. As noted in Part I, the relational autonomy interests of the donor are often less significant than that of the intended

281. See MACINTYRE, *supra* note 26, at 217, 205–06 (“[T]he story of my life is always embedded in the story of those communities from which I derive my identity. I am born with a past; and to try to cut myself off from the past, in the individualist mode, is to deform my present relationships. . . . What I am, therefore, is in key part what I inherit, a specific past that is present to some degree in my present.”); *id.* at 205 (“I inherit from the past of my family, my city, my tribe, my nation, a variety of debts, inheritances, rightful expectations and obligations. These constitute the given of my life This is in part what gives my life its own moral particularity.”); Shanley, *supra* note 278, at 268 (“The right to learn the identity of one’s genetic forebear stems from some people’s desire to be able to connect themselves to human history concretely as embodied beings, not only abstractly as rational beings or as members of large social (national, ethnic, religious) groups.”).

282. Cahn, *Children’s*, *supra* note 230, at 20.

283. See generally Suter, *Disentangling*, *supra* note 20.

284. See *supra* Part I.

285. See *supra* text accompanying notes 26–33, 53–60.

286. See *supra* text accompanying notes 28–33.

287. See Cahn, *Children’s*, *supra* note 230, at 18.

288. James L. Nelson, *Cloning, Families, and the Reproduction of Persons*, 32 VAL. U. L. REV. 715, 719 (1998) (quoted in Cahn, *Children’s*, *supra* note 230, at 18); see Shanley, *supra* note 278, at 267 (“[I]f the genetic tie had no significance whatsoever, it would not need to be hidden.”).

parents.²⁸⁹ So too are they less than that of the child. The decision to sell the gamete is a form of separation, which treats the gamete as a commodity, and therefore implicates relational self-definition less fully, even if the biological connection implicates self-identity to some extent.²⁹⁰ In contrast, as discussed above, the child's interest in his or her genetic heritage is a significant aspect of relational self-definition, especially since it includes a subjective desire for connection, not just an objective biological connection.²⁹¹ As a result, the presumption should lie in favor of resolving the conflict between the child and donor in favor of the child's right, at the age of majority, to access identifying information about the donor.²⁹²

Adoption raises similar conflicts of interest between the biological parents and the adoptee. As Professors Cahn and Singer have noted, in the context of adoption the competing interests of the various parties are fluid.²⁹³ When the child is born, the identity interests of the birth parents are more salient than those of the adoptee.²⁹⁴ Thus, Cahn and Singer argue for respecting the difficult choice of the birth parents as well as the "broad deference accorded to parental decision-making on behalf of children" at that point.²⁹⁵ But as the child reaches the age of maturity, "the child's identity interests outweigh the birth parent's earlier desire to prevent the establishment of a parent-child relationship."²⁹⁶ Similarly, as the child born via gamete or embryo donation matures, so does his or her interest in self-definition and identity begin to predominate over the gamete donor's interests in anonymity.²⁹⁷

There is an added reason to resolve the conflict in favor of the mature donor child's interests. Eliminating anonymity, at least provisionally, pushes all of the participants, especially the donors, to understand their choices not merely as individual acts, implicating solely their interests and desires, but as acts that have implications beyond themselves.²⁹⁸ Of course, donors or sellers motivated by altruism

289. See *supra* text accompanying notes 28–33.

290. See *id.*

291. See *supra* text accompanying notes 248–277.

292. Of course, the child should have the right not to seek out this information if he or she chooses not to do so.

293. Cahn & Singer, *supra* note 55, at 174.

294. *Id.*

295. *Id.*

296. *Id.*

297. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 232 ("As the child matures, however, the child's identity should begin to predominate.").

298. Shanley, *supra* note 278, at 269 ("Law and social practice should foster the understanding that what individuals do, even on a small scale, has repercussions beyond themselves and their intimate associates.").

consider the effects of their actions on others besides themselves.²⁹⁹ They may, however, be focusing primarily on the infertility of the buyers, but not as much on the child that will result.³⁰⁰ If we envision autonomy from a relational as opposed to an individualistic perspective, choices involving reproduction should consider the implications for the future children as well. Removing the presumption in favor of anonymity forces the sellers to view gametes and embryos less as commodities, but more as part of the creation of someone's future family.³⁰¹ In short, such an approach moves us from an individualistic conception of autonomy to a relational conception, where we understand our actions in terms of our place in the larger community.

The interests of the intended parents, however, are significant given their commitment to create a deep and enduring relationship with the donor child and their need to establish a stable family unit to nurture that relationship.³⁰² This means that resolving the conflict between their interests in anonymity of donors and the future child's interest in disclosure is more complicated. The parents' ability to create a family without interference from others seems as significant as the child's interest in discovering his or her origins. Yet part of relational autonomy requires consideration of the impact of choices not only on oneself but also on those who are central to one's self-definition.³⁰³ Removing the presumption in favor of anonymity would force intended parents to consider not only their own interests in having a family, but also their future child's interests in self-definition. Once parents are able to create the family they intended, their central relational interests have been largely met. As I discuss below, however, issues concerning the integrity of the family

299. See *supra* text accompanying notes 30–32.

300. See K.K. Ahuja et al., *An Assessment of the Motives and Morals of Egg Share Donors: Policy of 'Payments' to Egg Donors Requires a Fair Review*, 13 HUM. REPROD. 2671, 2671 (1998) (finding that donors in the United Kingdom typically share eggs out of concern for couples who otherwise would not be able to have children).

301. Professor Cahn observes that, unlike in the adoption context where biological mothers have expressed strong desires to know the adoptees, "there has been no corresponding movement among gamete providers." She hints that this "unsettling" casualness can commodify the resulting children, whom they may view as "'products' of their business" transaction. Cahn, *Children's*, *supra* note 230, at 12–13.

302. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 217 ("In the context of adoptees who are seeking information about their biological parents, critics have charged that the adoptees are overly concerned with biology, and are seeking to elevate biological relationships over adoptive relationships."); Cahn, *Children's*, *supra* note 230, at 5–6 ("In addition, non-disclosure implies that functional parents would be threatened if this additional information could be discovered, rather than recognizing the security and integrity of the functional parent/child bond.").

303. See *supra* text accompanying notes 26–27.

remain, which can be addressed in alternative ways. The child's relational autonomy interests, on the other hand, are potentially thwarted if donor anonymity is required.³⁰⁴

Again, as Cahn and Singer discuss with respect to adoption, the identity interests of the adoptee become quite powerful as the child reaches the age of majority.³⁰⁵ So too do the interests of the ART child.³⁰⁶ As a result, in most cases, we should favor the adult child's relational autonomy interests in obtaining information about the gamete donors over the intended parents' interests in retaining donor anonymity. Prohibiting the disclosure of identifying information "values contract over connection,"³⁰⁷ thus undermining the relational elements of self-definition for the child. When one considers that the child cannot negotiate in the market transactions that favor anonymity, the argument becomes even more powerful.³⁰⁸ Once again, we see how an unregulated market externalizes some of the true costs associated with the buying and selling of gametes.³⁰⁹

Arguing further in favor of this approach is the value to the community of giving social recognition to all of the vital participants in the creation of these ART families.³¹⁰ It takes a village to raise a child and sometimes a village to create one. But anonymity hides that fact. Anonymity provisions, while intended, in part, to benefit the families created through ART, may do damage to such families. They suggest that such families are not valid and must be disguised to blend in with and look like the typical nuclear family.³¹¹ Anonymity symbolically erases the contribution of others, suggesting that the only participants were the intended parents. It isn't surprising that when ART is used with single people or gay couples, anonymity is less important because in those cases there is no possibility of blending—such families, by definition, look different from the traditional nuclear family of one mother

304. See *supra* text accompanying notes 278–284.

305. Cahn & Singer, *supra* note 55, at 174.

306. See *supra* text accompanying note 297.

307. Cahn, *Children's*, *supra* note 230, at 26.

308. The goal here is not to allow the future child's interests to trump the interests of the parents or donors in all cases, but to bring the child's interests to the table and to create a presumption in favor of the child's interests, given the strong relational autonomy concerns at stake for the child.

309. See *supra* text accompanying notes 206–208.

310. Shanley, *supra* note 278, at 269 ("It is good, however, when social practices reflect the fact that specific human beings are necessary for any person to come into existence . . .").

311. Cf. Cahn, *Children's*, *supra* note 230, at 25–26 (suggesting the secrecy surrounding gamete donation is "emblematic of the attempt to make adoptive, or gamete, families 'look like' other families, to create the family 'as if' it had been biologically created").

and one father.³¹² If we want greater social acceptance of families created through ART, we should be willing to acknowledge, rather than hide, them. “The requirement to make a provider’s identity available upon the request of the offspring would constitute social recognition of the fact that children come into the world through the actions of specific persons, which can now include both ‘intentional’ parents . . . and genetic providers.”³¹³

In removing the presumption in favor of anonymity and emphasizing the interests of the child, however, we need mechanisms to protect the interests of the intended parents and the donors as well as the integrity of the newly created family. If we allow children to trace their genetic roots upon the age of majority, we must have clear legal rules establishing that the intended parents are the legal parents.³¹⁴ Further, to prevent donors from intruding upon the family, laws must ensure that the “the donor would have no access rights to the child: they would only be available if the child chose to contact them.”³¹⁵ Similarly, to honor the rationale for removing the presumption in favor of anonymity, only the child (upon reaching the age of majority), not the purchasers of the genetic material, should have the right to know the identity of the donor.³¹⁶

312. See Cahn, *Children’s*, *supra* note 230, at 15.

313. Shanley, *supra* note 278, at 268–69. A related argument against anonymity is the potential role it could play in reducing the risk of “accidental incest,” the unknowing procreation with a half-sibling. See generally Naomi Cahn, *Accidental Incest: Drawing the Line—or the Curtain?—for Reproductive Technology*, 32 HARV. J.L. & GENDER 59 (2009) (arguing that incest prohibitions should apply to consanguineous relationships created by ART and suggesting methods to reduce the risk of accidental incest). Of course, eliminating anonymity completely is not the only solution to the risk of accidental incest. As Professor Cahn suggests, limiting the number of donations that sperm or egg donors can make is one solution, as is informing children of their donor conception or requiring genetic screening before marriage to ensure the couple are not genetically related. See *id.* at 99–104.

314. See Carbone & Gottheim, *supra* note 4, at 536–37 (noting that essential to the clients’ trust in Rainbow Flag Health Services, a sperm bank whose philosophy is to disclose donor identity, is a background state law that “severs the parental status of the donor when the parties use a physician to perform the insemination”). The 2002 Uniform Parentage Act (“UPA”), for example, establishes that a “donor is not a parent of a child conceived by means of assisted reproduction.” UNIF. PARENTAGE ACT § 702 (2002). Removing anonymity, of course, does not in itself change any existing rules that prohibit donors from being recognized as legal parents. But a clear statement that donors will not be recognized as legal parents with possible explicit exceptions might be important to reassure intended parents and donors.

315. Frith, *supra* note 227, at 823.

316. Shanley, *supra* note 278, at 268.

Of course, this approach is not without its risks. Many worry that it could limit the availability of donors.³¹⁷ When June Carbone and Paige Gottheim first learned of efforts in Australia to eliminate anonymity of donors, they hypothesized that such a policy would “cause shortages that would either drive artificial insemination underground into more informal practices or spur fertility tourism abroad.”³¹⁸ Their research revealed that a shortage of sperm donors in Australia occurred even before any changes in anonymity provisions were made and was due to the ban on payment of donors.³¹⁹ In other countries, however, prohibiting anonymous donation has been shown to cause a shortage of donors.³²⁰ Evidence suggests, however, that these declines need not be permanent. In Sweden, for example, the drop in number of donors and demand for artificial insemination by donor was ultimately reversed.³²¹ A period of readjustment might be necessary as we make the cultural shift toward greater openness.

A number of approaches are possible in the context of embryo and gamete donation. One approach is to prohibit anonymity across the board. While this protects the child’s interests in relational self-definition by guaranteeing her access to information about her biological parents upon the age of majority, it runs the risk of completely ignoring the other values and interests at stake.³²² A more balanced approach would be to create a presumption of disclosure. This could happen legislatively, with laws that require openness unless good cause is shown for protecting anonymity. One commentator has even suggested that sperm banks “charge clients for health updates and pay more to donors [for] keeping in touch.”³²³ Alternatively, to draw upon the importance of deliberative decision making discussed in Part III, a full discussion of the value of openness could be part of the informed consent process.³²⁴ Part of the

317. See, e.g., CAHN, TEST TUBE FAMILIES, *supra* note 1, at 120; *id.* at 227 (“One of the primary—and strongest—arguments against disclosure of the identity of gamete providers is that it will have a negative effect on the supply of sperm and eggs.”); Cahn, *Children’s*, *supra* note 230, at 24; van den Akker, *supra* note 238, at 93.

318. Carbone & Gottheim, *supra* note 4, at 509.

319. *Id.* at 510.

320. See *id.* at 540 (describing shortages in Sweden, Austria, and the Netherlands); Godman et al., *supra* note 238, at 3022 (describing shortages in Western Australia).

321. Cahn, *Children’s*, *supra* note 230, at 25; Ken Daniels & Othon Lalos, *The Swedish Insemination Act and the Availability of Donors*, 7 HUM. REPROD. 1871 (1995); van den Akker, *supra* note 238, at 93.

322. See *supra* text accompanying notes 240–247.

323. See Rosas, *supra* note 243, at 418 n.216.

324. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 162 (noting that a regulated baby market “might include informed consent from recipients and providers concerning mandatory disclosure for children”).

value of avoiding anonymity is to help make the gamete sellers become aware of the full implication of their decisions—to help them see their actions, not as the sale of a good, but as assisting in the creation of another human being and a family.³²⁵ Simply prohibiting anonymity may not achieve this goal as fully as educating the donors about the interests of the child in knowing something about her genetic parents. My inclination is to include a combination of these approaches. That is, to require a presumption in favor of openness, as well as a full discussion of the reasons for this presumption, when individuals consider whether to sell gametes or embryos. Such an approach tries to balance the fact that the child cannot negotiate his or her preferences at this point and emphasizes the full relational significance of the act of selling gametes—pushing the sellers to see their actions, not as business transactions, but as family building.³²⁶

In dealing with the issue of anonymity, we have some limited guidance from the adoption world, where similar debates have been ongoing about an adopted child's right to access information about her biological parents.³²⁷ Historically, adoption records remained sealed unless the adoptee demonstrated good cause.³²⁸ Often a "compelling medical need"

325. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 162 (stating that market regulation could "include an improved system for informed consent for all gamete providers concerning not just the physical risks (which vary for sperm and egg donation), but also the consequences of providing gametes: the creation of a child"); Shanley, *supra* note 278, at 268–69 ("Stipulating that the provider's name can be disclosed at the request of the grown child precludes imagining the child as the genetic offspring of 'nobody' or of 'anybody,'" rather than of an individual. Abolishing anonymity not only addresses the identity interests of the person who comes into being as a result of gamete transfer but also encourages society to think of human agency and responsibility in collaborative procreation.).

326. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 162 (explaining how a discussion of disclosure impresses on donors the "consequences of providing gametes: the creation of a child"). Cf. *supra* text accompanying note 313.

327. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 225 ("The analogies between the donor's claim to privacy and those claims asserted in the adoption context are quite strong."); Cahn, *Children's*, *supra* note 230, at 5–8; Cahn & Singer, *supra* note 55, at 173–75; Paula J. Manning, *Baby Needs a New Set of Rules: Using Adoption Doctrine to Regulate Embryo Donation*, 5 GEO. J. GENDER & L. 677, 679 (2004) ("Over the previous decade, lawmakers, social workers, birth mothers, adoptees, and their advocates, have worked hard to dismantle adoption laws that originally promoted secrecy and denied adoptees access to their own birth records."); McGee et al., *supra* note 229, at 2033–34 ("Traditionally, in the domain of adoption, couples had been advised not to tell their child of his/her origin. Secrecy was believed to be in the best interest of the child. . . . This tendency toward secrecy has shifted, however, and today most adoption agencies advise parents to disclose to the child that they were adopted.").

328. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 225–26 ("In both [adoption and gamete donation], state statutes have typically specified that disclosure is available upon a

sufficed,³²⁹ and in a few instances, “the right to identity” sufficed.³³⁰ Today many states grant adoptees access to information about their genetic origins.³³¹ Some states have developed mutual consent registries.³³² In a few states, adoptees no longer must demonstrate good cause and can access medical and “other non-identifying information,” sometimes even without the consent of the birth parent.³³³ Finally, in some states, adoptees may now access all adoption records, including identifying information.³³⁴ These laws do not require good cause or consent of the birth parents.³³⁵ In crafting laws to guarantee greater openness of donor information in baby markets, we can look to the adoption debate both for reasons for such openness and for ideas as to how to legislate provisions guaranteeing such openness.

V. ACCESS

So far we have seen how unregulated baby markets might create power imbalances and distort decision making of both sellers and buyers as well as respond to their preferences for anonymity at the expense of the future child’s interests in relational autonomy. With respect to access, markets play a complicated role. As noted earlier, many argue in favor of unfettered markets as a means to increase access to assisted reproduction.³³⁶ Markets might achieve this in two ways. First, markets

showing of ‘good cause,’ and ultimately, courts have decided that good cause can sometimes trump these privacy interests.”); Manning, *supra* note 327, at 714–15.

329. Manning, *supra* note 327, at 714–15.

330. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 229 (“A few courts have allowed birth record disclosure based on an adoptee’s severe psychological need to learn about the identity of her biological parents.”); *see, e.g., In re Dixon*, 323 N.W.2d 546, 552 (Mich. Ct. App. 1982); *Mills v. Atlantic City Dep’t of Vital Statistics*, 372 A.2d 646, 655 (N.J. Super. Ct. App. Div. 1977). *But see In re Maples*, 563 S.W.2d 760, 766 (Mo. 1978) (finding such reasons insufficient for opening sealed records); *In re Assalone*, 512 A.2d 1383, 1389 (R.I. 1986) (same).

331. Baines, *supra* note 240, at 121.

332. *Id.* at 122.

333. Manning, *supra* note 327, at 715.

334. *Id.*; Baines, *supra* note 240, at 123 (noting that some states have completely open adoption records).

335. *Id.* at 715–16, 716 n.281.

336. Ertman, *supra* note 15, at 16 (“Moreover, lack of regulation [of the parenthood market] and a relatively low price for the gametes means that it is both an open market in which a large number of people can participate, and a free market that flourishes because of its comparative freedom from regulation.”); Landes & Posner, *supra* note 84, at 339 (“[T]he baby shortage . . . [is] the result of legal restrictions that prevent the market in operating freely in the sale of babies, as of other goods.”); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 150–51 (“[M]arketization—the creation of a free

can increase the supply of reproductive materials by enticing people to make their gametes or embryos available in exchange for financial compensation.³³⁷ In addition, unregulated markets allow individuals to sell their reproductive materials on terms that they choose.³³⁸ Thus, for example, as Part IV discussed, letting sellers remain anonymous may affect supply.³³⁹ Second, unfettered markets theoretically prevent discriminatory barriers that would otherwise keep certain marginalized individuals (e.g., single women or gay and lesbian couples) from taking advantage of this technology.³⁴⁰

In spite of these benefits, as Judith Daar has nicely demonstrated, evidence suggests that within baby markets, three major barriers prevent would-be buyers from participating: cost, minority status, and being single.³⁴¹ As Part V argues, there is reason to question the claims that markets will overcome these barriers. The first claim that markets increase supply, ultimately goes to questions of cost.³⁴² If supply increases, the cost of reproductive material might be less prohibitive, thereby allowing buyers who could not otherwise afford this technology to take advantage of it.³⁴³ Intermixed with issues of financial barriers are issues of race.³⁴⁴ As Sections A and B suggest, markets are not likely to overcome financial and racial barriers alone, even if they lead to a greater supply of reproductive material.³⁴⁵ The second claim about discrimination is more complicated. As Section C argues, unfettered markets are

economy—facilitates access by marginalized groups, such as single women and gay and lesbian partners, fosters new family forms through allowing the creation of families outside of the heterosexual nuclear and biologically-related family.”); *see also supra* note 68.

337. Carbone & Gottheim, *supra* note 4, at 522 (“The supply of gametes, like any other commodity, is a function of the available price and the relative demand.”); Garrison, *supra* note 208, at 1628 (“The U.K. largely outlaws payment to ova donors, with the result that demand for donated ova exceeds supply.”); *see* Landes & Posner, *supra* note 84, at 338 (arguing that one of the causes of the “baby shortage” is that there is no economic incentive to place children in adoption as opposed to placing them in foster care); *see also supra* note 68.

338. *See infra* text accompanying note 401.

339. *See supra* text accompanying notes 241–242.

340. *See infra* text accompanying note 401.

341. Judith F. Daar, *Assessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 22 (2008).

342. *See infra* Part V.A.

343. *See* CAHN, TEST TUBE FAMILIES, *supra* note 1, at 148 (“The sales practices reveal the blatant, unregulated market that characterizes the ART industry; gamete prices are the result of supply and demand.”); HUBERT D. HENDERSON, SUPPLY AND DEMAND 18 (2d ed. 1922) (“[W]hen supply exceeds demand the price tends to fall.”); *see also infra* text accompanying notes 348–351.

344. *See infra* Part V.B.

345. *See infra* text accompanying notes 353–360, 370–380.

not possible if legislatures are determined to discriminate. In short, we cannot rely on markets to overcome discriminatory impulses.

These three problems of access raise, however, different kinds of issues—whether people should have equal access to gametes, embryos, and ART, and whether people should be *entitled* to them. Markets inevitably ration goods, and they rarely do so equally.³⁴⁶ When markets lead to unequal access because they reflect discriminatory impulses that is particularly problematic.³⁴⁷ But whether there is an obligation to overcome every obstacle to reproduction is another question, raising different problems about access. Since each barrier—cost, minority status and marital status—raises different kinds of structural problems and solutions, I address each in turn.

A. Cost

Cost is the most obvious barrier given that a single cycle of IVF, for example, generally costs upwards of \$10,000.³⁴⁸ The fact that most health insurance plans fail to cover such treatment is a major barrier to many.³⁴⁹ This problem raises empirical questions about the effects of markets on supply and price. Does legitimizing or promoting baby markets increase supply³⁵⁰ and thereby reduce prices so that more individuals can participate in these markets?³⁵¹ My sense is that a free market probably cannot

346. Cf. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 134–44 (discussing “cultural infertility,” the “inability to become pregnant because of cost or discrimination or social attitudes”).

347. See CAHN, TEST TUBE FAMILIES, *supra* note 1, at 141 (discussing disproportionate access to ART along racial and cultural lines); *id.* at 150 (noting that opponents “argue that the sale of eggs and sperm results in a series of quantifiable harms, ranging from exploiting the gamete providers to encouraging eugenics, as consumers choose the ‘best possible’ genes, to leading down the slippery slope that ends in buying children, to discrimination based on class because of who is able to buy gametes”); Ertman, *supra* note 15, at 31–32 (discussing access concerns associated with an ART market).

348. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 8; RICHARD E. JONES & KRISTIN H. LOPEZ, HUMAN REPRODUCTIVE BIOLOGY 450 (3d ed. 2006) (The cost of one IVF cycle alone in 2002 was \$12,400.).

349. Daar, *supra* note 341, at 22; CAHN, TEST TUBE FAMILIES, *supra* note 1, at 136 (“Even for workers with health insurance, infertility services will probably not be covered.”).

350. Michele Goodwin is persuasive as to how the supply of organs could be increased with legitimate markets, which might benefit the very people many worry are harmed by markets. See Goodwin, *supra* note 68 *passim*.

351. Cf. *id.*; Mahoney, *supra* note 73, at 214–15 (“[P]ayments to those who have the right to agree to donate . . . organs could cause an increase in the supply of transplantable organs available,” which “could in turn decrease the costs of transplant procedures,

fully address cost and therefore cannot overcome these financial barriers. Indeed, as I suggested above, a feature of free markets is usually unequal participation in the market.³⁵²

Although evidence suggests that free markets may increase the supply of reproductive materials,³⁵³ complicated mechanisms are at work in baby markets that still limit access. First, in spite of the increased supply of reproductive material, prices for *some* ova have actually gone up as niche markets emerge in response to consumer demand for reproductive material from sellers with certain traits.³⁵⁴ Moreover, medical costs associated with bringing about pregnancy³⁵⁵ will not decrease simply because more reproductive material is available. These costs alone make infertility treatment prohibitively expensive for many and cannot drop to affordable levels for those facing economic hardships simply because more ova and sperm are available. Without some sort of mechanism to assist those who are priced out, access will remain an issue even with unfettered baby markets.

Judith Daar offers a nice discussion of the possible solutions to and complexities of these financial barriers, which unfortunately are not limited to ART; they pervade the delivery of healthcare generally in this country.³⁵⁶ She observes that simply mandating health-insurance coverage of infertility treatment, as some states have done, may “have little or no overall effect on the use of [fertility] treatments in the United States.”³⁵⁷ This is not entirely surprising given that health insurance is

resulting both in more operations and in increased accessibility of medical care for the less affluent.”).

352. See *supra* text accompanying note 346.

353. Kerry Howley, *Ova for Sale*, REASON, Oct. 2006, at 18 (describing how prohibitions or caps on compensation “dry up” “donations,” as illustrated by the two to eight year waiting lists in Britain, which imposes caps, and the “reproductive tourism” of individuals seeking to avoid the strictures of Britain, Australia, and Canada); see also Carbone & Gottheim, *supra* note 4, at 523.

354. See Stock, *supra* note 68, at 27 (noting that the supply of ova is not low, just the supply of high priced ova, which are valued accordingly); *infra* Part VI.

355. The cost of one IVF cycle alone in 2002 was \$12,400. Jones & Lopez, *supra* note 348, at 450. Given that most couples will repeat the procedure an average of four times and that the chance of having a live birth with any cycle is twenty-eight percent, the average expenditure for IVF per live birth is about \$60,000. *Id.*

356. Daar, *supra* note 341, at 36–38; see also CAHN, TEST TUBE FAMILIES, *supra* note 1, at 141 (discussing the disproportionate access to general healthcare coverage experienced by American minority groups).

357. Daar, *supra* note 341, at 37, 40 (noting, for example, that “disparities in access to infertility treatment continue to exist along racial and ethnic lines” in Massachusetts, which has a “comprehensive mandate to provide infertility services”); see also JESSICA ARONS, CTR. FOR AM. PROGRESS, FUTURE CHOICES: ASSISTED REPRODUCTIVE TECHNOLOGIES AND THE LAW 8–11 (2007), <http://www.americanprogress.org/issues/2007/>

tied to employment.³⁵⁸ The uninsured are of course not affected by such mandates. Because they generally represent a lower socioeconomic group than the insured, the uninsured are far less likely to have the resources to pay out-of-pocket for such treatments.³⁵⁹ Ultimately, “socioeconomic status and to a lesser extent employment status, significantly affect one’s ability to access ART services in the United States.”³⁶⁰

One solution to these financial barriers is universal access to health insurance that covers ART treatment. Political resistance to universal healthcare aside,³⁶¹ however, deciding to provide healthcare to all does

12/pdf/arons_art.pdf (describing the various state policies regarding insurance coverage and infertility treatment).

358. See Matthew Kanter, *Healthy Start: A Policy and Legal Analysis of Health Care Reform in Massachusetts*, 2 MCGILL J. L. & HEALTH 65, 72 (2008) (“[O]ne of the biggest problems in the American health insurance market today [is that] people drift in and out of insurance coverage as their employment status changes . . .”).

359. Daar, *supra* note 341, at 37 (“Because insurance mandates only affect individuals who have access to private health insurance, this group is generally wealthier and more likely to be employed than the general population. These are often the same individuals who can access ART with their own resources; thus the marginal benefit from insurance coverage tends not to increase usage among the insured.”).

360. *Id.* at 38 (noting that “one part of the solution to unequal access to infertility treatment may rest in improving coverage by employer-sponsored insurance among those most likely to need ART services”).

361. While our nation has periodically flirted with universal access to health insurance, the cultural and political resistance to universal insurance has always prevailed. Morning Edition: *Health Care Back in the National Spotlight* (NPR radio broadcast Mar. 19, 2007) (noting that the flirtation occurs with the frequency of the arrival of the cicadas), available at <http://www.npr.org/templates/story/story.php?storyId=8941004> (follow “listen now” hyperlink). A recent survey, however, indicates that “Americans across party lines [would be] willing to make some sacrifice to ensure that every American has access to health insurance.” Robin Toner & Janet Elder, *Most Support U.S. Guarantee of Health Care*, N.Y. TIMES, Mar. 2, 2007, at A1. A recent New York Times/CBS News poll found that a majority of Americans say that the federal government should “provide national health insurance.” CBS News / New York Times Poll, *American Public Opinion: Today vs. 30 Years Ago* (Feb. 1, 2009), http://www.cbsnews.com/htdocs/pdf/SunMo_poll_0209.pdf. Barack Obama’s victory in the presidential campaign is consistent with these beliefs given that a significant part of his platform was a promise to reform healthcare and make “health insurance affordable and accessible to all.” Obama Biden Health Care, <http://www.barackobama.com/issues/healthcare/> (last visited Feb. 3, 2009); see also Senator Barack Obama, *The Time Has Come for Universal Health Care*, Address before the Families USA Conference (Jan. 25, 2007) (“In the 2008 campaign, affordable, universal health care for every single American must not be a question of whether, it must be a question of how. We . . . will have universal health care in this country by the end of the next president’s first term.”); President-elect Barack Obama, Remarks at a Health Care Briefing Press Conference in Chicago (Dec. 11, 2008) (“The time has come this year in this new administration to modernize our health care system for the 21st century, to reduce costs for families and businesses, and to finally provide affordable, accessible health care for every single American.”) (transcript available at

not answer the difficult question of whether we should treat ART like other kinds of healthcare, i.e., whether we are morally obligated as a society to overcome the obstacles of infertility in the same way we are obligated to treat illnesses like cancer and diabetes. Not everyone who believes that all Americans should have access to health insurance believes that insurance should cover such treatment; many view infertility treatment as discretionary.³⁶² Of course, others disagree. For instance, the American Society for Reproductive Medicine defines infertility as a “disease of the reproductive system” and “NOT an inconvenience.”³⁶³ In addition, the consensus among courts is that infertility is a medical illness.³⁶⁴

Recent findings about the corollary public health issues associated with the expensive costs of infertility treatment may influence this debate. While some are completely priced out of the expensive ART market, others are *almost* squeezed out. Having scraped together enough

<http://www.nytimes.com/2008/12/11/us/politics/11text-obama.html>). As Congress battles over the details of healthcare reform, however, some of the public's enthusiasm for such reform seems to be waning a bit. Adam Nagourney & Megan Thee-Brenan, *New Poll Finds Growing Unease on Health Plan*, N.Y. TIMES, July 30, 2009, at A1 (noting that 69 percent of people polled feared “the quality of their own care would decline” if everyone received healthcare coverage, although 66 percent feared the loss of their own insurance without healthcare reform).

362. Daar, *supra* note 341, at 26.

363. American Society of Reproductive Medicine: *Frequently Asked Questions About Infertility*, <http://www.asrm.org/Patients/faqs.html> (last visited Mar. 10, 2009) (defining infertility as “a disease of the reproductive system that impairs the body's ability to perform the basic function of reproduction”); *See also* Kristen P. Wright & Julia V. Johnson, *Infertility*, in DANFORTH'S OBSTETRICS & GYNECOL. 705, 705 (Ronald S. Gibbs et al. eds., 10th ed. 2008); Spar & Harrington, *supra* note 3, at 68 (arguing that we should treat “infertility as a medical condition and incorporat[e] it into our health care system”). *But cf.* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES FOR WOMEN'S HEALTH CARE 330, 330 (William H.P. Herbert et al., 2d ed. 2002) (“There is a great emphasis in modern society to have only the number of children desired at the time in a woman's reproductive life that is most convenient. Thus many couples seek fertility services to overcome acquired diseases, enhance the naturally decreasing fertility associated with age, and accommodate their lifestyle agendas.”). Infertility might fall within the American with Disabilities Act because, as the Supreme Court found in *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998), reproduction is a major life activity. Of course this does not mean that an insurance plan must cover infertility treatment. *See Saks v. Franklin Covey Co.*, 316 F.3d 337, 340–41 (finding no ADA violation in failing to cover infertility treatments if the insurer denied such benefits to both fertile and infertile people); *see* Jessica L. Hawkins, Note, *Separating Fact from Fiction: Mandated Insurance Coverage of Infertility Treatments*, 23 WASH. U. J.L. & POL'Y 203, 208 (2007).

364. *See* Daar, *supra* note 341, at 29–30 (discussing the concept of infertility as a medical illness); *id.* at 44 (stating “the consensus among courts that infertility is a ‘medical illness’”).

money to afford a single IVF cycle, they are likely to choose to implant multiple embryos to increase the chances of bringing a child to term.³⁶⁵ Unfortunately, this also increases the risk of multiple births and all of the attendant health consequences to babies likely to be born prematurely.³⁶⁶ A recent study found that “patients prefer to transfer one embryo when freed from financial pressures to transfer multiple embryos, which can occur when patients have limited or no insurance to pay for treatment.”³⁶⁷ Thus government funding or insurance coverage of IVF, in reducing the need to implant more than one embryo, would reduce the public health risk and enormous costs of multiple births.³⁶⁸

The debate as to whether infertility treatment should be included in health-insurance coverage highlights the differences between financial barriers to access and discriminatory barriers. The former problems raise questions as to how we understand infertility treatment and the very difficult and inevitable rationing questions posed by attempting to provide healthcare to all. In other words, are we morally obligated as a society to make sure that everyone is entitled to infertility treatment, or is our obligation merely to ensure that no one is prevented access for discriminatory reasons? Inequity is always problematic, but inequity based on price differentials and inequity based on discrimination present different moral problems and concerns. I turn now to the latter, more serious, inequity: discriminatory barriers based on minority status.

B. Minority Status

As Professor Roberts has shown, minority status is another well-known barrier to accessing reproductive technologies.³⁶⁹ Assisted reproductive technologies are “accessible largely to white, middle- to upper-class infertile couples” because it is a “private, fee-for-service” treatment.³⁷⁰ This is both because of significant disparities in health-insurance

365. Stuart Laidlaw, *Fund IVF, Experts Urge Government*, TORONTO STAR, Feb. 11, 2009, at L1.

366. *Id.*

367. *New Study Proves Multiple Births From IVF Can Be Avoided*, P.R. NEWSWIRE, Feb. 3, 2009 <http://www.newscom.com/cgi-bin/prnh/20090203/DC66439LOGO>.

368. *Id.*; Laidlaw, *supra* note 365, at L1.

369. See generally Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935 (1996); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 141–42.

370. Marcia C. Inhorn & Michael Hassan Fakh, *Arab Americans, African Americans, and Infertility: Barriers to Reproduction and Medical Care*, 85 FERTILITY & STERILITY 844, 844 (2006); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 141.

coverage between minorities and non-minorities³⁷¹ and overall socioeconomic differences between these groups.³⁷² The relative lack of access to treatments of infertility among minorities is exacerbated by the fact that minority women are proportionately more likely to be infertile than white women.³⁷³ Distrust among some minorities of the healthcare profession generally, and with respect to reproductive technologies specifically, may make them “far less likely to seek treatment” than non-minorities.³⁷⁴ Much of this distrust may stem from a history of discrimination against minority groups within the healthcare system.³⁷⁵ It may also be heightened by fears that some physicians believe minorities shouldn’t be having any more children.³⁷⁶ Shame may also keep some minority women away from attempting to access such services.³⁷⁷

In part, the solution lies with efforts to address economic disparity along racial lines, but it also requires efforts to address underlying discrimination by healthcare providers, which may help overcome suspicion towards the medical community by some minority groups.³⁷⁸ Unfortunately, civil rights litigation has not been effective in addressing problems of inequity in healthcare generally.³⁷⁹ “As plaintiffs have often

371. Daar, *supra* note 341, at 39–40 (noting that thirty-three percent of Hispanics, twenty percent of blacks, but only eleven percent of whites, lack health insurance); CAHN, TEST TUBE FAMILIES, *supra* note 1, at 141–42 (“Since higher educational levels and greater financial means are more common among white women than among Hispanic and black women, seeking infertility services has also been more common among whites.”).

372. Daar, *supra* note 341, at 41.

373. *Id.* at 22.

374. *Id.* at 39–40 (noting that a study found that “Arab and African Americans . . . regard the U.S. health system with a degree of suspicion and distrust, based on past experiences of racism and discrimination”).

375. See, e.g., Paul A. Lombardo & Gregory M. Door, *Eugenics, Medical Education, and the Public Health Service: Another Perspective on the Tuskegee Syphilis Experiment*, 80 BULL. HIST. MED. 291 (2006).

376. Daar, *supra* note 341, at 41.

377. See DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY* 259 (1997) (describing one black woman’s shame in her infertility: “Being African-American, I felt that we’re fruitful people and it was shameful to have this problem”).

378. INST. OF MED. & NAT’L ACADS. OF SCIS., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 172–75 (2003) (discussing physician prejudices and bias and the resulting patient mistrust as being a source of healthcare disparities among minority populations); Daar, *supra* note 341, at 42.

379. See, e.g., Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinventing the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL’Y, L. & ETHICS 215, 220, 229 (2003) (Although “the legislative history of Title VI [of the Civil Rights Act] indicates that health care was prominent in the minds of its authors, . . . [p]laintiffs in the few Title VI health care cases that have been litigated over the years have tended not

failed to prevail in cases dealing with the provision of basic medical services . . . pursuing a case against a provider for refusing to provide what is often viewed as discretionary services seems impossible.”³⁸⁰ We might better direct our efforts toward influencing the attitudes of healthcare providers and addressing the minority communities’ deep distrust. One approach would be to increase sensitivity and awareness between the infertility industry and minorities by increasing interactions between these groups.³⁸¹ Training of medical professionals could focus on some service to minority communities.³⁸² Minority populations and the population at large would also be served by education regarding infertility, its treatments and causes.³⁸³ As Nanette Elster has suggested, “the infertility industry [could] become more patient-friendly to racial and ethnic minorities by, for example, lobbying to increase insurance coverage for ART services, locating fertility clinics in more diverse neighborhoods, and increasing public awareness in minority communities about infertility and its treatment.”³⁸⁴

C. Marital Status

Finally, marital status can influence one’s access to infertility services because of discrimination by providers or legislators who are uncomfortable with unmarried individuals using ART. One survey showed that roughly twenty percent of providers refuse to provide such services to unmarried women.³⁸⁵ A recent case, *North Coast Women’s Care Medical Group v. Superior Court*,³⁸⁶ illustrates these views. The plaintiff,

to fare well.”); Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1026 (2005) (“Despite [its] promise, Title VI [of the Civil Rights Act] has not prevented the massive hospital closures and removal of critical services from minority communities.”).

380. Daar, *supra* note 341, at 42 (noting that “attempts to address racial discrimination in health care via traditional civil rights litigation under existing statutory schemes have proved frustrating for private individuals, who often must show intentional discrimination on the part of the health care provider.”).

381. *Id.*

382. *Id.*

383. *See id.*

384. Daar, *supra* note 341, at 42 (discussing idea from Nanette R. Elster, *ART for the Masses? Racial and Ethnic Inequality in Assisted Reproductive Technologies*, 9 DEPAUL J. HEALTH CARE L. 719, 731–33 (2005)).

385. *See* Andrea D. Gurmankin et al., *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61, 65 (2005).

386. 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006), *review granted*, 139 P.3d 1 (Cal. 2006), *superseded by* 189 P.3d 959 (Cal. 2008).

Guadalupe Benitez, was a lesbian woman who had tried with her partner to conceive with self-insemination.³⁸⁷ After no success for fifteen years, she sought medical services for intrauterine insemination, which the North Coast doctors refused to provide, claiming it went against their religious beliefs.³⁸⁸ Although the California Supreme Court ultimately ruled that the physician's acts violated "California's Unruh Civil Rights Act . . . prohibition against discrimination based on a person's sexual orientation,"³⁸⁹ not all states have similar antidiscrimination statutes to protect against such discriminatory impulses among healthcare providers,³⁹⁰ which unfortunately are "not unusual."³⁹¹ Moreover, it is not clear whether even in California, Benitez would have been protected against discrimination if she were denied treatment because she was single, as opposed to being a lesbian.³⁹²

387. *N. Coast Women's Care Med. Group*, 189 P.3d at 963 n.1 (summarizing the holdings of the trial and appellate courts, which said that a healthcare provider could discriminate based on marital status).

388. *N. Coast Women's Care Med. Group*, 189 P.3d at 963 n.1. A question of fact was raised as to whether the religious objection was based on the plaintiff's sexual orientation or her marital status. The appellate court ruled that at the time of the suit, no law prohibited discrimination based on marital status. As a result, the trial court was instructed to determine the basis of the religious objection. *Id.*

389. *N. Coast Women's Care Med. Group* 189 P.3d at 962. The court rejected the arguments of the physicians that "the rights of religious freedom and free speech, as guaranteed in both the federal and the California Constitutions, exempt a medical clinic's physicians from complying with" the antidiscrimination provisions. *Id.*

390. Susan B. Apel, *Access Denied: Assisted Reproductive Technology Services and the Resurrection of Hill-Burton*, 35 WM. MITCHELL L. REV. 412, 416 (2009) ("Some state laws that prohibit discrimination on the basis of marital status and sexual orientation exist, but they are spotty in the sense that many states have no such legislation and those that do vary in the kinds of discrimination they prohibit and to which kinds of entities they apply"); Susan B. Apel, *Access to Assisted Reproductive Technologies*, 12 MICH. ST. U. J. MED. & L. 33, 38–39 (2008) [hereinafter Apel, *Access to ART*] ("At least ten states have [civil rights laws] that include both marital status and sexual orientation. Whether the state prohibitions apply to fertility clinics is a troublesome issue. State legislation tends to follow the federal law in prohibiting discrimination in employment and in public accommodations. The law as to whether fertility clinics constitute public accommodations is subject to dispute.") Although the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology "frown[] upon discrimination against same-sex individuals and single people," they "uphold the ability of providers to make decisions about access based upon the providers' judgments regarding the welfare of the potential child." Apel, *supra* at 416–17. Moreover, these positions "are advisory in nature" and there are no corresponding "effective enforcement mechanisms." *Id.* at 417.

391. *Id.* at 412 (2009) ("Surveys of fertility clinics in the United States show that this kind of discrimination is not unusual").

392. *Id.* at 417. *See* note 388 (observing that there was a question of fact as to the basis of the discrimination).

Another barrier to obtaining infertility services is created by legislatures that try to prevent unmarried individuals from accessing these technologies.³⁹³ Texas, Florida, Nevada, and New Hampshire, for example, appear to allow only married couples to enter into legally enforceable gestational surrogacy contracts.³⁹⁴ Legislators in a few states have tried explicitly to prohibit healthcare providers from offering medi-

393. Such statutes raise equal protection concerns under the Fourteenth Amendment of the United States Constitution. As Professor Radhika Rao has argued, such statutes would be unconstitutional because they would “treat the very same act—the use of a particular technology—differently based upon the marital status or sexual preference of the persons involved, with no real basis for the distinction other than societal disapproval or prejudice.” Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457, 1475–76 (2008) This, she argues, would be no different than a law regulating the distribution of contraception of unmarried individuals, which was found unconstitutional in *Eisenstadt v. Baird*. *Id.* at 1475. I have argued, however, that we cannot presume that the constitutional protections that apply to decisions concerning contraception and abortion necessarily apply to decisions to use ART technologies like IVF. Suter, *Repugnance*, *supra* note 224, at 1520–64. If the interest in using ART is not considered a fundamental constitutional interest, than the state need only find a rational basis for prohibiting the access of these technologies to some individuals. As Rao notes, the state prohibition of “the use of ARTs is permissible as long as it is based upon a legitimate interest that goes beyond mere prejudice. The government could limit the use of ARTs in order to prevent physical, psychological, or social harms to the participants or the resulting children.” Rao, *supra*, at 1479. State concerns about the welfare of children raised in a single-family household would likely be such a legitimate interest that is not based on prejudice.

394. See Daar, *supra* note 341, at 46 (citing TEX. FAM. CODE ANN. § 160.754(b) (West 2006); FLA. STA. ANN. § 742.15(1) (West 2006)); see also NEV. REV. STAT. ANN. § 126.045 (LexisNexis 2004) (restricting surrogacy agreements to people “whose marriage is valid” under Nevada law and defining “intended parents” as “a man and a woman, married to each other”); N.H. REV. STAT. ANN. § 168-B:1 (West 2002) (appearing to allow only married couples to enter into surrogacy contracts since “[i]ntended parents,’ including an ‘intended father’ and ‘intended mother,’ means people who are married to each other, and who . . . enter into a surrogacy contract with a surrogate by which they are to become the parents of the resulting child”). In a related vein, the Arkansas electorate recently voted in favor of an initiative that prohibits people cohabiting outside of a valid marriage from adopting a child or becoming a foster parent of someone less than eighteen years of age. Ark. Proposed Initiative Act 1 (Unmarried Couple Adoption Ban) (2008). Similarly, many state laws regarding donor insemination only discuss married couples. Human Rights Campaign, Donor Insemination, http://www.hrc.org/issues/parenting/donor_insemination/donor_insemination_laws.asp (last visited Feb. 2, 2009) (describing such statutes from Alabama, Alaska, Georgia, Illinois, Kansas, Massachusetts, Minnesota, Missouri, Montana, Nevada, New York, North Carolina, Oklahoma, and Tennessee). Some state laws, however, expressly or implicitly appear to allow unmarried women to undergo artificial insemination. See *id.* (describing statutes from Arkansas, California, Colorado, D.C., Idaho, Kentucky, Louisiana, Maine, Michigan, New Hampshire, New Jersey, New Mexico, Texas, and Wisconsin).

cal services to assist unmarried women in conceiving or procreating.³⁹⁵ These efforts have not yet succeeded, which has prompted some legislators to try to achieve these goals through less overtly discriminatory language. In 2006, State Senator Marshall of Virginia, introduced “a watered-down”³⁹⁶ bill that would prohibit the use of “anonymous donations of gametes” and require that “the identity of any unrelated oocyte or sperm donor . . . be noted in the health record of any woman patient” seeking assisted conception.³⁹⁷ While this might seem consistent with my argument that anonymity threatens children’s relational autonomy interests in knowing their genetic heritage,³⁹⁸ this law is clearly motivated by something different. It allows the intended mother to have this information, rather than just allowing the child to access such information upon the age of majority, a very different kind of proposal indeed. By tapping into the debate regarding anonymity of donors, Senator Marshall seems determined to do indirectly (and in a less overtly polarizing way) what he was not able to achieve with explicitly discriminatory legislation.³⁹⁹ His bill has not been enacted so far.⁴⁰⁰

Some have suggested that free markets can help overcome some of these non-financial barriers. As Martha Ertman points out, unfettered market in gametes and embryos can help individuals, who might otherwise be discriminated against by the Senator Marshalls of the world, to

395. Daar, *supra* note 341, at 43; Mary Beth Schneider, *Assisted Reproduction Bill Dropped*, INDIANAPOLIS STAR, Oct. 6, 2005, at 2B (describing a bill introduced in late 2005 by an Indiana State Senator that would have required couples seeking medical assistance in reproduction to be married to one another, but which was ultimately dropped because the Senator found the “issue has become more complex than anticipated”). A Virginia House Bill introduced in early 2006, which stated, “No individual licensed by a health regulatory board shall assist or perform any intervening medical technology . . . for or on an unmarried woman that completely or partially replaces sexual intercourse as the means of conception.” Daar, *supra* note 341, at 43. It was ultimately dropped two weeks later. *Id.*

396. A. Barton Hinkle, Editorial, *Marshall Mans the Barricades Against Child-Hating Lesbians*, RICHMOND TIMES-DISPATCH (Va.), Dec. 12, 2006, at A13.

397. H.B. 412, 2006 Gen. Assem., Reg. Sess. (Va. 2006) (introduced Jan. 11, 2006, continued to 2007). *See also* H.B. 2123, 2007 Gen. Assem., Reg. Sess. (Va. 2007) (a bill that would amend a statute relating to disclosure or risks associated with infertility treatment, and which would not allow anonymous donations).

398. *See supra* Part IV.

399. *Cf.* Daar, *supra* note 341, at 46 (describing such attempted legislation as appearing “facially neutral in terms of the marital status of the woman patient” but as potentially having “the most dramatic impact on single and lesbian women”).

400. H.B. 2123, 2007 Gen. Assem., Reg. Sess. (Va. 2007), was passed by indefinitely by the House Committee on Health, Welfare and Institutions, while H.B. 412, 2006 Gen. Assem., Reg. Sess. (Va. 2006), was continued to 2007, with no action to date.

make self-defining reproductive choices.⁴⁰¹ Truly free markets, with no discriminatory or other forms of government intervention, would allow marginalized groups to negotiate their own fertility arrangements. The problem is that history suggests that we are unlikely to witness such a broad scope of freedom of contract across the country.⁴⁰² Intellectual consistency might require supporters of free markets to oppose any limits on people's ability to enter into contracts, even unmarried individuals seeking infertility treatment. But of course, consistency is not a requirement for being a legislator. Many who theoretically support free markets may be the very ones who object to single people's accessing these markets.

Moreover, there is no guarantee that a completely unregulated private market will offer the types of choices that Ertman advocates.⁴⁰³ The private market will likely reflect majoritarian preferences, choosing to exclude certain groups from accessing ART in the same discriminatory fashion as the physicians in *North Coast Women's Care Medical Group*.⁴⁰⁴ Undoubtedly, some niche markets will arise to provide ART for otherwise marginalized groups,⁴⁰⁵ and surely this is better than an outright prohibition of their use of ART. Nevertheless, niche markets do not offer the full access that could theoretically be available if the law restricted the kind of discrimination that undergirds these exclusions.⁴⁰⁶

401. Ertman, *supra* note 15, at 35 (arguing that the baby market opens the option of parenthood to "previously excluded individuals[,] such as same sex couples).

402. *Cf.* Apel, *Access to ART*, *supra* note 390, at 44 (2008) ("In the United States, it is difficult to predict whether state and/or federal legislation in this area would be permissive or restrictive.").

403. *See* Ertman, *supra* note 15, at 41.

404. *See* Daar, *supra* note 341, at 43 (Under the current free market approach to ART, "single women and same-sex couples face reduced access from . . . provider discrimination against single and lesbian women Documented cases of provider discrimination against single women and lesbian couples are few, but recent research suggests that such conduct is widespread."); *see also* Apel, *Access to ART*, *supra* note 390 at 41 ("In the absence of law, decisions regarding access to ART are made by fertility clinics and health care professionals. In the only published survey of ART clinics on this issue . . . 79% of the responding clinics treated single women and 74% lesbian couples.").

405. *See* Carbone & Gottheim, *supra* note 4, at 535–37 (describing Rainbow Flag Services).

406. There is, however, some question as to whether antidiscrimination statutes would actually achieve full access. "Despite the governmental crackdown, discriminatory practices continue." *See MPs Challenge Fertility Clinic Ban on Lesbians*, *GUARDIAN*, July 3, 2006, at 7, available at <http://www.guardian.co.uk/uk/2006/jul/03/politics.gayrights>. A similar problem has arisen in Canada, where fertility clinics are specifically disabled from refusing treatment on the basis of sexual orientation. *See Lesbian Couples Say Hospital Denied Them In Vitro Fertilization*, *CBC NEWS*, Jan. 13, 2005, <http://www.cbc.ca/canada/montreal/story/2005/01/13/mon-lesbian-050113.html>.

Discrimination based on sexuality or marital status is in and of itself inherently problematic. But arguably discrimination in the delivery of ART services on this basis is also consequentially problematic. Such discrimination may create public health risks because “single women and same-sex couples that are otherwise excluded from access to infertility services often use other means to get access, leading to public health risks to both the woman and the child to be born.”⁴⁰⁷ Thus, if we are concerned about marginalization based on sexuality or marital status, we should find mechanisms under the law to prohibit discrimination in the delivery of ART based on marital status or sexual orientation.

Professor Susan Apel suggests that the Hill-Burton Act,⁴⁰⁸ which was enacted, in part, to make sure that healthcare services are provided to everyone within the territorial area of healthcare facilities that receive federal funds,⁴⁰⁹ can be interpreted to prohibit discrimination to ART based on “marital status, sexual orientation, or other non-medical reasons.”⁴¹⁰ Apel does note that the biggest obstacles to such a claim are state and federal conscience clauses, allowing providers to refuse to perform procedures like abortion or sterilization based on moral or religious objections.⁴¹¹ Nevertheless, she aptly points out that there is a significant distinction between a provider’s refusal to perform a particular *procedure* on moral grounds and a provider’s refusal to perform a particular procedure “depending on the identity or characteristics of an individual patient.”⁴¹² At this point, however, it remains to be seen whether courts will interpret the Act as she suggests, particularly since there has been very little litigation focusing on these provisions of the statute.⁴¹³

Given the uncertainties as to how courts will interpret the Hill-Burton Act, legislatures should expressly prohibit discrimination in the

407. Crystal Liu, *Restricting Access to Infertility Services: What is a Justified Limitation on Reproductive Freedom*, 10 MINN. J.L. SCI. & TECH 291, 321(2009).

408. Pub. L. No. 79-725, 60 Stat. 1041 (1946) (codified as amended at 42 U.S.C. §§ 291–291m); Pub. L. No. 93-641, 88 Stat. 2268 (1975) (codified as amended at 42 U.S.C. §§ 300q-300r).

409. Apel, *supra* note 390, at 418.

410. *Id.* at 423.

411. *Id.* at 428–30 (noting that while some of these clauses focus on procedures that might seem to be the antithesis of ART, “there is a synchronicity of cultural values that might make bedfellows of those who oppose abortion and those who oppose ART, at least for some patients” and that some of these conscience clauses are “not restricted to abortion and sterilization, but to all kinds of medical procedures”).

412. *Id.* at 430; *see also id.* at 431 (noting that conscience clauses, “like all legally protected rights, . . . must balance the patient’s need with the provider’s rights to act in accordance with moral convictions”).

413. *Id.* at 419.

delivery of ART based on marital status or sexual orientation. To give teeth to such prohibitions, legislatures should make clear that antidiscrimination provisions with respect to the delivery of medical services include the treatment of infertility.⁴¹⁴ A more difficult political problem is how to deal with legislatures that express discriminatory views in their efforts to limit access to infertility services to married or heterosexual couples. Trying to persuade the Senator Marshalls of the world not to introduce discriminatory legislation, let alone to pass legislation aimed at preventing the very discrimination they seek, is a serious challenge, which goes to the heart of the political battles surrounding marriage, reproduction, and sexuality.⁴¹⁵ But simply relying on unfettered markets to achieve the antidiscrimination goals will be ineffective in the face of such discriminatory views.

As I have suggested throughout this piece, the consequential harms of baby markets are too great and varied to leave these markets unrestricted. Deciding whether we should allow reproductive material to be bought and sold does not answer whether markets should be unfettered. The fact that we have baby markets and still encounter such discrimination is further reason not to depend on markets alone to solve these problems. We should instead focus on the kinds of transactions that will be allowed to occur and whether they are subject to the discriminatory barriers described above.

414. Daar, *supra* note 341, at 30–31 (noting that even though courts view infertility as an illness, it doesn't follow that they consider its treatment to be a medical service); *id.* at 31 n.40 (describing cases that disagree as to whether infertility should be treated as an illness for purposes of litigation concerning health-insurance coverage); see *supra* text accompanying notes 362–364 (noting that this is a contentious issue; courts vary in their views as to whether infertility treatment constitutes medical treatment for purposes of litigation concerning health insurance).

415. Some of these political battles were lost recently by the groups opposing discrimination. In Arizona, California, and Florida, voters passed propositions that only recognize marriage between one man and one woman. See Ariz. Proposition 102 (2008), <http://www.azsos.gov/election/2008/Info/PubPamphlet/english/Prop102.pdf> (last visited Feb. 14, 2009); Cal. Proposition 8 (2008), <http://www.voterguide.sos.ca.gov/text-proposed-laws/text-of-proposed-laws.pdf#prop8> (last visited Feb. 14, 2009); Fla. Marriage Prot. Amend. 2 (2008), <http://election.dos.state.fl.us/initiatives/fulltext/pdf/41550-1.pdf> (last visited Feb. 14, 2009); see also Jesse McKinley & Laurie Goodstein, *Bans in 3 States on Gay Marriage*, N.Y. TIMES, Nov. 5, 2008, at A1 (noting that the above propositions were passed); but see Marie Szaniszló, *5th Anniversary for Gay Weds*, BOSTON HERALD, May 17, 2009, at 10 (“Connecticut, Iowa, Maine, and Vermont have all legalized gay marriage this spring. . . .”); Abby Goodnough, *New Hampshire Legalizes Same-Sex Marriage*, N.Y. TIMES, Jun. 4, 2009, at A19 (noting that New Hampshire is the sixth state to legalize gay marriage). As Professor Apel notes, the infertility medical services are unique in that they result in a child, and therefore they raise issues about lifestyle and the welfare of the child. Apel, *supra* note 391, at 414.

VI. EUGENICS

Finally, another potential danger of baby markets is the eugenics-like effect of market preferences. As Gregory Stock has noted, there really is no shortage of gametes.⁴¹⁶ Instead, there is only a shortage of gametes from sellers with particular characteristics.⁴¹⁷ Ova from white Ivy League students, with model-like proportions, for example, can command prices as high as \$50,000 or even \$100,000,⁴¹⁸ whereas a typical ovum goes for \$3,000–5,000.⁴¹⁹ And sperm from donors with advanced degrees may sell for more than other sperm.⁴²⁰ Recently the first made-to-order embryo bank was created, allowing couples to have embryos designed according to their particular preferences.⁴²¹ In short, the market prices reproductive material according to consumer predilections. Not surprisingly, these preferences reflect the traits that the privileged in our culture deem socially desirable and advantageous.⁴²² To many, this is, quite simply, a form of eugenics.⁴²³

416. Stock, *supra* note 68, at 27.

417. *Id.* (arguing that “there is no shortage of donors in general, just a shortage of donors with certain profiles of intelligence, beauty, education, religion, and other factors”).

418. CAHN, TEST TUBE FAMILIES, *supra* note 1, at 148 (describing the price of a “desirable” egg being more than \$50,000); Carbone & Gottheim, *supra* note 4, at 515 (describing prices as high as \$50,000); Couple Seeks Eggs for \$100,000, *supra* note 4, at A16 (describing prices as high as \$100,000); Steinbock, *supra* note 35, at 259 (describing an ad to pay an egg donor \$80,000 if the donor had preferred traits: “height approximately 5’6”, Caucasian, S.A.T. score around 1250 or high A.C.T., college student or graduate under 30, no genetic medical issues”).

419. SPAR, *supra* note 4, at 45.

420. CAHN, TEST TUBE FAMILIES, *supra* note 1 at 148 (A “vial of sperm . . . can cost between \$200 and \$600, although sperm from donors with advanced degree . . . may cost more.”).

421. Martin, *supra* note 12, at 7 (describing an embryo bank’s new service allowing couples to purchase a made-to-order embryo based on particular traits and qualities).

422. Kari L. Karsjens, *Boutique Egg Donations: A New Form of Racism and Patriarchy*, 5 DEPAUL J. HEALTH CARE L. 57, 78 (2002) (“[T]he entire premise of boutique egg donation is to perpetuate certain characteristics that are deemed salient by a select few. Wealthy couples, who utilize egg brokers or high profile advertisements, do not seek general traits. These couples are seeking a ‘perfect gene pool’ for their commodity—notice the highly sought after donor is a woman who has blonde hair, blue eyes, received a 1400 on her SAT, attends an Ivy League school, and who preferably has some additional talents such as music, sports, or theatre.”).

423. Karsjens, *supra* note 422, at 87 (“[T]ruly, it is now arguable that medical technologies are on the slippery slope to eugenics or racial brokering.”); Jeffery T. Wise, *Embryo Banking as a Novel Option for the Infertile? Law, Policy, and a Proposed Model Act*, 8 HOUS. J. HEALTH L. & POL’Y, 163, 184 (2007) (“The primary arguments against embryo banking are that the practice leads to a commodification of human life and that it constitutes another step in the direction of eugenics.”).

Such a characterization of baby markets is loaded and dismisses all such choices as bad. Because I recently explored what it means to describe advanced reproductive technologies as eugenic, and whether all eugenic choices are per se morally problematic,⁴²⁴ I only briefly address the eugenics concern here. One view is that these market choices are an expression of individual procreative autonomy and therefore are quite different from the eugenics of the early twentieth century, when policy makers tried to influence “the fit” to reproduce and discourage “the unfit” from reproducing (often through laws mandating involuntary sterilization).⁴²⁵ Under this view, these market preferences are simply an expression of reproductive choice made free of government interference, which is consistent with a liberal conception of autonomy.⁴²⁶

I have argued, however, that if we analyze attempts to control reproduction under a relational conception of autonomy, the moral propriety of such choices depends heavily on context, motivations, and intentions.⁴²⁷ Evaluating consumer choices in baby markets under the lens of relational autonomy suggests that some features of classic eugenics may sometimes be present, even if people decide to purchase particular reproductive material without state coercion.⁴²⁸ For example, a particularly troubling aspect of classic eugenics was the underlying racism and social prejudice that inspired it.⁴²⁹ Some of the market preferences today reveal, and may even enhance, similar underlying prejudices and discriminatory views.⁴³⁰ Of course, they may also be

424. See generally Suter, *Brave New World*, *supra* note 16.

425. *Id.* at 905–15 (describing the history of eugenics legislation and court action in the United States); *id.* at 937–38 (“Today, selecting against undesirable births is an individual decision. In the classic eugenics era, such selection was often a decision made by the state or by physicians at prisons and institutions for the ‘feebleminded.’”).

426. *Id.* at 949 (“It seems difficult to criticize, on its face, the underlying goal of eugenics—improving birth—especially when expressed through individual decision making, without state interference. . . . Because neoeugenics involves fundamental decisions about parenting, including whether to retain the capacity to become a parent or whether actually to become a parent, some aspects of it arguably fall within a fundamental liberty or privacy interest.”).

427. *Id.* at 954 (“[T]he lens of relational autonomy focuses on intent and motivation and reveals problems with neoeugenics that are more subtle and contextual than state interference with reproductive and medical decision making.”).

428. *Id.* at 955 (“By promoting technologies to avoid the birth of children with genetic conditions or unwanted traits, we define the ‘unfit’ (though perhaps we don’t use precisely that expression) in terms of that disability or trait. This fact alone may devalue the lives of those with the trait.”).

429. *Id.* at 912 (stating that what was wrong with eugenics was the “underlying racism and class biases, reinforcement of social inequities, and threats against democracy.”).

430. *Id.* at 956 (“[I]f certain traits—e.g., short stature, gender, certain body-types, etc.—can be selected against and are widely disfavored, individual choices, in the aggregate,

based on parents' desires to have children that look like them, which does not in itself reflect any views about race or the value of particular traits. Often, the motivations may be mixed and not fully clear.⁴³¹ Nevertheless, even if the motivations themselves are not all discriminatory, the social effects of consumers valuing the reproductive material of some groups over those of others is disquieting. At best, it reflects the fact that the most privileged have greatest access to ART.⁴³² At worst, it highlights the devaluation of certain groups in our culture.⁴³³

Another concern regarding these market preferences is that they are part and parcel of contemporary efforts to control, or commodify, the process of reproduction, a criticism that can be leveled at the eugenics movement.⁴³⁴ In other words, some of these consumers are trying to "produce" babies, rather than accept reproduction as a gift.⁴³⁵ Of course, even if we assumed that all parents who pay top dollar for certain ova viewed reproduction as baby production (a questionable assumption), this does not also preclude them from accepting the resulting child as a gift, rather than (solely) as a commodity.⁴³⁶ Nevertheless, we should be

may lead to fewer people with those traits. The resulting lack of diversity . . . may contribute to a lack of tolerance for diversity and enhance existing prejudices against individuals with the particular trait.").

431. *Cf. id.* at 947 ("Just as classic eugenics was not motivated solely by social well-being, current and future reproductive technologies are advocated not solely to allow individuals to make decisions compatible with their values and goals. The technologies are also promoted and encouraged as socially responsible.").
432. *Id.* at 959 ("Those with the greatest advantages in society (and often with the traits most widely favored) will often have greater resources and therefore greater access to technologies that allow them to select against certain traits or disease or to enhance certain traits."); *see also* Daar, *supra* note 341, at 38 ("[I]t appears that socioeconomic status, and to a lesser extent employment status, significantly affect one's ability to access ART services in the United States. For wealthy individuals who can afford to pay directly for these services, access, for the most part, appears to be wide open.").
433. Suter, *Brave New World*, *supra* note 16, at 955 ("By promoting technologies to avoid the birth of children with genetic conditions or unwanted traits, we define the 'unfit' (though perhaps we don't use precisely that expression) in terms of that disability or trait. This fact alone may devalue the lives of those with the trait.").
434. *See id.* at 912–13 ("A few religious leaders, especially those of the Catholic Church, objected that eugenics threatened human dignity by commodifying and restricting reproduction."); *id.* at 969 ("[W]hen examined through the lens of relational autonomy, [neoeugenics] remains problematic when applied in ways that reflect underlying discriminatory attitudes, exacerbate inequities, or commodify individuals or reproduction.").
435. *Id.* at 960–61 ("The essence of this claim is that commodification intrinsically harms our human spirit by altering our relationship with procreation and our children because it transforms reproduction into a process akin to manufacture.").
436. *Id.* at 961 ("Simply because parents try to control the outcome of reproduction, rather than to allow things to happen 'naturally,' does not preclude them from viewing their children as a gift."); *see also* CAHN, TEST TUBE FAMILIES, *supra* note 1, at

concerned about moving in a direction that may push some parents to see their child more as object than as other. More troublesome, I believe, is the possibility of distorting the parent-child relationship if those parents demand that their children fulfill the expectations that led them to seek particular traits, or if they see their children solely in terms of the sought-after traits rather than in their fullness as human beings.⁴³⁷ Again, not all parents will have such reactions.⁴³⁸ The process of picking and choosing and trying to control the outcome of one's future child, however, may increase the possibility of such reactions among some.

Perhaps the greatest and most likely danger is that niche markets, like classic eugenics, will exacerbate social inequities. Because the price of reproductive material reflects market preferences, gametes or embryos believed to possess the most advantageous genetic material will be the priciest.⁴³⁹ "When people know that the genetic material that made a particular child's existence possible was bought for a higher (or lower) price than that of some other child, such knowledge may undermine the proposition that all persons are of equal dignity regardless of their wealth or social status."⁴⁴⁰ In addition, given that lower socioeconomic groups already face barriers to ART, the market will effectively price out all but the most socially advantaged from accessing the most highly sought-after reproductive material.⁴⁴¹ In baby markets, advantage may literally beget advantage.

In any one instance, a buyer's market preferences might not be problematic per se, but given existing inequities and racial and social prejudices, we should be troubled by the tendency to move in this direction. The problem is that we cannot condemn every choice to seek out ova or sperm from a particular kind of seller without knowing more about the reasons that one makes such a choice. Some such choices may be grounded in precisely the prejudice that made classic eugenics

146 ("Putting a price on something does not necessarily destroy its intrinsic value or indicate that it is measured only by its economic price.").

437. Suter, *Brave New World*, *supra* note 16, at 963.

438. *Id.*

439. See *supra* text accompanying note 418–419. Genetics essentialism underlies these market preferences. The presumption is that the intelligence, good looks, social status, and any other desirable traits of the seller are largely, if not exclusively, genetic. Certainly genes can play a strong role in influencing traits, but their role is stronger with respect to some traits than others. Because of the complexity of genetics and environmental influences, there is no guarantee that a child conceived with these gametes will necessarily possess the desired traits.

440. Shanley, *supra* note 278, at 272; Steinbock, *supra* note 35, at 260 (noting that John Arras "has jokingly suggested that perhaps U.S. News and World Report should include how much their coeds can get for their eggs in their rankings of colleges").

441. See *supra* text accompanying note 352–354.

problematic and therefore morally troubling.⁴⁴² But some such choices may be grounded in efforts to give one's child the best chance in life based on the reality that certain traits offer certain advantages in a society where all is not equal.⁴⁴³ This kind of choice is less morally problematic, but highlights and exacerbates the problems of a world of inequity.

Of course, preferences grounded in discrimination and prejudice will exist whether or not we buy and sell gametes. They are reflected in non-market decisions of all types, including whom to befriend, and of course whom to marry or have a child with.⁴⁴⁴ Figuring out how to address these preferences, which may reflect better or worse intentions, in a world that values reproductive autonomy is a very difficult problem, well beyond the scope of this Article. My goal here is not to solve that problem, but to address the consequential harm of markets, which exacerbate the lurking problems of prejudice and social inequity.

One solution to this problem is to set price limits on reproductive material.⁴⁴⁵ This would not address the underlying desires that drive up

442. Cf. Suter, *Brave New World*, *supra* note 16, at 969 (“Neoeugenics as a practice should trouble us if the underlying intent is not focused on the best interests of the child or family, but instead is built on discriminatory attitudes, concerns about prestige, or narrow conceptions of the full value of the future child.”).

443. *See id.* at 935.

But when major life opportunities depend so strongly on abilities (admission to good schools being the prime example), it is hard to imagine that many parents wouldn't feel subtle, or perhaps not so subtle, pressures to seek such advantages for their children. In fact, public opinion polls suggest that there may be substantial demand for genetic enhancement. Forty to forty-five percent of the American public polled in 1986 and 1992 approved of gene therapy to enhance physical and intellectual traits.

Id.

444. Ertman, *supra* note 15, at 30 (“But if we condemn would-be mothers for selecting donors who, they believe, will transmit what they deem to be socially optimal genes to their children, then we could ask the same question of both men and women who select their partners on similar grounds. If we scrutinize white single mothers' selection of white sperm donors, we should also critique white men who choose to marry white women or Harvard graduates who prefer to marry others who attended elite colleges.”); Suter, *Brave New World*, *supra* note 16, at 957 (“Of course many decisions we make as a society or individually influence who will come into existence and who will not. Decisions such as whom to marry, when or whether to procreate, as well as decisions about health policy and social services, for example, all influence who will be born and who will not.”).

445. This approach is recommended by the ASRM, which states that “[t]otal payments to donors in excess of \$5,000 require justification and sums above \$10,000 are not appropriate.” Ethics Comm. for the Am. Soc'y for Reproductive Med., *Financial Compensation of Oocyte Donors*, 88 *FERTILITY & STERILITY* 305, 305 (2007). Likewise, Professor Naomi Cahn argues for a uniform fee schedule for the purchase of gametes:

such prices, but would minimize the exacerbating effects of such markets.⁴⁴⁶ Of course, to the extent that access is already deeply problematic for many, regardless of whether they seek out the most highly priced gametes or embryos,⁴⁴⁷ it is not clear how much this would achieve. Nevertheless, it would perhaps minimize some of the coercive influence of markets discussed in Part III. \$50,000 might be much more coercive than \$3,000, for example, in enticing women to sell their ova. Allowing the sale of eggs with caps on payment would reduce those consequential effects while still offering the financial compensation necessary to maintain an appropriate supply of eggs.⁴⁴⁸

Nevertheless, I am somewhat ambivalent about this approach. For one, it starts to move us in the direction of eliminating the commodification of reproductive material. I have suggested many forms of regulation in baby markets as a compromise to address my uneasiness with baby markets. Part of my reluctant acceptance is the recognition that black markets may emerge if we try to prohibit them. While black markets are a threat any time we try to regulate baby markets, they seem most likely to emerge in response to efforts to limit commodification since pricing is so intrinsically linked to markets.⁴⁴⁹ In the end, however, there are normative reasons to express our concerns about prices that go too high: such prices exacerbate social inequities and devalue certain groups.⁴⁵⁰ Allowing the market to proclaim so vividly who is valued and who is not, in a country that has a history of abuse in this respect and that still struggles with social inequities, is a serious problem. Thus, a law setting price limits can express the moral obligation to recognize the

One option would set a uniform fee schedule to apply to all sales of eggs, sperm, and embryos, providing a standard rate for providers and recipients. This model has the benefit of ensuring that Ivy League credentials, race, height, and other personal qualifications are financially irrelevant; it helps insurance companies set a fee structure; and, depending on the price, it may make these gametes more affordable.

CAHN, TEST TUBE FAMILIES, *supra* note 1, at 162. This approach is not unheard of. California has taken this approach in relation to eggs bought for research purposes. See Sarah B. Angel, *The Value of the Human Egg: An Analysis of Risk and Reward in Stem Cell Research*, 22 BERKELEY J. GENDER L. & JUST. 183, 184–86 (2007) (discussing the Senate Bill 1260, limiting compensation for research egg donation). Senate Bill 1260 “strictly limits financial remuneration to reimbursement of direct expenses resulting from the procedure; the law bans any form of compensation above this amount.” *Id.* at 184.

446. See *supra* text accompanying notes 439–441.

447. See *supra* Part V.

448. See *supra* text accompanying note 337.

449. See Carbone & Gottheim, *supra* note 4, at 519 (“A partial ban, such as a ban on payment, may similarly produce black markets that evade state control.”).

450. See *supra* text accompanying notes 439–442.

equality of individuals and the unwillingness to accept the kind of social stratification that made eugenics so problematic. It is my final example of choosing the better, when we cannot have the best—of allowing markets, while actively trying to respond to their consequential threats.

CONCLUSION

Admittedly, my many recommendations are a tall order. Moreover, they are contrary to the ART industry's interest in avoiding regulation and difficult to implement in a culture that wants to preserve free markets. Too much is at stake, however, to leave it all to the market when the health and well-being of many are at risk. Asking the state to intervene here is not a radical proposal. Regulation of healthcare is a well-established police power of the state and baby markets fit well within that framework.⁴⁵¹ Where commodification raises problems of coercion, distorted decision-making, power imbalances, threats to the relational autonomy interests of the children, barriers to access, and the threat of some of the harms of eugenics, we cannot hope or expect market forces to address these problems. Indeed, evidence suggests that the market has not adequately addressed the consequential harms in baby markets. In giving in to baby markets, I am only willing to accept their intrinsic harms if we can try to address the consequential harms that exist because of, and exacerbate, the inequities of our culture. We live in a nonideal world. My pragmatic approach accepts a nonideal solution that nevertheless tries to bring us closer to our ideals. We shouldn't prohibit baby markets, but we must regulate them. ✿

451. See *supra* text accompanying note 223.