PRODUCING FAMILIES TODAY is a paradox. It is, for some, the most intimate of intimate acts and, for others, a multibillion-dollar business that simultaneously creates our closest relationships. Although 90 percent of Americans do not have fertility problems, 10 percent do. Each year, about one million people seek some sort of fertility treatment, and three hundred thousand go as far as undertaking in vitro fertilization. The infertility statistics are real and scary. A woman’s fertility drops off beginning in her late twenties, continues to fall even more dramatically after the age of thirty-five, and plummets when she reaches forty. Once a woman turns thirty, her chances of getting pregnant decrease about 3–5 percent each year. By the age of thirty, 7 percent of couples are infertile, and by the time they reach the age of forty, 33 percent of couples are infertile.

An industry—albeit with comparatively little legal regulation—has developed to help, with almost five hundred fertility clinics nationwide. Fertility drugs constitute a $3 billion yearly business. In 2005, there were more than 130,000 in vitro fertilization (IVF) cycles in the United States, with over 50,000 babies born.1 There are more than half a million frozen embryos in storage, and the Society for Assisted Reproductive Technology, an industry group, estimates that nine thousand donor-egg children were born in the United States in 2005, the most recent year for which statistics are available. In vitro fertilization accounts for about 99 percent of all assisted reproductive technology, and 18 percent of women using artificial reproductive technology (ART) services were over the age of forty in 2004.

Does IVF work? IVF success rates (the birth of a healthy baby) vary with the parents’ age, but the most successful fertility clinics report pregnancy rates higher than 30 percent. After months or years of a couple’s not conceiving, these statistics provide promise, although for any individual, the odds of having a baby are either 0 percent or 100 percent.

About fifteen years ago, after my third failed IVF attempt, my husband’s and my reproductive endocrinologist suggested that our fertility problems
resulted from my eggs. They just were not good, he explained. I was thirty-five, had experienced an early miscarriage, and was stunned when he recommended donor eggs to us. It had simply not occurred to me, even after years of infertility, that we might be candidates for using someone else’s gametic material to create “our” child. Even though we briefly considered trying to search for a suitable candidate to provide the necessary eggs, we decided, instead, to try another fertility clinic, where, on our first try, I produced beautiful eggs, one of which became our first daughter. Our second daughter was conceived completely outside the fertility industry.

In writing a book about reproductive technology and other-provided gametes, my physician’s words, and my initial shock, have constantly guided me. How do we navigate this world of thoroughly modern family-making? What guides—legal, emotional, and sociological—are there for us as individuals and as a society?

In my dual roles as a lawyer who teaches family law and as a player in the fertility game, I have learned that there is comparatively little legal regulation of any aspect of this industry and its participants. Although the fertility trade potentially affects millions of people—as consumers and producers, as physicians and patients—the regulation that does exist is piecemeal; purchasing eggs or semen involves entirely different regulations from those involved in determining whether the seller or purchaser is the parent or whether donor-conceived offspring have any rights to information about their donors. To a large extent, legal regulation of the fertility market, of the identity needs of resulting children, and of the determination of parenthood, have developed separately, and the legal approaches have evolved well after the technological innovations appeared. Indeed, the law has been in a catch-up mode, not in a shaping mode. The law has only minimally responded to the legal conundrums posed by ARTs, rather than guiding their expanding uses, and individual cases rather than broader legislation have more typically provided legal signposts.

The Continental philosopher Jürgen Habermas has suggested that “new technological developments have created new regulatory needs,” and he challenges existing regulations that ensure that “freedom of science and research is entitled to legal guarantees.” Instead, he argues that there is a need to “moralize human nature” and assert “an ethical self-understanding of the species.” In responding to this challenge and examining the morality of our current approaches to the new reproductive technologies, my intent is to promote an ethical approach to developing new laws that respects human dignity.
The promise of the reproductive technologies—producing babies—now goes beyond curing infertility and challenges our conceptions of natural families as families that are static and unchanging. Creating a family, regardless of whether you are an infertile husband-and-wife couple, a same-sex couple, or a single person, now involves deliberate choice. Indeed, approximately two-thirds, or four million, of all pregnancies in the United States are “wanted” (although only a very small portion of these are to the millions of people defined as infertile). We can imagine a continuum of procreative choices, ranging from birth control at one end and the advanced technologies at the other end, with a range of decisions on childbearing in between and a variety of legal protections for each of these decisions.

Of course, as discussed in chapter 9, the possibility of choosing to form a family outside the traditional heterosexual married couple is controversial both practically and legally. And use of the technologies is not equally available to all, regardless of sexual orientation, class, or race. Moreover, the possibility of purchasing eggs, sperm, or embryos from another person has engendered its own controversies. Finally, although the law clarifies some of the resulting legal, social, and personal relationships, there are multiple gaps.

This book examines three distinct issues and their relationship to the law: the market in gametes, the creation of familial relationships through ART, and the identity interests of the resulting children. Legally, each of these issues has developed at different times, responding to different pressures. The gamete market, which began with sperm and now includes surrogacy, eggs, and embryos, has been subject to little regulation, reflecting the secrecy that was integral to early sperm provision. Recognition of the legal relationships that resulted from the creation of families through ART has similarly developed in reaction to the stigma of illegitimacy; on the other hand, early cases pondered whether a married woman’s use of donor sperm, even with her husband’s consent, constituted adultery that would render any child illegitimate. In many cases, of course, only the doctor knew, and neither the mother nor father had any reason to air the issue in public; many children are unaware that they are “donor babies” and may never find out without DNA tests. Finally, the identity interests of resulting children have been camouflaged by the traditional secrecy that attended use of ART as well as by analogy to adoption, for which, for roughly the past half century, most birth records have been sealed. These diverging and overlapping origins have helped ensure that laws pertaining to each aspect have been viewed as relatively independent.
The politics of reproductive technology are deeply intertwined with the politics of reproduction. This is a message that conservatives understand profoundly and that accounts for many of the legal and policy debates discussed in chapter 9. On the other hand, many feminists have not connected the two movements, and, although the reproductive rights issue has a long feminist genealogy, infertility does not. Much of the feminist history of reproductive politics involves an examination of attempts to control fertility and sexuality by women, such as through contraception or the power to say no to sex, and by others, such as through eugenics. This history has typically included neither an examination of the need to enhance fertility nor an examination of the laws surrounding conception support. *Test Tube Families* joins the nascent discussion of legal approaches to reproductive technology, proposing that the law respond comprehensively to the issues involved in market regulation, parenthood determination, and identity needs.

Infertility has always existed (many people list Abraham’s wife, Sarah, from the Bible as the first historical example of infertility), but over the past several decades, as the secrecy surrounding adoption has dissolved and as science has learned more about fertility, reproductive politics has expanded to include the politics of contraception and conception. For feminists, however, discussion of infertility may be threatening on two levels: first, it reinforces the importance of motherhood in women’s lives, and second, the specter of infertility reinforces the difficulty of women’s “having it all.”

When the American Society for Reproductive Medicine (ASRM) decided to launch an infertility-awareness campaign in 2001, emphasizing that a number of factors—ranging from smoking to age—affect infertility, it was concerned that a discussion of age might be seen, on the one hand, as encouraging adolescent pregnancy and, on the other hand, as castigating women. And when the ASRM rolled out these “Protect Your Fertility” advertisements, the National Organization for Women viewed it as a “scare campaign.” Advertisements like those involving a baby bottle shaped like an hourglass (see figure 1.1) were viewed as giving the impression that younger women must “hurry up and have kids” or give up and never have them, claimed Kim Gandy, the head of the National Organization for Women. Others saw the message as telling women that they should not be too ambitious and should return to their homemaking roles. Lisa Marcus, a thirty-seven-year-old professor of women’s studies undergoing infertility treatment, asked in the *Women’s Review of Books,*
“Do I blame my infertility on my desire to divorce destiny from biology, to nurture a career rather than a child? Not for a minute. But the popular press is doing a number on women who’ve delayed motherhood.”

Shunning information about the relationship between infertility and age, however, ignores biological facts and, ultimately, does a disservice to women both in terms of approaching their own fertility and in providing the legal structure necessary to provide meaning to reproductive choice. The feminist classic *Our Bodies, Ourselves* is designed to provide accurate and clear information so that women can become experts in managing their own health. Particularly in light of the premises of the feminist health movement, information about controlling fertility must range from the means for preventing conception to the means for promoting conception. It is only with this information that reproductive choice becomes a meaningful concept; choice cannot mean only legal control over the means *not* to have a baby but must include legal control over the means to have a baby.

Even the discussion of the technology itself is not always a celebration. Feminists are divided over the multiple legal and policy issues posed by the new reproductive technologies, thereby providing inconsistent and incomplete guidance on how the law in this area should develop. In its starkest terms, the basic scholarly debate goes like this: for those who have access to it, reproductive technology exploits women because it reinforces a pronatalist ideology; for those who do not have access to it, reproductive technology provides evidence of privilege, allowing wealthy white women to reproduce themselves; and the mere concept of reproductive technology encourages women to live men’s lives. With donor eggs or surrogacy, the process involves the transfer of money from wealthier couples to
poor women, who do not freely choose their participation. It is a market transaction that resembles a sale. Indeed, as one legal writer has charged, it is difficult to control the “rapaciousness of U.S. baby consumers.” The money and energy spent chasing reproductive technology could be better spent on reforming the child welfare system both here and abroad and paying for basic access to reproductive services for all women.

For example, Elizabeth Bartholet, a professor at Harvard Law School, regrets the years she spent on the “treadmill” of infertility treatment, pursuing yet one more cycle of in vitro fertilization in her desperate hope for a biological child. She believes that the trend toward insurance coverage of IVF is destructive because it will encourage women to continue often-futile treatment. In Bartholet’s view, the increasing use of IVF conditions women to want only biological children and renders adoption a rather undesirable option. She suggests that, rather than encourage fertility treatments, as a society we should improve counseling for the infertile so that they understand the risks of various treatments, remove the hurdles in the adoption process, and create incentives to adopt. Although the information that Bartholet provides suggests that these may be important measures, her analysis reflects the notion that women cannot make appropriate reproductive choices because of the strong, socially constructed imperative toward biological childbearing. For example, while mandatory counseling ensures informed consent to undergo invasive medical procedures, it is also paternalistic to impose such a requirement. Ultimately, Bartholet advocates restricting women’s options to undergo infertility treatments because she believes that women’s decisions to pursue such treatments cannot be freely and validly made.

In this area, Bartholet draws heavily on some feminists’ analysis of the new reproductive technologies. Some have suggested a “patriarchal reproduction” position, which fears that women are unable to choose the new technologies voluntarily and that, instead, male doctors simply appropriate women’s bodies to produce children. Gena Corea, one of the leading proponents of this perspective, has argued that the concepts of “choice” and “consent” with respect to women’s participation in assisted reproduction are artificial on two levels: women’s actual understanding of the technology and the patriarchal structuring of women’s lives. According to Corea, women are victimized by a society that values them for producing children; they do not choose the new reproductive technologies so much as they are socially coerced to choose. Catharine MacKinnon has made similar arguments with respect to the authenticity of women’s
voices, emphasizing that women are unable to make valid choices under patriarchy. In other words, infertile women are socialized into wanting biological children, and therefore, the law should foreclose the possibility of choosing the new technologies so that women are not victimized. Bartholet makes a related, and more practical, argument that IVF may eliminate the possibility of parenting because, by the time they have finished their medical treatment, some patients are too old and too exhausted to adopt. She provides no statistics or studies for this conclusion; it appears to be speculation based, perhaps, on her own experiences. In addition, by focusing on reproductive technology and the pressures for biological parenting, or even on the empowering possibilities of adoption, Bartholet leaves unchallenged the more general social discipline on women to become mothers. A celebration of adoptive parenting still does not question a gendered socialization process in which women are expected to become mothers and to perform the appropriate caretaking roles.

Although this “patriarchal reproduction” analysis presents a significant and cautionary perspective, it nonetheless both denies women any agency and reinforces the restrictions on options by income and class. By denying the possibility of choice under existing social conditions, this view treats women as passive victims, disempowered from making their own legal choices concerning the reproductive technologies. Philosopher Karey Harwood, who is concerned about the “overconsumption” of the new reproductive technologies and about the way ART encourages women to delay their childbearing, has nonetheless suggested that “the charge of pronatalism is overly simplistic” and that the focus should shift to how our culture can support caregiving.

Another account is more celebratory, suggesting that reproductive technology allows both traditional and nontraditional families the opportunity to create children. This alternative perspective suggests that women may have helped to shape the new technologies or that women have, at least in some sense, chosen to undergo the risks associated with them. It may even be, as Martha Ertman argues, that women and men change roles when it comes to consumption of donor sperm. That is, men are the mere sperm providers, and women, the discerning consumers who want men only for their bodies. Indeed, although women’s experiences are mediated through a culture that reinforces biological motherhood, women may still look to technology as means of empowerment.

The dichotomy between women as victims of technology and women as agents in needing and demanding the technology is false. Instead,
while women make choices constructed by and within a social ideology that values childbearing, they are still able to exercise some control over their options within these social constraints. Arguing that women are unable to make their own decisions about reproductive technology reflects an outmoded view of women as dependent, passive creatures, without a corresponding recognition of the context in which these choices are constructed. Instead of taking away options for women, the focus should be on reforming the surrounding social ideology: motherhood at any cost.

A related issue focuses on legal access to reproductive technologies for poor and middle-class women, who have generally been unable to afford this technology. The expense of the new technologies—a single IVF cycle may cost upward of ten thousand dollars—has generally denied poor women even the opportunity to “choose” them; restricting access further essentially prevents poor women from ever being able to use them. Indeed, continuation of existing methods for funding IVF reinforces a situation in which the technology allows only rich white women to bear biological children.

Ironically, antiabortion activists have pursued a similar class-based legal strategy, believing that denying funding for abortion will discourage women from choosing abortion. The impact of such a policy is, however, most clearly felt by poor women, who cannot afford abortions, while middle-class and wealthy women are more easily able to exercise their abortion choices. Likewise, decreased funding for infertility treatment will not affect wealthier women, who will still be able to afford the treatment. As we discuss the parameters of public or private funding for infertility treatments, we must recognize that limiting insurance coverage will affect poorer women and will have a disproportionate effect based on race.

Because reproductive technologies develop and exist as part of a larger culture, they must be evaluated within that context. In general, the notion that women should not have access to the reproductive technologies (or that such technologies should not even be developed) is paternalistic and seems to echo an outdated belief that the infertile do not deserve medical treatment. On the other hand, the medicalization of fertility, pregnancy, and childbirth, and the consequent usurping of a woman’s choice not to avail herself of the techniques for motherhood, all raise legitimate fears. As technology becomes more accessible, there is certainly more pressure on women to use it. One challenge, then, is to reconstruct the choices women (and men) confront when they seek to become parents. A second challenge is to add into this discussion the interests of the other participants:
the children who are ultimately produced, the medical profession, and the
gamete providers.

This book adopts a feminist perspective on these developments, but as
is clear, there is no one feminist approach to fertility. The basics, examin-
ing the impact of gender, race, sexual orientation, and class of any particu-
lar approach or policy, are a given. Beyond that, however, how to measure
those impacts, how to assess those impacts, how to accommodate those
impacts, there is no agreement. Consequently, I respect insights from the
divergent perspectives within feminism to craft my approach, one that ex-
amines the potentially conflicting rights of all involved in the reproductive
technology area, of women and men wanting babies, of women willing to
provide eggs, men willing to provide sperm, and couples willing to give
embryos, of the middle people who facilitate gamete transactions, and of
industry representatives, as well as examining the needs of the fertile and
infertile and their children.

The book is organized according to three interconnected legal themes:
market regulation, parenthood determination, and identity formation. Part
1 of the book has two chapters. The first chapter provides background in-
formation on the problematic and complicated status of legal regulation of
each of these three areas. By contrast, the second chapter provides a more
sociological and psychological approach to the contemporary usage of re-
productive technologies, analyzing the meaning of infertility in contempo-
rary culture and its impact on individuals seeking fertility treatment. Part
2 continues to expand on the three themes concerning market, parents,
and identity, through four chapters, each of which examines the legal pa-
rameters for one set of participants in the reproductive technology world.
Chapter 3 explores the technology market, including the fertility clinics
and gamete suppliers. Chapters 4 and 5 explore the second set of themes,
the different adults involved in technology who might have any legal claim
to be parents: the intending parents and the donors. Chapter 6 examines
the third theme, the complicated set of issues involved in identity disclo-
sure. Part 3 provides theoretical frameworks for analyzing the three inter-
connected themes. Chapter 7 examines the structural and cultural barriers
to using ART, barriers based on marital status, sexual orientation, and ra-
cial and ethnic background. Chapter 8 explores the cost barrier, articulat-
ing the jurisprudential and practical issues surrounding the commodifica-
tion of sperm, eggs, and embryos. Chapter 9 turns to the cultural clashes
affecting future regulation of ART, clashes ranging from the potential of
ART to challenge the traditional two-parent heterosexual family to the
ability of technology to allow parents to engage in prenatal screening. Finally, part 4 sets out recommendations for future regulation, with chapter 10 focusing on the market, chapter 11 on parenthood determination, and chapter 12 on identity claims. These chapters establish a preliminary framework for further regulation of the reproductive technology field, a framework that is sensitive to race, class, and sexual orientation issues and that includes parameters for market transactions, for certainty of parenthood determination, and for mandatory access to identity information.

A final note on terminology: There are a series of linguistic choices that reveal much more than language. Egg and sperm are typically bought and sold. Yet the rhetoric of the fertility markets suggests that gamete providers are engaging in altruistic acts and so refers to egg and sperm “donors.” Injecting sperm into a woman’s vagina other than through sexual intercourse has generally been called “artificial insemination,” contrasting it with the “real” type of insemination. Some have begun to call this process “alternative insemination,” attempting to make it more value-neutral. And the children produced through donor gametes remain “donor children,” regardless of their age or the fact that parents always donate their gametes to their children. They are also called “donor offspring” or “donor-conceived adoptees.” Although I use all these terms throughout the book, I carefully considered each of these “linguistic choices” and further discuss their implications in other chapters.