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Protecting Women: Preserving Autonomy in the Commodification of Motherhood

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PROTECTING WOMEN: PRESERVING AUTONOMY IN THE COMMODIFICATION OF MOTHERHOOD

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INTRODUCTION

The development of new technology has often begged questions that are not answered by the previously existing legal framework.¹ Current advances in modern technologies are no different and are outpacing legislative and regulatory developments.² Lack of regulation and a developed legal framework can make it impossible to control the risks associated with new technology.³ Such non-regulation of modern reproductive technologies will ultimately lead to the unavoidable commodification of motherhood.⁴

1. Ivan K. Fong, *Law and New Technology: The Virtues of Muddling Through*, 19 YALE L. & POL’Y REV. 443, 444 (2001) (book review).

2. Gary E. Marchant et. al., *What Does the History of Technology Regulation Teach Us about Nano Oversight?*, 37 J.L. MED. & ETHICS 724, 726-27 (2009).

3. See *id.* (discussing “four potential problems that may result from the failure of law to keep pace with technology”).

4. For a definition of “commodification,” see Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1859 (1987) (“The term ‘commodification’ can be

Commodification of the womb, sex cells, and DNA will revolutionize the way we view reproduction. This could potentially lead to a change in the way society views the role of motherhood in defining womanhood. Although this may be seen as an unwanted side effect to modern reproductive technologies, it also seems virtually unavoidable.

Instead of spending time and legislative energy trying to prevent commodification, the federal government, states, and medical associations should focus on regulating the safety of reproductive technologies. In order to best protect women's health and preserve their decision-making autonomy, it is necessary that we accept the unavoidable commodification of some aspects of traditional motherhood and focus legislative efforts on regulating the medical administration of modern reproductive technologies.

I. RISE OF MODERN REPRODUCTIVE TECHNOLOGIES

For the purposes of this Note, the term "modern reproductive technologies" (MRT) refers to certain medical procedures currently available that were developed with the intention of aiding human reproduction.⁵ Specifically, MRT will refer to artificial insemination, Assisted Reproductive Technologies (ART), which include *in vitro* fertilization, as well as surrogacy,⁶ and also to genetic engineering and cloning of embryos. Each of these technologies will be discussed in turn below.

MRT began with the birth of "[t]he first test tube baby" in 1978, who was conceived through *in vitro* fertilization.⁷ More than thirty

construed narrowly or broadly. Narrowly construed, commodification describes actual buying and selling (or legally permitted buying and selling) of something. Broadly construed, commodification includes not only actual buying and selling, but also market rhetoric, the practice of thinking about interactions as if they were sale transactions, and market methodology, the use of monetary cost-benefit analysis to judge these interactions. Universal commodification embraces this broad construction in its most expansive form, limiting actual buying and selling only by the dictates of market methodology, and solving problems of contested commodification by making everything in principle a commodity." (internal citations omitted).

5. For an overview of several forms of technology-aided reproductive methods, see Murray L. Manus, *The Proposed Model Surrogate Parenthood Act: A Legislative Response to the Challenges of Reproductive Technology*, 29 U. MICH. J.L. REFORM 671, 677-79 (1996).

6. The Centers for Disease Control and Prevention define ART as "all fertility treatments in which both eggs and sperm are handled." *Assisted Reproductive Technology*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ART> (last visited Mar. 28, 2011). According to this definition, ART does not encompass artificial insemination because sperm is the only thing handled. *Id.* Nor does ART include the administration of medicine to increase egg production. *Id.* Medical treatment is only categorized as ART if both an egg and sperm are manipulated together with the intention of creating a baby. *Id.*

7. Ruby L. Lee, Note, *New Trends in Global Outsourcing of Commercial Surrogacy: A Call for Regulation*, 20 HASTINGS WOMEN'S L.J. 275, 275 (2009).

years later, what once seemed like science fiction⁸ has become common practice. In 2006 alone, the number of “test-tube” babies born in the United States numbered 54,656.⁹ More impressively, if the recent trend continues, the number of “test-tube” births will continue to rise.¹⁰

There seem to be at least two cooperating theories seeking to explain the growth in the MRT market. The first theory is that high infertility rates have created a large group of people looking for alternative means to start a family.¹¹ MRT offers infertile parents the chance to conceive a child that is biologically their own,¹² fulfilling a desire to unite a family through “flesh and blood.”¹³ MRT can provide the closest substitute for natural conception because the resulting child can be genetically linked to both parents.

The second theory is that the definition of the modern family has broadened the MRT consumer base to more than just young, infertile, married couples.¹⁴ Over time, there has been increased cultural acceptance of both MRT and non-traditional family structures.¹⁵ “Non-traditional” families might include those with a single parent,¹⁶ homosexual parents, older parents, and career-focused mothers. In order to have children, many of these modern families are turning to MRT.¹⁷

8. See *The First Test-Tube Baby*, TIME, July 31, 1978, <http://www.time.com/time/magazine/article/0,9171,946934,00.html> (comparing the first test-tube baby to the reproduction methods described in Aldous Huxley’s science fiction novel *Brave New World*).

9. CTRS. FOR DISEASE CONTROL & PREVENTION, 2006 ASSISTED REPRODUCTIVE TECHNOLOGY (ART) REPORT: SECTION 5—ART TRENDS 1996-2006, fig. 49 [hereinafter 2006 ART REPORT], available at http://www.cdc.gov/ART/ART2006/sect5_fig49-64.htm#f49.

10. See *id.* (showing a yearly increase in the number of infants conceived and born through ART between 1996 and 2006).

11. Manus, *supra* note 5, at 676.

12. *Id.*

13. Janet L. Dolgin, *Biological Evaluations: Blood, Genes, and Family*, 41 AKRON L. REV. 347, 366 (2008).

14. See Nadine A. Gartner, *Lesbian (M)Otherhood: Creating an Alternative Model for Settling Child Custody Disputes*, 16 LAW & SEXUALITY REV. 45, 48 (2007) (recognizing the “surge of lesbian motherhood” as part of the “gayby boom”); Sherri A. Jayson, Comment, *“Loving Infertile Couple Seeks Woman Age 18-31 to Help Have Baby. \$6,500 Plus Expenses and a Gift”: Should We Regulate the Use of Assisted Reproductive Technologies by Older Women?*, 11 ALB. L.J. SCI. & TECH. 287, 288-90 (2001) (noting that older women now use ART more frequently than do younger women); see also Lee, *supra* note 7, at 282 (discussing the increase in the number of “career women” seeking surrogates to bear their children).

15. See Jayson, *supra* note 14, at 290 (mentioning changing societal attitudes as a contributing factor to why older women are seeking out ART at higher rates).

16. See Dolgin, *supra* note 13, at 355 n.39 (“Eight[y]-six percent of all children lived in two-parent homes in 1950, as opposed to just 72 percent in 1990.” (quoting STEPHANIE COONTZ, *THE WAY WE REALLY ARE: COMING TO TERMS WITH AMERICA’S CHANGING FAMILIES* 37 (1997))).

17. Jayson, *supra* note 14, at 290.

II. CURRENT TECHNOLOGIES

Fiction writers like Aldous Huxley, in *Brave New World*,¹⁸ and Andrew Niccol, in the motion picture *Gattaca*,¹⁹ have recognized the possibility of a society that creates children in laboratories.²⁰ Their fantasy stories are becoming reality in today's world of reproductive technology. Despite the reluctance of law-makers to recognize the drastic change that occurred when reproductive technology jumped from the pages of fiction into our homes and communities,²¹ MRT is firmly embedded in our culture.²²

A. Sperm Donation

The most common form of MRT is *in vitro* fertilization (IVF).²³ The IVF procedure involves removing unfertilized eggs from the intended genetic mother, fertilizing them in a laboratory with sperm from the intended genetic father, and then placing the fertilized egg in the uterus of the intended birth mother.²⁴

Sperm donation is an important part of IVF.²⁵ Donors, other than those with the intention of creating a child of their own, often donate anonymously to commercialized sperm banks.²⁶ Most anonymous donors are motivated primarily by the promise of compensation.²⁷ Some donors, however, claim to be motivated by altruism.²⁸

The sperm donation process is currently regulated by the federal government,²⁹ individual states,³⁰ and professional organizations,³¹

18. ALDOUS HUXLEY, *BRAVE NEW WORLD* (The Modern Library 1932).

19. *GATTACA* (Columbia Pictures Corp. 1997).

20. Bryan Appleyard, *The Gene Machine*, AUSTRALIAN, Apr. 21, 1998, at 11.

21. See Michelle Bercovici, *Biotechnology Beyond the Embryo: Science, Ethics, and Responsible Regulation of Egg Donation to Protect Women's Rights*, 29 WOMEN'S RTS. L. REP. 193, 194 (2008) ("The U.S. is far behind other countries in crafting a legislative response to curb dangers inherent in advances in ART . . .").

22. See 2006 ART REPORT, *supra* note 9, fig. 49 (showing how, each year, the number of infants born from ART has increased).

23. CTRS. FOR DISEASE CONTROL & PREVENTION, ASSISTED REPRODUCTIVE TECHNOLOGY (ART) REPORT: NATIONAL SUMMARY REPORT (2007), available at <http://apps.nccd.cdc.gov/art/NationalSummaryReport.aspx> (select year 2007 from drop-down box).

24. 2006 ART Report Commonly Asked Questions, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/ART/ART2006/faq.htm> (last visited Mar. 18, 2011).

25. Vanessa L. Pi, Note, *Regulating Sperm Donation: Why Requiring Exposed Donation Is Not the Answer*, 16 DUKE J. GENDER L. & POL'Y 379, 382 (2009).

26. *Id.*

27. *Id.*

28. *Id.* For a discussion of the societal perception of sperm donors' altruistic motivations, see Kimberly D. Krawiec, *Sunny Samaritans and Egomaniacs: Price-Fixing in the Gamete Market*, 72 LAW & CONTEMP. PROBS. 59, 61-63 (2009).

29. Human Cells, Tissues, and Cellular and Tissue-based Products, 21 C.F.R. § 1271 (2010).

30. Pi, *supra* note 25, at 382.

31. *Id.*

but there is concern that “[f]ederal and state regulation of sperm donation lags far behind the constantly evolving science of ART, causing uncertainty, fear, and even medical harm.”³² For example, even though “the FDA requires [sperm banks to conduct] a donor medical history interview,”³³ donors are not required to update their medical files if diagnosed with a disease after donation, preventing individuals using donor sperm from knowing about potential genetic health risks.³⁴ The net result of the lack of regulation is a potentially incomplete medical history for children conceived with sperm from an unknown donor,³⁵ frustrating the possibility of preventative care for possible genetic disorders.

Further, sperm banks do not necessarily keep a comprehensive record of the number of times a donor has donated sperm.³⁶ Popular characteristics can lead to demand for a certain donor’s genetic material and can result in many children in one area having the same biological father.³⁷ The resulting problem, termed “consanguinity,” is that the children may eventually marry and reproduce with their own half-siblings without ever having discovered their biological relationship.³⁸

B. Egg Donation

Egg donation, like sperm donation, is becoming a fixture in the MRT world.³⁹ Perhaps unlike sperm donation, however, searching for an egg donor has become a very public task. Publicly accessible websites advertise the availability of “desirable” eggs,⁴⁰ and hopeful parents can even place advertisements for egg donors with certain characteristics in periodicals likely to reach a target population, such as college newspapers.⁴¹

32. *Id.* at 401.

33. *Id.* at 383 (citation omitted).

34. *Id.* at 390.

35. *Id.* at 389.

36. *Pi*, *supra* note 25, at 389-90.

37. *Id.* at 389 (describing a donor who “is the biological father of at least 36 children all born between 2002 and 2007” (internal quotation marks and citation omitted)).

38. *Id.*

39. Sarah Terman, Note, *Marketing Motherhood: Rights and Responsibilities of Egg Donors in Assisted Reproductive Technology Agreements*, 3 NW. J.L. & SOC. POL’Y 167, 167 (2008) (“Each year thousands of young women enter the American gamete market as egg providers.”).

40. *See, e.g.*, A PERFECT MATCH, <http://www.aperfectmatch.com/> (last visited Mar. 28, 2011) (“A Perfect Match . . . specializ[es] in the recruitment of intelligent, well-educated, accomplished and affordable college-aged donors to be matched with intended parents who need the help of an egg donor to create their family. We also recruit young, healthy gestational surrogates who are prescreened and ready to cycle immediately.”).

41. AARON D. LEVINE, HASTINGS CTR., SELF-REGULATION, COMPENSATION, AND THE ETHICAL RECRUITMENT OF OOCYTE DONORS 25, 27 (2010) (“Three ads, in the *Harvard*

Women undergoing the ovum donation procedure for purposes other than to create a child of their own are often motivated by monetary compensation.⁴² Many donors also state that they are motivated by the thought of helping infertile women conceive a child,⁴³ but there is significant evidence that this is largely untrue.⁴⁴

Ovum donation, also known as egg harvesting,⁴⁵ is a complicated process that is potentially very risky for the donor.⁴⁶ First, the donor's menstrual cycle is synchronized with the recipient's cycle using birth control pills.⁴⁷ Then, the donor receives a hormone suppressant to prevent normal ovary function.⁴⁸ Next, the donor receives another round of hormones, this time to "hyper-stimulate" egg production so that multiple eggs can be harvested at one time, increasing the likelihood of a successful donation.⁴⁹ The recipient also receives hormone medication to prepare her uterus for implantation of the fertilized eggs.⁵⁰

The eggs are later fertilized in the laboratory using sperm donated by the genetic father.⁵¹ After the fertilized eggs have reached the proper stage of maturity, typically one or two of the fertilized eggs are implanted into the recipient's uterus.⁵²

There are at least three distinct controversies surrounding ovum donation. First, the egg harvesting process can pose high risks for the donor.⁵³ Egg retrieval surgery risks damage to blood vessels and organs located near the ovaries and can possibly result in infection

Crimson, the *Daily Princetonian*, and *Yale Daily News*, offered \$35,000, and an ad in the *Brown Daily Herald* offered \$50,000 to 'an extraordinary egg donor.'").

42. Pi, *supra* note 25, at 382; Jim Hopkins, *Egg-donor Business Booms on Campuses*, USA TODAY, Mar. 15, 2006, http://www.usatoday.com/money/industries/health/2006-03-15-egg-donors-usat_x.htm.

43. Pi, *supra* note 25, at 382.

44. See Krawiec, *supra* note 28, at 61-62 (noting that, despite the perception of an egg donor as a "sunny Samaritan" willing to donate her eggs for altruistic purposes, without compensation, women are likely to stop donating).

45. Bercovici, *supra* note 21, at 195.

46. "During the entire process, the donor is subject to a number of health risks, including possible bleeding or infection during the removal procedure." *Id.* at 194 (citation omitted).

47. *Patient Education: Egg Donation Process for Recipients*, UCSF MED. CTR., http://www.ucsfhealth.org/education/ovum_donation_process_for_recipients/index.html (last visited Mar. 28, 2011) [hereinafter *Patient Education*].

48. *Id.*

49. Bercovici, *supra* note 21, at 195.

50. *Patient Education*, *supra* note 47.

51. *Id.*

52. *Id.*

53. Bercovici, *supra* note 21, at 194; see also Emily Galpern, *Beyond Embryo Politics: Women's Health and Dignity in Stem Cell Research*, WOMEN'S HEALTH ACTIVIST NEWSLETTER (Nat'l Women's Health Network, Wash., D.C.), May/June 2006, available at <http://nwln.org/beyond-embryo-politics-womens-health-and-dignity-stem-cell-research> (noting the health risks related to egg donation for stem cell research).

and infertility.⁵⁴ Additionally, as with any surgery involving sedation, egg donation carries the possibility of “anesthetic complications.”⁵⁵ Studies have also suggested that there is a link between the hormone therapy administered to stimulate ovulation and some types of cancer.⁵⁶

Beyond the proven risks, the complete list of potential dangers posed by hormone administration is unknown,⁵⁷ making it difficult to inform donors of the actual risks of donation. The lack of knowledge about long-term effects of the hormone therapy, combined with the expected risks in any invasive surgery, can create an ethical dilemma, especially as “there is a conflict of interest between those seeking eggs and potential donors”⁵⁸ The nature of the informed consent required from egg donors is inconsistent and, at best, only vague in its warning about health risks.⁵⁹

The second controversy surrounding ovum donation is its association with stem cell research.⁶⁰ In the past, stem cell research relied exclusively on the use of “leftover” fertilized eggs that were not implanted into the recipient during ovum donation.⁶¹ New cloning technology called “somatic cell nuclear transfer (SCNT),” however, requires freshly harvested eggs.⁶² The ovum donation procedure is the same for SCNT donation as for IVF donation.⁶³ After harvesting, however, instead of being fertilized, each egg’s nucleus is removed and replaced with the nucleus from a somatic cell, or “body cell,”⁶⁴ resulting in an egg that can be used to grow a stem cell line.⁶⁵ Because DNA is contained in the nucleus of a cell, each egg is a clone of the somatic cell, rendering it ideal for research purposes.⁶⁶

54. *The Medical Procedure of Egg Donation*, EGG DONOR INFO. PROJECT, <http://www.stanford.edu/class/siw198q/websites/eggdonor/procedures.html> (last updated June 5, 2002).

55. *Id.*

56. Helen Pearson, *Health Effects of Egg Donation May Take Decades to Emerge*, 442 NATURE 601, 607 (2006), available at <http://www.nature.com/nature/journal/v442/n7103/pdf/442607a.pdf>.

57. *Id.* at 608 (“It’s important for people to understand in the consent process that we don’t know as much as we should about what th[e] risks are”) (quoting Mildred Cho).

58. Bercovici, *supra* note 21, at 210.

59. *Id.* at 209-10. For an example of an informed consent form used in egg donation for IVF procedures, see the OHSU Center for Women’s Health website. *Patient Handouts*, OHSU CTR. WOMEN’S HEALTH, <http://www.ohsu.edu/xd/health/services/women/services/fertility/patient-resources/upload/IVF-Informed-Consent.pdf> (last visited Mar. 18, 2011).

60. See Bercovici, *supra* note 21, at 195 (discussing the two markets of “the ‘egg trade’”: “IVF treatments and . . . research purposes” (citation omitted)).

61. Galpern, *supra* note 53.

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.*

Stem cell research has been publicly condemned by pro-life organizations as a violation of protected rights of an unborn child.⁶⁷ Adding fuel to their fire, in March of 2009, President Barack Obama signed an executive order lifting the ban on federal funding for embryonic stem cell research⁶⁸ imposed by President George W. Bush.⁶⁹ Despite the medical breakthroughs predicted by those involved in stem cell research,⁷⁰ many pro-life supporters strongly oppose the use of embryos, whether left over from the IVF process or cloned specifically for research purposes, because all “embryos and fetuses are human beings worthy of respect.”⁷¹

The third controversy surrounding ovum donation is the potential coercive threat it poses to economically desperate women.⁷² A woman in a difficult financial position may feel compelled to undergo the dangerous medical procedure to make ends meet.⁷³ The concerns with ovum donation for-pay are analogous to potential ethical concerns regarding organ donation, or even prostitution, because of the risky nature of the egg donation procedure, combined with the potentially high financial pay off.⁷⁴

Despite these concerns, compensation for egg donation is not federally regulated.⁷⁵ Instead, independent agencies have issued

67. Press Release, Nat'l Right to Life Comm., National Right to Life Says the Obama Administration is Pushing Step-by-Step the Creation and Harvesting of Human Embryos for Research (Apr. 17, 2009), available at http://www.nrlc.org/press_releases_new/Release_041709.html (“[L]ongstanding law . . . actually prohibits funding of research that creates or harms human embryos, including all creation of human embryos by cloning.”).

68. Exec. Order No. 13,505, 74 Fed. Reg. 10,667 (Mar. 9, 2009).

69. Daniel Nasaw, *Obama Ends Bush Ban on Embryo Stem Cell Research*, GUARDIAN.CO.UK, Mar. 6, 2009, <http://www.guardian.co.uk/world/2009/mar/06/embryonic-stem-cell-research-obama>.

70. See, e.g., *Stem Cells and Diseases*, NAT'L INSTS. HEALTH, <http://stemcells.nih.gov/info/health.asp> (last modified Jan. 7, 2011) (“Studying stem cells will help us understand how they transform into the dazzling array of specialized cells that make us what we are. Some of the most serious medical conditions, such as cancer and birth defects, are due to problems that occur somewhere in this process. A better understanding of normal cell development will allow us to understand and perhaps correct the errors that cause these medical conditions.”).

71. Erin P. George, Comment, *The Stem Cell Debate: The Legal, Political and Ethical Issues Surrounding Federal Funding of Scientific Research on Human Embryos*, 12 ALB. L.J. SCI. & TECH. 747, 782 (2002).

72. Bercovici, *supra* note 21, at 197.

73. *Id.*

74. See Joseph B. Clamon, *Tax Policy as a Lifeline: Encouraging Blood and Organ Donation Through Tax Credits*, 17 ANNALS HEALTH L. 67, 84-85 (2008) (discussing the ethical concerns of being able to buy and sell life-necessary organs in a free market); Emily Bazelon, *Why Is Prostitution Illegal?: The Oldest Question about the Oldest Profession*, SLATE (Mar. 10, 2008, 7:12 PM), <http://www.slate.com/id/2186243> (discussing the ethical considerations of legalizing prostitution).

75. Bercovici, *supra* note 21, at 204. In contrast, England's Human Fertilisation and Embryology Authority (HFEA) long “prohibited payment for egg donors, limiting donor

guidelines defining proper compensation. For example, the American Society for Reproductive Medicine (ASRM) guidelines suggest:

Compensation should be structured to acknowledge the time, inconvenience, and discomfort associated with screening, ovarian stimulation, and oocyte retrieval. Compensation should not vary according to the planned use of the oocytes, the number or quality of oocytes retrieved, the number or outcome of prior donation cycles, or the donor's ethnic or other personal characteristics.⁷⁶

The ASRM's guidelines further state that "[t]otal payments to donors in excess of \$5,000 require justification and sums above \$10,000 are not appropriate."⁷⁷ These guidelines, however, are merely advisory, and agencies can choose whether to comply.⁷⁸ The ASRM website lists egg donor agencies that are in compliance with its guidelines but notes that the agencies have paid a fee to be listed on the website and that neither the ASRM nor any other authority has verified the agencies' assertions that they are in compliance with the guidelines.⁷⁹

Although some states regulate egg donor compensation, there is no clear trend in the substance of the regulations.⁸⁰ For example, Louisiana, one of the few states that specifically addresses egg donor compensation, statutorily prohibits all compensation, and also generally prohibits egg donation,⁸¹ whereas Virginia specifically excludes the sale of eggs from its prohibition on the donation of body parts.⁸²

C. Commercial Surrogacy

Another controversial form of MRT is commercial surrogacy.⁸³ Commercial surrogacy comes in two forms. The first involves paying a woman to relinquish her parental rights after giving birth to a child that is genetically her own.⁸⁴ The second form, "gestational

compensation to fifteen pounds (approximately thirty dollars) plus reasonable out-of-pocket expenses incurred." *Id.* at 204-05 (citing Press Release, Human Fertilisation & Embryology Auth., HFEA Confirms UK Position on Payment for Egg Donors (Feb. 25, 2004), available at <http://www.hfea.gov.uk/784.html>).

76. AM. SOC'Y REPROD. MED., *Financial Compensation of Oocyte Donors*, 88 FERTILITY & STERILITY 305, 305 (2007).

77. *Id.*

78. See LEVINE, *supra* note 41, at 26 (describing the fertility industry as self-regulated).

79. ASRM Patient Resources: *Egg Donor Agencies*, AM. SOC'Y REPROD. MED., <http://www.asrm.org/detail.aspx?id=856> (last visited Mar. 28, 2011).

80. Bercovici, *supra* note 21, at 203.

81. *Id.* (citing LA. REV. STAT. ANN. § 9:122 (2011)).

82. *Id.* (citing VA. CODE ANN. § 32.1-291.16 (West 2010)).

83. See Lee, *supra* note 7, at 281 (discussing the potential for "surrogacy agencies and medical practitioners [to] employ[] unethical practices solely to generate profit").

84. *Id.* at 275-76.

surrogacy,”⁸⁵ is more common in modern society.⁸⁶ Gestational surrogacy requires ovum donation and IVF, but, instead of the fertilized egg being implanted into the egg donor herself, the egg is implanted into a third party who agrees to carry the child to term for a fee and then relinquish all parental rights to the paying party.⁸⁷ Gestational surrogates have no genetic link to the baby,⁸⁸ avoiding some of the legal issues posed by early MRT litigation surrounding post-birth parental rights.⁸⁹

As with other forms of MRT, commercial gestational surrogacy is not federally regulated in the United States.⁹⁰ Some states have adopted their own laws regarding commercial gestational surrogacy, but there is no dominant approach to the regulation.⁹¹

D. Preimplantation Genetic Diagnosis

Preimplantation Genetic Diagnosis (PGD) is used to diagnose genetic or chromosomal problems in embryos before they are implanted in the mother’s uterus.⁹² PGD allows potential parents to screen the embryos for disorders such as Down Syndrome and Tay-Sachs.⁹³

The PGD process works like any IVF procedure: the hopeful mother goes through an egg-harvesting procedure, the hopeful father donates sperm, and the eggs are fertilized by a technician.⁹⁴ Only some of the eggs will be fertilized successfully and begin the cell division process.⁹⁵ After allowing the eggs to grow for a few days, a technician will take “an embryo biopsy” and conduct genetic testing on the cells.⁹⁶ Embryos that have an undesirable trait are usually donated for research purposes or discarded.⁹⁷ Then, a few “good” embryos are placed in the uterus.⁹⁸

85. *Id.* at 276.

86. *Id.* at 275.

87. *Id.* at 276.

88. *Id.*

89. Lee, *supra* note 7, at 275-76 (mentioning the case of *In re Baby M*, 537 A.2d 1227 (N.J. 1988), which highlights the difficulties inherent in determining the parental rights of a surrogate who uses her own eggs).

90. *Id.* at 288, 292.

91. *Id.* at 288-90 (discussing the “fragmented approach” of the states in regulating commercial surrogacy).

92. Jaime King, *Predicting Probability: Regulating the Future of Preimplantation Genetic Screening*, 8 YALE J. HEALTH POL’Y L. & ETHICS 283, 285 & n.1 (2008).

93. *Id.* at 290.

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.* at 291.

98. King, *supra* note 92, at 291.

PGD can also be used to screen embryos for “non-medical” genetic traits, such as sex, deafness, dwarfism, and blood and tissue type.⁹⁹ This type of screening can raise ethical concerns and is much less common than screening for medical genetic disorders.¹⁰⁰

The limited use of PGD is due in part to the lack of reliable genetic tests for many traits and lack of public knowledge of the field.¹⁰¹ It is possible to imagine that, in time, parents may “screen kids almost before conception for an enormous range of attributes, such as how tall they’re likely to be, what body type they will have, their hair and eye color, what sorts of illnesses they will be naturally resistant to, and even, conceivably, their IQ and personality type.”¹⁰² The ability to select the genetic makeup of children could result in extreme disparities between children of different economic classes, making those whose parents can afford PGD smarter and healthier than those whose parents cannot.¹⁰³

The President’s Council on Bioethics doubts that the ability to create such a “designer baby” is imminent but also recognizes that “PGD risks normalizing the idea that a child’s particular genetic make-up is quite properly a province of parental reproductive choice”¹⁰⁴ Assuming PGD is in fact recognized as a “reproductive choice,” it is currently possible to buy certainty that your child will be a girl, and that she will be free from over 100 diseases currently identifiable through genetic testing.¹⁰⁵ Despite the controversial applications of PGD, however, the United States currently does not federally regulate its use.¹⁰⁶

99. *Id.* at 296; see also Susan M. Wolf et al., *Using Preimplantation Genetic Diagnosis to Create a Stem Cell Donor: Issues, Guidelines & Limits*, 31 J.L. MED. & ETHICS 327, 328-29 (2003) (discussing a case in which parents used PGD in order to ensure that the mother would give birth to a child who would be a bone-marrow match for a sick sibling).

100. *Id.*

101. King, *supra* note 92, at 297-98.

102. Michael D. Lemonick et al., *Designer Babies*, TIME, Jan. 11, 1999, at 64, available at <http://www.time.com/time/magazine/article/0,9171,989987,00.html>.

103. See *id.* at 66 (describing “a scenario in which society splits into two camps, the ‘gen-rich’ and the ‘gen-poor’”). For a more frightening interpretation of the possibilities of PGD, see George J. Annas, *The Changing Face of Family Law: Global Consequences of Embedding Physicians and Biotechnology in the Parent-Child Relationship*, 42 FAM. L.Q. 511, 526 (2008) (discussing how genetic engineering may result in the creation of a “superhuman” that sees humans “as an inferior subspecies without human rights to be enslaved or slaughtered preemptively”). Annas refers to this theory as “gender genocide.” *Id.* at 525.

104. PRESIDENT’S COUNCIL ON BIOETHICS, REPRODUCTION AND RESPONSIBILITY: THE REGULATION OF NEW BIOTECHNOLOGIES 95 (2004), available at <http://bioethics.georgetown.edu/pcbe/reports/reproductionandresponsibility/>.

105. *Id.* at 90-91.

106. King, *supra* note 92, at 321.

III. OVERVIEW OF CURRENT REGULATIONS

As indicated in the sections above, there is a lack of uniform, mandatory regulation of MRT. There are, however, a number of regulatory forces that affect the current structure of MRT service delivery.

A. Federal Funding

The development of MRT is regulated in practice by the limited amount of funding available for research.¹⁰⁷ Without resources from federal and private agencies, research laboratories are often limited in the amount of resources they can devote to developing and improving MRT.¹⁰⁸ In essence, MRT's expansion is regulated by its limited ability to advance without research funding.

Recently, however, the federal government has been relatively generous with funding for MRT-related research. As of March 2009, the federal government is once again allotting federal funding for stem cell research in order to develop new gene therapies targeting some of the human population's most deadly diseases.¹⁰⁹ An increase in federal funding for new technology could improve MRT effectiveness and applicability, specifically in relationship to the burgeoning field of PGD.

Another example of federally-funded MRT research is the National Human Genome Research Institute's completion of the Human Genome Project in April 2003.¹¹⁰ The culmination of the Human Genome Project was the sequencing of the entire human genome,¹¹¹ which "gave us the ability to, for the first time, to [sic] read nature's complete genetic blueprint for building a human being."¹¹² The future goal of the National Human Genome Research Institute is to use the power of sequencing to collect information about the function of different genes so that we may more easily predict how

107. *See id.* (discussing the federal government's limitation on federal funds for embryonic research).

108. *Id.* at 322 (describing how this lack "of federal research funding has pushed reproductive genetics out of the laboratory and into medical practice").

109. *See* Exec. Order No. 13,505, 74 Fed. Reg. 46 (Mar. 9, 2009) (repealing the federal ban on funding for stem cell research).

110. *All About the Human Genome Project (HGP)*, NAT'L HUMAN GENOME RESEARCH INST., <http://www.genome.gov/10001772> (last visited Mar. 18, 2011) [hereinafter *All About the HGP*].

111. *Human Medical Sequencing Program and Current Initiatives*, NAT'L HUMAN GENOME RESEARCH INST., <http://www.genome.gov/15014882> (last visited Mar. 18, 2011) [hereinafter *Human Medical Sequencing Program*].

112. *All About the HGP*, *supra* note 110.

our genes affect our lives.¹¹³ If this goal becomes reality, it is possible to imagine using PGD in order to select for a variety of traits.¹¹⁴

B. Self-Regulation

Doctors and scientists working in the MRT field are often free from federal or state regulation and, instead, voluntarily self-regulate.¹¹⁵ There are a number of obvious ethical problems with self-regulation, such as a desire to maximize profits by downplaying risks, inflating success rates, and providing new, yet experimental, treatment, potentially exposing patients to unknown risks.¹¹⁶ MRT providers are also not licensed in any special way,¹¹⁷ revealing that there is little to no uniform oversight of the procedures or reporting requirements.¹¹⁸

Individual doctors also have the opportunity to regulate MRT use by declining to enter into the doctor-patient relationship with someone interested in using MRT.¹¹⁹ Though a doctor can almost always refuse to treat a patient, she cannot, within the bounds of professional ethics, refuse treatment based on “a patient’s personal characteristics if the treatments would be provided to other patients with similar medical profiles.”¹²⁰ This means that a doctor risks violating the ethical code by refusing to use MRT treatment for the benefit of an unmarried woman or a woman in a lesbian union if the doctor *would* treat a married woman with the same medical characteristics.¹²¹ That is not to say that a doctor is limited to perusing medical records when making her decisions with respect to providing MRT treatment. A doctor can also “take into account known or reasonably suspected characteristics that would render the parent(s) unable to deliver a decent minimum of child-rearing.”¹²²

113. *Human Medical Sequencing Program*, *supra* note 111.

114. PRESIDENT’S COUNCIL ON BIOETHICS, *supra* note 104, at 91 (noting traits such as “height, leanness, or temperament”).

115. Jayson, *supra* note 14, at 332.

116. Sonia M. Suter, *Giving in to Baby Markets: Regulation Without Prohibition*, 16 MICH. J. GENDER & L. 217, 253-56 (2009).

117. *Id.* at 252.

118. *Id.* at 252-53.

119. See Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18, 64-65 (2008) (“[A] physician is free to determine whether or not to enter into a doctor-patient relationship with a prospective patient . . .”).

120. *Id.* at 66.

121. *Id.* at 66-67.

122. *Id.* at 67. For additional information regarding a physician’s ability to deny care based on her judgment of a parent’s child-rearing capabilities, see *id.* at 67-68.

C. Federal Regulation

Federal regulations of MRT are currently found in the Fertility Clinic Success Rate and Certification Act (FCSRCA),¹²³ and in FDA donor tissue regulations.¹²⁴ The FCSRCA calls on the Centers for Disease Control and Prevention (CDC) to develop an accreditation program that sets standards for embryo agencies.¹²⁵ The CDC released its “Model Program” in 1999,¹²⁶ but state and individual-agency compliance with the Model is optional.¹²⁷ Importantly, neither the FCSRCA nor the CDC Model Program include minimum safety requirements for MRT procedures.¹²⁸

The FDA donor tissue regulations do set standards for screening and testing donors, attempting to reduce the number of infectious diseases transferred during MRT.¹²⁹ The regulations do not require testing for genetic diseases, however,¹³⁰ nor do they set standards for MRT procedural safety.¹³¹

Non-regulatory federal bodies have attempted to address questions left unanswered by federal regulation. For example, the President’s Council on Bioethics issued a report in March 2004 titled *The Regulation of New Biotechnologies*.¹³² The report makes recommendations for the appropriate use of MRT.¹³³ The report weighs the ethical concerns surrounding MRT, expresses growing uneasiness with its existence, and recognizes the inability of current federal legislation to fully address its legal and ethical implications.¹³⁴

123. 42 U.S.C. § 263(a)(1) (2006).

124. Human Cells, Tissues, and Cellular and Tissue-based Products, 21 C.F.R. §§ 1271.1, 1271.3 (2005).

125. Yaniv Heled, *The Regulation of Genetic Aspects of Donated Reproductive Tissue—The Need for Federal Regulation*, 11 COLUM. SCI. & TECH. L. REV. 243, 250 (2010), available at <http://www.stlr.org/cite.cgi?volume=11&article=8>.

126. *Id.*

127. *Id.* at 251.

128. *Id.* at 250.

129. *Id.* at 251-52.

130. *Id.* at 253-54.

131. See Human Cells, Tissues, and Cellular and Tissue-based Products, 21 C.F.R. § 1271 (2005) (lacking provisions for safety verification of MRT procedures themselves). Although the lack of regulation regarding screening gamete donors for genetic diseases is outside the scope of this Note, a poignant example of the deleterious effects of this “hole” in legislation can be found in an article by William Heisel titled “Egg Donor Gives Life—and a Death Sentence.” SEATTLE TIMES, Dec. 13, 2007, available at http://seattletimes.nwsourc.com/html/health/2004068536_eggdonor13.html (discussing an egg donor who recently learned that one of the children conceived with her eggs has Tay-Sachs disease).

132. PRESIDENT’S COUNCIL ON BIOETHICS, *supra* note 104.

133. *Id.* at 205-24. For example, the report calls for “increased oversight by professional societies and practitioners.” *Id.* at 215.

134. *Id.* at 36-37, 171.

The egg donation process itself, not even considering compensation standards, is largely unregulated at the federal level.¹³⁵ The regulations that do exist differ for the donation of an egg to produce an embryo meant for childbirth and the donation of an egg for research purposes.¹³⁶ Clinics can voluntarily choose to conform to federal MRT regulations.¹³⁷ The lack of enforceable regulations raises concerns for the health of the women involved in egg donation, as well as concerns about whether the current system allows women to make truly *informed* decisions regarding donation.¹³⁸

D. State Legislation

One way state law regulates MRT is through physician and facility licensure.¹³⁹ Several states have also attempted to compensate for the lack of federal regulation by passing their own laws regarding MRT, in addition to any licensure requirements they may have.¹⁴⁰ For example, many state legislatures have statutorily created regulatory schemes regarding commercial surrogacy agreements.¹⁴¹ Scholars have broken down the various regulatory models for surrogacy contracts into four distinct types.¹⁴²

Statutes in the first category make all surrogacy contracts unenforceable in that state.¹⁴³ States that have such statutes may pass other statutes that define the “legal parent” of a child conceived under the auspices of a surrogacy contract.¹⁴⁴ Many of “[t]hese jurisdictions have effectively chosen to subjugate the rights of the genetic/intended parents to those of the birth parents.”¹⁴⁵ Violation of the statute by forming a surrogacy contract can cause the contracting parties to be charged with a crime for which they may face a misdemeanor or felony conviction and hefty fines.¹⁴⁶

Statutes in the second category only prohibit contracts that will compensate the surrogate for more than just her medical expenses.¹⁴⁷

135. Bercovici, *supra* note 21, at 198 (“[T]here is at best a patchwork system of federal oversight of reproductive services and research.” (citation omitted)).

136. *Id.* at 194.

137. *Id.* at 199.

138. *Id.* at 194, 207.

139. Heled, *supra* note 125, at 255.

140. Lee, *supra* note 7, at 289-90.

141. Adam P. Plant, *With a Little Help from my Friends: The Intersection of the Gestational Carrier Surrogacy Agreement, Legislative Inaction, and Medical Advancement*, 54 ALA. L. REV. 639, 649 (2003).

142. *Id.*

143. *Id.*

144. *Id.* at 650-51.

145. *Id.* at 651.

146. *Id.*

147. Plant, *supra* note 141, at 649.

Controversy over surrogacy compensation can echo that of egg donation: critics are overwhelmingly concerned with the commodification of the womb and even the commodification of children.¹⁴⁸

Statutes in the third category address only parts of the surrogacy contract or surrogacy law generally, avoiding broad prohibitions.¹⁴⁹ Many of these statutes merely decriminalize surrogacy.¹⁵⁰ Some states have also passed legislation regarding the presumed parentage of children conceived through a surrogacy contract.¹⁵¹ These laws may establish a preference for the biological parent, either the mother or the father, or may involve some other calculation to determine parental rights.¹⁵²

Statutes in the fourth category explicitly make surrogacy contracts legal and enforceable.¹⁵³ While these statutes may seem progressive, many of these states have also passed sister legislation, which heavily regulates the situations in which surrogacy contracts will be held enforceable.¹⁵⁴ For example, some states require that a couple prove medical incapability of conceiving “naturally,” while others require that individuals seeking to hire a surrogate be married.¹⁵⁵

E. Effects of Unregulated MRT: MRT Tourism

Citizens from countries that have strict regulations concerning commercial surrogacy travel to other, less regulated, countries, such as the United States and India, in order to reap the benefits of MRT.¹⁵⁶ These potential parents are looking for good technology at the right price.¹⁵⁷ Not only is commercial surrogacy an illustration of MRT's nature as a commodity, but it also shows that the domestic market is not the only influence on MRT.

IV. LEGAL BACKGROUND OF MRT

The rapid development of MRT has posed many novel legal questions concerning parental rights.¹⁵⁸ The section below discusses

148. *Id.* at 652 (describing the fear of “baby-selling”).

149. *Id.* at 649.

150. *Id.* at 653.

151. *Id.* at 654.

152. *Id.*

153. Plant, *supra* note 141, at 654.

154. *Id.* at 654-55.

155. *Id.* at 655.

156. Lee, *supra* note 7, at 284.

157. *Id.* at 276-77.

158. See Barbara K. Kopytoff, *Surrogate Motherhood: Questions of Law and Values*, 22 U.S.F. L. REV. 205, 206 (1988) (discussing “just how unprepared the law is to deal with the questions that are raised” by “surrogate motherhood”).

two key cases in the development of surrogacy law that highlight the diverging interests of “procreative liberty” and traditional notions of family.

A. *In re Baby M*¹⁵⁹

In *re Baby M* was the first major case in the United States to grapple with the issue of parental rights when a child results from MRT.¹⁶⁰ The parties to the case were, on one side, the intended parents and, on the other, a surrogate who was hired to conceive a child with the intended father.¹⁶¹ Importantly, the surrogate mother was also the natural biological mother of the child.¹⁶²

The two parties created a surrogacy contract, but, after the birth of the child, the surrogate refused to give the child to the intended parents,¹⁶³ even though the contract terminated her parental rights.¹⁶⁴ The court held that the surrogacy contract was invalid and “restore[d] the ‘surrogate’ as mother of the child.”¹⁶⁵

The Supreme Court of New Jersey made clear that the egg and the womb should not be treated as commodities; the court refused to validate the “sale” by contract of the womb.¹⁶⁶ Instead, the court held that such contracts were contrary to public policy¹⁶⁷ and endorsed the Superior Court’s test for the award of parental rights by considering “the child’s best interests,”¹⁶⁸ an analysis typically used in determining child custody rights upon family dissolution.¹⁶⁹

It is undeniable that surrogacy scenarios create a complex problem in contract law due to the potential of extreme emotional vulnerability among the parties.¹⁷⁰ This might suggest—as the court held in *Baby M*—that such contracts should be deemed against public policy, and that disputes over parentage should be settled using traditional family law. It is equally undeniable, however, that such concerns, and

159. 537 A.2d 1227 (N.J. 1988).

160. *Developments in the Law: The Law of Marriage and Family*, 116 HARV. L. REV. 1996, 2069 (2003).

161. *In re Baby M*, 537 A.2d at 1235, 1237.

162. *Id.* at 1234.

163. *Id.* at 1237.

164. *Id.* at 1238.

165. *Id.* at 1234.

166. *Id.* at 1240.

167. *In re Baby M*, 537 A.2d at 1240.

168. *Id.*

169. Linda Kelly, *Family Planning, American Style*, 52 ALA. L. REV. 943, 948 (2001).

170. Flavia Berys, Comment, *Interpreting a Rent-a-Womb Contract: How California Courts Should Proceed When Gestational Surrogacy Arrangements Go Sour*, 42 CAL. W. L. REV. 321, 331-32 n.58 (2006) (noting emotional and economic vulnerability).

the resulting denial to enforce surrogacy contracts, can infringe on “procreative liberty.”¹⁷¹

*B. Johnson v. Calvert*¹⁷²

The California case of *Johnson v. Calvert* explored a question left open by the New Jersey court in *Baby M*: how to determine parental rights of gestational, not traditional, surrogates.¹⁷³ The Supreme Court of California noted that though there is support for both the genetic mother’s and the gestational mother’s parental rights¹⁷⁴ under California law there can be “only one natural mother.”¹⁷⁵ The court held that when there are two such conflicting claims of motherhood, the woman “who intended to procreate,” essentially the woman to whom the surrogacy contract granted custody, shall be awarded parental rights.¹⁷⁶

The *Johnson* court implicitly recognized that there is some allowable level of commodification of children and the womb;¹⁷⁷ the court viewed the embryo and the womb as things that can be dealt with by using normal contract principles without violating public policy.¹⁷⁸

Comparing the “best interests” test used in *Baby M* with the “intent” test later used by the majority in *Johnson*, it becomes clear that MRT is changing the way courts and individuals think of the definition of “family.”¹⁷⁹ Notably, however, there is some reluctance to embrace the change, as indicated by Justice Kennard’s dissent in *Johnson* advocating for application of the “best interests” test for parentage articulated in *Baby M*.¹⁸⁰

V. CULTURAL RESISTANCE TO MRT COMMODIFICATION

Since the birth of the first test-tube baby in 1978, there have been countless articles, books, and theories written regarding MRT.

171. John A. Robertson, *Technology and Motherhood: Legal and Ethical Issues in Human Egg Donation*, 39 CASE W. RES. L. REV. 1, 10 n.29 (1989).

172. 851 P.2d 776 (Cal. 1993) (en banc).

173. *Id.* at 777-78.

174. *Id.* at 782.

175. *Id.* at 781.

176. *Id.* at 782.

177. *Id.* at 785.

178. *Johnson*, 851 P.2d at 783-84. *But see* Jennifer S. Hendricks, *Essentially a Mother*, 13 WM. & MARY J. WOMEN & L. 429, 429-33 (2007) (arguing that existing constitutional jurisprudence supports granting parental rights to gestational mother instead of genetic mothers, even where surrogacy contracts exist).

179. *See* Dolgin, *supra* note 13, at 371 (“In short, the presumption that both autonomous choice and the preservation of tradition can be central to the construction of a family suggests a contradiction at the center of society’s view of family.”).

180. *Johnson*, 851 P.2d at 789, 799 (Kennard, J., dissenting).

Arguments for and against the use of MRT are vehement. Regardless, the market for MRT services is growing.¹⁸¹

Ethical arguments against commodification of MRT are often just another vehicle to argue about the ethics of abortion.¹⁸² “Pro-life” advocates view embryos as persons,¹⁸³ and so may have problems not just with the commodification of the embryo and womb, but rather, with *any* use of MRT, because it typically results in the production of embryos, some of which will never be used or will be used for stem cell research.¹⁸⁴

Others taking issue with the unregulated MRT cite extreme cases such as “octo-mom” Nadya Suleman, a single woman who requested implantation of a large number of embryos in hopes of having multiple children at one time, despite lacking sufficient income to support so many children.¹⁸⁵ It is argued that Suleman’s story is the perfect example of how complete freedom of choice with respect to MRT can lead to an unhealthy family situation.¹⁸⁶ The response to Suleman’s story not only caused “public fury and social hysteria,”¹⁸⁷ it also led lawmakers to consider legislation regulating MRT by limiting the number of embryos that can be implanted during one procedure.¹⁸⁸

An additional argument against commodification asserts that the practice of buying and selling gametes can devalue human life and harm “the dignity of donors.”¹⁸⁹ Some argue that “[c]ommercialization of gametes and embryos (putting a price on them by the donors and the scientists who profit from embryo research) causes further harm by viewing uniquely human entities as objects in commerce rather than as inalienable symbols of humanity.”¹⁹⁰

181. 2006 ART REPORT, *supra* note 9, fig. 49.

182. Bercovici, *supra* note 21, at 193.

183. Sherry F. Colb, *To Whom Do We Refer When We Speak of Obligations to “Future Generations”? Reproductive Rights and the Intergenerational Community*, 77 GEO. WASH. L. REV. 1582, 1601 (2009).

184. *Id.* at 1601-02.

185. See Alison Stateman, *The Octuplets Mom Speaks, and the Questions Grow*, TIME, Feb. 7, 2009, <http://www.time.com/time/nation/article/0,8599,1877962,00.html> (discussing the negative reaction to Nadya Suleman’s delivery of eight babies).

186. *Id.*

187. Kimberly D. Krawiec, *Why We Should Ignore the “Octomom,”* 104 NW. U. L. REV. COLLOQUY 120, 120 (2009), <http://www.law.northwestern.edu/lawreview/colloquy/2009/34>.

188. *Id.*; see also Camille M. Davidson, *Octomom and Multi-Fetal Pregnancies: Why Federal Legislation Should Require Insurers to Cover In Vitro Fertilization*, 17 WM. & MARY J. WOMEN & L. 135, 135-36 (2010) (arguing that Congress should pass the Family Building Act of 2009 or similar legislation mandating insurance coverage for *in vitro* fertilization in order to reduce multiple embryo transfers).

189. Ann Alpers & Bernard Lo, *Commodification and Commercialization in Human Embryo Research*, 6 STAN. L. & POLY REV. 39, 43 (1995).

190. *Id.*

Many opposed to commodification also argue that compensating women for their eggs can result in the exploitation of economically desperate women.¹⁹¹ Compensation for egg donation has been reported to range from \$1,500 to \$150,000, with the average compensation falling between \$4,217 and \$5,200.¹⁹² As mentioned previously, the ASRM recommends a maximum payment of \$5,000, stating “sums of \$5,000 or more require justification and sums above \$10,000 are not appropriate.”¹⁹³ The ASRM justifies these numbers by saying that keeping the amount of payment low “minimizes the possibility of undue inducement of donors and the suggestion that payment is for the oocytes themselves.”¹⁹⁴

VI. AN ARGUMENT FOR ALLOWING MRT COMMODIFICATION

Many of the arguments against MRT commodification cannot withstand careful scrutiny and cannot be used to justify legislative action. This section will address several of the more convincing concerns regarding MRT commodification and argue that regulatory efforts are unnecessary to address these concerns.

First, legislation is unnecessary to prevent socially undesirable situations typified by “octo-mom” Nadya Suleman. Although perhaps well-intended, state legislative efforts to set a maximum number of embryos for implantation is redundant. Doctors are already able to make recommendations about care and refuse any “treatment request [that] is known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient.”¹⁹⁵ Further, a doctor can refuse non-discriminatory treatment that “is incompatible with the physician’s personal, religious, or moral beliefs.”¹⁹⁶ It seems clear that there is already precedent in the medical field for a doctor to refuse implantation of a certain number of fertilized eggs when she finds it inappropriate for the patient.

Second, the argument that commodification of MRT devalues human life falls short, in part, because it is outrageous to say that a child conceived using MRT or a child born from a gestational surrogate

191. *E.g.*, Bercovici, *supra* note 21, at 197.

192. Krawiec, *supra* note 28, at 66. Krawiec is careful, however, to note that these numbers are “self-reported” and may be unreliable, but she acknowledges that, ultimately, these are the best numbers available. *Id.* at 66-67.

193. AM. SOC’Y REPROD. MED., *supra* note 76, at 308.

194. *Id.*

195. *Code of Medical Ethics: Opinion 10.05—Potential Patients*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1005.shtml> (last visited Mar. 18, 2011) (citing Opinion 8.20).

196. *Id.*

is less of a person than those conceived or born in a more traditional way. If this were the case, it is unlikely that MRT use would have exploded in recent decades, with more than 400 fertility clinics in existence¹⁹⁷ and approximately 1.2 million women seeking fertility treatment in 2005.¹⁹⁸ Although the commodification of sex cells and the womb may reshape the idea of how families are formed, the valuation of the individual family members is certainly not affected.

The new conception of “family” may already be commonplace.¹⁹⁹ Professor of health care law Janet L. Dolgin writes in her article *Biological Evaluations: Blood, Genes, and Family*:

Many commentators—in universities, in courts, in the media, and in private settings—have noted the increasing importance of autonomous individuality and choice to understandings of families in the U.S. For almost a half century, society and the law have increasingly viewed family members—especially adults within families—as autonomous individuals, free to forge their own bargains within family settings. In consequence, families shaped by individuals’ nontraditional choices are now commonplace.²⁰⁰

Echoing the majority in *Johnson*, Professor Dolgin specifically notes the modern trend in recognizing “adults within families . . . as autonomous individuals, free to forge their own bargains.”²⁰¹ Legislation preventing a woman from contracting and making autonomous decisions about her own body could, in fact, do more damage to our modern conception of family decision-making than will the commodification of reproduction by MRT.²⁰²

In a related concern to the argument that commodification of reproduction devalues human life, some claim “that ‘paid surrogacy within the current gender structure may symbolize that women are fungible baby-makers for men whose seed must be carried on,’”²⁰³ or that such a market for embryos “turn[s] ‘women’s labor into something that is used and controlled by others.’”²⁰⁴ This point, however,

197. Daar, *supra* note 119, at 26.

198. *Id.* at 24-25.

199. Dolgin, *supra* note 13, at 348.

200. *Id.* at 347-48 (internal citations omitted).

201. *Id.* at 348.

202. *See id.* at 348-50 (discussing the tensions between traditional “flesh and blood” family composition and new ideas about individual autonomy, decision-making, and bargaining).

203. Richard A. Epstein, *Surrogacy: The Case for Full Contractual Enforcement*, 81 VA. L. REV. 2305, 2328 (1995) (quoting Margaret J. Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1935 (1987)).

204. *Id.* (quoting Debra Satz, *Markets in Women’s Reproductive Labor*, 21 PHIL. & PUB. AFF. 107, 123-24 (1992)).

ignores the fact that a woman is capable of exercising her autonomy in order to make such a valid, legally-recognized decision for herself.²⁰⁵

Third, concerns that a woman cannot make MRT decisions for herself without being exploited are likely exaggerated by an inappropriate viewing of contract law as strict and unyielding.²⁰⁶ Current contract doctrine “aimed at deterring coercion and minimizing negative externalities . . . can obtain some of the benefits that are presumed to be gained by a family law approach.”²⁰⁷

Arguments in favor of legislating a maximum compensation for egg donors in order to curtail the potential for exploitation are weakened by situations typified by South Korean stem cell researcher, Dr. Hwang Woo Suk.²⁰⁸ Dr. Suk used his position of power to coerce women into donating eggs for only \$1,400.²⁰⁹ Two of Dr. Suk’s research assistants donated eggs without receiving any compensation whatsoever.²¹⁰ Imposing a compensation ceiling will not prevent situations like those encountered by Dr. Suk’s research assistants. Existing contract and tort law, however, can address Dr. Suk’s misconduct.

Those arguing for limits in compensation may also be concerned that free-market sales have resulted in lower payment for eggs used in research than for those sold to mothers hoping to conceive a child.²¹¹ The fear is that the dual market may create two distinct classes of donors: one consisting of individuals whose eggs are desirable for reproductive donation—typically white or Asian women who tend to be “highly educated”—and another consisting of those whose eggs are desirable only for research purposes, for which they would receive less compensation.²¹² To prevent this problem, it might be tempting to draft legislation that would require research laboratories to rely instead on altruistic egg donation.²¹³ Practically, however, the fact that donation is altruistic does not affect the riskiness of the procedure and, as demonstrated by the actions of Dr. Suk, altruistic donation does not prevent coercion.

205. *Id.* at 2329.

206. Lori B. Andrews, *Beyond Doctrinal Boundaries: A Legal Framework for Surrogate Motherhood*, 81 VA. L. REV. 2343, 2344 (1995) (“Contract law need not be the cold, heartless, masculine doctrine that some feminists and family law professors accuse it of being.”).

207. *Id.* at 2344-45.

208. Bercovici, *supra* note 21, at 198.

209. *Id.*

210. James Brooke, *Korean Leaves Cloning Center in Ethics Furor*, N.Y. TIMES, Nov. 25, 2005, at A5.

211. Bercovici, *supra* note 21, at 197.

212. *Id.*

213. *Id.* at 198; Brooke, *supra* note 210, at A1.

VII. CORRELATIONS AND JUSTIFICATIONS

In considering arguments for and against commodification, it is informative to analyze potential double standards within the MRT regulatory effort. Differences in compensation between sperm and egg donation and differences in ethical concerns between surrogacy and simple egg donation may reveal the dangerousness of legislation aimed at “protecting” women from commodification.

First, a comparison of egg donation and sperm donation reveals that there is little correlation between the dangerousness of the procedure and the payment received for the gamete. As mentioned before, egg donor compensation in the United States purportedly varies from \$1,500 to up to \$150,000, with most clinics reporting that donors receive an average of between \$4,217 and \$5,200 per donation.²¹⁴ Dividing the total payment amount by the number of hours a woman spends undergoing various medical procedures involved in ovum donation results in a total pay of between approximately seventy-five dollars and ninety-three dollars per hour.²¹⁵ This payment is roughly the same compensation rate per hour that men receive for sperm donation, a virtually risk-free procedure.²¹⁶ Although difficult to claim with certainty, cultural assumptions that eggs are donated for altruistic purposes and sperm is donated for profit may be responsible for the questionable cost-to-risk ratio of egg donation.²¹⁷ Prejudicial legislative efforts that set a compensation ceiling for egg donation, but not for sperm donation, may reinforce both cultural assumptions and payments for egg donation that do not correspond to the high-risk nature of the procedure.

Second, as discussed previously, much of the concern regarding compensation of egg donors is linked to a fear that economically desperate women may risk the invasive procedure in order to receive reportedly high levels of compensation. This contrasts with the view that opponents to compensated surrogacy take, which is “grounded in a judgment that commodification of women’s reproductive capacity is harmful for the identity aspect of their personhood and in a judgment that the closeness of paid surrogacy to baby-selling harms our self-conception too deeply.”²¹⁸ The concern that an individual woman is not able to make a rational decision to donate her eggs

214. Krawiec, *supra* note 28, at 66.

215. *Id.* at 67.

216. *Id.*

217. *See id.* at 67-68, 71-72 (discussing cost-to-risk ratio of sperm and egg donation and differing cultural assumptions regarding egg and sperm donors’ motivations).

218. Radin, *supra* note 4, at 1932.

contrasted with the concern that all gestational surrogacy will devalue all of humanity may reflect an incongruous societal conception of “womanhood” and “motherhood.”²¹⁹

VIII. PROPOSED SOLUTION TO AN INEVITABLE “PROBLEM”

If there is one point of clarity in the MRT legislative debate, it is that reproductive technology is here to stay. It prevents genetic illness, it provides a solution to infertility, it is profitable, and it is common. Yet it also seems fairly clear that something about the current state of MRT delivery is not ideal. In order to provide a better, safer system—one that recognizes a woman’s right to access reproductive technology as equivalent to a person’s right to contract, reproduce, and make decisions—perhaps we should reconsider our regulatory focus. Instead of concentrating legislative and regulatory efforts on avoiding commodification through contracts and compensation, we should focus on ensuring that the administration of MRT is done in the proper clinical setting, with stringent federal requirements for reporting, informed consent, and clinical trials. Federal legislation is necessary to provide consistent and reliable protection for women making the autonomous decision to use MRT.

As mentioned in the earlier discussion regarding federal and state legislation of MRT, little attention has been paid to the safety of women undergoing MRT-based treatment.²²⁰ In order to truly protect women, federal legislation should address both the physical and mental health risks posed by MRT.²²¹

The potential for mental health risks is often used as an argument against commodification, namely that women cannot rationally choose to become surrogates because they are likely to regret the decision.²²² Although potential mental health risks may be serious, they are likely exaggerated. “[F]ewer than one percent of surrogates . . . change their mind” at some point during the surrogacy process and take steps to become the child’s mother.²²³ This number is close to the percentage of women who report regretting their decision to have an abortion or to be sterilized.²²⁴ A logical interpretation of these statistics

219. *See id.* at 1930 (“Surrogates may feel they are fulfilling their womanhood by producing a baby for someone else, although they may actually be reinforcing oppressive gender roles.”).

220. *See, e.g.,* Galpern, *supra* note 53 (noting that “[s]ome of the drugs used for egg extraction have never been subjected to rigorous safety studies investigating their use for the procedure”).

221. Andrews, *supra* note 206, at 2361-62.

222. *Id.* at 2350.

223. *Id.* at 2351.

224. *Id.*

indicates that women entering into surrogacy agreements may be no more vulnerable to experiencing regret than women making any other long-term decision regarding reproductive health. Women entering surrogacy agreements, therefore, are just as capable of rational decision-making as those choosing to have an abortion or become sterilized and need no greater legislative or regulatory protection, as long as they are fully informed of the potential physical risks.

Additionally, the American Medical Association's position is that *gestational* contracts should be strictly enforced, and that the risk of psychological detriment to the surrogate mother is small and is outweighed by the surrogate's lack of "genetic tie to the fetus" and the "mutually beneficial" surrogacy arrangement.²²⁵ The AMA also posits that *traditional* surrogacy arrangements, those in which the gestational mother also bears a genetic relationship to the child, should be enforced, with the exception of allowing the gestational mother to void the contract within a reasonable time after the child's birth.²²⁶

Still, some may consider it an important goal to attempt to eliminate even the small remaining risk to the psyche of the surrogate mother in order to truly allow free contracting. To do so, regulations could require surrogate mothers to undergo basic psychological screening that test potential surrogates for duress or psychological vulnerability.²²⁷ Just as surrogate mothers are commonly screened for physical disorders that may affect the child they have contracted to carry, they would also be mandatorily screened for issues that might make MRT dangerous to their mental well-being.²²⁸

As noted earlier, there are serious health risks associated with MRT procedures that have been virtually ignored.²²⁹ Emily Galpern writes, "[t]he anti-choice movement's single-minded focus on the moral status of the embryo has put women's health advocates in a defensive position and obscured concerns about the safety of the procedure for women whose eggs are being extracted."²³⁰ In order to protect women, it is important to step outside of opposition to the commodification of the womb and instead focus on how regulations can be imposed in a way that will keep women safe from MRT's medical risks.²³¹

225. *Code of Medical Ethics: Opinion 2.18—Surrogate Mothers*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion218.shtml> (last visited Mar. 18, 2011).

226. Galpern, *supra* note 53.

227. Andrews, *supra* note 206, at 2374-75.

228. Morgan Holcomb & Mary Patricia Byrn, *When Your Body is Your Business*, 85 WASH. L. REV. 647, 652-53 & n.21 (2010).

229. Galpern, *supra* note 53.

230. *Id.*

231. *See id.* (discussing regulations as one method for "protect[ing] the health and dignity of women who provide eggs").

Galpern makes a list of recommendations that, if enacted, would accomplish this goal of safety.²³² Her recommendations include the establishment of a federal regulatory body charged with “oversight of drugs used for egg extraction”²³³ and requiring clinics to report any adverse effect on women who undergo egg extraction.²³⁴ These regulations would create a better standard of care for women undergoing MRT by making sure that drugs and procedures are carefully studied and adverse effects publically reported.

Beyond regulation, Galpern notes that “[w]omen and other disenfranchised groups have often been used as guinea pigs in research”²³⁵ and recommends conducting studies in order to fully understand the long-term health effects of the drugs used in stimulation of egg production and egg harvesting.²³⁶ She also calls for studies to explore an alternative to the current egg-extraction procedure that would pose less of a risk to the donor.²³⁷

If regulation were to establish clear guidelines for the testing and use of MRT, its currently-unknown risks could then be discovered and made public. Armed with the full knowledge of risks and benefits of using MRT, a woman could give truly *informed* consent to MRT. This would alleviate much of the worry surrounding MRT because it would be certain that a woman was not coerced, and was instead making an autonomous and informed decision to enter into a contract.

The idea of the modern family in the United States embraces an individual’s ability to make choices about her family structure.²³⁸ It has also been noted that acknowledging the freedom to contract is an important element of recognizing the legal capacity of women to enter into surrogacy agreements.²³⁹ As early as 1993, a court upheld a surrogacy contract as valid, finding the “intent” of the contract to grant parental rights.²⁴⁰ Although there are arguments to the contrary, there seems to be a rallying force that would allow a woman the autonomy to freely contract for the sale of her sex cells and womb. Relying on the market-economy justification and existing contract law principles “allows women to define themselves and their relationships.”²⁴¹

232. *Id.*

233. *Id.*

234. *Id.*

235. Galpern, *supra* note 53.

236. *Id.*

237. *Id.*

238. Dolgin, *supra* note 13, at 371.

239. Epstein, *supra* note 203, at 2328-29.

240. Johnson v. Calvert, 851 P.2d 776, 782 (Cal. 1993) (en banc).

241. Andrews, *supra* note 206, at 2345.

CONCLUSION

MRT will necessarily redefine some aspects of traditional motherhood as a commodity unless the government enacts laws regulating the growth of the MRT industry. Such regulation, however, violates the modern view of personal autonomy and should not be used to “protect” a woman from her ability to freely contract. This is not to say that MRT should exist entirely unchecked in the market. Instead, all legislative and regulatory efforts aimed at MRT should be refocused to address the safety concerns posed by MRT procedures.

The federal government should require investigative studies to explore risks of MRT procedures and should require that these risks be fully divulged during the informed consent stage of any MRT administration. Once fully informed, a woman will be better able to evaluate the risks and benefits of MRT and use that information to choose whether to enter into a contract for egg donation or surrogacy for a price that meets her autonomous determination of value. Information, not legislation, will address concern surrounding MRT and allow women using the technology to protect themselves.

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