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## A Trust Analysis of a Gestational Carrier's Right to Abortion

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## A Trust Analysis of a Gestational Carrier's Right to Abortion

### Cover Page Footnote

The authors gratefully acknowledge comments on drafts of this Article by Bruce Burton, Bruce Jacob, Helen Jenkins, Paul McGreal, Mark Siegel and Carol Takami. Many thanks to Monica Ortale who provided invaluable library research assistance; without her, this Article would never have been completed. Also, we would like to thank the many research assistants who helped on this Article. Although our list is most likely incomplete, those that helped on this Article in various ways include: Jenevieve Cardona, Stephanie Jue, Rebecca Turini, Estella Sandoval, Stephanie Spanhel and Sarah Youngdahl.

# A TRUST ANALYSIS OF A GESTATIONAL CARRIER'S RIGHT TO ABORTION\*

Kevin Yamamoto ♦ & Shelby A.D. Moore ♦ ♦

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## INTRODUCTION

The number of couples in the United States who are medically deemed infertile is rising at an alarming rate.<sup>1</sup> These numbers are expected to increase dramatically within the next two decades.<sup>2</sup> In response to this growing concern, medical researchers have attempted to assist infertile couples by developing methods which give them a chance at having a 100% genetically related child.<sup>3</sup> The first major medical advance—*in vitro* fertilization (“IVF”)—allowed doctors more control over the human reproductive process.<sup>4</sup> IVF has been expanded to allow a gestational carrier, a woman who is not the

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1. See *infra* notes 28–31 and accompanying text.

2. See *infra* note 31 and accompanying text.

3. For an overview of the basic techniques used in assisted reproduction, see *infra* Part I.E.

4. For a history of IVF, see *infra* notes 16-24 and accompanying text.

genetic parent of the fetus, to carry a fetus to term for the intended parents.<sup>5</sup> This allows couples to have genetically related children even when the woman has no means of bearing a child herself.<sup>6</sup>

It is important to contrast gestational carrier situations with traditional surrogacy; the procedures differ in a critical way. In traditional surrogacy the intended father and the woman who carries the fetus provide its genetic make-up.<sup>7</sup> By contrast, in gestational surrogacy, the woman who carries the fetus has provided none of the genetic material.<sup>8</sup> In many cases, both of the intended parents provide the genetic material for the fetus.<sup>9</sup> It is clear, however, that with both

5. This article will use either the term "gestational carrier" or "gestator" to refer to the woman who bears and gives birth to the child. The couple who provides the genetic material for the child will be referred to either as "intended parents" or "genetic mother/father." These terms are in keeping with the scientific and legal literature in the area. See Unif. Parentage Act art. 8, prefatory cmt. (2000) (using the term "gestational mother" because the woman "provides the gestational heritage of a child to be raised by the intended parents"); Frances R. Batzer et al., *Genetic Offspring in Patients with Vaginal Agenesis: Specific Medical and Legal Issues*, 167 Am. J. Gynecol. 1288, 1291 (1992) (recommending the term gestational carrier be used "to avoid confusion and eliminate the negative connotation of other terminologies"); Hilary Hanafin, *Surrogacy and Gestational Carrier Participants*, in *Infertility Counseling: A Comprehensive Handbook for Clinicians* 376 (Linda Hammer Burns & Sharon N. Covington eds., 1999). The term "surrogate" is deemed disparaging by some medical professionals and authors. See Hanafin, *supra*, at 376; Nicole Miller Healy, *Beyond Surrogacy: Gestational Parenting Agreements Under California Law*, 1 UCLA Women's L.J. 89, 90 n.5 (1991).

6. See *infra* note 25 and accompanying text.

7. In traditional surrogacy, the child is conceived pursuant to an agreement under which the surrogate will turn the child over to the male who provides the inseminating sperm. See *infra* notes 61-66 and accompanying text.

8. See *Jaycee B. v. Superior Court*, 49 Cal. Rptr. 2d 694, 695 (1996); see also *infra* notes 67-70 and accompanying text. Cheryl Tieg and James Taylor are two high-profile individuals who, with their separate spouses, have had children by gestational carriers. Julie K.L. Dam & Meg Grant, *Bringing Up Babies*, People, Nov. 27, 2000, at 68 (stating that Tieg and her husband were having twin boys); Ellen Glazer, *Sharing a Pregnancy Society: What is It Like for a Woman to Bear Another Woman's Child?*, Boston Globe, June 10, 2001, at C1 (indicating that Taylor and his wife were expecting twins); Karen Springen et al., *Should You Have Your Baby Now?*, Newsweek, Aug. 13, 2001, at 40, 44 (stating that Tieg used her own eggs in the process).

9. The intended parents do not always contribute the genetic material; in some cases, it may be contributed by third-party donors. See, e.g., *Jaycee B.*, 49 Cal. Rptr. 2d at 696 (gestator carried fetus which was created from donor sperm and donor eggs); Unif. Parentage Act art. 8, prefatory cmt. (2000) (stating that an "egg donor or a sperm donor, or both, may be involved"). For additional information on the *Jaycee B.* case, see Jerald V. Hale, *From Baby M. to Jaycee B.: Fathers, Mothers, and Children in the Brave New World*, 24 J. Contemp. L. 335 (1998) (discussing the legal consequences of assisted reproductive technology); Christine L. Kerian, *Surrogacy: A Last Resort Alternative for Infertile Women or a Commodification of Women's Bodies and Children?*, 12 Wis. Women's L.J. 113 (1997) (supporting the enforcement of surrogacy contracts and urging government regulation); Gary Whiter, *Surrogate Contracts: Another Cry from the California Courts for Legislative Action*, 19 J. Juv. L. 437 (1998) (discussing the need for legislation that regulates surrogate contracts and urging the legislature to provide specific definitions for "parents").

traditional and gestational surrogacy the intended parents must rely on the gestator to take care of the fetus and, ultimately, to deliver to the intended parents a child who is as healthy as reasonably possible. This Article posits that the requirement of a gestational carrier to produce a reasonably healthy child, by necessity, negates the gestational carrier's fundamental right to abort the fetus.<sup>10</sup>

While both types of surrogacy arrangements have faced considerable opposition and engendered heated debate, gestational surrogacy has received heightened attention because of the deep conflicts of interest between the intended parents, the fetus and the gestational carrier.<sup>11</sup> Indeed, the infertile couple, who desperately want a genetically related child, must endure tremendous emotional, physical and financial burdens with only a slim chance that their hope of a child will be realized.<sup>12</sup> The gestational carrier, however, also suffers considerable physical and emotional burdens given that carrying the fetus is a great intrusion upon her bodily integrity, albeit one voluntarily undertaken. The gestational carrier knows the purpose for which she has agreed to become a gestator and acknowledges the rights she temporarily surrenders for the benefit of the intended parents and fetus.

The authors argue that while the Supreme Court has determined the right to abort is a fundamental right of privacy, the right should not be absolute.<sup>13</sup> In situations where a gestational carrier is used, the right to abort must be balanced against the rights of both the fetus and the intended parents. The authors conclude that, based on the context within which these arguments are made, the gestational carrier must be required to carry the fetus to term unless her own life or health is at stake.<sup>14</sup>

The authors suggest that trust law might provide the legal justification to limit the rights of a gestational carrier to abort the fetus.<sup>15</sup> We argue that the gestational carrier is the trustee of the fetus, whom the intended parents have entrusted to her. As a result, the gestational carrier has a fiduciary obligation to carry the unborn fetus to term.

The remainder of this Article is divided into four primary sections. Part I discusses the medical aspects of infertility treatments, detailing the history of *in vitro* fertilization, how the female reproductive

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10. For a discussion on the right to abortion, see *infra* Part II. For the argument that the right of the gestational carrier to abort should be limited, see *infra* Part III.

11. See *infra* note 273 and accompanying text.

12. See *infra* notes 36–49 and accompanying text (regarding costs) and Parts I.E-F (regarding the IVF procedure).

13. See *infra* notes 366–71 and accompanying text.

14. See Unif. Parentage Act § 801(f) (2000) (“A gestational agreement may not limit the right of the gestational mother to make decisions to safeguard her health or that of the embryos or fetus.”).

15. See *infra* Part III.

system works and the present methods used in IVF. Part II reviews the right to obtain an abortion in the United States under current case law. Part III applies trust law to gestational carrier arrangements and finds that there is a fiduciary duty owed to both the intended parents and the fetus. Finally, Part IV discusses the various arguments against restricting abortion and why those arguments do not apply to limiting the right to abort in the gestational carrier situation.

## I. MEDICAL HISTORY AND INFORMATION ABOUT ASSISTED REPRODUCTION

### A. A Short History of Assisted Reproduction

The first successful *in vitro* procedure, or "test-tube" baby, was born on July 25, 1978.<sup>16</sup> Louise Brown was born to John and Lesley Brown, who had been trying to have a child for twelve years.<sup>17</sup> The procedure was performed in England by obstetrician Patrick Steptoe and reproductive physiologist Robert Edwards.<sup>18</sup> Oddly, no formal

16. Robert Edwards & Patrick Steptoe, *A Matter of Life* 176-81 (1980); see also Walter Sullivan, "Test-Tube" Baby Born in the U.S., *Joining Successes Around the World*, N.Y. Times, Dec. 29, 1981, at C1 (reporting birth of the first test-tube baby born in an American hospital). The first attempt at IVF in the United States was in 1973 in New York with John and Doris Del Zio. See Otto Friedrich, "A Legal, Moral, Social Nightmare:" *Society Seeks to Define the Problems of the Birth Revolution*, Time, Sept. 10, 1984, at 55. The procedure utilized was extremely crude as compared with today's methods. Mrs. Del Zio had one egg removed by laparoscopy; it was placed in a container and taken across New York City in a taxi to Columbia-Presbyterian Medical Center. See *id.* The egg was fertilized with Mr. Del Zio's sperm and placed in an incubator. *Id.* Before transfer, Dr. Raymond Vande Wiele, removed the test-tube holding the egg and sperm from the incubator since he was upset that the procedure was being performed. See *id.* His act succeeded in killing the embryo. See *id.* The Del Zios sued the hospital and received \$50,000 in damages. See *id.*; *Del Zio v. Presbyterian Hosp.*, No. 74-3588, 1978 U.S. Dist. LEXIS 14450 (S.D.N.Y. Nov. 14, 1978). For additional comments on the Del Zio case, see Alexander Morgan Capron, *Alternative Birth Technologies: Legal Challenges*, 20 U.C. Davis L. Rev. 679, 691 (1987); Tanya Feliciano, *Davis v. Davis: What About Future Disputes?*, 26 Conn. L. Rev. 305, 313-14 (1993); Kayhan Parsi, *Metaphorical Imagination: The Moral and Legal Status of Fetuses and Embryos*, 2 DePaul J. Health Care L. 703, 747-48 (1999); Lynne M. Thomas, Comment, *Abandoned Frozen Embryos And Texas Law Of Abandoned Personal Property: Should There Be A Connection?*, 29 St. Mary's L.J. 255, 276-78 (1997).

17. See Anne Taylor Fleming, *New Frontiers in Conception*, N.Y. Times, July 20, 1980, § 6, at 14. For the parents' story, see Leslie Brown & John Brown, *Our Miracle Called Louise: A Parent's Story* (1979).

18. John D. Biggers, *In Vitro Fertilization and Embryo Transfer in Human Beings*, 304 New Eng. J. Med. 336, 337 (1981); see also Claudia Wallis, *The New Origins of Life: How the Science of Conception Brings Hope to Childless Couples*, Time, Sept. 10, 1984, at 46 (describing the history of *in vitro* fertilization and modern advancements). The first successful IVF procedure in the United States was in 1981 with Roger and Judy Carr, who delivered a five pound, twelve ounce girl they named Elizabeth Jordan Carr. Sullivan, *supra* note 16. The physicians were the wife and husband team of Drs. Georgeanna and Howard Jones. See Philip Elmer-Dewitt, A

paper was ever published regarding this historic endeavor.<sup>19</sup> While much was made over the birth of Louise Brown, the success rate for Drs. Steptoe and Edwards was only two live births among the first seventy-nine patients.<sup>20</sup> The low success rate was due to the procedures they used to perform IVF.

In the first attempts at IVF, doctors made no effort to regulate the women's hormones or stimulate the ovaries to produce more than the normal number of eggs per cycle.<sup>21</sup> Attempts to cause the ovaries to produce more than the normal one egg per cycle ("superovulation") were not made during the early attempts at IVF because, during early trials, superovulated eggs failed to implant. Doctors felt this failure to implant was due to the drugs used, which affected the womb.<sup>22</sup> With the woman under general anesthetic, a laparoscope was used to recover any eggs present, but since the timing for egg release by the ovaries was uncertain, the attempt was often unsuccessful.<sup>23</sup> In contrast to present protocols followed after egg retrieval, the early IVF attempts tried to fertilize the eggs with the sperm as soon as possible after the eggs were recovered.<sup>24</sup>

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*Revolution in Making Babies*, Time, Sept. 30, 1991, at 56, 62; see also John A. Robertson, *Assisted Reproductive Technology and the Family*, 47 Hastings L.J. 911, 911 (1996) (discussing assisted reproductive techniques available to infertile couples).

19. Fleming, *supra* note 17. Steptoe and Edwards did publish several non-technical papers on their achievement. See Edwards & Steptoe, *supra* note 16, at 176-81; P.C. Steptoe & R.G. Edwards, *Birth After the Reimplantation of a Human Embryo*, 2 Lancet 366 (1978).

20. See Biggers, *supra* note 18, at 338 (reporting a three percent success rate for Steptoe and Edwards in their first attempts); Fleming, *supra* note 17. The second child, a boy, was born to another couple and was named Alastair Montgomery. See Fleming, *supra* note 17; *Test-Tube Babies: Doing What Comes Naturally—Almost*, Economist, Feb. 3, 1979, at 88 [hereinafter *Test-Tube Babies*].

21. See Edwards & Steptoe, *supra* note 16, at 145; see also Fleming, *supra* note 17; *Test-Tube Babies*, *supra* note 20, at 88 ("The team has ceased to use hormones to help nature along, the point being to interfere as little as possible with the natural processes of ovulation, conception, and birth."). Natural Cycle Ovulation Retrieval in *In Vitro* Fertilization ("NORIF") is performed presently by some doctors. See Gail Dutton, *A Matter of Trust: The Guide to Gestational Surrogacy* 37-38 (1997). The advantages are that NORIF costs less and there are no side effects present as compared to the drugs used in standard assisted reproductive techniques. See *id.*; see also S. Bassil et al., *Outcome of In-Vitro Fertilization Through Natural Cycles in Poor Responders*, 14 Hum. Reprod. 1262, 1262, 1264 (1999) (asserting that IVF with no stimulation drugs may be the best option for women who lack oocytes or have resistant ovary syndrome).

22. See Richard G. Matson, *Collaborative Baby-Making: Surrogacy and Related Bio-Medical Considerations*, 24 Willamette L. Rev. 1100, 1109 (1988); Fleming, *supra* note 17.

23. See John A. Robertson, *Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction*, 59 S. Cal. L. Rev. 939, 948 (1986); Wallis, *supra* note 18, at 49. In the early procedures, Steptoe and Edwards had a total of forty-four eggs recovered from sixty-eight patients. See Fleming, *supra* note 17.

24. See Wallis, *supra* note 18, at 48; see also David R. Meldrum et al., *Evolution of a Highly Successful In Vitro Fertilization-Embryo Transfer Program*, 48 Fertility & Sterility 86 (1987) (discussing the treatment protocol of an assisted reproduction



### B. Infertility: The Basics

A gestational carrier is medically implicated for infertile couples where the woman is incapable of bearing children.<sup>25</sup> A couple is defined as "infertile" if they cannot conceive a child within one year of having frequent, unprotected intercourse.<sup>26</sup> In contrast to those who are unable to conceive within one year, ninety percent of couples, both of childbearing age, who engage in intercourse without using birth control for one year will conceive.<sup>27</sup>

program in the early 1980s).

25. See Susan Lewis Cooper & Ellen Sarasohn Glazer, *Choosing Assisted Reproduction: Social, Emotional & Ethical Considerations* 290 (1998); John A. Robertson, *Children of Choice: Freedom and the New Reproductive Technologies* 9 (1994); Stephen L. Corson et al., *Gestational Carrier Pregnancy*, 69 *Fertility & Sterility* 670, 670 (1998); Ethics Committee of the American Fertility Society, *Surrogate Gestational Mothers: Women Who Gestate a Genetically Unrelated Embryo*, 46 *Fertility and Sterility* (Supp. 1) 58S, 61S (1986); David R. Meldrum, *In Vitro Fertilization and Embryo Transfer*, in *Gynecology and Obstetrics* 10 (John J. Sciarra ed., 1999) [hereinafter Meldrum, *In Vitro Fertilization*]. In the first gestational carrier program, patients were accepted only if they had ovaries and either no or a severely abnormal uterus, over five recurrent abortions, or some other medical problem with conceiving (for example, DES exposure, severe heart disease, diabetes mellitus). See Wulf H. Utian et al., *Preliminary Experience With In Vitro Fertilization—Surrogate Gestational Pregnancy*, 52 *Fertility and Sterility* 633, 634 (1989) [hereinafter Utian et al., *Preliminary Experience*]. A gestational carrier is also recommended for individuals who have had a hysterectomy, or those with Rokitansky syndrome (a condition where the vagina and uterus do not develop normally). See, e.g., Shohre Beski et al., *Gestational Surrogacy: A Feasible Option for Patients with Rokitansky Syndrome*, 15 *Hum. Reprod.* 2326 (2000); Godwin I. Meniru & Ian L. Craft, *Experience with Gestational Surrogacy as a Treatment for Sterility Resulting from Hysterectomy*, 12 *Hum. Reprod.* 51, 54 (1997).

26. See Joyce C. Abma et al., *Fertility, Family Planning, and Women's Health: New Data From the 1995 National Survey of Family Growth* (National Center for Health Statistics, *Vital and Health Stat.*, No. 19) 1997, at 7; Leon Speroff et al., *Clinical Gynecologic Endocrinology and Infertility* 1013, 1013 (6th ed. 1999); Karen D. Bradshaw, *Evaluation and Management of the Infertile Couple*, in *Gynecology and Obstetrics*, *supra* note 25, at 2; Anjani Chandra & William D. Mosher, *The Demography of Infertility and the Use of Medical Care for Infertility*, in 5 *Infertility and Reproductive Medicine Clinics of North America: Study Designs and Statistics for Infertility Research* 283, 285 (1994).

27. See Bradshaw, *supra* note 26, at 2; Christopher Tietze et al., *Time Required for Conception in 1,727 Planned Pregnancies*, 1 *Fertility & Sterility* 338, 338 (1950); Sharon Begley, *The Baby Myth*, *Newsweek*, Sept. 4, 1995, at 38. Even though non-infertile couples have a ninety percent chance of conception within one year, this does not mean getting pregnant is easy. See Michael R. Soules, *The In Vitro Fertilization Pregnancy Rate: Let's be Honest With One Another*, 43 *Fertility & Sterility* 511, 511 (1985). Even under optimum conditions, fertile couples fail to conceive seventy-five percent of the time. See *id.*; Elmer-Dewitt, *supra* note 18, at 56 ("Even under the best of circumstances... [conception] fails 3 times out of 4"). The probability of becoming pregnant within one menstrual cycle is called "fecundability." Speroff et al., *supra* note 26, at 1013. The ability to achieve a live birth is called "fecundity." *Id.*; see also Chandra & Mosher, *supra* note 26, at 284 ("[F]ecundity refers to a woman's ability to conceive and carry a baby to term and a man's ability to impregnate."). There are three basic types of pregnancy: 1) a chemical pregnancy, which is a rise in the human chorionic gonadotropin ("hCG") levels but clinically is an unrecognized

The number of American couples who are diagnosed as infertile is stated to have reached "epidemic" levels.<sup>28</sup> The latest surveys estimate that 7.1% of married couples and 10.2% of women of childbearing age are infertile.<sup>29</sup> Several reasons have been postulated for this increase.<sup>30</sup> The number of infertile women and couples in the United States is expected to climb dramatically over the next twenty-five years.<sup>31</sup>

Infertile couples can be separated into two groups, those with primary infertility and those with secondary infertility. Primary infertility is the term used for couples who are unable to become pregnant and who have not previously conceived.<sup>32</sup> Secondary

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spontaneous abortion; 2) recognized spontaneous abortion, normally between six to twenty weeks' gestation; and 3) viable pregnancies. Soules, *supra*, at 511.

28. Elmer-Dewitt, *supra* note 18, at 56; Wallis, *supra* note 18, at 50 (stating that the number of infertile couples has tripled from 1964 to 1984). While the total number of infertile couples in the United States has increased, the percentage of infertile women and couples remained stable at approximately eight percent from 1965 to 1988. See Chandra & Mosher, *supra* note 26, at 283, 286; see also Elizabeth H. Stephen & Anjani Chandra, *Updated Projections of Infertility in the United States: 1995-2025*, 70 *Fertility & Sterility* 30, 30 (1998) (stating that infertility rates were stable throughout the 1980s). The dramatic rise in the number of infertile couples is attributed to the baby-boomer generation getting older. See Chandra & Mosher, *supra* note 26, at 288-89; Stephen & Chandra, *supra*, at 30. While there is some debate as to whether infertility is increasing in statistically significant numbers, there is no doubt that the number of couples seeking treatment for infertility is rising rapidly. See *infra* note 35.

29. Abma et al., *supra* note 26, at 7; Stephen & Chandra, *supra* note 28, at 32. There has been an approximate two percent increase in the overall percentage of infertile women from 1982 to 1995. See Stephen & Chandra, *supra* note 28, at 32. The increase has occurred primarily after 1988. See Abma et al., *supra* note 26, at 7; see also Speroff et al., *supra* note 26, at 1014 (noting the increase in the overall percentage of infertile women from 1988 to 1995).

30. Some of the different reasons given for the increasing number of couples facing infertility are that women are postponing child birth due to the Pill, the women's movement, and a greater focus on their careers; liberalized sexual behavior has increased the incidence of pelvic inflammatory disease; some women in their late thirties and forties have malformed reproductive systems due to DES (diethylstilbestrol); greater participation by women in athletics has decreased these women's body fat to levels too low to produce the required hormones; and women have increased stress. See Capron, *supra* note 16, at 683; Elmer-Dewitt, *supra* note 18, at 56; *The Saddest Epidemic*, *Time*, Sept. 10, 1984, at 50; Springen et al., *supra* note 8, at 42 (reporting that the rate of first births to women in their thirties and forties has quadrupled since 1970).

31. See Stephen & Chandra, *supra* note 28, at 34. In 1982, 4.5 million women reported being infertile. *Id.* at 32. This increased to 4.9 million in 1988, and 1995 saw a sharp rise to 6.2 million. *Id.* It is predicted that the number of infertile women will increase to between 5 and 6.3 million in 2000, and to between 5.4 and 7.7 million by 2025. *Id.* at 32, 34; see also Michael D. Lemonick, *The New Revolution In Making Babies*, *Time*, Dec. 1, 1997, at 40, 42 (stating that there has been a sharp rise in infertility over the last thirty years); Wallis, *supra* note 18, at 46 (noting that infertility among married women increased 177% from 1965 to 1982).

32. Office of Technology Assessment, Congress of the United States, *Infertility Medical and Social Choices*, app. J at 386 (1988); Bradshaw, *supra* note 26, at 1; see also Chandra & Mosher, *supra* note 26, at 285 (indicating that "primary" or

infertility exists when a couple cannot presently conceive, but either already has one child or can document a prior conception either through a blood test or ultrasound.<sup>33</sup> Secondary infertility accounts for a significant portion of the total number of infertile couples in the United States.<sup>34</sup>

Many infertile couples are currently seeking treatment for their infertility.<sup>35</sup> While many couples experiencing infertility require only minor treatment in order to conceive, others are forced to undergo very expensive procedures to bear a child.<sup>36</sup> The standard "high tech" treatment is IVF.<sup>37</sup> The present cost of one cycle of standard IVF

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"secondary" refers to the "absence or presence of a prior pregnancy").

33. Office of Technology Assessment, *supra* note 32, at 51; Bradshaw, *supra* note 26, at 1.

34. See Alicia C. Shepard, *One is Not Enough: The Tribulations of Secondary Infertility*, Wash. Post, Jan. 14, 1994, at G5. Most commonly, secondary infertility is caused by blocked fallopian tubes due to delivery, infection, abortion or endometriosis. *Id.* There are 1.4 million American couples who suffer from secondary infertility. *Id.*

35. In 1995, approximately fifteen percent of women of reproductive age reported seeking help for infertility. See Abma et al., *supra* note 26, at 7; Speroff et al., *supra* note 26, at 1014.

Not all countries are as accepting of assisted reproduction techniques as the United States. In Japan the use of donor sperm and eggs is called "extramarital fertilization" and is a medical taboo. See Mary Jordan & Kevin Sullivan, *Japan Takes Dim View of Fertility Treatments: Doctor Who Went Public Loses License*, Wash. Post, July 5, 1998, at A13. One doctor who completed such a procedure was expelled from Japan's leading obstetric society, with some calling for the revocation of his license to practice medicine. *Id.* For this reason, Japanese couples requiring the use of donor eggs or sperm are giving patronage to assisted reproduction clinics in the United States. See *id.*; see also Suvendrini Kakuchi, *Japan: Storm Over Surrogate Motherhood*, Inter Press Service, Sept. 15, 1992, LEXIS, News Library, Wires File (reporting on the use of United States assisted reproduction facilities by Japanese couples).

For a list of international views and laws on assisted reproduction, see Office of Technology Assessment, *supra* note 32, app. E at 329-63; Dutton, *supra* note 21, at 77-83; see also Ruth Halperin-Kaddari, *Redefining Parenthood*, 29 Cal. W. Int'l L.J. 313 (1999) (discussing Israeli law on surrogacy); Todd M. Krim, *Beyond Baby M: International Perspectives on Gestational Surrogacy and the Demise of the Unitary Biological Mother*, 5 Annals Health L. 193, 215-21 (1996) (reviewing laws of other countries and noting that many industrialized nations have banned commercial gestational carriers); see generally Angie Godwin McEwen, *So You're Having Another Woman's Baby: Economics and Exploitation in Gestational Surrogacy*, 32 Vand. J. Transnat'l L. 271 (1999) (reviewing the surrogacy laws of several countries).

36. See Laurence Zuckerman, *Couple Now Has No Savings, More Debt and Little Hope of Having a Baby*, N.Y. Times, Jan. 9, 1996, § 1, at 39. Some of the "low tech" methods to aid conception are the use of boxer shorts for the male in order to assist sperm production, the use of drugs to stabilize ovulation, and the use of ovulation predictor kits, such as Clear Blue Easy or Ovu Quick. See Begley, *supra* note 27, at 40.

37. See *infra* Parts I.E-H (describing, in depth, the IVF procedure). IVF literally translated means "fertilization in a glass." Webster's New World Dictionary of the American Language 742 (2nd ed. 1984) [hereinafter Webster's New World Dictionary]. IVF with no donor gametes and non-frozen embryos accounts for seventy-three percent of all the assisted reproductive cycles completed in the United States. Center for Disease Control, 1998 Assisted Reproductive Technology Success

treatments typically ranges from \$8000 to \$11,000.<sup>38</sup> This estimate is only for standard IVF with the costs for more exotic procedures such as Intracytoplasmic Sperm Injection ("ICSI"), Gamete Intra-Fallopian Transfer ("GIFT") and Zygote Intra-Fallopian Transfer ("ZIFT") being much higher.<sup>39</sup>

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Rates: National Summary and Fertility Clinic Reports 11 (2000) [hereinafter Center for Disease Control]. The other methods (GIFT, ZIFT, Interuterine Insemination ("IUI"), use of donor gametes and frozen embryos) make up the remainder. *Id.*

38. See James Holman, *Medical Necessity: Whose Call Is It?*, Wash. Post, July 12, 1998, at C3. The cost of IVF treatments has steadily increased over time. In 1984 the cost per cycle was between \$3000 and \$5000. Wallis, *supra* note 18, at 50. The cost in 1991 was approximately \$6000, and in 1996 the median cost was \$7800. Elmer-Dewitt, *supra* note 18, at 62; Trip Gabriel, *High-Tech Pregnancies Test Hope's Limit*, N.Y. Times, Jan. 7, 1996, § 1, at 1; Zuckerman, *supra* note 36; see also Bradley J. Van Voorhis et al., *Cost-Effective Treatment of the Infertile Couple*, 70 Fertility & Sterility 995, 998 (1998) (finding that in 1992 the average cost per IVF cycle in the United States was \$8071, and the average cost of IVF before having a live birth was \$44,200). These costs are unlikely to decrease since many of the expenses are fixed costs, like lab equipment. See Soules, *supra* note 27, at 513. On the cost of infertility services, see generally Office of Technology Assessment, *supra* note 32, at Ch. 8 (listing the various costs for different assisted reproductive treatments).

A "cycle" is the period of treatment for infertility, from the drug therapy to the transfer of the embryos, and typically covers six weeks. Curt Suplee, *Fertility Clinics' Success Rate is About 1 in 5*, Wash. Post, Dec. 19, 1997, at A1. The \$8000 to \$10,000 in costs does not take into account the tremendous amount of time and emotional energy it takes to undergo infertility treatments. See, e.g., Robert J. Edelman, *Emotional Aspects of In Vitro Fertilization Procedures: Review*, 8 J. Reprod. Infant Psychol. 161 (1990) (discussing the psychological characteristics of couples selected for IVF, and the impact and counseling needs of IVF couples); Carolyn M. Mazure et al., *Assisted Reproductive Technologies II: Psychologic Implications for Women and Their Partners*, 1 J. Women's Health 275, 277-78 (1992) (listing the various reasons why assisted reproduction is very stressful on couples); Springen et al., *supra* note 8, at 44 (indicating that the process is "financially, physically and emotionally draining"). The constant doctor visits, blood tests, ultrasounds, shots and emotional trials can ruin a couple's careers. Surveys of individuals undergoing IVF treatments found that twenty-five percent had to quit their jobs or reduce work hours to undergo infertility treatments. See Sue Shellenbarger, *Infertile Employees Seek Firms' Support*, Wall St. J., May 12, 1992, at B1. Another sixteen percent found less demanding jobs to accommodate their treatment schedules. See Weldon E. Havins & James J. Dalessio, *The Ever-Widening Gap Between the Science of Artificial Reproductive Technology and the Laws Which Govern that Technology*, 48 DePaul L. Rev. 825, 831 (1999) (speculating that the Pregnancy Discrimination Act of 1978 could be used to allow women more leeway from employers to use various reproductive technologies). For Supreme Court dicta indicating that infertility might be covered by the Americans with Disabilities Act of 1990, see *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998), *on remand*, 163 F.3d 87 (1st Cir. 1998). The Supreme Court wrote, "[r]eproduction falls well within the phrase 'major life activity.' Reproduction and the sexual dynamics surrounding it are central to the life process itself." *Id.* But see *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318 (S.D.N.Y. 2000) (holding that an employer was not required to provide insurance coverage under the Americans with Disabilities Act).

39. See *infra* notes 129-50 and accompanying text. The costs also exclude any expenses for donor gametes. See Gina Kolata, *\$50,000 Offered to Tall, Smart Egg Donor*, N.Y. Times, Mar. 3, 1999, at A10. In March 1999, an advertisement ran in the newspapers of Stanford University, MIT and Cal Tech offering \$50,000 for a 5' 10", athletic woman who scored at least 1400 on the SAT and suffered no major family

While the cost to undergo treatment is high, there are no guarantees the treatments will be successful. National averages show that thirty-two percent of women under age thirty-five undergoing IVF can expect a live birth, and the percentage is significantly lower for women thirty-five years and older.<sup>40</sup> In many cases, a live birth is achieved only after three or four treatment cycles.<sup>41</sup>

While the probability for live birth is low with IVF, in many cases the procedure is a couple's only chance at having a genetically related child. This may account for the estimated \$1 billion dollars per year that is spent by infertile couples in the pursuit of pregnancy.<sup>42</sup> Of the

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medical problems. *Id.* More than 200 women responded in just one week. *Id.*; see also Jay A. Soled, *The Sale of Donors' Eggs: A Case Study of Why Congress Must Modify the Capital Asset Definition*, 32 U.C. Davis L. Rev. 919 (1999) (suggesting a woman's eggs should be treated as a capital asset); Michael D. Lemonick, *Hot Genes for Sale? A Website Offers Eggs—But Maybe Just for Browsing*, Time, Nov. 8, 1999, at 56 (discussing a website which auctions the eggs of "beautiful models"). Once a couple elects to use donor eggs they must decide whether to use those from someone they know or from an anonymous donor. See P. Baetens et al., *Counseling Couples and Donors for Oocyte Donation: The Decision to Use Either Known or Anonymous Oocytes*, 15 Hum. Reprod. 476 (2000) (discussing factors couples use to determine whether to use the oocytes of someone they know or an anonymous donor). However, it has been noted that egg donation is not an easy way to make money. M.L. Lyke, *You Wouldn't Want to Make it a Career*, Seattle Post-Intelligencer, Aug. 31, 1999, at D4 ("As jobs go, egg donation is no slacker's holiday. It's a seven-day-a-week, 24-hour-a-day, physically demanding stint, with irregular hours and unknown risks.").

40. See Center for Disease Control, *supra* note 37, at 47. The reason for a lower success rate in older women is the decrease in fecundity as a woman grows older. Chandra & Mosher, *supra* note 26, at 288. But see Jane Menken et al., *Age and Infertility*, 233 Science 1389, 1389, 1393 (1986) (asserting that there is a weak connection between fecundity and age). Over eighty percent of women treated for infertility are under forty years old. See Begley, *supra* note 27, at 38.

In late 1998, a New York fertility clinic successfully transferred the DNA of one human egg to that of another human egg. Rick Weiss, *Fertility Experiments Mix Genes of 2 Women*, Wash. Post, Oct. 9, 1998, at A1. The egg was then fertilized and the resulting embryo placed in a womb. *Id.* The reason behind this procedure was to overcome the lower fertilization rates for women over the age of thirty-five, which is thought to be caused by poor egg quality. See *id.*

41. See Mabelle M. Seibel et al., *In Vitro Fertilization: How Much is Enough?*, 321 New Eng. J. Med. 1052, 1053 (1989) (stating "eighty-four percent of the births occurred after two IVF cycles"). This is an unfortunate consequence since most couples can only afford two IVF cycles. Office of Technology Assessment, *supra* note 32, at 10; see Holman, *supra* note 38. In 1992, the average cost of IVF treatments per live birth was \$44,200. Van Voorhis, *supra* note 38, at 998; see also David R. Meldrum et al., *Success Rate with Repeated Cycles of In Vitro Fertilization-Embryo Transfer*, 69 Fertility & Sterility 1005, 1008 (1998) (stating that analysis of all cycles done in one year in SART programs in the United States showed only a "modest decline of success" for each cycle attempted) [hereinafter Meldrum, *Success Rate*].

42. Mabelle M. Seibel & Susan L. Crockin, *Family Building Through Egg and Sperm Donation* 24 (1996) (stating that \$1 billion was spent to overcome infertility in 1987); Bradshaw, *supra* note 26, at 1; see also Office of Technology Assessment, *supra* note 32, at 10 (stating that in 1987 seven percent of the money spent on infertility was on assisted reproductive techniques). The \$1 billion spent by infertile couples is a 500% increase from the \$200 million that was spent on infertility treatments in 1983.

\$1 billion dollars spent, eighty-five percent of the costs are borne by the patients themselves, since infertility treatments are generally not covered by health insurance plans.<sup>43</sup> Several states require all health plans to offer IVF coverage, but most states which have statutes providing for infertility insurance have significant exceptions.<sup>44</sup>

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See Robertson, *supra* note 23, at 946.

43. See Gabriel, *supra* note 38. How do couples afford the treatment? "The first step usually involves exhausting their savings. The next step is signing up for a host of credit cards and charging up to their credit limit. If they can, they usually then borrow from relatives or friends." Esther B. Fein, *Calling Infertility a Disease, Couples Battle with Insurers*, N.Y. Times, Feb. 22, 1998, § 1, at 1.

A 1997 survey found that one-half of large employers covered some form of infertility services. Holman, *supra* note 38. When adding small employers, the coverage rate dropped to twenty-five percent. *Id.*; see also Office of Technology Assessment, *supra* note 32, at 148-57 (providing overview of state laws on insuring treatment for infertility); Seibel & Crockin, *supra* note 42, app. 1-J at 32 (reprinting letter in *The Lancet* concerning the additional cost per insured to insure for infertility).

Employers are also not required to provide insurance coverage under the Americans with Disabilities Act. See *Saks v. Franklin Covey Co.*, 117 F. Supp. 2d 318, 326 (S.D.N.Y. 2000). In *Saks*, the District Court held that the plaintiff, while having standing to pursue ADA claims, could not use the statute to recover expenses for infertility care. *Id.* at 326-28. The plaintiff's ADA claim failed since her employer did not offer less pregnancy-related coverage to infertile as compared to fertile people. Moreover, the defendant's insurance plan was not covered by ADA since it was a self-insured plan. *Id.*

A small comfort for couples who pay the cost of treatments themselves is that, generally, infertility treatments may be tax deductible. See 26 U.S.C. § 213(a) (1986); Mark Reid & Daphne Main, *Tax Issues Surrounding Assisted Reproduction Expenses*, 78 Taxes 26, 27 (2000) (stating that the IRS should allow a deduction for infertility treatments since the costs of preventing pregnancy are deductible). However, the payments are only deductible for those amounts greater than 7.5% of a couple's adjusted gross income. 26 U.S.C. § 213(a). The cost of medical treatments, prescribed drugs and transportation to seek treatment may also be treated as medical expenses. *Id.* at § 213(b), (d)(1)(A), (B), (d)(3). But see Priv. Ltr. Rul. 57-07-244900A (July 24, 1957) (disallowing the deduction for expenses associated with artificial insemination). The cost of hiring a gestational surrogate or payments for donor egg or sperm may not be tax deductible. See Reid & Main, *supra*, at 29 (finding "no justification for claiming a deduction" for payments to gestational carriers). But see James Edward Maule, *Federal Tax Consequences of Surrogate Motherhood*, 60 Taxes 656, 663 (1982) (allowing for a medical deduction for the cost of traditional surrogacy since the costs are "designed to mitigate the effects of a disease or bodily malfunction" of the woman).

44. The following states have statutes regarding health coverage for infertility.

Broad Mandatory Coverage:

Massachusetts: Any blanket or general policy (except supplemental coverage of Medicare or governmental programs) that provides hospital expense or surgical expense insurance which includes pregnancy-related benefits must provide coverage for medically necessary expenses for diagnosis and treatment of infertility. Mass. Gen. Laws Ann. ch. 175, § 47H (West 1997). Massachusetts further provides for the same mandatory coverage under subscription certificates and contracts under hospital service plans with certain restrictions and qualifications. Mass. Gen. Laws Ann. ch. 176A, § 8K; ch. 176B, § 4J; ch. 176G, § 4 (West 1997).

Rhode Island: Rhode Island law requires most insurers (including Health Maintenance Organizations ("HMOs")) to cover the cost of medically necessary expenses associated with the diagnosis and treatment of infertility if the policies

include coverage for pregnancy services. R.I. Gen. Laws §§ 27-18-30, 27-19-23, 27-20-20, 27-41-33 (1998). The patient's co-payment cannot exceed twenty percent. *Id.* To receive this coverage for infertility treatments, the individual must be an "otherwise healthy married individual who is unable to conceive or produce conception during a period of one year." *Id.*; see also Note, *In Vitro Fertilization: Insurance and Consumer Protection*, 109 Harv. L. Rev. 2092, 2095 n.19 (1996) [hereinafter Note, *In Vitro Fertilization*] (discussing availability of IVF treatment and insurance coverage).

Restricted Mandatory Coverage:

Illinois: Subject to certain limitations, Illinois requires insurance policies that insure more than twenty-five people and provide pregnancy related benefits to cover the costs of diagnosis and treatment of infertility, including IVF. 215 Ill. Comp. Stat. Ann. 5/356m(a) (West 2000). The statute has no dollar limitation, but only allows up to four completed oocyte retrievals, unless a live birth occurs, in which case two more completed oocyte retrievals are covered. 5/356m(b)(1)(B). This statute applies to HMOs, but infertility procedures are specifically excluded from coverage for qualified plan members under the Comprehensive Health Insurance Plan Act. 215 Ill. Comp. Stat. Ann. 125/5-3, 105/8 (West 2000). The statute mandates coverage for IVF, ZIFT, and GIFT, but only if less expensive treatments have been unsuccessful. Lisa M. Kerr, *Can Money Buy Happiness? An Examination of the Coverage of Infertility Services Under HMO Contracts*, 49 Case W. Res. L. Rev. 599, 613 (1999) (urging federal legislation that would require all HMOs to provide coverage for assisted reproduction to address the wide variance in this area from state to state).

Maryland: Maryland does not allow health insurance policies (including HMOs) that provide pregnancy-related benefits to exclude benefits for outpatient expenses arising from IVF. Md. Code Ann., [Ins.] § 15-810(b) (1997); Md. Code Ann., [Health-Gen. I] § 19-706(00) (2000). The allowed benefit includes up to three IVF attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000. Md. Code Ann., [Ins.] § 15-810(d). However, HMOs are only required to provide coverage for IVF to the same extent as the benefits provided for other pregnancy-related services. *Id.* at § 15-810(b)(2).

Hawaii: Hawaii requires that all health insurance policies (individual and group) providing pregnancy-related benefits cover all outpatient expenses for at least one IVF procedure. Haw. Rev. Stat. Ann. §§ 431:10A-116.5, 432:1-604 (Michie 1993). This coverage is contingent upon the insured's meeting several conditions. *Id.*

Mandatory coverage excludes HMOs:

Arkansas: All disability insurance companies doing business in the state must cover the cost of IVF. Ark. Code Ann. §§ 23-85-137, 23-86-118(a) (Michie 1999). HMOs are not specifically directed to include or exclude these services from their coverage. § 23-76-104(a).

Infertility Coverage Included as Basic Health Care Services (includes HMOs):

Montana: As part of basic health care services, Montana state law requires HMOs to cover infertility. Mont. Code Ann. § 33-31-102(2)(h)(v) (1999). As for health insurers other than HMOs that qualify as association plans, the law specifically excludes infertility coverage from the required scope of health benefits insurers must provide. § 33-22-1521(3)(b)(xii).

Ohio: Ohio requires health insuring corporations (the definition of which includes HMOs) to cover basic health care services, which includes infertility. Ohio Rev. Code Ann. § 1751.01(A)(7) (Anderson 2001). There is no requirement for other health insurers to provide treatment for infertility. § 1751.01(N).

West Virginia: West Virginia includes infertility services in the definition of basic health care services required to be provided by HMOs. W. Va. Code Ann. §§ 33-25A-2(1), 33-25A-4(2)(b) (Michie 2000).

Montana, Ohio, and West Virginia consider infertility treatments to be preventative care, leaving the laws open to the interpretation that IVF should not be covered as it does not "prevent" infertility; but rather, it just remedies the problem caused by infertility. Note, *In Vitro Fertilization, supra*, at 2095 n.19.

Mandate to offer:

However, even in the states that do require coverage, the laws do not cover those employers that are self-insured.<sup>45</sup> Although the cost of IVF is high for individual couples, the cost to add infertility treatments to employee health plans is small. Estimates suggest adding standard infertility treatments to employee health coverage would cost about three dollars per employee, per year.<sup>46</sup>

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California: Every health care service plan except for HMOs must offer coverage for the treatment of infertility. Cal. [Health & Safety] Code § 1374.55(a) (West 2000). IVF is not required as part of the treatment for infertility. *Id.*

Connecticut: Connecticut insurance law requires health insurers to offer coverage for infertility diagnosis and treatment, including IVF. Conn. Gen. Stat. Ann. § 38a-536 (West 2000).

Texas: Texas requires insurers that cover pregnancy services to also offer coverage for infertility diagnosis and treatment. Tex. [Ins.] Code Ann. § 3.51-6(3)(A) (Vernon 2001). However, an insurer, HMO or self-insuring employer associated with a bona-fide religion that believes in-vitro fertilization to be immoral will be exempt from this section's mandate to offer coverage for in-vitro fertilization. § 3.51-6(3)(A)(f).

No mandatory coverage:

New York: Under New York law, health insurance policies cannot exclude coverage for the diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility. N.Y. [Ins.] Law § 3216(h)(13) (McKinney 2001). The statute says nothing about coverage for IVF treatments. See American Society of Reproductive Medicine, *State Infertility Insurance Laws*, at <http://www.asrm.com/Patients/insur.html> (last visited March 7, 2001). However, recent case law indicates that if an insurer provides some type of infertility benefit, New York law mandates IVF coverage as well. Note, *In Vitro Fertilization*, *supra*, at 2095 n.19 (citing *Empire Blue Cross Is Fined \$1.1 Million, Setting Record*, N.Y. Times, Mar. 2, 1996, at 24).

There is no inter-state uniformity in insurance law regarding IVF, but of those states not listed above, eight others have considered enacting legislation on IVF. *Supra*, Note, *In Vitro Fertilization*, at 2095 n.18 (indicating that Florida, Louisiana, Michigan, Nebraska, Oklahoma, Pennsylvania, Virginia and Wisconsin have considered proposals relating to IVF); see also Fein, *supra* note 43 (discussing various state requirements); Shellenbarger, *supra* note 38; Zuckerman, *supra* note 36. The number of states which require mandatory insurance coverage of infertility is unlikely to change in the near future. Norbert Gleicher, M.D., *Strategies to Improve Insurance Coverage for Infertility Services*, 70 *Fertility & Sterility* 1006, 1006 (1998).

45. Fein, *supra* note 43. Many insurance companies and self-insured companies say that they will not cover infertility because they do not consider it a "disease" and believe having children is elective. See Holman, *supra* note 38. One doctor's response to this was, "if having children is elective, why cover maternity benefits?" *Id.*

46. See Dale W. Stovall et al., *The Cost of Infertility Evaluation and Therapy: Findings of a Self-Insured University Healthcare Plan*, 72 *Fertility & Sterility* 778, 779 (1999) (finding the cost of infertility insurance for a university-based, self-insured health plan to be \$2.79 per member per year, or twenty-three cents per member, per month); Fein, *supra* note 43. Employers may be concerned that if they added IVF coverage, many more employees would take advantage of this benefit. For example, in France where IVF is commonly covered by health insurance, the use of IVF treatments per-capita is five times greater than in the United States. See Gabriel, *supra* note 38; see also Office of Technology Assessment, *supra* note 32, at 54 (giving a list of questions couples should ask themselves when they consider discontinuing treatment); Seibel & Crockin, *supra* note 42, at app. 1-J at 32 (stating that most patients do not undergo more than four treatments due to other than financial reasons).



The lack of insurance coverage and the lack of government funding for research means that infertility clinics are largely unregulated.<sup>47</sup> Health economists suggest that the lack of government funding creates higher costs, since insurance companies are not present to curb prices.<sup>48</sup> Therefore, there is no pressure on doctors or clinics to cut fees and eliminate unnecessary procedures.<sup>49</sup> However, this lack of oversight and the possibility of high profit margins have in part led to the vast expansion of infertility clinics in the United States.<sup>50</sup> In the last decade, the number of infertility clinics has increased by a power of ten, from 30 to more than 300.<sup>51</sup>

With the increase in the number of clinics, a tremendous increase in the number of babies born through IVF procedures has occurred. Only 100 babies were born as a result of assisted reproduction methods in the United States from the first successful IVF procedure in 1981 until 1984.<sup>52</sup> From 1984 to 1996, however, there were approximately 40,000 babies conceived, resulting in 33,000 live births.<sup>53</sup>

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47. There is no federal oversight since the clinics are not covered by federal regulations governing human-subjects research. See National Inst. Of Health, Development Of NIH Guidelines Governing Research Involving Human In Vitro Fertilization and the Preimplantation Embryo 1 (1995); Capron, *supra* note 16, at 689 n.24 (citing the Health Research Extension Act of 1985, Pub. L. No. 99-158, 99 Stat. 820 (1985), as a reason for lack of federal oversight); Robertson, *supra* note 18, at 919 (noting that any doctor can perform infertility services without special certification or education); Rick Weiss, *Fertility Innovation or Exploitation? Regulatory Void Allows for Trial-and-Error Without Patient Disclosure Rules*, Wash. Post, Feb. 9, 1998, at A1 [hereinafter Weiss, *Fertility Innovation or Exploitation*]. One professor of obstetrics and gynecology put it this way: “[A] woman gets more regulatory oversight when she gets a tattoo than when she gets IVF.” Weiss, *Fertility Innovation or Exploitation*, *supra*. This lack of federal funding has also created an industry which is on “an aggressively entrepreneurial track.” Rick Weiss, *Babies in Limbo: Laws Outpaced by Fertility Advances*, Wash. Post, Feb. 8, 1998, at A1 [hereinafter Weiss, *Babies in Limbo*] (discussing the use of a deceased woman’s eggs in a gestational surrogate arrangement). For information on possible Congressional action to support reproductive research see Office of Technology Assessment, *supra* note 32, at 29–31 (providing various options and levels of commitment to support fertility research); see also Havins & Dalessio, *supra* note 38, at 843–44 (noting that the Center for Disease Control was given the responsibility of establishing a model for states to adopt for the certification of IVF laboratories, but that no program has been established due to lack of proper funding); Warren A. Kaplan, *Fetal Research Statutes, Procreative Rights, and the “New Biology”*: *Living in the Interstices of the Law*, 21 Suffolk U. L. Rev. 723 (1987) (noting the need for federal legislation to regulate the fertility industry).

48. See Gabriel, *supra* note 38.

49. See *id.*

50. One clinic’s profit margin was 37.5% for each cycle. *Id.*

51. See *id.*; see also Center for Disease Control, 1996 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports 1 (1996) (noting that there were 300 clinics in 1996). In 1998, there was a further increase to 360 clinics. Center for Disease Control, *supra* note 37, at 4.

52. Friedrich, *supra* note 16, at 54.

53. See Gabriel, *supra* note 38; Lemonick, *supra* note 31, at 42.

Given the large number of couples who require assistance to conceive children and the high profit margin, there is a great deal of competition among clinics for patients. This can lead clinics to provide misleading statistics to the public in order to attract more patients.<sup>54</sup> The most important statistic for a clinic is the number of live deliveries per number of treatment cycles started.<sup>55</sup> Some clinics report the number of pregnancies per cycle, but this can be misleading since fourteen percent of the pregnancies resulting from assisted reproduction end in miscarriage or are just chemical pregnancies.<sup>56</sup>

To aid people in their decisions regarding the choice of an infertility clinic, Senator Ron Wyden (D-Oregon) sponsored the Fertility Clinic Success Rate and Certification Act in 1992.<sup>57</sup> The bill required the Center for Disease Control to survey participating clinics and publicly report the findings.<sup>58</sup> The bill was passed in 1992, but it did not take effect until 1994 and was not implemented until after 1996 due to inadequate funding.<sup>59</sup> The survey is now available and contains information on 360 clinics providing assisted reproductive services across the United States.<sup>60</sup>

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54. See Seibel & Crockin, *supra* note 42, at app. 1-B at 19; Soules, *supra* note 27, at 512.

55. See Soules, *supra* note 27, at 511, Gabriel, *supra* note 38.

56. See Abma et al., *supra* note 26, at 7; see also Seibel & Crockin, *supra* note 42, app. 1-B at 19-20 (discussing the manipulation of IVF success rates); Soules, *supra* note 27, at 512; Gabriel, *supra* note 38 (reporting an eighteen percent difference between reported pregnancies and live births). A chemical pregnancy is one where the only evidence of pregnancy is a rise in certain hormones associated with pregnancy (specifically beta-hCG), but there is no fetus. See Meldrum, *In Vitro Fertilization*, *supra* note 25, at 10.

57. 106 Stat. 3146, Pub. Law 102-493, *codified* at 42 U.S.C. §§ 263a-1, 263a-7 (1992). The legislative history says the bill was enacted to "provide for reporting of pregnancy success rates of assisted reproductive technology programs and the certification of embryo laboratories." *Id.*; see also Office of Technology Assessment, *supra* note 32, at 18-20 (discussing the various options and consequences, pro and con, of informing the public); Havins & Dalessio, *supra* note 38, at 843-44 (providing short overview of the history of the bill); Robertson, *supra* note 18, at 919 (giving the inflated claims of some IVF programs and the Federal Trade Commission's citations for false advertising as the reason for the bill); Sheryl Gay Stolberg, *U.S. Publishes First Guide to Treatment of Infertility*, N.Y. Times, Dec. 19, 1997, at A22 (stating that the purpose of the Center for Disease Control report on fertility clinics was to give consumers a "starting place" and not to be used to compare one clinic against the other).

58. See 42 U.S.C. § 263a-1(a)(1), (2) (1992).

59. *Id.* at § 263a-1(a); Suplee, *supra* note 38.

60. See Center for Disease Control, *supra* note 37, at 4. While the information contained in the survey is self-reporting, the Center for Disease Control does a random survey of eight percent of the clinics (29 out of 360) to validate the data. *Id.* at 5.

### C. Traditional Surrogacy v. Gestational Surrogacy

Traditional surrogacy<sup>61</sup> involves a situation where the child is conceived pursuant to an agreement under which the surrogate mother will turn the child over to the male who provides the inseminating sperm. The surrogate mother provides both the female gametes and the gestational component for the child.<sup>62</sup> This type of surrogacy has been utilized since Biblical times and is usually completed without advanced reproductive techniques.<sup>63</sup> Contract surrogacy is traditional surrogacy, but the woman contractually agrees to be inseminated and bear a child for another couple. This type of surrogacy is thought to be the creation of a Michigan attorney, Noel Keane, in 1976.<sup>64</sup> Contract surrogacy entered the national scene with

61. "Surrogate" means "a substitute figure." Webster's New World Dictionary, *supra* note 37, at 1433. "Traditional surrogacy" refers to situations where: (1) the surrogate mother is related to the child she will bear in that her egg was inseminated with the sperm of the sponsoring male; (2) she is having the child for an already established couple; (3) the child was conceived under an agreement the surrogate would turn the child over; and (4) insemination was done artificially. See Ethics Committee of the Am. Fertility Soc'y, *supra* note 25, at 58s. Artificial insemination may be done in a hospital setting or informally at home. See Utian et al., *Preliminary Experience*, *supra* note 25, at 634 (discussing the distinction between "traditional surrogacy" and "IVF surrogacy"). But see Capron, *supra* note 16, at 679 n.1 (saying that the term "surrogate mother" is incorrect and should be used for the wife of the biological father). The first recorded artificial insemination took place in 1799. See Office of Technology Assessment, *supra* note 32, at 36.

62. Ethics Committee of the Am. Fertility Soc'y, *Surrogate Gestational Mothers: Women Who Gestate a Genetically Unrelated Embryo*, 53 Fertility and Sterility (Supp. 2) 64S, 64S (1990).

63. See *Genesis* 16: 1-4 (King James).

Now Sarai Abram's wife bore him no children: and she had an handmaid, an Egyptian, whose name was Hagar. And Sarai said unto Abram, Behold now, the Lord hath restrained me from bearing: I pray thee, go in unto my maid; it may be that I may obtain children by her. And Abram hearkened to the voice of Sarai. And Sarai Abram's wife took Hagar her maid the Egyptian, after Abram had dwelt ten years in the land of Canaan, and gave her to her husband Abram to be his wife. And he went in unto Hagar, and she conceived.

*Id.*; see also Shari O'Brien, *Commercial Conceptions: A Breeding Ground for Surrogacy*, 65 N.C. L. Rev. 127, 133-34 (1986) (pointing out that Hagar was later cast out of Abraham's household at his wife's insistence); *Genesis* 30:1-4 (King James) (describing how Jacob's wife, Rachel, told Jacob to bear children by her servant); Andrea Mechanick Braverman & Stephen L. Corson, *Characteristics of Participants in a Gestational Carrier Program*, 9 J. Ass. Reprod. Genet. 353, 353 (1992).

64. George J. Annas, *Fairy Tales Surrogate Mothers Tell*, 16 Law Med. & Health Care 27, 27 (1988); Richard Lacayo, *Whose Child is This? Baby M. and the Agonizing Dilemma of Surrogate Motherhood*, Time, Jan. 19, 1987, at 56, 57. Surrogate mothers decide to contract to have a child for another couple for various reasons. These reasons include: the enjoyment of being pregnant, a desire to share maternal joy with others, a need for money and the desire to atone for past abortions. Philip J. Parker, *Motivation of Surrogate Mothers: Initial Findings*, 140 Am. J. Psychiatry 117, 118 (1983) (providing survey results from 125 applicants to be surrogate mothers); Claudia Wallis, *A Surrogate's Story*, Time, Sept. 10, 1984, at 53; see also Noel P. Keane, *Legal Problems of Surrogate Motherhood*, 1980 S. Ill. U. L.J. 147 (discussing

the "Baby M" case, in which the surrogate mother, Mary Beth Whitehead, decided during pregnancy to keep the child she was carrying.<sup>65</sup> While contract surrogacy has allowed couples to have children, it does not provide them with a 100% genetically related child.<sup>66</sup>

Gestational surrogacy is assisted reproduction using a gestational carrier and differs from traditional surrogacy in that the gestating woman is not the genetic parent of the fetus she carries.<sup>67</sup> Because of

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the various legal challenges to contract surrogacy).

65. See *In re Baby M*, 537 A.2d 1227 (N.J. 1988); see also Carol Lawson, *Couples' Own Embryos Used in Birth Surrogacy*, N.Y. Times, Aug. 12, 1990, § 1, at 1 (contrasting traditional surrogacy and the *Baby M* case with gestational surrogacy). The contracting couple, William and Elizabeth Stern, contracted with Mary Beth Whitehead to be inseminated with Mr. Stern's sperm, gestate the fetus, and return it to the Sterns after delivery. See *In re Baby M*, 537 A.2d at 1235. The Sterns paid Mrs. Whitehead \$10,000 plus medical expenses during pregnancy. *Id.* at 1235. The Sterns said they decided on a surrogacy arrangement since Mrs. Stern had mild multiple sclerosis and she might not be able to carry a child without some physical harm. *Id.* There was some question, however, whether the real reason for the surrogacy arrangement was that Mrs. Stern did not want to interrupt her medical career as a pediatrician. Lacayo, *supra* note 64, at 58. The New Jersey Supreme Court granted custody to the Sterns while Whitehead received visitation rights. *In re Baby M*, 537 A.2d at 1258, 1263. For a more detailed discussion of the case, see Bonnie Steinbock, *Surrogate Motherhood as Prenatal Adoption*, in *Surrogate Motherhood: Politics and Privacy* 123-28 (Larry Gostin ed., 1990); see also Thomas Wm. Mayo, *Medical Decision Making During a Surrogate Pregnancy*, 25 Hous. L. Rev. 599, 607-09 (1988) (discussing the *Baby M* case and analyzing the legal implications of surrogacy); Peter H. Schuck, *Some Reflections on the Baby M Case*, 76 Geo. L.J. 1793 (1988) (discussing the *Baby M* case and arguing that surrogacy contracts should be upheld).

66. Not all traditional surrogacy agreements are successful. One of the more infamous cases involved a surrogacy contract between Alexander Malahoff and Judy Stiver. See *Stiver v. Parker*, 975 F.2d 261, 263 (6th Cir. 1992). Under the terms of the contract, Mrs. Stiver agreed to be inseminated with Mr. Malahoff's sperm and carry the child. *Id.* Due to a cytomegalovirus ("CMV") infection the child was born microcephalic (having a small head) and mentally retarded. See *id.* Mr. Malahoff refused to accept the child, claiming it was not his and demanding a blood test to determine paternity. See Friedrich, *supra* note 16, at 55. The results of the blood test were given on national television on the Phil Donahue Show. See *id.*; see also William Raspberry, *Layaway Baby*, Wash. Post, Feb. 4, 1983, at A17 (citing the *Phil Donahue Show: "The Case of the Layaway Baby"* (NBC television broadcast, Feb. 2, 1983)). The blood test showed that Mr. Malahoff was not the father. See Friedrich, *supra* note 16, at 55. During the show, the Stivers decided they would care for the child. Eric Press & Frank Maier, *A Surrogate Mother's Story*, Newsweek, Feb. 14, 1983, at 76. It was later revealed that Mr. Stiver had intercourse with his wife several days before the insemination. See *Stiver*, 975 F.2d at 266. The Stivers later sued the hospital, the doctors, the attorney who drafted the agreement, and Mr. Malahoff for negligence because they believed Mr. Malahoff was the source of the CMV infection. See *id.* at 264; see also Capron, *supra* note 16, at 690-91 (describing the difficulties arising between the Stivers and the Malahoffs when the baby was born with a birth defect); John J. Mandler, *Developing a Concept of the Modern "Family": A Proposed Uniform Surrogate Parenthood Act*, 73 Geo. L.J. 1283, 1285-86 (1985); Friedrich, *supra* note 16, at 55.

67. Seibel & Crockin, *supra* note 42, at 13; see Ethics Committee of the Am. Fertility Soc'y, *supra* note 25, at 58S. For a description of the current medical procedures used for gestational carrier births, see *infra* Part G.

the lack of a genetic relationship, this type of surrogacy arrangement is also known as "host surrogacy."<sup>68</sup> In 1997, of the approximately 6,000 live births by surrogate mothers, around 500 were by gestational surrogates.<sup>69</sup> The ability to have a genetically related child without the hassles and pain of childbirth has led some to voice concerns about the exploitation of women who bear these children for other women, who do not want their careers to be interrupted by gestating their own child.<sup>70</sup>

#### D. *How the Female Reproductive System Works*

The entire process of assisted reproduction can be seen as trying to retrieve as many eggs as possible from the woman and to fertilize them with the man's sperm.<sup>71</sup> To accomplish this, doctors monitor and control the woman's physiological processes that mature the eggs.<sup>72</sup> An overview of the normal female reproductive cycle will help to understand the enormity of the task and degree of difficulty that assisted reproduction must surmount for an infertile couple to bear a child.

The basic building blocks of sexual reproduction are gametes, which are present in both males and females. In the male they are called spermatozoa (or sperm), and in the female they are called ova (or eggs), and both carry one-half of the resulting child's genetic material.<sup>73</sup> When the sperm and egg combine, the union is a single cell

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68. Dutton, *supra* note 21, at 11.

69. Hanafin, *supra* note 5, at 376.

70. The Huntington Reproductive Center in Pasadena, California only uses gestational surrogacy when medically necessary. See Lawson, *supra* note 65. "The hospital board is concerned that if you are thirty-nine years old, successful and very busy, you might want to rent someone's womb as a convenience." *Id.* On the possibility that surrogacy exploits poor women, see Martha Field, *Reproductive Technologies and Surrogacy: Legal Issues*, 25 Creighton L. Rev. 1589, 1590 (1992) [hereinafter Field, *Reproductive Technologies*]; John Dwight Ingram, *Surrogate Gestator: A New and Honorable Profession*, 76 Marq. L. Rev. 675, 683-84 (1993) (arguing that surrogacy does not exploit women); Robertson, *supra* note 23, at 1012 n.244 (suggesting that there might be "social infertility" in the future if women choose to use a gestational carrier for career or lifestyle reasons); Sherrie Lynne Russell-Brown, *Parental Rights and Gestational Surrogacy: An Argument Against the Genetic Standard*, 23 Colum. Hum. Rts. L. Rev. 525, 542-45 (1991-92).

71. For an overview of the IVF process see Seibel & Crockin, *supra* note 42, at 3-5 (providing an overview of the entire IVF procedure); William A. Sieck, *In Vitro Fertilization and the Right to Procreate: The Right to No*, 147 U. Pa. L. Rev. 435, 437-41 (1998) (same).

72. Long-term studies on the increased incidence of cancer due to the use of fertility drugs have shown no overall increase in cancer rates for most patients. See Alison Venn et al., *Risk of Cancer After Use of Fertility Drugs With In-Vitro Fertilisation*, 354 Lancet 1586, 1586 (1999), available at <http://www.thelancet.com> (presenting a study of ten Australian IVF clinics). However, women with unexplained infertility are at increased risk of uterine and ovarian cancer. See *id.*

73. Havins & Dalessio, *supra* note 38, at 832; see also Webster's New World Dictionary, *supra* note 37, at 573 (defining "gamete" as a reproductive cell which can

called a "zygote."<sup>74</sup> After this zygote has divided several times it is called a "blastocyst."<sup>75</sup> "Embryo" is the term used for the union of sperm and egg up to the ninth week following conception.<sup>76</sup> In medical terms, an embryo is formed from the zygote only when the "primitive streak" appears,<sup>77</sup> which is around ten to fourteen days after fertilization.<sup>78</sup>

Several hormones control the female system for maturing and releasing eggs.<sup>79</sup> A woman's eggs are carried in her ovaries and mature, normally one at a time, under the influence of hormones.<sup>80</sup> To start the process of egg maturation, the hypothalamus, located in the brain, produces gonadotropin-releasing hormone.<sup>81</sup> This hormone in turn triggers the pituitary gland (the "master" gland) to produce

join with another and develop into a new individual).

74. Havins & Dalessio, *supra* note 38, at 832; Webster's New World Dictionary, *supra* note 37, at 1656 (defining zygote as a "fertilized egg before cleavage"). This event starts the gestational clock and gives the gestational age. See Clifford Grobstein, *The Early Development of Human Embryos*, 10 J. Med. & Phil. 213, 215 (1985). Gestational age differs by about two weeks from the menstrual age of the embryo which begins at the beginning of the last menstrual period. See *id.*

75. Webster's New World Dictionary, *supra* note 37, at 149 (defining a blastocyst as a group of cells around which forms a sphere); see also Daniel Navot & Paul A. Bergh, *Implantation, in Gynecology and Obstetrics*, *supra* note 25, at 1-2 (discussing the embryo before implantation into uterus).

76. Office of Technology Assessment, *supra* note 32, at 384; see also Biggers, *supra* note 18, at 336-37 (explaining early embryonic development). For a list of all the changes to the embryo over the nine weeks, see Grobstein, *supra* note 74, at 216-17 tbl.I.

77. The "primitive streak," also called the "primitive neural streak," indicates when the embryo is determined to be a "distinct developing individual." National Institutes of Health, Report of the Human Embryo Research Panel 47 (Sept. 1994). This occurs because, soon after the primitive streak appears, the development of the nervous system begins, with the primitive streak forming the spinal column. See *id.* It is after the primitive streak appears that the National Institutes of Health concluded that there should be no experimentation allowed on the developing fetus. *Id.* at 51.

78. See Havins & Dalessio, *supra* note 38, at 833; Robertson, *supra* note 23, at 974.

79. A hormone is a chemical substance which is formed in one place in the body and carried by the blood stream to another place in the body. Stedman's Medical Dictionary 807 (26th ed. 1995). There are many different types of hormones, all of which have various effects on the human body. See *id.* at 807-08.

80. See Speroff et al., *supra* note 26, at 108-09. About seven months before a female is born, the eggs start to form within her ovaries. See *id.* at 112. A female will be born with the maximum number of eggs she will ever have after she exits the womb, about two million. See Biggers, *supra* note 18, at 337. By the time puberty is reached, this number will be reduced to 400,000. See Elmer-Dewitt, *supra* note 18, at 59. This number slowly declines after puberty until menopause. See Speroff et al., *supra* note 26, at 116. The actual number of eggs which mature is about 400. See *id.*; Biggers, *supra* note 18, at 337; Elmer-Dewitt, *supra* note 18, at 59. At the start of each cycle, approximately twenty eggs start the maturation process, but normally only one will reach full maturity. See Seibel & Crockin, *supra* note 42, at 3.

81. See New York State Task Force on Life and the Law, Assisted Reproductive Technologies: Analysis and Recommendations for Public Policy 7 (1998) [hereinafter New York State Task Force]. The term "Gonadotropin" refers to the nourishing of the ovaries (gonad: ovaries; trophic: to nourish). Dutton, *supra* note 21, at 14.

both follicle-stimulating hormone ("FSH") and lutenizing hormone ("LH").<sup>82</sup>

FSH causes the growth and development of undeveloped eggs in the ovaries.<sup>83</sup> While in the ovary, the egg is surrounded by a layer of cells that produces both estrogen and progesterone.<sup>84</sup> After the egg is released, this layer of cells is called the *corpus luteum*, and continues to produce both hormones.<sup>85</sup>

Estrogen affects the reproductive cycle in two ways. First, as estrogen increases, the level of LH produced by the pituitary gland also increases.<sup>86</sup> Second, estrogen, along with progesterone, fosters the creation of the uterine lining (the endometrium) in preparation of the egg and sperm union, the embryo.<sup>87</sup>

The rise in LH is what causes the matured egg to release from the follicle.<sup>88</sup> Once the egg is released, the empty follicle (the *corpus luteum*) produces even greater amounts of estrogen and progesterone, further developing the endometrium.<sup>89</sup>

Once the egg is released, it is picked up by the fallopian tubes and transported to the uterus.<sup>90</sup> It is in the fallopian tubes where the union of egg and sperm commonly occurs.<sup>91</sup> If the egg is fertilized and reaches the uterus, the resulting blastocyst will embed in the endometrium.<sup>92</sup> Once in the endometrium, some of the blastocyst will become the placenta, while other portions become the embryo. The placenta provides the connection between the mother and the embryo.<sup>93</sup> The placenta also produces human chorionic gonadotropin ("hCG").<sup>94</sup> The hCG helps to maintain the *corpus luteum* so that it

82. New York State Task Force, *supra* note 81, at 7; Dutton, *supra* note 21, at 14. FSH and LH are both gonadotropins. *Id.*

83. Speroff et al., *supra* note 26, at 117; Gregory F. Erickson, *Follicle Growth and Development*, in *Gynecology and Obstetrics*, *supra* note 25, at 4-6.

84. Speroff et al., *supra* note 26, at 119.

85. *Id.* Before the egg is released this layer of cells makes up the preovulatory follicle. *Id.* at 118-19.

86. David Jensen, *The Principles of Physiology* 974 (2d ed. 1980).

87. Dutton, *supra* note 21, at 14; *see also* Speroff et al., *supra* note 26, at 123-53 (providing in-depth information about uterine development and function).

88. Erickson, *supra* note 83, at 13-14.

89. New York State Task Force, *supra* note 81, at 7; Jensen, *supra* note 86, at 974.

90. Speroff et al., *supra* note 26, at 252-56; Robert H. Glass, *Egg Transport and Fertilization*, in *Gynecology and Obstetrics*, *supra* note 25, at 1.

91. New York State Task Force, *supra* note 81, at 7, 8; Seibel & Crockin, *supra* note 42, at 5; Speroff et al., *supra* note 26, at 254-56; Glass, *supra* note 90, at 2, 3.

92. Speroff et al., *supra* note 26, at 262-64. The fertilization process takes several hours to complete. *See generally* Navot & Bergh, *supra* note 75 (discussing implantation of the embryo into the uterus). The endometrium is the layer of tissue which lines the uterus and is sloughed off during a woman's menstrual period. *See* *Stedman's Medical Dictionary*, *supra* note 79, at 570.

93. Speroff et al., *supra* note 26, at 265.

94. New York State Task Force, *supra* note 81, at 8.

will continue its production of estrogen and progesterone, both of which help to sustain the early embryo and halt the onset of menses.<sup>95</sup>

### E. How Infertility Treatments Are Performed

Once a couple is diagnosed as infertile, a standard evaluation is performed to determine the reason for the infertility.<sup>96</sup> A common reason for infertility is blocked or abnormal fallopian tubes.<sup>97</sup> In fact, one infertility specialist described what he does as “old-fashioned plumbing problems being treated with extraordinary new techniques.”<sup>98</sup>

The overall procedure used in IVF may seem dry and tedious when reduced to a verbal description, but for the infertile couple it is infused with intense emotion: hope, disappointment, joy and even physical pain. The overview included here is as plain as possible, so that the impassive reader may gain a window of understanding into the “normal” cycle for attempting pregnancy through IVF.

A typical assisted reproductive cycle is as follows: On the fourteenth day of the woman’s menstrual cycle<sup>99</sup> she begins taking a gonadotropin-releasing hormone agonist (“GnRH-a”).<sup>100</sup> GnRH-a

95. See *id.*; Speroff et al., *supra* note 26, at 132 (stating that without estrogen and progesterone the uterine lining degrades).

96. Standard evaluation for infertility is semen analysis for the man; endometrial biopsy, hysterosalpingography (placing dye in the woman’s fallopian tubes to check for blockage), and laparoscopy (inserting a scope into the abdominal cavity under general anesthesia for a visual survey) for the woman; and to test for serum antisperm antibodies for the couple. David S. Guzick et al., *Efficacy of Superovulation and Intrauterine Insemination in the Treatment of Infertility*, 340 *New Eng. J. Med.* 177, 177 (1999); see also Bradshaw, *supra* note 26 (outlining infertility evaluation and treatment).

For insight into the causes of infertility, see generally Office of Technology Assessment, *supra* note 32, at 61–82 (listing the primary reasons for infertility as infection by sexually transmitted disease, hormonal imbalance, endometriosis (cells which are normally present in the uterine lining present outside the uterus), varicocele (varicose vein of the testis), and other external factors (contraception, abortion, environment, drugs, genetic factors, cancer, etc.)).

97. Elmer-Dewitt, *supra* note 18, at 60; Wallis, *supra* note 18, at 46.

98. Cynthia Gorney, *The Egg Man*, *Bazaar*, Dec. 1998, at 265.

99. The menstrual cycle is counted from the first day a woman’s period starts. Marilyn J. Chohaney, *Tune in to Menstrual Evolution*, *Cap. Times*, Oct. 19, 1995, at 2F; *The Cutting Edge*, *Wash. Post*, Nov. 23, 1999, at Z5.

100. See Dutton, *supra* note 21, at 14; Machel M. Seibel, *Ovulation Induction with Gonadotropins*, in *Gynecology and Obstetrics*, *supra* note 25, at 4–5. Examples of GnRH-a are leuprolide acetate (common name Lupron), nafarelin acetate (common name Synarel), and goserelin acetate (common name Zoladex). New York State Task Force, *supra* note 81, at 49 n.76; Dutton, *supra* note 21, at 14. These drugs are given either by tablet or subcutaneous injection. Dutton, *supra* note 21, at 14–15. Subcutaneous injections are preferred to inter-muscular injections since they use shorter, thinner needles causing less pain and can be more easily self-administered. See *Serono Labs Reports, Introduction of Fertinex Improves Quality of Patient Care by Reducing Stress, Improving Convenience of Infertility Therapy*, PR Newswire, Nov. 4, 1996, available at LEXIS, News Library, USNEWS File.



causes the pituitary gland to switch off and stop producing FSH and LH (the egg producing, maturing hormones), thereby allowing the physician to control the maturation and timing of the follicles.<sup>101</sup> GnRH-a causes the cessation of production by desensitizing the pituitary gland after several days of use.<sup>102</sup> One side effect of GnRH-a is a lowering of estrogen levels, which causes some women to experience menopausal symptoms (hot flashes, cold sweats, etc.).<sup>103</sup> Typically, after two weeks on GnRH-a and during the woman's period, a blood test will be performed to verify that the pituitary gland has been shut down.<sup>104</sup> When this occurs, the egg production phase of the assisted reproductive cycle can begin.

The woman will now take less GnRH-a and begin taking drugs to stimulate her ovaries.<sup>105</sup> In a woman's normal cycle, FSH is produced by the pituitary to signal the ovaries to begin maturing follicles to produce eggs.<sup>106</sup> In an assisted reproductive cycle, human menopausal gonadotropin ("HMG") is used to achieve this same goal.<sup>107</sup>

HMG is manufactured from two different sources.<sup>108</sup> The first reliable source of HMG was processed from human urine.<sup>109</sup> There

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Recently a new type of drug, a GnRH antagonist, has been used to prevent the production of LH. See Mehmet A. Akman et al., *Addition of GnRH Antagonist in Cycles of Poor Responders Undergoing IVF*, 15 Hum. Reprod. 2145, 2145 (2000). The advantage of using an antagonist is that it works immediately to prevent the LH surge that triggers the eggs to release. See *id.* This allows them to be added to the patient's treatment much later in the cycle after the eggs have developed. See *id.* This is thought to be especially beneficial for those women who do not respond well to the stimulation drugs. See *id.* However, there is some data to suggest that antagonists could lead to lower implantation rates. Eleuterio R. Hernandez, *Embryo Implantation and GnRH Antagonists, Embryo Implantation: The Rubicon for GnRH Antagonists*, 15 Hum. Reprod. 1211, 1211 (2000).

101. See New York State Task Force, *supra* note 81, at 49; Seibel & Crockin, *supra* note 42, at 4.

102. Paul Devroey, *GnRH Antagonists*, 73 Fertility & Sterility 15, 15 (2000).

103. Dutton, *supra* note 21, at 14; Speroff et al., *supra* note 26, at 1120.

104. See Speroff et al., *supra* note 26, at 104-05.

105. See *id.* Early attempts at IVF did not use any ovulatory drugs to increase the number of follicles. See *supra* Part I.A (discussing early IVF protocols). In the early 1980's Clomid and Pergonal were used to increase the number of eggs per cycle. See Wallis, *supra* note 18, at 48.

106. See *supra* text accompanying notes 83-84.

107. Dutton, *supra* note 21, at 15; Seibel & Crockin, *supra* note 42, at 4; Speroff et al., *supra* note 26, at 1104. Before HMG, Clomiphene Citrate (drug name Clomid or Serophene) was used to stimulate the pituitary to secrete more FSH and increase egg production. See New York State Task Force, *supra* note 81, at 44. See generally Mary G. Hammond, *Induction of Ovulation with Clomiphene Citrate*, in *Gynecology and Obstetrics*, *supra* note 25 (reviewing treatment protocols and results using Clomiphene Citrate). HMG is more widely used because, when using clomiphene citrate, doctors cannot control the timing of the LH surge which causes the follicles to release the eggs. See Hammond, *supra*, at 1, 2.

108. Speroff et al., *supra* note 26, at 1110.

109. Seibel, *supra* note 100, at 1. At first, gonadotropins were obtained from pregnant mares, but this proved unsatisfactory for human use. *Id.* Next, FSH and LH were obtained from human pituitary glands containing both hormones. *Id.* However,

are two disadvantages of urinary HMG.<sup>110</sup> One is the availability of urine from which to extract HMG.<sup>111</sup> The other is that many of the drugs made with urinary HMG are typically given with inter-muscular injections, a much more painful method than subcutaneous injections, and cannot (without even more pain) be self-administered.<sup>112</sup> The other source of HMG is genetically engineered FSH.<sup>113</sup> This process was granted approval by the federal Food and Drug Administration ("FDA") in 1997.<sup>114</sup> With the advent of recombinant technologies, HMG, and therefore assisted reproduction, is available to more couples.<sup>115</sup>

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due to the small number of human pituitary glands which contained the hormones, the source was too unreliable. *See id.* Menotropin (common name Pergonal) was one of the first widely used sources of HMG. *See id.* This comes from the urine of post-menopausal women. *See New York State Task Force, supra* note 81, at 46. Since post-menopausal women can no longer create eggs, and therefore do not have a corpus luteum (the old egg sac), they are unable to produce estrogen. *See Speroff et al., supra* note 26, at 226-38 (describing the hormonal phases of ovulation). This lack of estrogen means the pituitary does not stop making FSH and LH, resulting in higher constant concentrations of both in the urine of post-menopausal women. *See id.*

110. There are several drugs presently on the market which are made from urinary HMG. Drugs like Pergonal and Humegon are a mixture of FSH and LH. New York State Task Force, *supra* note 81, at 46. Others, like Metrodin and Fertinex, contain only FSH (urofollitropin). *Id.* Metrodin was removed from the market since Fertinex contained a more purified form of FSH and could be taken via subcutaneous injection. New York State Task Force, *supra* note 81, at 46 n.56; Seibel, *supra* note 100, at 2. Metrodin was the fertility drug used by Bobbi McCaughey, the woman who gave birth to the United States' first set of septuplets, and only the second set in the world. *See Pam Belluck, Progress Made by Seven Babies Encourages Their Doctors*, N.Y. Times, Nov. 21, 1997, at A32; Michael D. Lemonick, "It's A Miracle," Time, Dec. 1, 1997, at 35.

111. Treating the estimated number of infertile women with urinary gonadotropins would require 100 million liters of urine to be processed. Seibel, *supra* note 100, at 1.

112. New York State Task Force, *supra* note 81, at 46 n.58; Dutton, *supra* note 21, at 16.

113. *See* Seibel, *supra* note 100, at 1. The two types of recombinant FSH currently on the market are Gonal-F (follitropin alpha) and Follistim (follitropin beta). Salim Daya & Joanne Gunby, *Recombinant Versus Urinary Follicle Stimulating Hormone for Ovarian Stimulation in Assisted Reproduction*, 14 Hum. Reprod. 2207, 2207 (1999). To create this recombinant drug, the gene which creates FSH was isolated and combined into the genome of Chinese hamster ovaries. *See* Seibel, *supra* note 100, at 1. This makes the hamster ovaries produce FSH which is harvested, purified, processed and sold to the consumer. *See id.* at 2. Recombinant FSH has been linked to many benefits over urinary FSH. *See* Daya & Gunby, *supra*, at 2211 (reviewing studies comparing recombinant FSH to urinary FSH and concluding that the use of recombinant FSH led to more clinical pregnancies); F. Raga et al., *Recombinant Follicle Stimulating Hormone Stimulation in Poor Responders with Normal Basal Concentrations of Follicle Stimulating Hormone and Oestradiol: Improved Reproductive Outcome*, 14 Hum. Reprod. 1431, 1431, 1433 (1999) (stating that the use of recombinant FSH led to more and better quality eggs retrieved, better embryos obtained, and shorter treatment periods with lower dosages than those cycles in which urinary FSH was used).

114. New York State Task Force, *supra* note 81, at 46.

115. The price of either urinary or recombinant HMGs is still one of the most costly aspects of an assisted reproductive cycle. The drugs are sold by "ampule" and,

During the administration of the HMG, the woman is required to undergo several blood tests and ultrasound examinations, sometimes daily.<sup>116</sup> These tests provide information on the number and quality of the eggs and indicate the optimum time to retrieve the matured eggs.<sup>117</sup> During early clinical trials in assisted reproduction, ultrasound was not available.<sup>118</sup> This meant that patients were monitored by observing cervical mucus changes and pelvic examinations.<sup>119</sup> This resulted in many cases of hyperstimulation of the ovaries.<sup>120</sup> However, with the technology available today, doctors are able to determine the number and size of follicles and can more accurately judge when to retrieve the follicles.

Approximately thirty-six hours before retrieval of the eggs the woman is given a shot of hCG.<sup>121</sup> The hCG is similar to the LH that is normally released by the pituitary gland to trigger the release of the eggs from the follicles.<sup>122</sup>

Retrieval is normally an outpatient procedure completed under general anesthetic.<sup>123</sup> The physician uses a needle that is placed through the vaginal wall to aspirate the eggs from the follicles that surround the ovaries.<sup>124</sup> The doctor guides the needle with the help of

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if purchased in the United States, typically cost around sixty dollars per ampule. See Freedom Drug, <http://www.freedomdrug.com/prices.html> (as of July 27, 2001, advertising Gonal-F for \$54.40 per ampule). Purchased from either France or Great Britain the cost per ampule decreases to around forty-five dollars. See Pharma-Med, Ltd., <http://www.pmed.com/> (as of April 26, 2000, advertising Gonal-F for \$45.95 per ampule.). Since the HMG injections last for ten to twelve days and a woman can take from four to six ampules per day, the cost for the HMG drugs alone ranges from approximately \$1800 to approximately \$4320. See *id.*; Dutton, *supra* note 21, at 17; Meldrum, *In Vitro Fertilization*, *supra* note 25, at 5; Glazer, *supra* note 8 (providing that the cost for one month of fertility medications for one woman was \$3300). These costs are typically not covered by insurance. See *supra* notes 43 to 45 and accompanying text.

116. See Dutton, *supra* note 21, at 16; Vicken Sahakian & Mary G. Hammond, *The Role of Ultrasound in Infertility*, in *Gynecology and Obstetrics*, *supra* note 25, 2-3. There is some danger of "hyperstimulation" where the ovaries increase dangerously in size. See Geoffrey Cowley & Karen Springen, *Multiplying the Risks: More Group Births Mean More Preemies and, Often, More Problems*, *Newsweek*, Dec. 1, 1997, at 66. During the drug treatments, the ovaries can swell to ten times their normal size, which would make them roughly the size of a grapefruit. *Id.*

117. See Dutton, *supra* note 21, at 17; Sahakian & Hammond, *supra* note 116, at 3.

118. Siebel, *supra* note 100, at 1.

119. See *supra* notes 21-24 and accompanying text.

120. See Seibel, *supra* note 100, at 1.

121. New York State Task Force, *supra* note 81, at 48; Dutton, *supra* note 21, at 17.

122. See New York State Task Force, *supra* note 81, at 48.

123. Dutton, *supra* note 21, at 18-19; Meldrum, *In Vitro Fertilization*, *supra* note 25, at 6; Susan W. Trout et al., *Conscious Sedation for In Vitro Fertilization*, 69 *Fertility & Sterility* 799, 800 (1998). In order to reduce costs of assisted reproduction, some women choose to use just a local anesthetic. Edward C. Ditkoff et al., *Anesthesia Practices in the U.S. Common to In Vitro Fertilization (IVF) Centers*, 14 *J. Assisted Reprod. Genet.* 145, 146-47 (1997).

124. Dutton, *supra* note 21, at 18-19; Speroff et al., *supra* note 26, at 1137; Sahakin & Hammond, *supra* note 116, at 3-6. Some retrievals are done by laparoscopy, but

ultrasound that gives an accurate, if albeit fuzzy, picture of the ovaries and follicles.<sup>125</sup> The entire procedure, from start to finish, takes approximately thirty minutes.

After the eggs are retrieved, the husband is asked to give a sperm sample.<sup>126</sup> The sperm are prepared by removing a portion of the sperm, in a process called capacitation, and then placing them into another liquid.<sup>127</sup> After several hours, the sperm and egg are mixed together and placed in an incubator. They will stay there undisturbed for ten to twelve hours.<sup>128</sup>

An alternative to passive fertilization is ICSI.<sup>129</sup> In this process, a single sperm is injected into the egg.<sup>130</sup> This process is used or recommended for those couples in which the male has a low sperm count, has the cystic fibrosis gene, or there is a lack of fertilization for an unexplained reason.<sup>131</sup>

If the egg and sperm unite, the result is a zygote.<sup>132</sup> The resulting embryo is left to incubate and divide for several days before being

the procedure is done infrequently since the recovery period is longer. *See* Seibel & Crockin, *supra* note 42, at 4; Sahakian & Hammond, *supra* note 116, at 2.

125. *See* Dutton, *supra* note 21, at 18-19; Sahakin & Hammond, *supra* note 116, at 3-6.

126. This can be done beforehand, but fresh samples of sperm are linked with a higher success rate than frozen sperm. *See* Meldrum, *In Vitro Fertilization*, *supra* note 25, at 6.

127. Dutton, *supra* note 21, at 18; Seibel & Crockin, *supra* note 42, at 5; Meldrum, *In Vitro Fertilization*, *supra* note 25, at 6. The most motile sperm are separated by the "swim-up" technique, where the sperm are layered with another substance and the ones which "swim-up" are used. Office of Technology Assessment, *supra* note 32, at 127. This leaves the abnormal or nonmotile sperm remaining. *Id.*

128. *See* Meldrum, *supra* note 25, at 6-7; *see also* Office of Technology Assessment, *supra* note 32, at 123 (stating that the egg and sperm are left undisturbed for eighteen hours). To prevent mix-ups of patient gametes all containers are clearly labeled and color-coded for a specific patient. *See* Belsito v. Clark, 644 N.E.2d 760, 761 (1994).

129. Scott E. Smith & Michael J. Tucker, *Micromanipulation for Assisted Reproduction*, in *Gynecology and Obstetrics*, *supra* note 25, at 3. ICSI, pronounced "Icksee," adds approximately \$1,500 to the overall cost of the cycle. *See* Geoffrey Cowley, *The Future of Birth: Reproductive Medicine is Still Evolving*, Newsweek, Sept. 4, 1995, at 42-43 [hereinafter Cowley, *The Future of Birth*]. Other methods of assisted fertilization are zona drilling (puncturing the shell of the egg, called the zona pellucida, to facilitate fertilization) and subzonal insemination ("SUZI") (several sperm are placed under the zona pellucida). Seibel & Crockin, *supra* note 42, at 12.

130. Smith & Tucker, *supra* note 129, at 3-4; Begley, *supra* note 27, at 41. One study showed no increase in major congenital abnormalities with ICSI, but did show minor developmental delay at one year. *See* Jennifer R. Bowen et al., *Medical and Developmental Outcome at One Year for Children Conceived by Intracytoplasmic Sperm Injection*, 351 *Lancet* 1529 (1998).

131. *See* Smith & Tucker, *supra* note 129, at 3; P.A. Veld et al., *Genetic Counseling Before Intracytoplasmic Sperm Injection*, 350 *Lancet* 490, 490 (1997) (suggesting genetic counseling before use of ICSI since male infertility can be associated with male genetic abnormalities).

132. The terms used for the egg-sperm union vary with the amount of time and placement. A zygote is the union of egg and sperm before the resulting cell divides. Stedman's Medical Dictionary, *supra* note 79, at 1976. When the egg and sperm unite the resulting mass of cells is called an embryo until the ninth week. *See id.* at 559. A

transferred to the womb.<sup>133</sup> After three days, many of the embryos will not attach to the uterine wall.<sup>134</sup> Because of this, some doctors transfer multiple embryos, which in turn can lead to multiple births.<sup>135</sup> However, Australian embryologist David Gardner developed a medium, similar to the environment found in the human womb, which allows the cells to grow *in vitro* for five days, until they reach the blastocyst stage.<sup>136</sup> This technique doubles the implantation rate, and infertility specialists hope that by using this method the incidence of higher-order multiple births will be reduced.<sup>137</sup>

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blastocyst is an embryo at the preimplantation stage. See Speroff et al., *supra* note 26, at 261; see also Office of Technology Assessment, *supra* note 32, at 383.

133. See Meldrum, *In Vitro Fertilization*, *supra* note 25, at 10.

134. See David K. Gardner et al., *Culture and Transfer of Human Blastocysts Increases Implantation Rates and Reduces the Need for Multiple Embryo Transfers*, 69 *Fertility & Sterility* 84, 84 (1998). Low doses of aspirin (less than 80 mg) are thought to help implantation of the embryo into the uterine wall. See Mara Rubinstein et al., *Low-Dose Aspirin Treatment Improves Ovarian Responsiveness, Uterine and Ovarian Blood Flow Velocity, Implantation, and Pregnancy Rates in Patients Undergoing In Vitro Fertilization: A Prospective, Randomized, Double-blind Placebo-controlled Assay*, 71 *Fertility & Sterility* 825, 827 (1999); Cowley, *The Future of Birth*, *supra* note 129, at 42-43.

135. See Dutton, *supra* note 21, at 20-23. Some infertility specialists believe that the chance of a live birth from four embryos transferred is no greater than if only one embryo is transferred. *Id.* at 21. But see David Finkel, "What Kind of Choice Is That?": *Science's War on Infertility Can Deliver Painful Decisions*, *Wash. Post*, Mar. 21, 1999, at A1 (stating that for a woman under the age of thirty-five, if one embryo is transferred there is a 9% chance of a live birth, two embryos transferred 20%, and with four embryos transferred the chance of live birth is 37%). In the United Kingdom there is a restriction on the number of embryos that may be transferred to reduce the number of incidences of multiple births. Judy Peres, *Setting Limits on High-Tech Babymaking*, *Chi. Trib.*, July 26, 1998, at Perspective 1. The American Society for Reproductive Medicine recommends that a maximum of three to five embryos be transferred at one time to lower the incidences of multiple births. *Id.*

136. Gardner et al., *supra* note 134, at 85. There are two primary advantages of blastocyst transfer. See *id.* at 87. First, the female reproductive tract is more synchronized with the blastocysts. *Id.* Second, the lab has longer to assess the viability of the embryo. *Id.*; see Lemonick, *supra* note 31, at 44.

137. See Speroff et al., *supra* note 26, at 1139; Gardner et al., *supra* note 134, at 84-85; see also Amin A. Milki et al., *Two-Blastocyst Transfer Has Similar Pregnancy Rates and a Decreased Multiple Gestation Rate Compared with Three-Blastocyst Transfer*, 72 *Fertility & Sterility* 225, 226-27 (1999) (stating that two-blastocyst transfers had the same success rate as three-blastocyst transfers, with a lower incidence of triplets); Basak Balaban et al., *Blastocyst Quality Affects the Success of Blastocyst-Stage Embryo Transfer*, 74 *Fertility & Sterility* 282, 285-87 (2000) (finding that the quality of the blastocyst positively correlates with implantation rates); Barry Behr, *Blastocyst Culture and Transfer*, 14 *Hum. Reprod.* 5, 5-6 (1999) (suggesting that blastocyst transfer always be used to identify the most viable embryos to transfer); Jan Gerris & Eric Van Royen, *Avoiding Multiple Pregnancies in ART, A Plea for Single Embryo Transfer*, 15 *Hum. Reprod.* 1884 (2000) (giving reasons for single embryo transfer and possible tests to indicate which embryos would have the best chance at implantation); P. Wolner-Hanssen & H. Rydhstroem, *Cost-Effectiveness Analysis of In Vitro Fertilization: Estimated Costs per Successful Pregnancy After Transfer of One or Two Embryos*, 13 *Hum. Reprod.* 88, 92 (1998) (suggesting that a lower overall cost to society would be present if single embryos were transferred versus multiple embryo transfers due to the higher costs involved in multiple births).

The techniques just described represent methods used in traditional IVF. To complete a traditional IVF cycle the embryos are placed into the womb or can be frozen for later use.<sup>138</sup> The transfer procedure is simple: first the woman's womb is readied with progesterone, then the embryos are placed inside it by one of several different methods.<sup>139</sup> Typically, the transfer is completed with no anesthetic, and takes only about five minutes.<sup>140</sup> The transfer is aided by the use of an

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138. Dutton, *supra* note 21, at 23. The freezing of embryos was first done in the Netherlands in 1983. See P. Mazur, *Freezing of Living Cells: Mechanisms and Implications*, 247 Am. J. Physiology C125 (1984). To freeze the embryos, they are slowly taken down to minus 80 degrees Celsius and stored for later thawing and transfer. See Don P. Wolf, *Gamete and Embryo Cryopreservation*, in *Gynecology and Obstetrics*, *spura* note 25, at 4. For articles which discuss the various issues frozen embryos create see Nicole L. Cucci, *Constitutional Implications of In Vitro Fertilization Procedures*, 72 St. John's L. Rev. 417, 431-44 (1998) (reviewing case law, state legislation and international law on the treatment and disposition of frozen embryos); Jennifer Marigliano Dehmel, *To Have or Not to Have: Whose Procreative Rights Prevail in Disputes Over Dispositions of Frozen Embryos?*, 27 Conn. L. Rev. 1377 (1995) (discussing the legal disposition of frozen embryos); Donna A. Katz, *My Egg, Your Sperm, Whose Preembryo? A Proposal for Deciding Which Party Receives Custody of Frozen Preembryos*, 5 Va. J. Soc. Pol'y & L. 623 (1998) (explaining custody issues arising from frozen embryos); Alise R. Panitch, *The Davis Dilemma: How to Prevent Battles over Frozen Preembryos*, 41 Case W. Res. L. Rev. 543 (1991) (focusing on disputes between spouses who disagree about the disposition of their preembryos); John A. Robertson, *Prior Agreements for Disposition of Frozen Embryos*, 51 Ohio St. L.J. 407 (1990) (examining issues raised by a couple's prior agreement with respect to disposition); John A. Robertson, *Resolving Disputes over Frozen Embryos*, 19 Hastings Ctr. Rep. Nov.-Dec. 1989, at 7 (examining alternative resolutions to disputes over the disposition of the embryos); Marcia Joy Wurmbbrand, *Frozen Embryos: Moral, Social, and Legal Implications*, 59 S. Cal. L. Rev. 1079 (1986) (suggesting that all embryos should either be used or frozen, but none destroyed).

Approximately seventy-eight percent of couples starting an assisted reproductive cycle transfer embryos. See New York State Task Force, *supra* note 81, at 52. Embryos are frozen instead of eggs, since eggs do not freeze well. The first successful pregnancy from frozen eggs was reported in October 1997 at Reproductive Biology Associates ("RBA") in Atlanta, Georgia. See Weiss, *Fertility Innovation or Exploitation?*, *supra* note 47. Until 1997, RBA reported only two live births in twenty-three attempts using frozen eggs. See *id.* In addition to low success rates, there is a published report that freezing damages the egg's DNA. Springen et al., *supra* note 8, at 43 (reporting that the reason freezing eggs is not currently an option is that "eggs tend to crystallize in sub-zero temps, disrupting their chromosomal integrity"); Weiss, *Fertility Innovation or Exploitation?*, *supra* note 47. Research is presently being done on freezing a woman's ovarian tissue which contains thousands of immature follicles to be used later by that same woman. See Springen et al., *supra* note 8, at 43.

139. In May 1984, 1209 pregnancies were reported from 9641 IVF treatments, for a thirteen percent viable pregnancy rate. Soules, *supra* note 27, at 511-12. The rate of embryos transferred ranged from ten percent viable pregnancies per single embryo transfer, to nineteen percent per three embryos transferred. See *id.* at 512. A minority of programs achieve this rate, while some programs never have a pregnancy. See *id.* In 1995, the live birth rate via IVF increased substantially. Out of 27,000 procedures performed in 1995, the live-birth rate was 18.6%. Begley, *supra* note 27, at 41.

140. Dutton, *supra* note 21, at 22 (stating that embryo transfer takes about five minutes to complete); Meldrum, *In Vitro Fertilization*, *supra* note 25, at 8-9. "Embryo transfer (ET) is one of the most critical procedures to successful assisted reproduction." Rhonda M. Hearn-Stokes et al., *Pregnancy Rates after Embryo*

ultrasound device that helps the physician place the embryos into the womb.<sup>141</sup>

The process in ZIFT<sup>142</sup> is similar to the traditional IVF process in every way except where the zygote is placed in the woman's body and the amount of time the zygote is allowed to incubate.<sup>143</sup> After one day of incubation, the single-celled zygote is placed inside the fallopian tube.<sup>144</sup> This procedure is done under general anesthetic and with a laparoscope.<sup>145</sup> The zygote then travels to the uterus naturally and implants itself into the uterine wall. The rationale for using this technique is that the implantation rate is thought to be higher than traditional IVF, since there is less trauma for the embryos on transfer.<sup>146</sup>

In the process of GIFT,<sup>147</sup> fertilization takes place inside the woman.<sup>148</sup> A catheter is loaded with the couple's eggs and sperm

*Transfer Depend on Provider at Embryo Transfer*, 74 *Fertility & Sterility* 80, 80 (2000).

There is a debate in the medical literature as to the need for bed rest following embryo transfer. See Raoul Orvieto et al., *Bed Rest Following Embryo Transfer—Necessary?*, 70 *Fertility & Sterility* 982 (1998) (suggesting that bed rest after embryo transfer may have no effect on pregnancy rates due to the decrease in stress levels associated with a return to a daily routine); Khaldoun Sharif et al., *Is Bed Rest Following Embryo Transfer Necessary?*, 69 *Fertility & Sterility* 478, 480 (1998) (finding higher pregnancy rates in patients who were not told to have bed rest after transfer).

141. See B. Coroleu et al., *Embryo Transfer Under Ultrasound Guidance Improves Pregnancy Rates After In-Vitro Fertilization*, 15 *Hum. Reprod.* 616, 617-19 (2000) (reporting that use of ultrasound to place catheter 1.5 cm from fundus of uterine cavity was found to be an "essential factor" to improving IVF results). As Dr. Patrick Steptoe, the first to have a live birth, said: "The skill of the person doing the replacement is very important . . . . The womb doesn't like things being put into it." Wallis, *supra* note 18, at 49; see Hearn-Stokes et al., *supra* note 140, at 85 (finding a correlation in pregnancy rates to various doctors who performed embryo transfers, although the same techniques and equipment were used by all, and each provider used the same ratio of high-grade embryos). "The biggest snag comes when the embryo is inserted in the uterus, an operation that can be very disruptive to the womb. As a result, such embryos often fail to take root, or implant." Philip Elmer-Dewitt, *A Revolution In Making Babies: New Techniques Help Childless Couples—Even After Menopause*, *Time*, Nov. 5, 1990, at 76, 76.

142. Zygote Intra-Fallopian Transfer ("ZIFT").

143. ZIFT was pioneered by Dr. Ricardo Asch. Elmer-Dewitt, *supra* note 18, at 61. Pronuclear Stage Tubal Transfer ("PROST"), Tubal Embryo Transfer ("TET"), and ZIFT are all variations of GIFT and all require IVF to be performed initially. Seibel & Crockin, *supra* note 42, at 7. All require fertilization to be performed before any transfer to the woman. *Id.*

144. Edmond Confino, *Tubal Transfer Techniques for Assisted Reproduction*, in *Gynecology and Obstetrics*, *supra* note 25, at 1.

145. *Id.* at 2.

146. See Begley, *supra* note 27, at 41. Out of 1500 procedures performed in 1995 there was a twenty-four percent live birth rate. *Id.*

147. Gamete Intra-Fallopian Transfer ("GIFT"). Both GIFT and ZIFT were pioneered by Dr. Ricardo Asch, who at the time was at the University of Texas at San Antonio. See Ricardo H. Asch et al., *Gamete Intra-Fallopian Transfer (GIFT): A New Treatment for Infertility*, 30 *Int. J. Fertility* 41, 41 (1985); Confino, *supra* note 144, at 1;

(separated by an air bubble) and the gametes are placed into the fallopian tube.<sup>149</sup> Hopefully, fertilization will take place, and the embryo(s) will travel to and implant inside the uterine wall.<sup>150</sup>

#### F. Chances of Conceiving with IVF

The good news is that fifty to sixty percent of couples who currently seek infertility treatments will conceive a child if they are motivated and follow prescribed treatment procedures.<sup>151</sup> The bad news is that

Elmer-Dewitt, *supra* note 18, at 61. Dr. Asch later was named director of the Center for Reproductive Health at the University of California, Irvine. See Geoffrey Cowley et al., *Ethics and Embryos*, Newsweek, June 12, 1995, at 66, 66. The U.C. Irvine program closed in 1995 after allegations were made public that the program used women's eggs, without consent, in the assisted reproductive procedures of other infertile patients. *Id.*; Susan Kelleher et al., *Asch Charged with Insurance Fraud*, Orange County Reg., Nov. 15, 1996, at A1 [hereinafter Kelleher, *Insurance Fraud*]. These allegations led to more than 107 lawsuits, and at least fifteen children were born from the misappropriated eggs. Susan Kelleher & Kim Christensen, *Stone Says Partners Knew of Egg Thefts*, Orange County Reg., Mar. 18, 1998, at A1. In 1995, Dr. Asch fled the United States, just before he was indicted by a federal grand jury on mail fraud charges for fraudulent bills to insurers and conspiracy to defraud patients of their genetic material. Susan Kelleher, *Regents to Sue Fertility Surgeons for Settlements Paid Out in UCI Scandal*, Orange County Reg., July 17, 1999, at B7 (hereinafter Kelleher, *Regents to Sue*); Kelleher & Christensen, *supra*; Kelleher, *Insurance Fraud*, *supra*. In 1999, the University of California Regents said it would sue Dr. Asch and his partners for the \$16.7 million that was paid to patients to settle lawsuits over the egg swapping. Kelleher, *Regents to Sue*, *supra*, at B7; see also Havins & Dalessio, *supra* note 38, at 862-65 (providing background on lawsuits against Dr. Asch and his partners); Krim, *supra* note 35, at 194-95 (discussing lawsuits against U.C. Irvine in aftermath of Asch scandal); Rebecca S. Snyder, *Reproductive Technology and Stolen Ova: Who is the Mother?*, 16 Law & Inequality 289, 294, 334 (1998) (suggesting that family law should be used to resolve custodial issues of children born from misappropriated gametes). For additional newspaper articles on the lawsuits, see Susan Kelleher, *16-year Wait for Former UCI Fertility Clinic Patient Ends in Birth of 'Miracle'*, Orange County Reg., Feb. 4, 1997, at B1; John McDonald, *Fertility Clinic Doctor Out on Bail*, Orange County Reg., Dec. 24, 1997, at A1.

148. While insemination is *in vivo*, the procedure is still classified under IVF because of its artificial nature. Seibel & Crockin, *supra* note 42, at 5-7. Gamete Uterine Transfer ("GUT") is like GIFT except that the transferred sperm and egg are placed in the uterus instead of the fallopian tubes. *Id.* at 7. The primary advantage is that transfer can be performed by ultrasound and can be performed on a woman who does not have fallopian tubes. *Id.*

149. Seibel & Crockin, *supra* note 42, at 7-11; see Confino, *supra* note 144, at 3; J. Evans et al., *A Possible Effect of Different Light Sources on Pregnancy Rates Following Gamete Intra-Fallopian Transfer*, 14 Hum. Reprod. 80, 80-82 (1999) (finding that light sources which emitted lower amounts of ultra-violet light increased pregnancy rates when used in GIFT procedures).

150. Out of 4200 procedures performed in 1995, the live birth rate was twenty-eight percent. Begley, *supra* note 27, at 41.

151. Bradshaw, *supra* note 26, at 2; Barbara Stewart, *Tough Choices: In Vitro vs. Adoption*, N.Y. Times, Jan. 8, 1995, § 13, at 1. More than ninety percent of the babies born with IVF techniques come within four IVF cycles, with eighty percent occurring after two IVF cycles. Seibel & Crockin, *supra* note 42, at 17 app. 1-E at 24; Seibel et al., *supra* note 41, at 1053. Couples who are unsuccessful after four to six attempts are not encouraged to pursue any further treatment. See Seibel et al., *supra* note 41, at



for any single assisted reproduction cycle the chance the couple will produce a healthy baby is only around twenty percent.<sup>152</sup> The chance of a live birth per cycle does vary dramatically with the age of the woman undergoing the procedure.<sup>153</sup> Approximately 29% of the cycles performed on women under the age of thirty-five resulted in live births, as compared to only 8.7% of those performed on women thirty-nine and older.<sup>154</sup> Medical professionals believe that egg quality decreases with age and this accounts for the dramatic decrease in fertilization and live births per cycle for older women.<sup>155</sup>

### G. Using a Gestational Carrier

Assisted reproduction by a gestational carrier applies the techniques of IVF as described above, split between two women. Dr. Wulf Utian achieved the first successful pregnancy by a gestational carrier in 1985.<sup>156</sup> The genetic mother was a thirty-seven year old woman who had undergone a hysterectomy.<sup>157</sup> The gestational carrier was a twenty-two year old friend of the couple who previously had two children.<sup>158</sup> The pregnancy led to the birth of a baby girl in the next year.<sup>159</sup>

A growing number of clinics in the United States permit the use of a gestational carrier.<sup>160</sup> The clinics that permit this procedure typically have strict screening criteria for both the intended parents and the gestational carrier.<sup>161</sup> Typically all parties involved must submit to full

1053. *But see* Meldrum, *Success Rate*, *supra* note 41, at 1008 (reviewing all cycles done by fifty-four clinics in the United States and finding only a "modest decline in success" for each cycle attempted).

152. New York State Task Force, *supra* note 81, at 52; *see* Society for Assisted Reproductive Technology & The American Society for Reproductive Medicine, *Assisted Reproductive Technology in the United States and Canada: 1994 Results Generated from the American Society for Reproductive Medicine/Society for Assisted Reproductive Technology Registry*, 66 *Fertility & Sterility* 697, 698 (1996); Gabriel, *supra* note 38, at 1; Stolberg, *supra* note 57.

153. Abma et al., *supra* note 26, at 35.

154. *Id.*

155. Speroff et al., *supra* note 26, at 1016-17. *But see* Menken et al., *supra* note 40, at 1393 (stating that there is no connection between fecundity and age).

156. Wulf H. Utian et al., *Successful Pregnancy After In Vitro Fertilization and Embryo Transfer From an Infertile Woman to a Surrogate*, 313 *New Eng. J. Med.* 1351, 1351-52 (1985) [hereinafter Utian et al., *Successful Pregnancy*].

157. *Id.* at 1351.

158. *Id.* at 1352.

159. Utian et al., *Preliminary Experience*, *supra* note 25, at 633.

160. Corson et al., *supra* note 25, at 670. The National Summary of fertility clinics shows that sixty-one percent of the fertility clinics in the United States offer a gestational carrier option. *See* Center for Disease Control, *supra* note 37, at 47. This is up from just thirty-seven percent two years earlier. Center for Disease Control, 1996 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports 35 (1996). One informal estimate provides that up to 1000 babies are born to gestational carriers per year. Glazer, *supra* note 8.

161. Braverman & Corson, *supra* note 63, at 353-54 (detailing the psychological

medical and psychological evaluations, meet certain age requirements, and be represented by legal counsel.<sup>162</sup> Of course, for the intended parents, an unwritten but very real requirement is the financial ability to complete the procedure.

Apart from the cost of the assisted reproductive procedure,<sup>163</sup> a gestational carrier is typically paid for her services. The payment can range from \$10,000 to \$50,000 for a successful pregnancy.<sup>164</sup> If the pregnancy is not successful, the gestational carrier typically does not receive the entire payment, sometimes as little as ten percent of the agreed amount.<sup>165</sup>

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screening of gestational carriers and intended parents in one clinic); Corson et al., *supra* note 25, at 670-71 (detailing the various requirements for admission into the hospital's program); Hanafin, *supra* note 5, at 379; Richard P. Marrs et al., *The Use of Surrogate Gestational Carriers for Assisted Reproductive Technologies*, 168 Am. J. Obstetrics & Gynecology 1858, 1859 (1993). Screening of the gestational carrier is required since there is a risk of the gestational carrier being less concerned for the child than a pregnant woman who will rear the child. Mary E. English et al., *Semantics and Science: The Distinction Between Gestational Carrier and Traditional Surrogacy Options*, 3 Commentary 155, 156 (1991) (stating that gestational surrogates are less emotionally attached to the fetus than to their own children); Ethics Committee of the American Fertility Society, *supra* note 25, at 60S. In one clinic, the pool of gestational carriers came from three sources: 1) a relative or friend of the patient, 2) a response to an advertisement placed by the intended parents, or 3) a person who contacted the program independently. Braverman & Corson, *supra* note 63, at 354.

162. Batzer et al., *supra* note 5, at 1289; Braverman & Corson, *supra* note 63, at 354 (detailing the psychological testing done in one clinic); Corson et al., *supra* note 25, at 670-71; Hanafin, *supra* note 5, at 378-82 ("Personality assessment is the most important aspect of the assessment process."); Marrs et al., *supra* note 161, at 1859; Judy Parkinson et al., *Perinatal Outcome After In-vitro Fertilization-Surrogacy*, 14 Hum. Reprod. 671, 671-72 (1998) (requiring prospective gestational carriers to have delivered a child without complications, and no mental illness or postpartum depression). It is suggested that programs explore many different areas of a prospective gestational carrier life: her references; criminal background; history of psychological care; history of chemical dependency; and any psychological disorders associated with prior pregnancy, such as anxiety or postpartum depression. Hanafin, *supra* note 5, at 380; *see also* Unif. Parentage Act § 803 (amended 2000) (requiring a court hearing to validate any gestational carrier agreement and requiring that "all parties have voluntarily entered into the agreement and understand its terms").

163. *See supra* notes 38-39 and accompanying text.

164. *See Johnson v. Calvert*, 851 P.2d 776, 778 (Cal. 1993) (describing how the couple contracted to pay the gestational carrier \$10,000 and purchased a \$200,000 insurance policy on her life); McEwen, *supra* note 35, at 276 (stating that \$10,000 was the typical payment to a gestational carrier); Glazer, *supra* note 8, (stating that payments to gestational carriers range from \$13,000 to \$17,000); *cf.* Marrs et al., *supra* note 161, at 1861 (stating that the entire procedure costs couples around \$40,000). By agreement, payments are not made for the child, but rather "the couple is paying the woman to provide temporary care for their own genetic child." Ethics Committee of the American Fertility Society, *supra* note 25, at 60S. There are instances where the gestational carrier does not charge a fee, such as when she is related to one of the genetic parents. *See, e.g., Belsito v. Clark*, 644 N.E.2d 760, 761 (Ohio Ct. C.P. 1994) (gestational carrier was sister of genetic mother).

165. *See* McEwen, *supra* note 35, at 276-77. The two main forms of surrogacy are "traditional" and "gestational." Traditional surrogacy consists of artificially inseminating the surrogate with the husband's sperm. Gestational surrogacy is

The perceived need and desire for money is the main reason why women decide to be gestational carriers.<sup>166</sup> While many feminist

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different in that an already fertilized egg is implanted into a host female that is genetically unrelated. The Uniform Parentage Act ("UPA") consolidates the two types of surrogacy mentioned above into the single descriptive term for the woman, "gestational mother." The current version of the UPA allows gestational agreements and allows the intended parents to compensate the gestational mother. However, the UPA also requires that the agreement be scrutinized by a court before it becomes effective. Statutorily, several states have followed suit and passed legislation regarding gestational surrogacy. Several states have enacted portions of the UPA. None allow the parents to compensate the surrogate mother for performing the surrogate contract, but do generally allow for reasonable payment of medical and living expenses related to the pregnancy. Florida, Nevada, New Hampshire, Virginia and Kentucky allow gestational contracts, but only if there is no compensation paid to the gestational mother. Weldon E. Havins & James J. Dalessio, *Reproductive Surrogacy at the Millennium: Proposed Model Legislation Regulating "Non-Traditional" Gestational Surrogacy Contracts*, 31 McGeorge L. Rev. 673, 686-87, app. at 694-95 (2000) (citing Fla. Stat. Ann. §§ 742.13, 742.15-742.16 (West 1985 & Supp. 1999); Nev. Rev. Stat. Ann. § 126.045 (Michie Supp. 1999); N.H. Rev. Stat. Ann. §§ 168-B:1 to 168-B:22 (1994 & Supp. 1999); Va. Code Ann. §§ 20-156 to 20-165 (Michie 1995 & Supp. 1999); Ky. Rev. Stat. Ann. § 199.590(4) (Banks-Baldwin 1997)) (noting that only New Hampshire, Virginia and Florida distinguish between traditional and gestational surrogacy). Generally, however, medical expenses and reasonable living expenses are not included as "compensation" and are therefore allowed. *Id.* Each state has a slightly different definition of what compensation is forbidden, but Florida provides a common example. *See* Fla. Stat. Ann. § 742.15. Florida allows the couple that has commissioned the surrogacy contract "to pay only reasonable living, legal, medical, psychological, and psychiatric expenses... that are directly related to prenatal, intrapart, and postpart periods." *Id.* Of the six states that have statutes providing for criminal penalties for entering into surrogacy agreements (District of Columbia, Kentucky, Michigan, New York, Utah and Washington), only two of those focus the penalties on surrogacy in exchange for consideration (Kentucky and Washington). *See* Havins & Dalessio, *supra*, at 687, app. at 699-700 (citing D.C. Code Ann. § 16-402 (1997); Ky. Rev. Stat. Ann. § 199.990(2) (Michie 1995); Mich. Comp. Laws Ann. § 722.857 (West 1993 & Supp. 1999); N.Y. Dom. Rel. Law § 123 (McKinney 1999); Utah Code Ann. § 76-7-204 (1995); Wash. Rev. Code Ann. § 26.26.250 (West 1997)).

Eight states void surrogacy agreements altogether. *Id.* at 687, app. at 697-98 (citing Ariz. Rev. Stat. Ann. § 25-218(A) (West 1991); Ind. Code Ann. §§ 31-20-1-1 to 31-20-1-2 (Michie 1997); La. Rev. Stat. Ann. § 9:2713 (West 1991); Mich. Comp. Laws Ann. § 722.855 (West 1993); Neb. Rev. Stat. § 25-21.200 (1995); N.Y. Dom. Rel. Law § 122 (McKinney Supp. 1999); N.D. Cent. Code § 14-18-05 (1997); Tenn. Code Ann. § 36-1-102(46)(C) (1996). Surrogacy agreements in these states are not illegal, but are simply not enforced as against public policy. *See* Ariz. Rev. Stat. Ann. § 25-218(A) (West 1991); Ind. Code Ann. §§ 31-20-1-1 to 31-20-1-2 (Michie 1997); La. Rev. Stat. Ann. § 9:2713 (West 1991); Mich. Comp. Laws Ann. § 722.855 (West 1993); Neb. Rev. Stat. § 25-21.200 (1995); N.Y. Dom. Rel. Law § 122 (McKinney Supp. 1999); N.D. Cent. Code § 14-18-05 (1997); Tenn. Code Ann. § 36-1-102(46)(C) (1996).

166. *See* Braverman & Corson, *supra* note 63, at 357 (indicating that psychological tests and clinical observation of gestational carriers "demonstrated that the women who seek to be gestational carriers do so because it meets their own internal needs to be important and vital in other people's lives"); Hanafin, *supra* note 5, at 379 (discussing what motivates both gestational carriers and surrogate mothers to participate); Parker, *supra* note 64, at 118 (listing motivations of traditional surrogates). Other reasons women gave for participating were the perceived enjoyment and desire to be pregnant, the desire to give the gift of a child to a couple

authors use this fact to support their claims about the possible exploitation of women,<sup>167</sup> these assertions are not supported by the profile of a typical gestational carrier. The women who participate are primarily white, married, high school graduates, between twenty-six and twenty-eight years of age, with household incomes between \$30,000 and \$50,000.<sup>168</sup>

The medical procedure of IVF, as described above,<sup>169</sup> is the same for the intended mother in a gestational carrier situation, if she provides the eggs, until transfer of the embryo. The gestational carrier is given GnRH-a to stop normal endocrine activity and then estrogen and progesterone to prepare her uterus for transfer.<sup>170</sup> Transfer is completed by one of the methods previously mentioned.<sup>171</sup>

The success rate for gestational carrier pregnancies is similar to non-gestational carrier assisted reproduction. Early reports showed a success rate of 12% from attempts done from 1984 to 1989.<sup>172</sup> Later studies have reported a live birth rate per cycle of 18.5%, with one

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and resolving guilt over previous abortions. Parker, *supra* note 64, at 118. Close to ninety percent said the money was important, but not the only factor. *Id.* Since the woman is not contributing any of her genetic material, gestational carriers are easier to recruit than traditional surrogates. See Lawson, *supra* note 65.

167. See Field, *Reproductive Technologies*, *supra* note 70, at 1590; Margaret Jane Radin, *Market-Inalienability*, 100 Harv. L. Rev. 1849, 1935 (1987) [hereinafter Radin, *Market-Inalienability*]; cf. Richard A. Epstein, *Surrogacy: The Case for Full Contractual Enforcement*, 81 Va. L. Rev. 2305, 2325-30 (1995) [hereinafter, Epstein, *Full Contractual Enforcement*]; Ingram, *supra* note 70, at 683-85 (saying surrogacy does not exploit women); Richard A. Posner, *The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood*, 5 J. Contemp. Health L. & Pol'y 21, 25 (1989) (writing that a "couple would be unlikely to want the baby of a *desperately* poor woman; they would be concerned about her health, and therefore the baby's"); Russell-Brown, *supra* note 70, at 542-45; Debra Satz, *Markets in Women's Reproductive Labor*, 21 Phil. & Pub. Affairs 107, 123-24 (1992).

168. Healy, *supra* note 5, at 102; see also Parkinson et al., *supra* note 162, at 671 (reporting that the average age of gestational carriers in several hospitals was 30.4 years of age); Nancy E. Reame & Philip J. Parker, *Surrogate Pregnancy: Clinical Features of Forty-Four Cases*, 162 Am. J. Obstetrics and Gynecology 1220, 1221 (1990) (describing the typical surrogate mother in one program as one with a high school education, married, and twenty-five years old). Most programs require the prospective gestational carrier to be financially stable in order to participate in the program. See Hanafin, *supra* note 5, at 379.

169. See *supra* notes 96-137 and accompanying text.

170. Corson et al., *supra* note 25, at 671; James M. Goldfarb et al., *Fifteen Years Experience with an In-Vitro Fertilization Surrogate Gestational Pregnancy Programme*, 15 Hum. Reprod. 1075, 1076 (2000); Marrs et al., *supra* note 161, at 1859; Utian et al., *Preliminary Experience*, *supra* note 25, at 635; see also Belsito v. Clark, 644 N.E.2d 760, 761 (Ohio Ct. C.P. 1994) (describing the procedure for both women as taking medications to "align their fertility cycles and prepare their bodies for the procedure").

171. See Corson et al., *supra* note 25, at 672; Marrs et al., *supra* note 161, at 1859. For success rates of traditional IVF treatments, see *supra* text accompanying notes 40-41.

172. See Utian et al., *Preliminary Experience*, *supra* note 25, at 637 (reporting seven pregnancies out of fifty-nine cycles in one study).

program having an approximately 50% per couple success rate.<sup>173</sup> In 1998, 809 cycles were reported to the Center for Disease Control with an overall success rate of 29.2%.<sup>174</sup>

#### H. Success and Failure of IVF

After transfer, the waiting game begins until a pregnancy test determines if any of the transferred embryos have implanted. During the time before the pregnancy test, progesterone is prescribed in order to maintain the uterine lining.<sup>175</sup> While almost eighty percent of couples in an assisted reproduction cycle get to the point of transfer, only about twenty-three percent of the women get pregnant, with a slightly lower success rate for gestational carriers.<sup>176</sup>

Even after a successful pregnancy test, the couple still must wait. This is because two very different negative results can take place at this stage, both of which are equally devastating. First, the pregnancy could end unsuccessfully. Approximately thirty-three percent of the pregnancies end in miscarriages in the first three months.<sup>177</sup> Second, there could be too many fetuses that implant, which means that "selective reduction" might be indicated.<sup>178</sup>

173. See Corson et al., *supra* note 25, at 672 (reporting a 16.67% success rate per cycle and 49.3% success rate overall for couples); Marrs et al., *supra* note 161, at 1860 (reporting an 18.5% success rate per cycle); see also Parkinson et al., *supra* note 162, at 674 (reporting slightly over thirty-seven percent delivery rate per embryo transfer).

174. Center for Disease Control, *supra* note 37, at 5.

175. See Speroff et al., *supra* note 26, at 1139.

176. See *id.* at 1140; Corson et al., *supra* note 25, at 672 (reporting a 16.67% success rate per cycle when using gestational carriers); Marrs et al., *supra* note 161, at 1860 (reporting an 18.5% success rate per cycle with gestational carriers).

177. See Wallis, *supra* note 18, at 50 (stating that in 1984 one-third of the pregnancies ended in miscarriages). A miscarriage is very traumatic:

Of the thousands of women hoping to get a baby though the 200-odd IVF programs across the globe, the vast majority have been disappointed. The cycle of hopes raised (she's accepted into the program) and dashed (doctor could not get an egg), raised (got an egg) and dashed (egg was abnormal), raised (got a normal egg) and dashed (embryo did not implant), raised (embryo implanted) and dashed (miscarried) harms women in ways [medicine] ha[s] not acknowledged.

Gena Corea, *The Mother Machine: Reproductive Technologies From Artificial Insemination to Artificial Wombs* 180 (1985). "They [infertile couples in IVF] live their life balancing between hope and despair, see-sawing around the menstrual period perhaps until menopause." Ann Lalos, *Breaking Bad News Concerning Fertility*, 14 Hum. Reprod. 581, 582 (1999); see also Springen et al., *supra* note 8, at 40 (quoting one woman whose IVF failed, "It's devastating. It's a terrible sense of failure.").

178. See Judith F. Daar, *Selective Reduction of Multiple Pregnancy: Lifeboat Ethics in the Womb*, 25 U.C. Davis L. Rev. 773, 792-806 (1992) (arguing that increased information must be provided to patients on selective reduction, and present abortion statutes do not cover the procedure); Elizabeth Villiers Gemmette, *Selective Pregnancy Reduction: Medical Attitudes, Legal Implications, and a Viable Alternative*, 16 J. Health Pol., Pol'y & L. 383, 390 (1991).

While on the one hand having no live fetuses is traumatic, an excess number is equally or possibly even more devastating.<sup>179</sup> The incidence of triplets and other "higher order" multiple births rose from 1034 in 1971 to 4973 in 1995, a 480% increase.<sup>180</sup> When a woman is pregnant with three or more fetuses there are many possible complications. These include spontaneous abortion, premature delivery due to uterine over-distention, umbilical cord accidents, pregnancy-induced hypertension, developmental delays, cerebral palsy, and financial and emotional strain on the parents.<sup>181</sup> "[E]ach additional fetus shortens the usual 40 week gestation period by three and one half weeks."<sup>182</sup>

With three or more fetuses there are three possible decisions: (1) terminate the pregnancy; (2) continue the pregnancy; or (3) terminate one or more of the fetuses.<sup>183</sup> If the fetuses are selectively terminated, the number of fetuses are reduced, but the pregnancy can continue.<sup>184</sup>

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179. "Whereas most ordinary abortions occur when a baby is unwanted, fetal reduction is usually recommended to couples who desperately yearn for children; after long trying to conceive, they usually have resorted to fertility drugs or stretched their finances to the limit for a shot at in-vitro fertilization." Barbara Carton, *Agonizing Decision: Multiple Pregnancies Are Often Pared Back in 'Fetal Reduction'*, Wall St. J., Nov. 21, 1997, at A1.

180. Claudia Kalb, *The Octuplet Question: A Historic Delivery Raises Concerns about Multiples*, Newsweek, Jan. 11, 1999, at 33. The number of multiple pregnancies has been called "a growing health crisis." Cowley & Springen, *supra* note 116.

181. Richard L. Berkowitz et al., *Selective Reduction of Multifetal Pregnancies in the First Trimester*, 318 New Eng. J. Med. 1043, 1045 (1988); K.A. Fackelmann, *Experimental Method Lowers Multifetal Risk*, Sci. News, May 5, 1990, at 279 (stating that four or more fetuses increases the risk that the child will die soon after birth or have permanent disabilities); Finkel, *supra* note 135. An example of the complications that can happen are the Frustaci septuplets born in 1985. Of the seven children, four died within weeks of birth. Daar, *supra* note 178, at 775. The three survivors remained hospitalized four months after birth and suffered from physical and developmental impairment, such as cerebral palsy and eye problems. *Id.* For the emotional strain on the parents of triplets see Micheline Garel et al., *Psychological Consequences of Having Triplets: A 4-year Follow-up Study*, 67 Fertility & Sterility 1162, 1163 (1997) (reporting that mothers of triplets showed a high degree of emotional stress which was primarily due to fatigue and stress).

182. Cowley & Springen, *supra* note 116.

183. Mark I. Evans et al., *Multiple Gestation: The Role of Multifetal Pregnancy Reduction and Selective Termination*, 19 Clinics in Perinatology 345, 347 (1992). While the right to abort deals with the rights of a woman versus the rights of the state, selective reduction has been defined as the rights of one fetus versus the rights of another fetus. See Gemmette, *supra* note 178, at 390. "Selective termination," or selective reduction, is the termination of an "anomalous fetus" in a multifetal gestation. Yuval Yaron et al., *Selective Termination and Elective Reduction in Twin Pregnancies: 10 Years Experience at a Single Centre*, 13 Hum. Reprod. 2301, 2301 (1998). This is contrasted to "multifetal pregnancy reduction," where a normal fetus is terminated to improve the survival rate of those that remain. *Id.*

184. George Annas, professor of Health Law at Boston University, says that "[w]hat is troubling is the prospect of a woman trying for years to become pregnant, undergoing enormous emotional strain and financial sacrifice to have a family of her own, and then ending up having to kill perfectly healthy fetuses." Gemmette, *supra* note 178, at 387.

While it is possible to reduce twins, some doctors say that the selective reduction procedure should not be offered for this purpose.<sup>185</sup>

Selective reduction used to be completed by the aspiration of one or more fetuses from the womb, but this sometimes led to complications and spontaneous abortions of the non-selected fetuses.<sup>186</sup> The present method is to inject a small amount of potassium chloride into the fetus by using an ultra-sound-guided needle through the abdomen or vagina.<sup>187</sup> Potassium chloride is used because it kills the fetus quickly and will not harm the woman if a small amount enters her bloodstream.<sup>188</sup> The fetus is not removed from the womb; rather, over time it will disintegrate and be reabsorbed into the woman's body.<sup>189</sup> While this procedure can be done later, it is normally completed by the twelfth week of pregnancy.<sup>190</sup>

The process of "selecting" which fetus gets "reduced" is normally not a scientific one. If there seem to be abnormalities in one or more of the fetuses, those are chosen.<sup>191</sup> If no abnormalities are present or can be found, the "decision of which embryo to choose has been strictly a technical issue of which embryos are easiest to reach."<sup>192</sup>

185. Berkowitz et al., *supra* note 181, at 1046; *see also* Carton, *supra* note 179 (stating that some obstetricians are seeing selective reductions of twins due to primarily financial or lifestyle concerns). While there are state statutes which say that an abortion cannot be performed based solely on the sex of a child, e.g., 18 Pa. Cons. Stat. Ann. § 3204(c) (West 2000), these may not apply to selective reductions. *See* Daar, *supra* note 178, at 796.

186. *See* Gemmette, *supra* note 178, at 384-85.

187. *See* Berkowitz et al., *supra* note 181, at 1045; Finkel, *supra* note 135. *But see* G. Iberico et al., *Embryo Reduction of Multifetal Pregnancies Following Assisted Reproduction Treatment: a Modification of the Transvaginal Ultrasound-Guided Technique*, 15 Hum. Reprod. 2228, 2229, 2232 (2000) (reporting positive results using an ultrasound-guided needle to puncture the embryo's heart until asystolia was found and not injecting any fluids to kill the embryo).

188. Berkowitz et al., *supra* note 181, at 1045; Evans et al., *supra* note 183, at 349 (stating that 0.5 ml of potassium chloride injected into the fetal heart "results in cardiac standstill" within two minutes). The exact method is described as follows:

[T]he fetal heart is confirmed in both longitudinal and transverse planes, the needle is sharply thrust into the thorax. If the thrust is too gentle, the embryo will reflexively move or roll away, and the alignment process has to be completely redone. Even if one "misses" with an attempt, it is usually necessary to remove the needle completely.

*Id.*

189. *See* Evans et al., *supra* note 183, at 349; Finkel, *supra* note 135.

190. *See* Berkowitz et al., *supra* note 181 at 1046 (citing as reasons incomplete reabsorption of the fetus and the psychological difficulty for the couple of making the decision after this time). "For parents, distress is heightened because their pregnancy, unlike those of other abortion patients, has inevitably been closely monitored. They have usually seen their fetuses on ultrasound screens several times." Carton, *supra* note 179.

191. *See* Finkel, *supra* note 135.

192. Evans et al., *supra* note 183, at 349; *see also* Finkel, *supra* note 135 (explaining that when embryos are the same size and apparently healthy, doctors will select the most accessible embryo).

### I. Summary of Assisted Reproduction Using a Gestational Carrier

From an infertile couple's first desire for a child and the stark realization that they cannot conceive naturally, until the time they place an embryo into the care of a gestational carrier who will carry it in her womb until birth, the couple must travel a highly emotional, painful and costly journey. The medical procedure for each hope-filled attempt involves several weeks of injectible medications to control the female hormone cycle, frequent doctor visits, blood tests and invasive internal ultrasounds; then, aspiration of eggs and, if hope is rewarded, successful fertilization.<sup>193</sup> Fertilized eggs are incubated, and several days later one or more healthy embryos are identified as ready for transfer to the gestational carrier.<sup>194</sup> This terse list of procedures cannot begin to portray the intense emotional highs and lows experienced during this process.<sup>195</sup> Disappointment lurks at every turn, including poor response to the stimulation drugs, unsuccessful fertilization and unhealthy embryos.<sup>196</sup> Many couples must undergo multiple cycles before an embryo is available for transfer.<sup>197</sup> In addition to this, most insurance policies do not cover fertility treatments and, thus, the couple must bear the high cost themselves.<sup>198</sup> All this physical, emotional and financial burden is assumed for less than a twenty percent chance of achieving a live birth through the gestational carrier.<sup>199</sup> Additionally, the gestational carrier must undergo a medical and psychological screening process, and typically must endure several weeks of unpleasant inter-muscular injections during the first few weeks after transfer of the embryo(s) to her womb.<sup>200</sup> Thus, there are many personal reasons why the intended parents would want to restrict the gestational carrier's right to abort. This Article will utilize trust law as a framework for supporting such contracts.<sup>201</sup> Before discussing the application of trust law to gestational carrier agreements, however, Part II of the Article reviews the relevant Supreme Court cases regarding the right to abort in the United States.

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193. See *supra* notes 99-1321 and accompanying text.

194. See *supra* notes 133-37 and accompanying text.

195. "The frequent blood test and ultrasound studies, which are at best inconvenient, may also be significantly anxiety provoking." Mazure et al., *supra* note 38, at 275.

196. See *supra* note 177 (describing the emotional roller coaster during IVF treatments).

197. See *supra* notes 40-41 and accompanying text.

198. For the cost of IVF treatments, see *supra* notes 38, 164 and accompanying text. For the lack of insurance coverage, see *supra* notes 43-45 and accompanying text.

199. See *supra* text accompanying notes 172-73

200. See *supra* notes 162-70 and accompanying text.

201. See *infra* Part III.



## II. THE RIGHT TO ABORTION IN THE UNITED STATES

This part will briefly review the right of a woman to obtain an abortion. The abortion issue is one of the most divisive social issues in American culture today.<sup>202</sup> By a narrow majority, the Supreme Court has found that a woman has the right under the Constitution to obtain an abortion.<sup>203</sup> The Court did not make this extremely difficult decision lightly.<sup>204</sup> At the present time, the right of a woman to obtain an abortion, without any substantial hindrance or undue burden, is allowed before the fetus reaches the point of viability outside the womb with neonatal care.<sup>205</sup>

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202. "There simply is no middle ground between those who believe that abortion is murder and those who reject that view and believe that a woman should not be forced by the state to be an incubator." Erwin Chemerinsky, *Constitutional Law: Principles and Policies* 663 (1997). "Abortion has been an intractable issue because of the clash of moral absolutes it presents." Robertson, *supra* note 25, at 48; see also Philip Bobbitt, *Constitutional Fate: Theory of the Constitution* 157 (1982) (stating that *Roe* may be the most "controversial constitutional decision" of the 1970s); Earl M. Maltz, *Abortion, Precedent, and the Constitution: A Comment on Planned Parenthood of Southeastern Pennsylvania v. Casey*, 68 *Notre Dame L. Rev.* 11, 27 (1992) (asserting that *Roe* actually created more national debate on abortion); Donald H. Regan, *Rewriting Roe v. Wade*, 77 *Mich. L. Rev.* 1569, 1569 (1979) (stating that *Roe* was "one of the most controversial cases the Supreme Court has decided").

203. *Roe v. Wade*, 410 U.S. 113 (1973), modified by *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (creating an "undue burden" standard for testing any restrictions on abortion before viability).

204. As Justice Blackmun wrote in *Roe*:

We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion.

*Id.* at 116.

In the joint opinion of *Planned Parenthood v. Casey*, Justices O'Connor, Souter and Kennedy wrote:

Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage. Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision.

*Casey*, 505 U.S. at 850.

205. *Casey*, 505 U.S. at 870, 878. "Viability" is that point where the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid." *Roe*, 410 U.S. at 160. In 1973, viability for a fetus outside the womb was approximately twenty-eight weeks gestation. *Casey*, 505 U.S. at 860; *Roe*, 410 U.S. at 160. By 1992, viability was possible at twenty-three to twenty-four weeks. *Casey*, 505 U.S. at 860; see also *Stenberg v. Carhart*, 530 U.S. 914 (2000) (striking down a Nebraska statute which criminalized the performance of "partial birth abortions").

A. *Roe v. Wade*

The case of *Roe v. Wade* established the right to obtain an abortion in the United States.<sup>206</sup> Jane Roe,<sup>207</sup> a pregnant, single woman, “sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional on their face, and an injunction restraining the defendant from enforcing the statutes.”<sup>208</sup> The Texas statutes in question made it a crime to obtain or perform an abortion.<sup>209</sup> A three-judge District Court held that Jane Roe had a “fundamental right” to choose not to remain pregnant under the Ninth through the Fourteenth Amendments.<sup>210</sup> The District Court

206. *Roe*, 410 U.S. 113. *Doe v. Bolton* is the companion case to *Roe* and was decided at the same time. 410 U.S. 179 (1973). In *Bolton*, a married woman challenged the constitutionality of Georgia’s laws criminalizing abortion. Under Georgia law, abortions were prohibited unless a doctor determined that the pregnancy would endanger the woman’s life or health, the fetus likely would be born with a birth defect, or if the pregnancy resulted from rape. *Id.* at 183. Doe argued that she was forced to either relinquish her right to decide whether to bear a child or seek an illegal abortion. *Id.* at 185. The Supreme Court struck down the Georgia law as unconstitutional. *Id.* at 201.

207. “Jane Roe” was a pseudonym. *Roe*, 410 U.S. at 120 n.4. Jane Roe’s real name is Norma McCorvey. David Van Biema, *An Icon In Search Mode: Norma McCorvey, The “Jane Roe” Of Roe v. Wade, Experiences A Change Of Heart (Sort Of)*, Time, Aug. 21, 1995, at 36. In 1969, Sarah Weddington, one of the attorneys who filed the complaint in *Roe*, asked McCorvey to be the plaintiff in the case. Van Biema, *supra*, at 36; Steven Waldman & Ginny Carroll, *Roe v. Roe*, Newsweek, Aug. 21, 1995, at 22. Ironically, while the case involved the right to abort, Weddington told McCorvey that she could not get an abortion since, if she did, she would lack legal standing to sue. Waldman & Carroll, *supra*, at 22. McCorvey later gave birth to the child, a daughter. *Id.* But see Bobbitt, *supra* note 202, at 165 (stating that McCorvey terminated the pregnancy). The selection of McCorvey as Jane Roe seems to have been a bad one for both parties. Weddington said “I’m sorry I went to Dallas” and found McCorvey. Waldman & Carroll, *supra*, at 24. McCorvey regretted her involvement in the case, and in 1995 publicly stated that she was against all abortions. See Marc Peyser et al., *Jane Roe Moves Further Toward the Right to Life*, Newsweek, Nov. 16 1995, at 11.

208. *Roe*, 410 U.S. at 120. James Hubert Hallford and “John and Mary Doe” (pseudonyms) also attempted to be named plaintiffs in the case. *Id.* at 120, 121. James Hallford was a doctor who had previously been arrested on violations of the Texas abortion statutes being challenged by Jane Roe. *Id.* at 120. He was permitted to intervene by the District Court. *Id.* The Supreme Court dismissed Dr. Hallford’s complaint since “absent harassment and bad faith, a defendant in a pending state criminal case cannot affirmatively challenge in federal court the statutes under which the State is prosecuting him . . . .” *Id.* at 126–27. In a separate complaint, John and Mary Doe challenged the Texas abortion statutes since, due to Mary Doe’s physical limitations, “if she should become pregnant, she would want to terminate the pregnancy by an abortion performed by a competent, licensed physician under safe, clinical conditions.” *Id.* at 121. The District Court consolidated the case with that of Jane Roe, but after consolidation dismissed Doe’s complaint. See *id.* at 121–22. The Supreme Court upheld the dismissal. See *id.* at 128–29.

209. Tex. Penal Code Ann. §§ 1191-94, 1196 (West 1973); *Roe*, 410 U.S. at 117 & n.1.

210. *Roe v. Wade*, 314 F. Supp. 1217, 1225 (N.D. Tex. 1970), *aff’d in part and rev’d in part*, 410 U.S. 113 (1973) (writing that the “fundamental right of single women and married persons to choose whether to have children is protected by the Ninth Amendment, through the Fourteenth Amendment.”); *Roe*, 410 U.S. at 122.

went on to strike down the Texas statutes as unconstitutionally overbroad and vague.<sup>211</sup> The Supreme Court took the unusual move of granting certiorari directly from the District Court without an appeal to the United States Court of Appeals.<sup>212</sup>

Justice Blackmun wrote the opinion for the majority.<sup>213</sup> For a good portion of the opinion, Justice Blackmun chronicled the attitudes and laws on abortion throughout much of recorded history.<sup>214</sup> This portion of the opinion served to establish that the right of a woman to have an abortion is part of the right to privacy that is protected by the Constitution.<sup>215</sup> In his discussion of history, Justice Blackmun attempted to portray this right as central.<sup>216</sup> The reason for reviewing

211. The District Court wrote:

There is unconstitutional overbreadth in the Texas Abortion Laws because the Texas Legislature did not limit the scope of the statutes to such interests. On the contrary, the Texas statutes, in their monolithic interdiction, sweep far beyond any areas of compelling state interest. Not only are the Texas Abortion Laws unconstitutionally overbroad, they are also unconstitutionally vague.

*Roe*, 314 F. Supp. at 1223; *see also Roe*, 410 U.S. at 113.

212. The right to appeal directly to the Supreme Court from a district court of three judges is provided by 28 U.S.C. § 1253. 28 U.S.C. § 1253 (1994); *see also Roe*, 410 U.S. at 122.

213. *Roe*, 410 U.S. at 116. The decision was 7-2, with Justices White and Rehnquist dissenting. *Id.* at 115. The first portion of *Roe* dealt with justiciability, focusing on whether the case was appropriate for court review. *Id.* at 123-29. Jane Roe's case was challenged as moot since at the time the case was heard "she and all other members of her class [were] no longer subject to any 1970 pregnancy." *Id.* at 124. The Supreme Court held that the case was not moot since pregnancy "provides a classic justification for a conclusion of nonmootness. It truly could be 'capable of repetition, yet evading review.'" *Id.* at 125 (citations omitted).

214. In *Roe*, Blackmun discussed the treatment of abortion in ancient Greek and Roman law and society, early English common law, early English statutory law, and early American law. 410 U.S. at 130-41. He also wrote at some length on the positions of the American Medical Association, American Public Health Association, and American Bar Association on abortion. *Id.* at 141-47.

215. "We seek earnestly to do this, and, because we do, we have inquired into, and in this opinion place some emphasis upon, medical and medical-legal history and what that history reveals about man's attitudes toward the abortion procedure over the centuries." *Id.* at 116-17. *But see Roe*, 410 U.S. at 174 (Rehnquist, J. dissenting) (commenting that the right to abortion was not "so rooted in the traditions and conscience of our people as to be ranked as fundamental" (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934))).

216. *Roe*, 410 U.S. at 153; *see also Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." (emphasis in original)). *But see Planned Parenthood v. Casey*, 505 U.S. 833, 952-53 (1992) (Rehnquist, J., dissenting) (arguing that history does not support the conclusion that the right to an abortion is fundamental). In 1868, at the time of the adoption of the Fourteenth Amendment, twenty-eight out of thirty-seven states and eight territories banned or limited abortions. *Id.* at 952. By 1900 almost 100% of the states prohibited or restricted abortions. *See id.* On these facts, Justice Rehnquist in his dissent in *Casey* wrote "it can scarcely be said that any deeply rooted tradition of relatively unrestricted abortion in our history supported the classification of the right to

the history was to show that laws prohibiting abortion are fairly recent in origin:

It is perhaps not generally appreciated that the restrictive criminal abortion laws in effect in a majority of states today are of relatively recent vintage. Those laws, generally proscribing abortion or its attempt at any time during pregnancy except when necessary to preserve the pregnant woman's life, are not of ancient or even of common-law origin. Instead, they derive from statutory changes effected, for the most part, in the latter half of the 19th century.<sup>217</sup>

The remainder of the opinion analyzed the constitutionality of the Texas statutes prohibiting abortion, in two steps. First, the opinion addressed the question of whether a woman has a fundamental right to an abortion found in the First, Fifth or Fourteenth Amendments.<sup>218</sup> Second, the opinion discussed whether the State had a sufficient reason to restrict the exercise of that right.<sup>219</sup>

There is no right to abortion specifically evident in the Constitution.<sup>220</sup> When found at all, Courts look to the general "right of privacy," also not enumerated in the Constitution, but which the Supreme Court has said is present.<sup>221</sup>

abortion as 'fundamental' under the Due Process Clause of the Fourteenth Amendment." *Id.* at 952-53.

217. *Roe*, 410 U.S. at 129.

218. *Id.* at 152-56.

219. *Id.* at 156-62.

220. "Ultimately, this first objection to *Roe* turns on a much wider on-going debate over how the Court should interpret the Constitution and when, if at all, it is permissible for the judiciary to protect unenumerated rights." Chemerinsky, *supra* note 202, at 666. "[O]ne rarely encounters a law professor or judge willing to defend [*Roe*]." Bobbitt, *supra* note 202, at 157; see also Andrew Koppelman, *Forced Labor: A Thirteenth Amendment Defense of Abortion*, 84 Nw. U. L. Rev. 480, 480 (1990) (stating that *Roe* is an "unpersuasive opinion" and the right to abort should be based on the Thirteenth Amendment).

221. "The Constitution does not explicitly mention any right of privacy." *Roe*, 410 U.S. at 152. However, the "privacy right" is one of the "fundamental" rights provided by the Constitution. Decisions involving the issue of fundamental rights are typically analyzed in four parts: (1) whether a fundamental right is present; (2) whether the right is being infringed upon; (3) whether the government's action is sufficiently justified if it does infringe upon the right and (4) whether the means are sufficiently related to the goal being sought. See Chemerinsky, *supra* note 202, at 640. If a fundamental right is found, unless otherwise stated by the Supreme Court, a regulation impinging on that right is subject to "strict scrutiny." See *Troxel v. Granville*, 530 U.S. 57, 72-73 (2000) (holding that a Washington state statute permitting "any person" to petition for visitation rights "at any time" was unconstitutional since it infringed on a parent's fundamental right to make decisions concerning the care, custody and control of her children); *Griswold v. Connecticut*, 381 U.S. 479, 499-502 (1965) (Harlan, J., concurring) (arguing that the right to privacy is protected by the Due Process Clause of the Fourteenth Amendment).

Under strict scrutiny review, the government must have a "compelling interest" to justify the infringement and the regulation must be narrowly tailored to accomplish the interest involved. See Chemerinsky, *supra* note 202, at 643. This is in contrast to non-fundamental rights that must meet either intermediate scrutiny or the lower "rational relationship" test. Under intermediate scrutiny, the restrictions must

The opinion next gave a cursory review of the right of privacy and summarized the different views of the various Supreme Court justices regarding the constitutional basis for the right.<sup>222</sup> Justice Blackmun then found the right of privacy to exist in this instance, stating that the right, wherever found in the Constitution, was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."<sup>223</sup> This interpretation was in part due to the various harms that any law totally prohibiting abortion would cause the woman by forcing her to have a child—the medical, psychological and financial burdens of childbirth, the upbringing of the child, and the social stigma attached to being an unwed mother.<sup>224</sup>

While the Supreme Court did find a privacy right to have an abortion, that right was not absolute. Rather than allowing a woman

"serve important governmental objectives and must be substantially related to achievement of those objectives." *Craig v. Boren*, 429 U.S. 190, 197 (1976). This level of scrutiny has been applied to gender discrimination. See Chemerinsky, *supra* note 202, at 529. Under the lowest level of judicial review, the rational basis test, the restriction must only be rationally related to a legitimate government purpose. See *Washington v. Glucksberg*, 521 U.S. 702 (1997) (holding that a state law banning assisted suicide was rationally related to legitimate government interests); *Pennell v. City of San Jose*, 485 U.S. 1, 14 (1988); *United States R.R. Retire. Bd. v. Fritz*, 449 U.S. 166, 175 (1980); *Allied Stores v. Bowers*, 358 U.S. 522, 527 (1959); Chemerinsky, *supra* note 202, at 529 n.2.

222. See *Roe*, 410 U.S. at 152-53. After reviewing the various cases Blackmun wrote that the "decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' are included in this guarantee of personal privacy." *Id.* at 152 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) (citation omitted)).

223. *Id.* at 153. The notion that the "privacy right" encompasses a right to abortion has met heavy criticism. See, e.g., John Hart Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 Yale L.J. 920, 947-48 (1973) (asserting that *Roe* is "a very bad decision . . . It is bad because it is bad constitutional law, or rather because it is *not* constitutional law and gives almost no sense of an obligation to try to be."). But see Ronald Dworkin, *Life's Dominion* (1993); Robertson, *supra* note 25, at 57 (suggesting that from the right of couples to use contraception found earlier by the Supreme Court as a privacy right, "it is an incremental step to say that the same fundamental right presumptively exists when the woman is already pregnant"); Laurence H. Tribe, *Abortion: The Clash Of Absolutes* 99 (1990) (stating that many aspects of personal autonomy and independence that are "liberty" interests are covered in the Constitution but not specifically stated therein); Philip B. Heymann & Douglas E. Barzelay, *The Forest and the Trees: Roe v. Wade and Its Critics*, 53 B.U. L. Rev. 765, 775-77 (1973) (stating that the privacy right should cover a woman's right to abortion); Regan, *supra* note 202, at 1569 (supporting a woman's right to abort under common law since individuals are not forced to be "Good Samaritans").

For articles which suggest that the Supreme Court should have used the Equal Protection Clause as support for a woman's right to abortion, see Kristin Luker, *Abortion and the Politics of Motherhood* 92-125 (1984); Tribe, *supra*, at 105-08; Erin Daly, *Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of Planned Parenthood v. Casey*, 45 Am. U. L. Rev. 77, 116-18 (1995); Ruth Bader Ginsburg, *Some Thoughts On Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. Rev. 375 (1985); Kenneth L. Karst, *Forward: Equal Citizenship Under the Fourteenth Amendment*, 91 Harv. L. Rev. 1, 53-59 (1977); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955 (1984).

224. *Roe*, 410 U.S. at 153.

to get an abortion at any time,<sup>225</sup> the right could still be restricted in the name of "important state interests."<sup>226</sup>

The interest that Texas had in regulating abortion was also discussed in the opinion.<sup>227</sup> Of the various reasons given, two were found to be valid reasons for a state to prohibit abortions.<sup>228</sup> The first was a state's concern that abortion could be a dangerous medical procedure, coupled with its desire to protect the mother's health.<sup>229</sup> The Supreme Court noted that while abortion mortality was high until the advent of modern procedures and antiseptic techniques, the studies at the time showed mortality rates for legal abortions as low or lower than those for normal childbirth.<sup>230</sup> The other reason for a state to regulate abortions was the State's interest in protecting prenatal life.<sup>231</sup>

The majority found that the State's interest in protecting the mother's health from harm due to an abortion was not "compelling" until after the first trimester.<sup>232</sup> The first trimester was selected as a dividing line, since the mortality rate of first trimester abortions was documented to be as low or lower than the mortality rates of normal childbirth.<sup>233</sup> After the first trimester, a State could regulate the procedure only "to the extent that the regulation reasonably relates to

225. *Id.* at 153. "Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest,' and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake." *Id.* at 155 (citations omitted).

226. *Id.* at 154.

227. *Id.* at 148-52.

228. The only other reason discussed was that the laws "were the product of a Victorian social concern to discourage illicit sexual conduct." *Id.* at 148. However, the Court summarily dismissed this reasoning. *Id.*

229. *Id.* at 148-49.

230. *Id.* "Consequently, any interest of the State in protecting the woman from an inherently hazardous procedure, except when it would be equally dangerous for her to forgo it, has largely disappeared. Of course, important state interests in the areas of health and medical standards do remain." *Id.* at 149.

231. *Id.* at 150; see Robert F. Drinan, *The Inviolability of the Right to Be Born*, 17 Case W. Res. L. Rev. 465, 479 (1965) (reviewing Anglo-American law and concluding that a fetus should be treated as a human being); David W. Louisell, *Abortion, the Practice of Medicine and the Due Process of Law*, 16 UCLA L. Rev. 233, 235-44 (1969) (discussing legal recognition of a fetus as a human being); John T. Noonan, Jr., *The Root and Branch of Roe v. Wade*, 63 Neb. L. Rev. 668 (1984) (stating that for the law to allow abortion means there must be a legal fiction created where a fetus is not a human being).

In another part of the opinion, the Supreme Court found that a fetus was not a "person" under the Fourteenth Amendment. See *Roe v. Wade*, 410 U.S. 113, 158 (1973). This was critical to the eventual holding of *Roe*, since if the "suggestion of personhood [was] established, [Roe's] case . . . collapses, for the fetus' right to life would then be guaranteed specifically by the [Fourteenth] Amendment." *Id.* at 156-57.

232. *Roe*, 410 U.S. at 163.

233. *Id.* at 149, 163.

the preservation and protection of maternal health.”<sup>234</sup>

The State’s interest in protecting the life of the child did not reach a “compelling” point until viability, since at this time the fetus had the capability of living outside the mother’s womb.<sup>235</sup> After this time, the State could enact laws that prohibited abortion, except in cases when it was necessary to preserve the life or health of the mother.<sup>236</sup>

Since the Texas statutes prohibited abortions without reference to the trimesters of pregnancy, these statutes were invalid and the District Court’s decision to strike them down was upheld.<sup>237</sup>

### B. Planned Parenthood v. Casey

The Supreme Court’s most recent case discussing the constitutional standards permitting abortion is *Planned Parenthood v. Casey*.<sup>238</sup> The

234. *Id.* at 163. The opinion gave the following examples of permissible state regulations: (1) providing requirements as to the qualifications and licenses required of the person who is to perform the abortion, and (2) providing requirements as to the type and license of the facility in which the procedure is to be performed (e.g., hospital, clinic or some other place of less-than-hospital status). *Id.*

235. *Id.* In 1973, viability outside the womb was normally possible after twenty-eight weeks of gestation. *See id.* at 160. Some commentators feel that the Supreme Court did not give enough importance to the State’s interest in protecting the life of the fetus:

No reason is given why viability should be the measure of the significance of the state’s interest. This metaphysical assessment of worth is scarcely inferable from the Constitution or from the record in the case. Moreover, it would appear to rely on the unacknowledged and plainly incorrect premise that only self-sufficient living entities may serve as objects of a state’s compelling interests.

Bobbitt, *supra* note 202, at 159; *see also* Noonan, *supra* note 231, at 668-69 (stating that the decision rested on the jurisprudence of viewing a “person” as being a construct of law, an interpretation which led to the legal system’s support of slavery). *But see* Frances Olsen, *Unraveling Compromise*, 103 Harv. L. Rev. 105, 127-28 (1989) (stating that legislatures should determine when something is “human”).

236. *Roe*, 410 U.S. at 163-64. It was this thinking that led to the “trimester” approach to abortion. Blackmun summarized the holding, which in legislative fashion circumscribed the ability of states to regulate abortion. In the first trimester (the first three months of pregnancy), the decision to abort must be left exclusively to the woman and her attending physician. *Id.* In the next trimester (four to six months), the State could promulgate laws in promoting the health of the mother. *Id.* In the final trimester (seven to nine months), the State could pass laws to protect the fetus. *Id.* at 164-65.

237. *Id.* at 164, 166-67. Congress’ initial reaction to *Roe* was to introduce a constitutional amendment designed to rein in *Roe*’s broad holding. *See* Gerald Gunther & Kathleen M. Sullivan, *Constitutional Law* 545 (13th ed. 1997) (discussing the attempts at creating a constitutional amendment and the proposed Human Life Statute of 1981); Peggy S. McClard, *The Freedom of Choice Act: Will the Constitution Allow It?*, 30 Hous. L. Rev. 2041, 2046 n.38 (1994).

238. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *see also* Daly, *supra* note 223, at 80 (stating that the “lead opinion is so fractured that, . . . there is something in it for everyone to hate”); David A. Strauss, *Abortion, Toleration, and Moral Uncertainty*, 1992 Sup. Ct. Rev. 1, 3 (1993) (stating that the main contribution of *Casey* was putting the focus on the social status of women and the moral status of fetal life); Robert H. Bork, *Again, a Struggle for the Soul of the Court*, N.Y. Times,

plurality opinion was written in an unusual fashion—it was jointly signed by three Justices, O'Connor, Souter and Kennedy.<sup>239</sup> While the facts of the case did not require a re-analysis of *Roe v. Wade*, the joint opinion in *Casey* goes into great detail about *Roe* and its holding. The primary purpose of this re-analysis can be found in the first line of *Casey*, “Liberty finds no refuge in a jurisprudence of doubt.”<sup>240</sup>

*Casey* involved a challenge by several abortion clinics and doctors against portions of the Pennsylvania Abortion Control Act.<sup>241</sup> The challenged statutes did not prohibit abortions, and were not like those examined in *Roe*. The Pennsylvania statutes addressed several different issues which could hinder the ability of a woman to receive an abortion. One of the statutes provided for an information and waiting period before a woman was allowed an abortion.<sup>242</sup> Another required a married woman to inform her husband before obtaining an abortion.<sup>243</sup> The last abortion restriction dealt with parental or judicial consent for minors seeking abortions.<sup>244</sup>

After a three-day bench trial, the District Court found that all the challenged statutes were unconstitutional and issued a permanent injunction against their enforcement.<sup>245</sup> The Court of Appeals for the

July 8, 1992, at A19 (stating that “on a constitutional spectrum [the *Casey*] joint opinion is more properly termed ‘radical’”).

239. See Chemerinsky, *supra* note 202, at 669. Traditionally one Justice will write an opinion and the other Justices who agree with the analysis and holding will sign on. David J. Garrow, *Abortion Before and After Roe v. Wade: An Historical Perspective*, 62 Alb. L. Rev. 833, 845 (1999). The writing of a joint opinion, which occurred only one other time in the history of the Court, was thought to be used to send “a clear symbolic message” of the “strong and unbreakable . . . institutional commitment the Supreme Court has made to” the right of a woman to choose to receive an abortion. *Id.*

240. *Casey*, 505 U.S. at 844. There was a great deal of speculation as to whether the Court would overrule *Roe v. Wade* with the *Casey* opinion. The reason for the speculation was that in 1989 the Court seemed on the brink of overturning *Roe*, with the 5-4 opinion in *Webster v. Reproduction Health Services*, 492 U.S. 490 (1989). After *Webster* was decided, two of the justices in the majority, Brennan and Marshall, resigned. These Justices were replaced with Justices Souter and Thomas, either of whom could cast the deciding vote to overturn *Roe*. However, one of the dissenting justices in *Webster*, Justice O'Connor, changed her vote and decided to uphold *Roe* in *Casey*. See Chemerinsky, *supra* note 202, at 668-69; Maltz, *supra* note 202, at 18 (stating that the *Casey* decision was a “surprise”).

241. *Casey*, 505 U.S. at 844-45.

242. 18 Pa. Cons. Stat. Ann. § 3205 (West 2000) (requiring that, before an abortion was performed, a woman must be given information and wait at least twenty-four hours); *Casey*, 505 U.S. at 844.

243. 18 Pa. Cons. Stat. Ann. § 3209 (West 2000) (requiring spousal notification for abortions by married women); *Casey*, 505 U.S. at 844.

244. 18 Pa. Cons. Stat. Ann. § 3206 (West 2000) (requiring parental or judicial consent for any abortions for minors, with certain exceptions); *Casey*, 505 U.S. at 844. The final statute reviewed dealt with reporting and regulating provisions on abortion providers. 18 Pa. Cons. Stat. Ann. §§ 3207(b), 3214(a), (f) (West 2000); *Casey*, 505 U.S. at 845.

245. See *Planned Parenthood v. Casey*, 744 F. Supp. 1323, 1396-97 (E.D. Pa. 1990); *Casey*, 505 U.S. at 845.



Third Circuit only affirmed the District Court's opinion on the unconstitutionality of the spousal notification provisions of the Pennsylvania Abortion Control Act.<sup>246</sup> The Third Circuit held that the remainder of the statutes were within the bounds of permissible state regulation of abortion.<sup>247</sup>

The joint opinion in *Casey* can be broken down into several sections. First, it reviews *Roe v. Wade* and its constitutional foundations at great length.<sup>248</sup> It examines the "liberty" interest as found in the Constitution, reiterating that the right to abortion is a protected interest. Second, the joint opinion does an extensive review of stare decisis.<sup>249</sup> Third, the joint opinion affirms what it labels the "essential holding" in *Roe* and then provides a new test with which to review the constitutionality of state laws regulating abortion.<sup>250</sup> In the final portion of the opinion, the new standards are applied to the Pennsylvania statutes in question.<sup>251</sup>

The first section of the analysis in the joint opinion states that the right to abortion is found in the Fourteenth Amendment.<sup>252</sup> It goes on to say that the right to abort is protected because the pain of pregnancy and childbearing is too "intimate and personal" to allow complete state interference with a woman's pregnancy.<sup>253</sup>

246. See *Planned Parenthood v. Casey*, 947 F.2d 682, 719 (3d Cir. 1991); *Casey*, 505 U.S. at 845.

247. See *Casey*, 947 F.2d at 719.

248. See *infra* notes 252-53 and accompanying text.

249. See *infra* notes 254-60 and accompanying text.

250. See *infra* notes 261-67 and accompanying text.

251. See *infra* notes 266-67 and accompanying text.

252. The Fourteenth Amendment reads:

All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. Const. amend. XIV, § 1. "Constitutional protection of the woman's decision to terminate her pregnancy derives from the Due Process Clause of the Fourteenth Amendment. . . . The controlling word is 'liberty.'" *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992).

253. *Casey*, 505 U.S. at 852. As the Court stated:

The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. . . . Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture.

*Id.* For a description of the many inconveniences and discomforts of pregnancy, see Regan, *supra* note 202, at 1579-83.

Justice Scalia wrote a strong dissent in *Casey*, rejecting the notion of abortion as a liberty interest protected by the Constitution:

The emptiness of the "reasoned judgment" that produced *Roe* is displayed in plain view by the fact that, after more than 19 years of effort by some of the brightest (and most determined) legal minds in the country, after more than

Next the joint opinion went into an extensive review of *stare decisis*, the doctrine by which courts adhere to former judgments made by the Court.<sup>254</sup> The joint opinion stated that there are three primary reasons to reject *stare decisis* and overrule former opinions: (1) if “the rule has proven to be intolerable simply in defying practical workability”;<sup>255</sup> (2) if the law evolved to the point which “left the old rule no more than a remnant of abandoned doctrine”;<sup>256</sup> or (3) the facts upon which the old opinion relies “have so changed, or come to be seen so differently, as to have robbed the old rule of significant application or justification.”<sup>257</sup> Also, if “the rule is subject to a kind of reliance that would lend a special hardship to the consequences of overruling and add inequity to the cost of repudiation,” it should not be overruled.<sup>258</sup> The joint opinion then examined each rationale in detail.<sup>259</sup> After its review of *stare decisis*, the Court did not find sufficient reason to overrule the “essential holding” in *Roe*, which permitted a woman to obtain an abortion in certain circumstances free from state interference.<sup>260</sup>

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10 cases upholding abortion rights in this Court, and after dozens upon dozens of *amicus* briefs submitted in these and other cases, the best the Court can do to explain how it is that the word “liberty” *must* be thought to include the right to destroy human fetuses is to rattle off a collection of adjectives that simply decorate a value judgment and conceal a political choice.

*Casey*, 505 U.S. at 983 (Scalia, J., dissenting).

254. See Chemerinsky, *supra* note 202, at 670; see also Maltz, *supra* note 202, at 31 (stating that the Supreme Court erred in relying on *stare decisis*).

255. *Casey*, 505 U.S. at 854-55.

256. *Id.* at 855.

257. *Id.*

258. *Id.* at 854.

259. Each reason to reject *stare decisis* is discussed in turn in the joint opinion. *Roe* was not unworkable and “the required determinations [fell] within judicial competence.” *Id.* at 855. The evolution of law was found not to have eclipsed *Roe*. *Id.* at 857. “No development of constitutional law since the case was decided has implicitly or explicitly left *Roe* behind as a mere survivor of obsolete constitutional thinking.” *Id.* The factual predicates of *Roe* were found to be similar. The joint opinion noted that while safe abortions may be obtained later in pregnancy and a fetus may be deemed viable earlier, “these facts go only to the scheme of time limits on the realization of competing interests, and the divergences from the factual premises of 1973 have no bearing on the validity of *Roe*’s central holding.” *Id.* at 860. Finally, there was reliance on *Roe* since peoples’ actions with regards to sexual conduct were made “in reliance on the availability of abortion in the event that contraception should fail.” *Id.* at 856. But see Maltz, *supra* note 202, at 20 (stating that there was no basis for the Court to make the claim of reliance).

260. *Casey*, 505 U.S. at 869. As the Court stated:

A decision to overrule *Roe*’s essential holding under the existing circumstances would address error, if error there was, at the cost of both profound and unnecessary damage to the Court’s legitimacy, and to the Nation’s commitment to the rule of law. It is therefore imperative to adhere to the essence of *Roe*’s original decision, and we do so today.

*Id.* But see *id.* at 954 (Rehnquist, J., dissenting). In his dissent, Justice Rehnquist wrote that *stare decisis* “is defined in Black’s Law Dictionary as meaning ‘to abide by,

After its review of *stare decisis*, the Court concluded, "that the essential holding of *Roe* should be reaffirmed," but went on to change the strict scrutiny test, which *Roe* required.<sup>261</sup> In recognizing the Court's initial purpose for constructing the trimester framework, the joint opinion stated that the framework was "erected to ensure that the woman's right to choose not become so subordinate to the State's interest in promoting fetal life that her choice exists in theory but not in fact."<sup>262</sup> The joint opinion, however, then noted that the rigid trimester approach was not necessary to accomplish that objective.<sup>263</sup> Nor was the trimester approach intended to prevent states from taking steps, even in the earliest stages of pregnancy, to ensure that a woman's choice was thoughtful and informed.<sup>264</sup> Notwithstanding the joint opinion's dismantling of the trimester paradigm, a majority of the Court reaffirmed the "essential holding" of *Roe*, particularly the

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or adhere to, decided cases.' Whatever the 'central holding' of *Roe* that is left after the joint opinion finishes dissecting it is surely not the result of that principle." *Id.* (citations omitted). Justice Scalia took issue with the joint opinion's use of popular opinion to reaffirm *Roe*. "I cannot agree with, indeed I am appalled by, the Court's suggestion that the decision whether to stand by an erroneous constitutional decision must be strongly influenced—*against* overruling, no less—by the substantial and continuing public opposition the decision has generated." *Id.* at 998 (Scalia, J., dissenting). *But see* Vanessa Laird, *Planned Parenthood v. Casey: The Role of Stare Decisis*, 57 *Mod. L. Rev.* 461, 466–67 (1994) (stating the use of *stare decisis* was not for increased judicial certainty, but for the protection of the judiciary against assaults by the other branches of government).

261. *Casey*, 505 U.S. at 871. The "essential holding" of *Roe* according to Justices Souter, O'Connor and Kennedy is:

First . . . a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. . . . Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child. These principles do not contradict one another; and we adhere to each.

*Id.* at 846. For application of the strict scrutiny test to state abortion regulations, see *Roe v. Wade*, 410 U.S. 113, 154–55 (1973).

262. *Casey*, 505 U.S. at 872.

263. "A framework of this rigidity was unnecessary and in its later interpretation sometimes contradicted the State's permissible exercise of its powers. . . . We reject the trimester framework, which we do not consider to be part of the essential holding of *Roe*." *Id.* at 872–73.

264. *Id.* at 872. As the Court stated:

Even in the earliest stages of pregnancy, the State may enact rules and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term and that there are procedures and institutions to allow adoption of unwanted children as well as a certain degree of state assistance if the mother chooses to raise the child herself.

*Id.*

woman's right to choose an abortion before the point of viability without undue interference from the state.<sup>265</sup>

While overruling all but the "essential holding" of *Roe*, the joint opinion did not allow a woman an unequivocal right to obtain an abortion. The three justices of the joint opinion determined that an "undue burden" analysis should be used to best balance the State's interest in protection of potential life versus a woman's constitutionally protected privacy right as recognized by *Roe*.<sup>266</sup> The opinion explained that an undue burden exists if "a State regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a non-viable fetus."<sup>267</sup>

In the last portion of the opinion, the Pennsylvania Abortion Control Act was analyzed under the undue burden standard. All but one of the statutes challenged did not impose an "undue burden" on the right of a woman to obtain an abortion in Pennsylvania.<sup>268</sup> The only statute that did not meet the new standard was the spousal notification requirement.<sup>269</sup>

The *Casey* decision provides no clear victory for either side of the abortion debate. After *Casey*, "*Roe* is either resting firmly on constitutional ground or quivering on the edge of demise."<sup>270</sup> The dissent in *Casey* made clear its intent to overturn *Roe* given the

265. *See id.* at 872-73.

266. "Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause." *Id.* at 874; Chemerinsky, *supra* note 202, at 669.

267. *Casey*, 505 U.S. at 877.

A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. . . . What is at stake is the woman's right to make the ultimate decision, not a right to be insulated from all others in doing so.

*Id.*

268. Four portions of the Pennsylvania Act were found not to impose undue burdens: (1) the definition of "medical emergency"; (2) the requirements of informed consent and the 24-hour waiting period prior to non-emergency abortions; (3) the requirement of parental or judicial consent for minors; and (4) the record-keeping and reporting requirements. *Casey*, 505 U.S. at 880-901; 18 Pa. Cons. Stat. Ann. §§ 3203, 3205-06 (West 2000).

269. *Casey*, 505 U.S. at 893-95.

The spousal notification requirement is thus likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle. We must not blind ourselves to the fact that the significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases.

*Id.* at 893-94.

270. Kelly Sue Henry, *Planned Parenthood of Southeastern Pennsylvania v. Casey: The Reaffirmation of Roe or the Beginning of the End?*, 32 U. Louisville J. Fam. L. 93, 93 (1993-94).

opportunity to do so, and if that opportunity is presented to the Court, the dissent needs only one vote to achieve this goal.<sup>271</sup>

The Supreme Court has not yet heard a case, nor have there been any reported cases, involving a gestational carrier's right to abort. Most lawyers and commentators believe a gestational carrier has the same unrestricted right as any other woman to abort the fetus she is carrying at any time she desires.<sup>272</sup> In the next section, the authors propose that a gestational carrier's right to abort should be restricted, since she owes a trustee's duty to both the fetus she is carrying and the intended parents. This duty is not an "undue burden," since it is one which the gestational carrier freely accepts. Therefore the trustee's duty should act to prohibit a gestational carrier's right to abort.

### III. THE GESTATIONAL CARRIER AS TRUSTEE

#### A. Basic Tenets

There is no precise legal theory analogous to the circumstances in which intended parents agree with a gestational carrier that she will be entrusted to act in the best interest of both the intended parents and the fetus by carrying the fetus to term. While traditional contract principles should be sufficient to cover these situations as long as the provisions do not violate public policy, many commentators have urged courts to find these agreements unenforceable on a number of grounds, particularly as they relate to the gestator's right to abort.<sup>273</sup>

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271. See *Casey*, 505 U.S. at 944-45 (1992) (Rehnquist, C.J., dissenting). Justice Blackmun in his concurrence to *Casey* wrote:

I fear for the darkness as four Justices anxiously await the single vote necessary to extinguish the light. . . . I am 83 years old. I cannot remain on this Court forever, and when I do step down, the confirmation process for my successor well may focus on the issue before us today. That, I regret, may be exactly where the choice between the two worlds will be made.

*Id.* at 923, 943 (Blackmun, J., concurring in part and dissenting in part).

272. See, e.g., *Johnson v. Calvert*, 851 P.2d 776, 784 (Cal. 1993).

273. For articles which state that the Thirteenth Amendment would prohibit enforcement of gestational surrogacy contracts, see Koppelman, *supra* note 220, at 486-92 (comparing gestational surrogacy contracts to the Thirteenth Amendment's prohibition of slavery); Mayo, *supra* note 65, at 613 (indicating that the Thirteenth Amendment would prohibit enforcement of restrictions on the right to abort contained in traditional surrogacy contracts); see also Shari O'Brien, *Commercial Conceptions: A Breeding Ground for Surrogacy*, 65 N.C. L. Rev. 127, 144 (1986) (indicating that not only does commercial surrogacy induce a poor woman to become a gestator, but it is also akin to slavery); Note, *Rumpelstiltskin Revisited: The Inalienable Rights of Surrogate Mothers*, 99 Harv. L. Rev. 1936, 1938-39 n.11-13 (1986) [hereinafter *Rumpelstiltskin*]. *Rumpelstiltskin* analyzes gestator agreements in light of the Thirteenth Amendment prohibition against involuntary servitude. See *id.* at 1937-39. The author concludes that the comparison between gestator agreements and slavery "fails because it overlooks a number of gaps in [T]hirteenth [A.]mendment doctrine." *Id.* at 1938. The Thirteenth Amendment does not appear to prohibit "several family arrangements that bear a striking similarity to slavery." *Id.*

As a result of the opposition to gestational carrier agreements, this part argues that an analogy that closely parallels these relationships can be found in trust law. This part posits that the relationship of the parties, the gestational carrier, intended parents, and the fetus, is analogous to the trust relationship.<sup>274</sup> As will be argued in greater detail later, the three relationships required for a trust are clearly present: the intended parents are the settlors who place the trust property with the trustee; the gestational carrier is the trustee who receives the trust corpus and agrees to assume responsibility for its well-being; and the intended parents are the trust beneficiaries who have the right to expect that no harm will come to the trust property.<sup>275</sup> The fetus is the beneficiary of the fiduciary relationship created between the intended parents and the gestator. As a result, the parties enter into what can be fairly characterized as a "confidential relationship"<sup>276</sup> that requires the gestational carrier to

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For example, children are obligated to obey their parents and must remain in their custody, and until recently, spouses were required to remain married unless one could show that the other breached the marriage contract. *Id.*

For articles which state that the enforcement of gestational surrogacy contracts is a violation of the gestational carrier's right to privacy, see Kermit Roosevelt III, *The Newest Property: Reproductive Technologies and the Concept of Parenthood*, 39 Santa Clara L. Rev. 79, 120 (1998) (arguing that enforcing gestational surrogacy agreements is a violation of the right of privacy); Andrea E. Stumpf, *Redefining Mother: A Legal Matrix for New Reproductive Technologies*, 96 Yale L.J. 187, 203 n.61 (1986) (asserting that despite any contractual arrangements suspending the right to abort, such a contract should not be upheld; instead, the intended parents must assume the risk that the gestator will not carry the child to term.).

For other articles which posit that the right to abort should not be limited, see Martha A. Field, *Surrogacy Contracts—Gestational and Traditional: The Argument for Nonenforcement*, 31 Washburn L.J. 1, 8 (1991) [hereinafter Field, *Surrogacy Contracts*] (arguing that upholding gestational surrogacy contracts will reduce the demand for adoption); Antoinette Sedillo Lopez, *Privacy and the Regulation of the New Reproductive Technologies: A Decision-Making Approach*, 22 Fam. L.Q. 173, 192 (1988) (claiming that gestator agreements degrade women); Radin, *Market-Inalienability*, *supra* note 167, at 1935 (arguing that gestator agreements result in the commodification of women's reproductive capabilities and exploit women); *Rumpelstiltskin*, *supra*, at 1936–37 (noting that courts must allow gestational surrogates to have abortions since doing otherwise would hamper a woman's "personhood" rights).

274. See *infra* notes 301-03 and accompanying text.

275. See *infra* notes 278- 300 and accompanying text.

276. Black's Law Dictionary 298 (6th ed. 1990). A "confidential relation[ship]" is a fiduciary relationship where

the law, in order to prevent undue advantage from the unlimited confidence or sense of duty which the relation naturally creates, requires the utmost degree of good faith in all transactions between the parties. It is not confined to any specific association of parties. It appears when the circumstances make it certain that the parties do not deal on equal terms, but on the one side there is an overmastering influence, or, on the other . . . [a] dependence, or trust, justifiably reposed. . . . It covers every form of relation[ship] between parties wherein confidence is reposed by one in another, and [the] former relies and acts upon representations of the other and is guilty of no derelictions on his own part.

refrain from engaging in any conduct resulting in harm to the subject of the trust. Arguably, this includes not aborting the fetus unless the life or health of the gestational carrier is at stake.

Relying on trust law for the analytical framework, this section addresses the gestational carrier's fiduciary responsibilities to both the fetus and the intended parents. While a trust analysis has been made in connection with the right to abort in general,<sup>277</sup> it has not been argued in the context of the gestational carrier/intended parent relationship.

### B. Basic Trust Doctrines

A trust has been defined as a fiduciary relationship in which one party holds title to property subject to an equitable obligation to keep or use that property for the benefit of another.<sup>278</sup> A trust generally involves three interests: settlor, beneficiary and trustee.<sup>279</sup> One party can hold any two of these interests.<sup>280</sup> There must be a settlor, one

*Id.*

This article posits that contrary to arguments that place the gestator in a weaker bargaining position, it is the intended parents who are dependent upon the gestator to deliver the child to term. *See infra* Part III.C.2. In the truest sense, the intended parents are more vulnerable. They are justified in trusting that the gestational carrier will do what she has agreed to do and are virtually powerless to prohibit an abortion, absent a court's willingness to uphold the agreement. *See* Linda D. Applegarth, *Emotional Implications, in Reproductive Endocrinology, Surgery & Technology 1953, 1961* (Eli Y. Adashi et al. eds., 1996) (suggesting that infertility patients pursue treatment with a tenacity equal to that of cancer patients).

277. *See* Jeffrey D. Goldberg, *Involuntary Servitudes: A Property-Based Notion of Abortion-Choice*, 38 UCLA L. Rev. 1597, 1612-13 (1991). Goldberg argues that in almost every case of unwanted pregnancy a woman does not intend to put her body in trust for a fetus. *Id.* at 1612. Absent the woman's intent or unjust enrichment, the law has no mechanism to imply a trust. *Id.* at 1612-13. In addition, a woman needs to have a beneficial interest in her body or at least in her labor. *Id.* at 1613. Without such an interest, a woman could not use her bodily resources for her own benefit. *Id.* "[U]nder [a] trust theory analysis, a woman has legal title to her bodily resources, [but] she cannot use them to her benefit in any significant way. *Id.*; *see also* Restatement (Second) of Trusts § 170(1) (1959) ("[T]he trustee is under a duty to the beneficiary to administer the trust solely in the interest of the beneficiary.")

278. George T. Bogert, *Trusts* § 1 (6th ed. 1987) (discussing the general duties of the trustee); *see also* Walter G. Hart, *What is a Trust?*, 15 L.Q. Rev. 294, 301 (1899) (defining a trust as "an obligation imposed either expressly or by implication of law whereby the obligor is bound to deal with property over which he has control for the benefit of certain persons of whom he may himself be one, and any one of whom may enforce the obligation").

279. A "settlor" creates and provides the consideration for the trust. *Black's Law Dictionary, supra* note 276, at 1373. A "beneficiary" is the party who is designated to benefit by, or receive something from, an appointment, disposition, or assignment. *Id.* at 157. A "trustee" holds the property in trust for the benefit of another and owes a fiduciary responsibility to the beneficiary. *Id.* at 1514.

280. *See* Henry Hansmann & Ugo Mattei, *Trust Law in the United States: A Basic Study of Its Special Contribution*, 46 Am. J. Comp. L. 133, 134 (1998) (noting that the same person can play more than one of the three roles in a trust relationship). Hansmann and Mattei suggest that the settlor and the beneficiary can be the same

who intentionally brings the trust into existence.<sup>281</sup> The trust may be created by oral communication or by a written instrument.<sup>282</sup> No formal or technical words are necessary to create a trust.<sup>283</sup> It is imperative, however, that the settlor's intent is clearly expressed, and that the trust describes with certainty the subject matter, beneficiaries and purpose of the trust.<sup>284</sup> To this end, a trust instrument must have a beneficiary, a person for whom the trust property is held or used by the trustee.<sup>285</sup> There must also be a trustee who is responsible for holding the trust property subject to the rights of the beneficiary.<sup>286</sup> The primary focus of the next section is the trustee's duties to the trust beneficiary.

### C. *The Trustee's Duties to the Beneficiary*

The relationship between trustee and beneficiary is an intimate one. It requires the beneficiary to place great confidence in the trustee who has nearly full control over the trust affairs of the beneficiary.<sup>287</sup> As a result, courts refer to this relationship as a "fiduciary relationship,"<sup>288</sup>

person. *Id.* In this case, the trust only involves a "delegation of responsibility for managing property from the settlor/beneficiary to the trustee." *Id.*; see also Bogert, *supra* note 278, at 3 (indicating that a trust may be valid if there are only two parties to it if, for example, the settlor also declares herself to be the trustee, thereby making the settlor and trustee the same person. The trust is valid as long as the beneficiary is a separate party.).

281. Hansmann & Mattei, *supra* note 280, at 134.

282. Bogert, *supra* note 278, at 24.

283. *Id.*

284. Restatement (Second) of Trusts §§ 23, 25 (1959) (discussing the forms in which the intent to create a trust can be manifested); Hansmann & Mattei, *supra* note 280, at 136 (indicating that as long as the parties characterize the relationship they have as a trust or make it clear they intend a trust-like relationship, they are bound by rules automatically inserted into their agreement under the law of trusts).

285. Hansmann & Mattei, *supra* note 280, at 134.

286. *Id.* at 137; see also Restatement (Second) of Trusts §§ 197-99 (1959) (discussing remedies of the beneficiary when a trustee does not carry out the trust intent).

287. See Bogert, *supra* note 278, at 2.

288. Black's Law Dictionary, *supra* note 276, at 626. A "fiduciary relationship" is "a very broad term embracing both technical fiduciary relations and those informal relations which exist wherever one person trusts in or relies upon another." *Id.* It has been defined as follows:

A relation[ship] subsisting between two persons in regard to a... contract... or... the general business of one of them, of such a character that each must repose trust and confidence in the other and must exercise a corresponding degree of fairness and good faith. Out of such a relation, the law raises the rule that neither party may exert influence or pressure upon the other, take selfish advantage of his trust, or deal with the subject-matter of the trust in such a way as to benefit himself or prejudice the other except in the exercise of the utmost good faith and with the full knowledge and consent of that other....

*Id.*; see also Restatement (Second) of Trusts § 2 (1959) (defining a trust as a "fiduciary relationship with respect to property, subjecting the person by whom the title to the property is held to equitable duties to deal with the property for the benefit of



which requires the trustee to act with "strict honesty and candor and solely in the interest of the beneficiary."<sup>289</sup> In fact, it has been argued that due to the nature of the trustee-beneficiary relationship, the court of equity imposes a duty of care upon the trustee higher than that existing in an ordinary business relationship.<sup>290</sup>

A trustee is imbued with a number of responsibilities. One such duty, the duty of loyalty, requires the trustee to act with unselfish, undivided loyalty<sup>291</sup> and extreme good faith.<sup>292</sup> The duty of loyalty dictates that a trustee refrain from placing herself in a position where her personal interests or those of third parties conflict with the interests of the beneficiaries.<sup>293</sup> The duty also requires that any act that impacts the trust must consider only the welfare of the trust beneficiaries.<sup>294</sup> In upholding the duty of loyalty, a court is not primarily concerned with preventing unjust enrichment or resolving

another person, which arises as a result of a manifestation of an intention to create it"); 1 Austin W. Scott & William F. Fratcher, *The Law of Trusts* § 2.5, at 43 (4th ed. 1987) (stating that a fiduciary relationship exists between the trustee and the beneficiary); Benjamin G. Carter, *Relief For Beneficiaries Suing for Breach of Fiduciary Duty: Payment of Accounting Costs Before Trial*, 76 Wash. U. L.Q. 1411, 1414 (1998) (indicating that a trustee has a fiduciary obligation to deal impartially with all beneficiaries and to faithfully administer the trust for their benefit). *But see* Jerome J. Curtis, Jr., *The Transmogrification of the American Trust*, 31 Real Prop. Prob. & Tr. J. 251, 252 (1996) (arguing that present trust law has relaxed so that trustees are often held only to standards applied to agents and sometimes trustees are judged more leniently than agents).

289. Restatement (Second) of Trusts §§ 170, 206 (1959) (discussing the duty of loyalty of the trustee); Bogert, *supra* note 278, at §§ 1, 2 (discussing the fiduciary relationship between the trustee and beneficiary).

290. Bogert, *supra* note 278, at § 95 (discussing the extreme difficulty of putting the beneficiary's interests before the trustee's); *see also* Meinhard v. Salmon, 164 N.E. 545, 546 (N.Y. 1928) (Chief Justice Cardozo noted that "many forms of conduct permissible in a workaday world for those acting at arm's length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.").

291. *See* Restatement (Second) of Trusts § 170 (1959); *see also* Mercury Bay Boating Club, Inc. v. San Diego Yacht Club, 557 N.E.2d 87, 95 (N.Y. 1990) (holding that a trustee owes an undivided duty of loyalty to all beneficiaries); Strickland v. Arnold Thomas Seed Serv., Inc., 560 P.2d 597, 601 (Or. 1977) (indicating that all courts recognize the trustee's fundamental duty of loyalty to a beneficiary); Willers v. Wettestad, 510 N.W.2d 676, 680 (S.D. 1994) (holding that "[a] trustee's duty to preserve the trust assets is in accord with the fundamental duty of loyalty and fidelity owed by every trustee to [his] beneficiary."); Carter, *supra* note 288, at 1415.

292. *See* Bogert, *supra* note 278, at § 95 (discussing the loyalty doctrine and the results of questionable transactions by the trustee); Carter, *supra* note 288, at 1415 n.22 (stating that the trustee is never relieved of the duty to act in good faith).

293. *See* Riegler v. Riegler, 553 S.W.2d 37, 40 (Ark. 1977) (stating that a trustee must act for the beneficiaries' benefit and not in his own self-interest); Carter, *supra* note 288, at 1415-16 (stating that if the trustee fails to act in the interest of the beneficiary, the beneficiary can petition the court to compel the trustee to comply with the terms of the trust).

294. *See* Bogert, *supra* note 278, at § 95 (discussing the temptations of the trustee to act in his own best interests).

the equities of the parties in a given case.<sup>295</sup> Rather, the rule is designed in large part to deter all trustees from acting contrary to the beneficiaries' rights.<sup>296</sup> Most important, however, is that where a trustee threatens to commit a disloyal act, a court of equity has the power to stop the act by entering an injunction against the trustee.<sup>297</sup>

In addition to the duty of loyalty, by accepting the responsibility to act in the best interest of the beneficiary, a trustee must defend the trust and the interest of its beneficiaries against attack by any person who attempts to destroy the trust.<sup>298</sup> This same duty also prevents a trustee from attaching or terminating the trust in violation of the settlor's intent.<sup>299</sup> Instead, a trustee has a duty to take whatever steps are necessary to protect and preserve the property from loss or damage.<sup>300</sup>

#### D. Gestational Carrier as Trustee

##### 1. The Gestator's Duties to the Trust Beneficiaries

The argument that the agreement between the intended parents and the gestational carrier creates a trust-like relationship is compelling. The relationship encompasses the required interests. The intended parents function as settlors who initiate the trust relationship. They provide the trust corpus, the embryo, which, standing alone, is the personal property of the intended parents. Further, the embryo retains its character as personal property until entrusted with the gestational carrier.<sup>301</sup> Once the carrier accepts the

295. See generally *In re Bond & Mortg. Guarantee Co.*, 103 N.E.2d 721, 725 (N.Y. 1952) (stating that the rule is primarily based on prevention and deterrence and is not primarily remedial).

296. See *id.*; see also *Carter*, *supra* note 288, at 1415 (citing *Smith v. First Nat'l Bank*, 624 N.E.2d 899, 907 (Ill. App. Ct. 1993) (stating that the "trustee's duty of loyalty to beneficiaries is more intense than in any other fiduciary relationship").

297. See Restatement (Second) of Trusts §§ 197-99 (1959) (discussing the legal and equitable remedies available to the beneficiary); *Bogert*, *supra* note 278, § 98 (discussing the duty of the trustee to defend the trust from attack).

298. See *id.* § 178 (discussing the trustee's duty to defend the trust from attack); see also *In re Estate of Strange*, 97 N.W.2d 199, 200 (Wis. Ct. App. 1959) (holding that respondents cannot hold themselves out as executors of an estate held in trust in order to finance a destruction of the trust).

299. See *Bogert*, *supra* note 278, § 98 (discussing the liability of the trustee if he fails to defend the trust); *Carter*, *supra* note 288, at 1416-17.

300. See Restatement (Second) of Trusts §§ 22, 24 (1959) (discussing the trustee's duty to carry out the settlor's intent); *Bogert*, *supra* note 278, § 99. While trustees have many other duties placed upon them by law, discussion of those duties is beyond the scope of this article.

301. See *Kass v. Kass*, 696 N.E.2d 174, 181 (N.Y. 1998) (indicating that frozen embryos were "property"); *York v. Jones*, 717 F. Supp. 421, 425 (E.D. Va. 1989). In *York*, the court held that where the defendant took possession of the plaintiffs' prezygote, it created a bailor-bailee relationship between the parties, even where there was no express intent to create such a relationship. *Id.* All that is needed to create a

embryo, she becomes the functional equivalent of a trustee, and she is responsible for the trust's well being, including protecting the fetus from attack and delivering it to term, nothing more than the gestator has expressly agreed to do.

The circumstances surrounding these agreements clearly show intent to enter into this association. The trust beneficiaries are the intended parents. The fetus benefits from this relationship. The intended parents enter the initial agreement with the expectation that the gestational carrier will do what is necessary to protect and ultimately deliver the child to term. It is clear that the gestational carrier accepts the responsibility for serving as trustee, particularly in light of the rigorous physical and psychological examinations she must generally endure before she is permitted to serve as a gestational carrier.<sup>302</sup> By submitting to the required procedures, she evidences her intent to serve as trustee for the beneficiaries. For a finite period, then, the gestational carrier has temporarily surrendered her largely unfettered right to abort by virtue of the inclusion of other parties comprising the trust relationship. She is not the sole actor. If the gestational carrier aborts the fetus, she breaches several duties of a trustee: to protect the subject of the trust, to defend the trust corpus from attack, to make the subject (fetus) productive, and to maintain the duty of loyalty to all beneficiaries.<sup>303</sup> In fact, the gestational carrier's act of aborting the fetus breaches the duty not to self-deal, since she has placed her personal interests above those of the subject (fetus) and the intended parents.

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bailment is lawful possession and the duty to account for the thing as the property of another. *Id.* In this regard, one who owns the pre-zygote is the owner of "property" and has a cause of action in detinue for wrongful detention of the pre-zygotes. *Id.* at 427; see also John A. Robertson, *In the Beginning: The Legal Status of Early Embryos*, 76 Va. L. Rev. 437, 454-55 (1990). Robertson noted that a question arises as to who owns or has a property interest in early embryos. Robertson cautions that "[a]pplying terms such as 'ownership' or 'property' to early embryo risks misunderstanding." *Id.* at 454. These terms do not indicate that embryos are to be treated in all respects like other property. Instead, such terms simply designate who has authority to decide among legally available options for an early embryo. *Id.* at 455. Robertson further asserts that having a property or ownership interest in early embryos should not be analogized to having a property interest in a car or furniture. Rather, the pivotal question is who has dispositional authority and what limits there are on what may be done. *Id.* at 455 n.48. *But see* Davis v. Davis, 842 S.W.2d 588, 597 (Tenn. 1992) (holding that frozen embryos are neither person nor property, but rather "occupy an interim category that entitles them to special respect because of their potential for human life").

302. See *supra* notes 160-71 and accompanying text (outlining the various requirements placed on women who want to be gestational carriers and the medical procedures incumbent upon them).

303. See *supra* notes 291-300 and accompanying text.

## 2. The Gestational Carrier's Duty to the Fetus

As trustee, the gestator's duties to the fetus are similar to those owed to the parents to the extent that the law imposes upon the pregnant woman certain fiduciary obligations to the fetus and holds her responsible for breaching such duties.<sup>304</sup>

In this respect, the gestational carrier stands in the position of a daycare facility that is accountable to the child and ultimately the parents. The facility assumes fiduciary responsibilities to the parents who are beneficiaries of the agreement, which places the child's well-being in the hands of the facility operators. As beneficiaries, the parents have certain expectations. During the period of entrustment, they are unable to directly care for their child. As a result, they deliver their child to the facility with the expectation that he will be cared for during the time of entrustment and that he will be returned to the parents unharmed at the end of the designated period. The parents are vulnerable while the child is in the hands of the facility's operators in that they are virtually helpless to defend their child from attack while he is entrusted to someone else. They must rely on the facility operators' promise not to harm the child or allow anyone else to harm him. In essence, daycare officials insure a child's safety for a specific period of time. This is the heart of the argument.

As a beneficiary of the fiduciary relationship between the intended parents and the gestator, the child has similar expectations. The day care center, however, has an even greater responsibility to the child who is vulnerable to attacks and is powerless to protect himself. At a minimum, the child is entitled to have his basic needs met while at the facility. Further, he has the right to be returned to his parents without having been intentionally or negligently harmed.

## IV. ARGUMENTS AGAINST RESTRICTING ABORTION

This Part considers some prominent arguments that might render gestator agreements unenforceable under any theory, including trust theory. It addresses feminists' concerns regarding commodification and inalienability of personhood rights.<sup>305</sup> In addition, it also examines the gestational carrier as a Good Samaritan.<sup>306</sup> This Part, however, concludes that these assertions are untenable and have not been recognized in the *Roe-Casey* line of decisions, nor in trust law.<sup>307</sup> These arguments should not serve as the basis for denying women the right to choose to serve as gestational carriers and to fulfill a legal promise not to abort a fetus and carry it to term, nor should these

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304. See *infra* Part IV.E.3.

305. See *infra* Part IV.A.1-3.

306. See *infra* notes 423-38 and accompanying text.

307. See *infra* Part IV.C.3.

assertions be voided to allow women to escape a legal promise which they subsequently find too burdensome to fulfill—carrying a fetus to term for the intended parents.

Some feminist legal scholars and academic commentators raise a number of arguments relative to the efficacy of gestational carrier agreements.<sup>308</sup> Much of the debate centers around the continued right of gestational carriers to abort despite agreeing not to do so. To this end, opponents of agreements not to abort may have a powerful objection to an argument that draws upon the daycare facility analogy and trust principles to explain the gestator/intended parent relationship, and the corresponding responsibilities the gestational carrier temporarily assumes for both the intended parents and the fetus. Juxtaposed with the right to abort, the daycare comparison appears to be overly simplistic. This analogy, it can be argued, ignores that entrusting a child to a daycare or similar facility involves no relinquishment of autonomy or personhood rights by the facility's owners or operators. It is in this light that opponents of gestational carrier/intended parent agreements argue that these agreements violate a woman's privacy and personhood rights. This part addresses a few of the more prominent arguments against gestational carrier/intended parent relationships, primarily assessing the contention that these relationships result in the commodification of personhood rights. After reviewing the arguments we conclude they are untenable.

### A. *The Right to Abort as an Inalienable Property Right*

#### 1. Market-Inalienability and Commodification

A prominent assertion against a trustee-type analysis is that gestator agreements result in a woman waiving her constitutional right to abort.<sup>309</sup> Critics allege that the surrender of abortion rights has a dehumanizing and oppressive effect on women. The right to abort, therefore, should be considered a personal property right and should be afforded legal protection from alienability in the marketplace,<sup>310</sup> even if a woman voluntarily relinquishes that right.<sup>311</sup> Margaret Radin

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308. The feminist movement asserts that "women are subordinated in capitalist (and other) societies, and their position must be changed" and the objective is "radical change." Richard S. Harnsberger, *Reflections About Law Reviews and American Legal Scholarship*, 76 Neb. L. Rev. 681, 696 (1997).

309. See *supra* note 273.

310. See Thomas A Shannon, *Surrogate Motherhood: The Ethics of Using Human Beings* 72 (1988) (arguing that by paying a gestational surrogate for her reproductive services, the possibility is great that we objectify and alienate a function which is essentially personal in nature); Radin, *Market-Inalienability*, *supra* note 167, at 1852-53;

311. See Radin, *Market-Inalienability*, *supra* note 167, at 1852-53.

refers to the notion of inalienability of personal property rights as "market inalienability,"<sup>312</sup> meaning that some rights, like the right to abort, cannot and should not be sold or traded in the marketplace.<sup>313</sup> Radin argues that, by rendering such rights non-salable, society recognizes that some rights cannot be treated as commodities.<sup>314</sup>

Market-inalienability is not limited to the circumstances in which a gestational carrier is willing to carry a fetus to term, thereby foregoing the right to abort.<sup>315</sup> Rather it encompasses any right that is central to

312. *Id.*

313. *See id.* Radin bases her commodification theory, at least in part, on Marxist theories. *Id.* at 1871. She argues that the freedom of alienation is the crucial characteristic of liberal property rights; yet Marx saw a necessary connection between market alienability and human alienation. *Id.* Radin reasons that in early writings Marx analyzed the connection between alienation and commodity production in terms of estranged labor; later he introduced the notion of commodity fetishism. In his treatment of estranged labor, Marx portrayed workers' alienation from their own human self-activity as the result of producing objects that became market commodities. By objectifying the labor of the worker, commodities create object-bondage and alienate workers from the natural world in and with which they should constitute themselves by creative interaction. Ultimately, laboring to produce commodities turns the worker from a human being into a commodity, "indeed the most wretched of commodities."

*Id.* (citations omitted). *But see* Wendy McElroy, *Breeder Reactionaries: The "Feminist" War on Reproductive Technologies*, Reason, Dec. 1994, at 18, 19-20. McElroy argues that radical feminists refer to themselves as post-Marxists; but it is not clear how far they have moved past Marxists theories. Radical feminists have taken Marxist theory and substituted gender for economic relations. "In place of capitalism, there is patriarchy...; in place of class exploitation, there is gender exploitation. Developments apparently benefiting women—such as longer lifespan, birth-control pills, increased access to property, wealth, and education—actually maintain the patriarchal status quo." *Id.* at 20. McElroy further asserts that because of their belief about exploitation and the oppressiveness of patriarchy, radical feminists find new reproductive technologies abhorrent. *Id.* at 20. Radical feminists conclude that these technologies are a creation of male science, which seeks to dominate nature. These scholars further contend that the legal bases for implementation of these new technologies, including individual rights and contract law, are an extension of an inherently exploitative capitalist system. *Id.* McElroy argues that these assertions are both absurd and contradictory. *Id.* For a definition of "radical feminists," see *infra* note 345.

314. *See* Margaret Jane Radin, *Property and Personhood*, 34 Stan. L. Rev. 957, 959 (1982) [hereinafter Radin, *Property*]. Radin argues that some property is more central to "personhood" than other property and that the law should protect these rights. *Id.* at 959-61. Further, Radin believes it is possible to measure an object's relationship to personhood by the "kind of pain that would be occasioned by its loss." *Id.* at 959; *see also* Rumpelstiltskin, *supra* note 273, at 1946-49 n.45 (arguing that the law should protect personhood rights).

315. *See* Rumpelstiltskin, *supra* note 273, at 1947 (asserting that in deciding whether a given right should be alienable, judges must initially assess the "centrality of freedom to the identity of current individuals and then compare it with the centrality of security from past selves to the personal identity of future individuals"); *see also* Radin, *Market-Inalienability*, *supra* note 167, at 1879-80, 1880 n.115 (suggesting "that property may be divide into fungible and personal categories for purposes of moral evaluation"); Radin, *Property*, *supra* note 314, at 959-61, 978-79, 986-88 (describing the intuitive personhood perspective).

one's identity or personhood.<sup>316</sup> "Centrality" to personhood is characterized by the notions and attributes that most people believe are important to their personality and feelings of self-worth.<sup>317</sup> Such rights are identified by the kind of pain that results by the loss of that right.<sup>318</sup> To this end, women cannot transfer gestational services, particularly as they impact abortion rights.<sup>319</sup>

Commodification of personhood rights supposes that gestational agreements turn humans into commodities, resulting in an inferior form of human life.<sup>320</sup> Such agreements fail to recognize the importance of bodily integrity, treating it as a fungible object rather than an attribute inextricably tied to human beings.<sup>321</sup> The danger to personhood in treating personal attributes as fungible objects is that it detaches something integral from the person.<sup>322</sup> Arguably, by allowing one to be separated from a non-detachable right, like the right to abort, proponents of free alienability of property rights do not realize that one cannot remain the same after the loss of a personhood right.<sup>323</sup>

## 2. Justifications for Rejecting the Sale of Personhood Rights

Market-inalienability, then, is viewed by these neo-Marxists as a means of correcting the market's failure to recognize some property interests as unsuitable for sale. Noncommodifiability of personhood rights is a means of controlling external factors that prevent the market from achieving an efficient result.<sup>324</sup> Noncommodifiability allegedly represents a better view of personhood because it recognizes the interconnectedness of the person and her environment as integral to personhood.<sup>325</sup> By promoting a positive view of freedom, it fosters

316. See Radin, *Market-Inalienability*, *supra* note 167, at 1849, 1916; *Rumpelstiltskin*, *supra* note 273, at 1949-50 (arguing that in the context of surrogacy, a woman should not have to give up the right to abort because it protects her control over her body and procreative decisions).

317. See *Rumpelstiltskin*, *supra* note 273, at 1947.

318. See *id.* at 1947 n.45.

319. See *id.* at 1950 (arguing that compelling a woman to continue with a pregnancy threatens her dignity and self-respect).

320. See Radin, *Market-Inalienability*, *supra* note 167, at 1872 (arguing that, as a result of debasing humans by commodifying them, Marx concluded that people must change in order to live without the market).

321. See *id.* at 1849, 1930; Mark Strasser, *Parental Rights Terminations: On Surrogate Reasons and Surrogacy Policies*, 60 Tenn. L. Rev. 135 (1992) [hereinafter Strasser, *Parental Rights Terminations*] (noting that an argument against surrogacy arrangements is that they increase the likelihood that women will be treated as fungible entities rather than as people who deserve respect).

322. See Radin, *Market-Inalienability*, *supra* note 167, at 1849.

323. *Id.*

324. *Id.* at 1904.

325. Radin asserts that in looking for a better view of personhood, freedom, identity and contextuality are three main considerations. She argues that

[t]he freedom aspect of personhood focuses on will, or the power to choose

a concept of human flourishing superior to that implied by universal commodification.<sup>326</sup>

Those who reject the salability of personhood rights realize that in a market society, whatever people want to buy and others want to sell is deemed transferable.<sup>327</sup> Market-inalienability seeks to create a case for preventing a person from choosing to make fungible personal attributes, rights or things.<sup>328</sup> Prohibiting the transferability of these rights seeks legitimacy under a number of theories. One argument is that it appeals to the sense of moral rightness that is fostered when we embrace a commitment to the sanctity of life.<sup>329</sup> Another method of justifying nontransferability suggests a domino effect from allowing the transfer of some sexual interactions.<sup>330</sup> The argument envisions a slippery slope that will result in the commodification of all sexual relationships.<sup>331</sup>

A final means of justifying an inalienability theory, which will be the primary focus of the remainder of this section, relies on the duty to protect women from their "choice" in placing personal property rights in the stream of commerce. It is a prophylactic measure.<sup>332</sup> The premise of this argument is that some property may be freely

for oneself. In order to be autonomous individuals, we must at least be able to act for ourselves through free will in relation to the environment of things and other people. The identity aspect of personhood focuses on the integrity and continuity of the self required for individuation. In order to have a unique individual identity, we must have selves that are integrated and continuous over time. The contextuality aspect of personhood focuses on the necessity of self-constitution in relation to the environment of things and other people. In order to be differentiated human persons, unique individuals, we must have relationships with the social and natural world.

*Id.* (footnotes omitted).

326. *Id.*

327. *Id.* at 1905. Radin refers to the alienability of anything in the marketplace as universal commodification. *Id.* She refers to this sort of freedom as negative liberty because in this context, freedom is the ability to use one's will to manipulate objects in order to gain the greatest monetary value. *Id.* Radin reasons, however, that "even negative liberty can reject the general notion of commodification of persons: the person cannot be an entity exercising free will if it is a manipulable object of monetizable value." *Id.* at 1905.

328. *Id.* at 1880-81.

329. *See id.* at 1912. Radin argues that "[s]omething might be prohibited in its market form because it both creates and exposes wealth- and class-based contingencies for obtaining things that are critical to life itself—for example, health care—and thus undermines a commitment to the sanctity of life." *Id.*

330. *Id.* at 1912-13.

331. *Id.* at 1913-14. Radin suggests that the domino theory assumes that, under some circumstances, the commodified and non-commodified versions cannot co-exist. *Id.* By this, she means that if we commodify some things, we prevent their non-commodified parallels from existing. *Id.* Based on this analysis, commodifying sexual interactions, like gestational carrier agreements, will lead to the commodification of all sexual relationships. Radin concludes that when commodification and non-commodification cannot co-exist, the non-commodification version is morally preferable. *Id.* at 1913.

332. *Id.* at 1909-10.



exchangeable as one sees fit. Personal property, however, is sometimes transferred under circumstances that raise suspicion as to the voluntariness of the decision.<sup>333</sup> The rationale for preventing such a decision is that

[g]iven that we cannot know whether anyone really intends to cut herself off from something personal by commodifying it, [a suspicion of coercion] might sometimes justify banning sales. The risk of harm to the seller's personhood in cases in which coerced transactions are permitted, . . . and the great difficulties involved in trying to scrutinize every transaction closely, may sometimes outweigh the harm that a ban would impose on would-be sellers who are in fact uncoerced.<sup>334</sup>

A prophylactic argument disallows a rebuttable presumption of non-coercion or even a case-by-case examination of the issue of voluntariness. The belief is that the risk of harm to personhood in a coerced transaction, which might be mistakenly seen as voluntariness, is so great that it is better to risk constraining the exercise of choice by those who really wish to trade a personhood right.<sup>335</sup>

### 3. Market-Inalienability Applied to a Gestational Surrogate's Right to Abort

Although based on faulty reasoning, the above and similar arguments suggest that women who agree to serve as gestational carriers view the alleged "commodification" of the right to procreate as the solution to their economic powerlessness or oppression.<sup>336</sup> If women are prevented from entering into gestational carrier agreements, they are placed in a "double-bind."<sup>337</sup> If we permit commodification, we may exacerbate the oppression of women. If, however, "we do not allow commodification, we force women to remain in circumstances that they . . . believe are worse than becoming

333. *Id.* at 1910.

334. *Id.* at 1909-10.

335. *Id.* at 1910. According to Radin's argument, so great is the risk to personhood in allowing commodification of personal attributes, that there could not even be a rule creating a rebuttable presumption that these transactions are uncoerced. *Id.* at 1910.

336. *Id.* at 1915-16.

337. *Id.* at 1915-17. A "double bind" generally refers to a situation in which someone receives conflicting information from a single source which does not permit any appropriate response to be made. Merriam Webster's Collegiate Dictionary 347 (10th ed. 1996). Radin argues that the double bind has two main consequences:

First, if we cannot respect personhood either by permitting sales or by banning sales, justice requires that we consider changing the circumstances that create the dilemma. We must consider wealth and power redistribution. Second, we still must choose a regime for the meantime, the transition, in nonideal circumstances. To resolve the double bind, we have to investigate particular problems separately; decisions must be made (and remade) for each thing that some people desire to sell.

Radin, *Market-Inalienability*, *supra* note 167, at 1917.

'sexual commodity-suppliers.'"<sup>338</sup> We deprive the women who are most in need of the opportunity to earn more money a chance to lead a better life.<sup>339</sup>

Radin also recognizes that gestational carriers may not experience a double bind at all.<sup>340</sup> Rather, these women may carry and deliver children for someone else out of a sense of altruism.<sup>341</sup> Even under these circumstances, Radin argues that gestational carriers may be unwittingly contributing to women's oppression by "reinforcing oppressive gender roles."<sup>342</sup> Similarly, another commentator asserts that permitting women "to contract away their right to abortion . . . enlist[s] the coercive machinery of the state in the project of compelling [women] to bear children," which is a privacy violation.<sup>343</sup>

In an effort to prevent gestational carriers from relinquishing the right to abort, supporters of an inalienable-personhood-rights argument contend that "compelling a woman to continue with a pregnancy . . . threatens her dignity and self-respect," because she would be forced to live with her decision until the child was born.<sup>344</sup> Based on this line of reasoning, if we invalidate gestational carrier agreements under all circumstances because of their dehumanizing effect on women, the fundamental right to abort remains intact, even if it denies women who knowingly and willingly consent to carry a child to term for the benefit of the intended parents, the right to make such agreements.

338. Radin, *Market-Inalienability*, *supra* note 167, at 1917.

339. *Id.* at 1916-17.

340. *Id.* at 1930.

341. *See id.*; *see also supra* note 166.

342. Radin, *Market-Inalienability*, *supra* note 167, at 1930-31.

343. *See* Roosevelt, *supra* note 273, at 120.

344. *See Rumpelstiltskin*, *supra* note 273, at 1948-50 (relying on Anthony T. Kronman, *Paternalism and the Law of Contracts*, 92 *Yale L.J.* 763, 780-84 (1983)). The commentator notes that people may make a decision which they later come to regret. *Id.* at 1948. The author argues that people must be able to depersonalize what they determine to be mistakes in order to protect their senses of personal integrity. *Id.* at 1948. Additionally, when a person changes her mind, she has "likely changed her mind about some value or goal, such as the value of choice in the future." *Id.* When a woman changes her mind about an agreement she has made, she likely views her earlier decision to enter the agreement as a "foreign and irrational act." *Id.* Accordingly,

[s]he will view her earlier self as almost a different individual—one who betrayed her by committing her to act against her best interests. This feeling of former self-betrayal and irrationality can undermine her ability to make decisions and future commitments by leaving her in doubt of her current rationality and of the effects of her present decisions on a future self. Specific performance of promises requiring personal cooperation intensifies her feelings of regret and self-betrayal, because it forces her physically to confront her former irrational commitment. Protecting her right to breach the promise and pay damages ensures her ability to depersonalize the relationship and thereby preserves her self-respect.

*Id.* (citations omitted).

#### 4. Market-Inalienability Should Not Limit the Ability of a Couple to Restrict a Gestational Carrier from an Abortion

Many of the concerns about gestational carrier agreements appear under the rubric of commodification. A common underpinning in these assertions seems to be the claim that women are being marginalized and victimized and must be protected from their own decisions. Critics claim that, even if there is no direct victimization, the supposed small number of women who might act out of altruism in carrying a child for a childless couple share some complicity in women's oppression by reinforcing gender role stereotypes.

These arguments, which seek to persuade law-makers and judges that gestational carrier agreements should be voided as repugnant to a number of social policies, are based on faulty reasoning, however, and should not be used as a basis for invalidating these agreements. This section seeks to dismantle some of these pursuits as weak arguments and, instead, asserts that gestational carrier agreements would be enforceable under trust law principles.

##### *a. Rejection of a Commodification Theory In Gestator Agreements*

To begin, radical feminists<sup>345</sup> argue that the gestational carrier/intended parent relationship is improper because it commodifies women, their labor and their offspring.<sup>346</sup> These arguments are fatally flawed for several reasons. First, neither the gestator nor the couple are forced into this market.<sup>347</sup> Infertile couples may pursue surrogacy or adoption, but have the right not to choose either.<sup>348</sup> Moreover, the vast majority of women who choose not to become gestational carriers are free to make their own choice.<sup>349</sup> As one author aptly concludes:

The claim about commodification . . . has nothing whatsoever to do with what a woman may or [may] not do with her own body, or what a man may or may not do with his own sperm. Instead, it is an effort by some to impose their own conception of the right and proper

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345. "Radical feminists" see women as "those from whom sex is taken," just as workers "are those from whom labor is taken." Robin West, *Jurisprudence and Gender*, 55 U. Chi. L. Rev. 1, 13 (1988). This group is seen by general society as being more separatist, more alarming and more sensitive to the power difference between men and women than other feminist groups. *Id.* In this way, radical feminists stand in contrast to "cultural feminists" for whom the "important difference between men and women is that women raise children and men don't." *Id.*

346. See Epstein, *Full Contractual Enforcement*, *supra* note 167, at 2326 n.31; Radin, *Market-Inalienability*, *supra* note 167, at 1855-56, 1928-36.

347. Epstein, *Full Contractual Enforcement*, *supra* note 167, at 2326.

348. *Id.*

349. *Id.*

thing to do with bodies, eggs, and sperm on other individuals who hew to different conceptions of the good.<sup>350</sup>

There must be more than the bare condemnation of surrogacy rubric in order to persuade society to restrain those who willingly pursue these relationships.<sup>351</sup>

Another reason for rejecting the commodification theory is that it wrongly characterizes women and their child-producing ability as “fungible.”<sup>352</sup> A fungibility argument envisions that women and their reproductive capabilities are interchangeable goods. It implies that one woman can simply replace another in fulfilling her obligation under the agreement.<sup>353</sup> True commodities are, *by definition*, designed to be exchanged in the market with relative speed.<sup>354</sup> “The key element of a commodity . . . is the perfect substitutability of one unit for another, from which it is easily inferred that there is no special subjective value that is attached to any particular unit.”<sup>355</sup>

By contrast, the very nature of gestator agreements belies the argument that women and their children are fungible. The intended parents and the potential carrier must agree to enter a relationship which the parties contemplate will last for the duration of the pregnancy. There is something special which motivates a woman to carry a child to term for the intended parents.<sup>356</sup> There is also something that draws a couple to accept a woman as a gestational carrier and trust that she will deliver their child to them upon its birth. Under these circumstances, there can be no “perfect substitute.” Clearly the agreement is not for resale.<sup>357</sup> Despite concerns about a gestator’s receiving payment, neither the agreements nor the products

350. *Id.*

351. *Id.* Epstein argues that, to prevent gestator agreements, there must be more than just disapproval of them. *Id.* at 2326. If this is the case, there must be an examination of the contracting process and the negative impact these agreements have on third parties, and neither of these considerations have any merit. *Id.*

352. Fungibles are defined as “goods . . . of which any unit is, by nature or usage of trade, the equivalent of any other like unit.” Black’s Law Dictionary, *supra* note 276, at 675.

353. See Radin, *Market-Inalienability*, *supra* note 167, at 1880-81. Radin argues that a fungible object can be replaced with money or its equivalent. *Id.* at 1880. For Radin, possessing fungible objects is the same as possessing money. *Id.* Accordingly, such objects “can pass in and out of the person’s possession without effect on the person as long as [their] market equivalent is given in exchange.” *Id.* Radin concludes that speaking of personal attributes as fungible goods is “intuitively wrong.” *Id.* But see Epstein, *Full Contractual Enforcement*, *supra* note 167, at 2328 (arguing that gestator agreements are not interchangeable, but are specifically tailored to the situation they address).

354. See *supra* note 352.

355. Epstein, *Full Contractual Enforcement*, *supra* note 167, at 2327.

356. See *supra* note 166 and accompanying text (discussing the motivations behind becoming a surrogate mother).

357. See Epstein, *Full Contractual Enforcement*, *supra* note 167, at 2327 (arguing that the participants in gestator agreements would not perceive the newborn child as a fungible commodity).

of these agreements are intended to be sold in the market as fungible goods. In fact, enforcing gestator agreements demonstrates that women and their children are not fungible commodities, but rather unique individuals.<sup>358</sup>

There are, however, other reasons why commodification arguments are simply untenable. If the potential for objectification and alienation of personal capacities, such as child bearing, are of such a nature that they preclude payment for the use of these capacities, a number of professions would be illegal.<sup>359</sup> For example, artists and caregivers should not be paid for their services since they provide personal services.<sup>360</sup> In addition, the pivotal issue is not whether a gestational carrier is paid for her services, but rather whether her value is viewed as reducible to the fee she has been paid.<sup>361</sup> As one scholar notes, people who believe that gestational carriers can be reduced to a fee would probably see the gestator as even less valuable if she did not receive remuneration for her services.<sup>362</sup> Logically, doctors and lawyers can offer services at a given sum without having people conclude that they are worth only that sum.<sup>363</sup> Further, one can pay the stated sum for those services without implicitly suggesting that the doctor or lawyer is worth only the amount received.<sup>364</sup> If this is so, one can pay a gestational carrier a specified sum without suggesting that either the child or the gestator is only worth the amount paid by the intended parents.<sup>365</sup>

### b. *Respecting a Woman's Freedom to Choose*

When comparing the rights of the intended parents and the fetus against the rights of the gestational carrier, the weight of authority balances in support of the right to abort as a fundamental right of privacy under *Roe v. Wade* and its progenies.<sup>366</sup> A number of other legal theories also suggest that a woman has a right to abort that

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358. Lori B. Andrews, *Beyond Doctrinal Boundaries: A Legal Framework for Surrogate Motherhood*, 81 Va. L. Rev. 2343, 2368-69 (1995) (quoting Marjorie M. Shultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender-Neutrality*, 1990 Wis. L. Rev. 297, 364 (“[T]he more every child is unique, the more women and children are neither fungible nor reducible to specific traits, the stronger the claim for specific performance upon breach of any such agreement.”)).

359. See Strasser, *Parental Rights Terminations*, *supra* note 321, at 211.

360. *Id.* (arguing that if gestators cannot be paid for their services, neither should artists and caregivers who provide services that are personal in nature, or for that matter, psychological counselors).

361. *Id.*

362. *Id.*

363. *Id.* at 212.

364. *Id.*

365. *Id.*

366. 410 U.S. 113 (1973); see, e.g., *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

cannot be impeded.<sup>367</sup> Those who support the unrestricted right to abortion in this context either expressly argue or tacitly accept that the right to abort is so fundamental that it cannot be waived, even if a woman is willing to do so.<sup>368</sup> This argument, however, seems to ignore an important point: the United States Supreme Court has recognized one's right to knowingly and voluntarily waive other fundamental rights,<sup>369</sup> including the First Amendment right of free speech,<sup>370</sup> the

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367. See *supra* note 273.

368. See *supra* note 273.

369. See, e.g., *Schneekloth v. Bustamonte*, 412 U.S. 218, 223-27 (1973) (right to be free from unreasonable search and seizures); *Miranda v. Arizona*, 384 U.S. 436, 444 (1966) (right to consult an attorney before questioning by the police); *Johnson v. Zerbst*, 304 U.S. 458, 464-65 (1938) (right to waive assistance of counsel in a criminal proceeding); *Arizona v. Jelks*, 461 P.2d 473, 475-76 (Ariz. 1969) (right to a jury trial); see also *Katie Marie Brophy, A Surrogate Mother Contract to Bear a Child*, 20 J. Fam. L. 263, 280-82 (1981-82). Brophy asserts that the gestator should agree that she will not abort the child once it is conceived. She suggests, however, that there are two exceptions to this proposition. "First, is if in the opinion of the inseminating physician, such action is necessary for the physical health of the [gestating mother]." *Id.* at 280. Second, is if the physician determines the child to be physiologically abnormal. See *id.*; Healy, *supra* note 5, at 119 n.124 (indicating that generally a waiver of constitutional rights requires that a party who waives the right does so knowingly, intelligently and voluntarily, questioning whether a contractual agreement meets the standard, and finally suggesting that it depends on the terms and circumstances of the agreement); Ingram, *supra* note 70, at 693 (noting that while *Roe v. Wade* protects a woman's right to have an abortion, the right may be voluntarily waived, like any other constitutional right); Mandler, *supra* note 66, at 1313-14; Kenneth W. Simons, *Rescinding a Waiver of a Constitutional Right*, 68 Geo. L.J. 919, 942-49 (1980) (supporting the enforcement of the waiver of the right to abort). In his article, Mandler argues that, once a gestator waives her right to abort and then aborts without the intended parent's consent, monetary damages are insufficient. Mandler, *supra* note 66, at 1313. The parents stake their hopes for a family on the gestator's promise to conceive, to bear and to allow them to assert parental rights over the child. *Id.* No legitimate interest is served by allowing gestators to change the terms of the agreement after the child is conceived. See *id.*

370. See *Snepp v. United States*, 444 U.S. 507, 511 (1980) (holding that an agreement between plaintiff and the Central Intelligence Agency ("CIA") was enforceable and all future profits would be the corpus of a constructive trust benefiting the CIA). Frank W. Snepp III, a former employee of the CIA, published a book without first submitting the book to the CIA for pre-publication review. *Id.* at 507. At the beginning of his tenure with the agency, Snepp signed a contract agreeing not to publish any information about the CIA either during his term of employment or after, without first submitting it to the CIA for review. *Id.* at 507-08. The government sued for damages and declaratory relief, and an injunction, preventing Snepp from publishing any information in the future without first submitting it to the CIA. *Id.* at 508. Snepp's primary argument was that the contract and subsequent injunction constituted an unenforceable prior restraint on free speech. *Id.* at 509 n.3. The Court quickly disposed of the argument in a footnote indicating: "When Snepp accepted employment with the CIA, he voluntarily signed the agreement that expressly obligated him to submit any proposed publication for prior review. He does not claim that he executed this agreement under duress. Indeed, he voluntarily reaffirmed his obligation when he left the Agency." *Id.* As a result, Snepp had to live with the consequences resulting from a contract he willingly signed, including the award of damages for his breach. Mayo, *supra* note 65, at 618-19. Mayo indicates that "since the chilling effect of damages on Snepp's right of free speech was an

waiver of which has consequences far beyond the relinquishment of the initial right.<sup>371</sup> While *Roe v. Wade* protects a woman's right to have an abortion, logically the right may be waived if exercised without coercion or duress. Nothing in Supreme Court jurisprudence indicates that the right to abort is to be afforded any more protection from waiver than any other fundamental right.

In reviewing arguments that reject gestational carrier/intended parent relationships, there is really no evidence that gestational carriers waive their rights due to coercion or oppression. Indeed, the circumstances surrounding these agreements indicate a willingness on the part of the gestational carrier to forego some rights for a limited time for the benefit of the intended parents and the fetus.<sup>372</sup> The gestator has consented to the waiver of some intimate personal rights, including the right to abort. In essence, she has agreed to serve as a trustee, a position which includes exercising loyalty to the parents by carrying the fetus to term. This does not, however, require the gestator to put her life or physical health in jeopardy.

Much of the anti-waiver-inalienability rhetoric emanates from radical feminists who suggest that women cannot consent to enter gestator carrier agreements and thus deny women the right to choose to participate in this or other new reproductive technologies.<sup>373</sup> Ironically, only recently the hue and cry from these same sources insisted that women must be free to choose what they want to do with their own bodies.<sup>374</sup> Suddenly, however, the landscape has changed.

incident of his prior exercise of his freedom of contract, there was no first amendment basis for setting aside the award of damages." *Id.* at 618. In addition, the Court affirmed the damages award under circumstances where there would have been no legitimate grounds for a lawful prior restraint against publication even to protect national security. *Id.* Mayo concludes both freedom of speech and privacy-based abortion rights involve core values protected by the first amendment. *Id.* at 619. Yet "*Snepp* was a weaker case for . . . uphold[ing] the constitutionality of an award of damages than is the surrogacy case, because *Snepp's* contract was with the . . . government, not . . . another private citizen." *Id.*

371. Mayo, *supra* note 65, at 618 ("[W]hat is clear from *Snepp* is that since the Court finds that there was no duress or coercion in the formation of the agreement, *Snepp's* right of free speech was, both presently and in the future, restricted by the contents of that voluntary agreement.").

372. See *supra* notes 160-71 and accompanying text.

373. See, e.g., McElroy, *supra* note 313, at 22. McElroy asks:

What do radical feminists tell women who choose to "medicalize" the birth process by using such devices as electronic fetal monitors? Or the many women who seek out new technologies in order to have a child? Or the women who choose to be surrogate mothers? Would these radical feminists deny these women the right to exercise medical choice over their own bodies? In a word: yes.

*Id.*; see also Karen H. Rothenberg, *Gestational Surrogacy and the Health Care Provider: Put Part of the "IVF Genie" Back into the Bottle*, 18 L. Med. Health Care 345, 348 (1990) (stating that the gestational carrier can never give informed consent).

374. McElroy, *supra* note 313, at 22 (asserting that radical feminists "once championed 'choice' in unfettered terms").

Women are now being told choice alone is insufficient; while they appear to be making informed choices, they are not really making choices at all. As Janice Raymond writes, “[f]eminists must go beyond choice and consent as a standard for women’s freedom. Before consent there must be self-determination so that consent does not simply amount to acquiescing to the available options.”<sup>375</sup> Reliance on these sorts of pronouncements is an attempt to create a conflict between consent and self-determination.<sup>376</sup> Some feminist writers concede that some women may *appear* to choose to carry a child for someone else, yet they rationalize that these women are not “choosing” and are incapable of doing so until they are free from oppressive technological advances and the free market.<sup>377</sup>

The advantage of shifting the focus of the debate is that women’s choices can be dismissed as lacking self-determination because such decisions are influenced by the oppression of patriarchy.<sup>378</sup> The new battle cry seeks to protect women from “bad” choices.<sup>379</sup> In the meantime, it denies women the ability to make certain choices at all.<sup>380</sup> Moreover, those who would deny women the chance to be gestational carriers ignore two inescapable facts. First, every choice is influenced by culture.<sup>381</sup> Second, choice, by its very nature, denotes limited options. As Wendy McElroy aptly notes:

[Having limited options] is true of women today and would be true of women in some future feminist utopia. To claim that such influences somehow negate a woman’s free will—and the right to control her own body—is to deny that anyone, male or female, ever truly chooses anything. It strips women of the only defense they really have against destructive influences: the ability to act freely in their own self-interests.<sup>382</sup>

In this context, the rhetoric leads in disturbing directions. Rather than acknowledging that women have the prerogative to participate in gestational carrier arrangements, and further to suspend or waive a fundamental right such as the right to abort, some radical feminist writers are willing to risk that women may be viewed as weak-willed,

375. See *id.* (quoting Janice G. Raymond, *Women as Wombs: Reproductive Technologies and the Battle Over Women’s Freedom* (1993)).

376. *Id.*

377. *Id.* (asserting that radical feminists claim that only when women are free from oppression will they have the possibility of making free choices).

378. *Id.*

379. *Id.*

380. *Id.* McElroy argues that radical feminists can dismiss women who choose new reproductive technology as lacking self-determination. They can eliminate any possibility of future embarrassing choices by simply banning them. By doing so, they gloss over the tension inherent in their competing claims: “1) Women must control their reproductive functions and 2) Certain reproductive choices are unacceptable.” *Id.*

381. *Id.*

382. *Id.*



as sheep being lead to slaughter. The outcome of their arguments would be to thrust women back into the darkness of a time when women were declared unable to make important decisions,<sup>383</sup> relegating them to a child-like status. "Since they define women as an oppressed 'class' that is denied choice, they must attack the very concept of individual choice because it threatens class solidarity."<sup>384</sup>

Those who would limit a woman's options make what is in essence an "average reciprocity of advantage"<sup>385</sup> argument: they want to force women to forgo the right to make *imperfect* choices such as deciding to become gestators, wherein they and others might benefit, to preserve the integrity of women as a class. Although average reciprocity of advantage is a property regulating concept, it can also be applied to the arguments of those who would try to control a woman's right to choose to become gestational carriers foregoing the right to abort, primarily because they view the right to abort as an inalienable property right. Their argument is that, while this restraint on the choice not to abort and carry a child to term for the intended parents might appear to be a burden to women because it interferes with their right of autonomy, these women may benefit in the long run. Under a theory of average reciprocity of advantage, women who refuse to be governed by modern reproductive techniques, including gestational surrogacy, benefit women individually and as a class by preserving their collective dignity and protecting them from the oppressive hegemonic structure. Those in favor of restricting the choice of women to become gestational carriers would find average

383. *Id.* McElroy notes, "[t]he irony is staggering. For centuries, men have declared that women don't know their own minds, that they can't be trusted with important decisions. Now, radical feminists mouth the same old patriarchal line." *Id.* at 23.

384. *Id.*; see also Strasser, *Parental Rights Terminations*, *supra* note 321, at 212-13. Strasser notes that there are clearly times when people should not be permitted to make decisions. For example, minors often do not have the experience and judgment to recognize and avoid choices that could be harmful to them. *Id.* However, women should not be treated like children who are incapable of making their own decisions, lacking the maturity and experience to be held responsible for their own decisions. *Id.*

385. See *Pennsylvania Coal Co. v. Mahon*, 260 U.S. 393, 415 (1922). Justice Holmes refers to an "average reciprocity of advantage that has been recognized as a justification of various laws." *Id.*; see also Edward H. Rabin et al., *Fundamentals of Modern Property Law* 604, n.1 (4th ed. 2000) (noting that many land use regulations that appear to burden a land owner may, in fact, benefit her). An example the authors give is as follows:

[S]uppose an ordinance requires every house to be set back from the sidewalk a minimum of twenty feet. Although landowner A may resent this ordinance since it reduces the area on which he or she can build, that landowner gains a benefit since he or she enjoys the open space created when landowners B, C, and D must also abide by the ordinance. On balance, all are benefited rather than injured by the reciprocal enforcement of the ordinance.

*Id.* at 604.

reciprocity of advantage an appealing concept, primarily because it brings consistency to otherwise inconsistent rhetoric.

However, the use of average reciprocity of advantage cannot be fairly applied to this situation. This is because a gestational carrier's agreement is not with an entire gender. It is, instead, with the intended parents. As a result there is no average reciprocity of advantage in denying women a choice to become gestational carriers. Therefore, those who would deny women the chance of becoming gestational carriers cannot tell women who decide to become gestators that they cannot temporarily forgo their right to abort when they have promised and suspended the right for the intended parents simply because it benefits women as a class.

There is another element critical to this new "self-determination" mantra of certain radical feminists, which posits that women must know of the material ramifications before making a decision. The argument is that in the gestational carrier contract, a woman cannot possibly give informed consent because she does not know how she will later feel toward the child she is bearing.<sup>386</sup> She may, in short, change her mind about the decision she has made. They argue that the appeal of bearing a child for someone else and the promised compensation may fade as the task becomes more burdensome.<sup>387</sup> Those that support the unfettered right to abort assert that a woman must be able to change her mind and abort a fetus.<sup>388</sup> They believe that to hold otherwise poses a threat to her integrity and self-respect

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386. See *id.* at 23-24. McElroy asserts that "the legal system at times seems to agree with the feminists." *Id.* McElroy further notes that the judge in the *Baby M* case indicated that surrogate mothers never make a completely voluntary, informed decision because any decisions prior to the child's birth are compelled, by contractual and monetary concerns, making any decision "less than totally voluntary." *Id.* at 23 (quoting *In re Baby M*, 537 A.2d 1227 (N.J. 1988)). McElroy argues that this sort of ruling not only invalidates gestator contracts, but also would invalidate any contractual agreements between human beings. *Id.* In addition, she notes that it could be said of almost any contract that people will not know how they will feel until the contract has been completed. *Id.* at 23-24. Additionally, an overwhelming majority of programs only accept women as gestational carriers if they have given birth and parented at least one child. Hanafin, *supra* note 5, at 379. Programs making this requirement do so since the prospective gestational carrier will have more knowledge of the medical risks and physical demands which will be placed on her, and will be better able to predict her emotions. *Id.*; Unif. Parentage Act, *supra* note 5, at § 803(b)(5) (requiring that, for a valid agreement, a court must find "the prospective gestational mother has had at least one pregnancy and delivery and her bearing another child will not pose an unreasonable health risk to the unborn child or to the physical or mental health of the prospective gestational mother," because "such a finding will help insure that she fully understands the nature and experience of pregnancy. Her consent to be the gestational mother is thus with full knowledge of what she has agreed to do, including to relinquish the child born to her to the intended parents").

387. Ingram, *supra*, note 70, at 684 (arguing that in cases involving gestator agreements "the appeal of the offered rewards may fade as the task becomes more onerous and seemingly never-ending. However, the task must be completed.").

388. *Rumpelstiltskin*, *supra* note 273, at 1950.

because forcing her to carry the fetus to term “imposes a constant, sometimes painful, and always invasive physical reminder of what seems a self-betrayal.”<sup>389</sup>

Changing one’s mind, however, is not limited to circumstances involving gestational carriers.<sup>390</sup> People often commit themselves to long-term ventures they later regret. Nonetheless, they must fulfill their obligations.<sup>391</sup> We do not, generally, “consider it exploitive to expect people to perform difficult and dangerous assignments that they have willingly and knowingly undertaken.”<sup>392</sup> That a woman might change her mind about, or regret a decision she has made should not interfere with a woman’s right to participate in gestational carrier agreements.<sup>393</sup> It would be paternalism at its worst.<sup>394</sup> “Women are not second-class citizens and do not need to be protected from themselves. They are fully capable of making their own decisions and accepting responsibility for them.”<sup>395</sup>

What opponents of gestator arrangements do not acknowledge is that the failure to enforce such agreements will harm personhood.<sup>396</sup> The law respects one’s right to freely contract. To refuse to enforce gestator agreements made in good faith and with the parties’ full knowledge of their repercussions—particularly the intended parents who have detrimentally relied upon the gestator’s promise—would be to deny the autonomy and decision-making power of the gestator.<sup>397</sup>

## B. *The Violinist*

### 1. Thomson’s Argument

Many commentators and scholars who address a woman’s right to abort invariably include in their discussion Judith Jarvis Thomson’s

389. *Id.* (arguing that a woman should be able to change her mind even if she has agreed to carry a fetus to term). “Judges should therefore hold that abortion rights are inalienable.” *Id.* To hold otherwise violates a women’s right of privacy. *Id.*

390. Ingram, *supra*, note 70, at 684.

391. *Id.* Ingram indicates that when people commit to activities they do not want to complete, they must still complete them because they have no other alternatives. For example they may not want to complete “polar or space expeditions, military combat, or an ocean voyage; performing a long and delicate operation; or caring for children in the parents’ absence.” *Id.* Nevertheless, they must still fulfill the obligation they have undertaken. *Id.*

392. *Id.*

393. *See id.*

394. *See id.*

395. *Id.* at 685. Ingram argues that women should be able to choose to become gestators. In fact, gestators have the potential to create “new opportunities for women that might not otherwise be economically possible.” *Id.* The role of gestator is “left to those who choose it,” so it cannot be degrading for a woman who willingly bears a child for someone else. *Id.* at 685.

396. Strasser, *Parental Rights Terminations*, *supra* note 321, at 212-13.

397. *Id.*

now famous article, "*A Defense of Abortion*,"<sup>398</sup> which posits that a fetus does not necessarily have the right to life.<sup>399</sup> Thomson likens a woman's carrying a pregnancy to term to a Good Samaritan.<sup>400</sup> She reasons that from a moral standpoint, "a woman who carries a pregnancy to term is like a person who generously offers, at some considerable cost to herself, to provide what another needs but does not have the right to, while a woman who terminates a pregnancy is like a person who declines to offer such assistance."<sup>401</sup> For Thomson, abortion is not immoral; rather, requiring a woman to continue with the burdens of pregnancy goes beyond what a woman is morally required to do.<sup>402</sup>

Thomson's argument turns critically on an analogy between a woman's being pregnant as compared with a woman's being kidnapped and plugged into a famous violinist who needs to use her kidney for nine months in order to survive.<sup>403</sup> The analogy proceeds as follows:

You wake up in the morning and find yourself back to back in bed with an unconscious violinist. A famous unconscious violinist. He has been found to have a fatal kidney ailment, and the Society of Music Lovers has canvassed all the available medical records and found that you alone have the right blood type to help. They have therefore kidnapped you, and last night the violinist's circulatory system was plugged into yours, so that your kidneys can be used to extract poisons from his blood as well as your own. The director of the hospital now tells you, "Look, we're sorry that the Society of Music Lovers did this to you—we would have never have permitted it if we had known. But still, they did it, and the violinist [is] now plugged into you. To unplug you would be to kill him. But never mind, it's only for nine months. By then he will have recovered from his ailment, and can safely be unplugged from you."<sup>404</sup>

The question is whether it is morally permissible to unplug the violinist while denying a pregnant woman the right to abort.<sup>405</sup> Those who accept the positions of the violinist and the fetus as comparable argue that, if we conclude that one has a right to unplug the violinist, then a woman has a right to abort the fetus in both rape and non-rape cases.<sup>406</sup>

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398. Judith Jarvis Thomson, *A Defense of Abortion*, 1 Phil. & Pub. Aff. 47 (1971).

399. *Id.* at 54-60.

400. *Id.* at 62-64.

401. *Id.*

402. *Id.*

403. *Id.* at 48-49.

404. *Id.*

405. *Id.*

406. See David Boonin-Vail, *Death Comes for the Violinist: On Two Objections to Thomson's Defense of Abortion*, 23 Soc. Theory & Prac. 324, 330-38 (1997) [hereinafter Boonin-Vail, *Death Comes for the Violinist*] (indicating that there is no morally relevant distinction between killing a fetus and letting it die—if a woman has

## 2. Challenges to the Violinist Analogy

There are some ostensibly powerful objections to Thomson's use of the violinist analogy as a parallel to the right to abort. As we shall see later, however, these objections are insufficient to address the gestational carrier's obligation not to abort and to carry the fetus to term.<sup>407</sup> An initial line of argument is that while one may be morally able to unplug the violinist, it does not follow that a woman can abort a fetus. Those who support this position posit that there is a morally relevant difference between killing a person and letting him die, in that abortion kills the fetus while unplugging the violinist merely allows him to die,<sup>408</sup> something he would have done had he not been impermissibly plugged to the woman's kidney. A similar argument is that there is a morally relevant difference between intending death, as with abortion, and merely foreseeing it if we unplug the violinist who has been attached to the woman involuntarily and without her consent.<sup>409</sup>

Others challenge Thomson's violinist analogy with a "Responsibility Objection,"<sup>410</sup> which encompasses two distinct arguments. One responsibility argument, referred to as the "Tacit Consent Version" posits that the fetus has a right to use the pregnant woman's body in non-rape cases because the pregnant woman is at least partially responsible for the fetus's existence.<sup>411</sup> The reasoning is that by engaging in intercourse "knowing that this may result in the creation of a person inside her body, she implicitly gives the resulting person a right to remain."<sup>412</sup> The reasoning is that presuming that the

a right to unplug the violinist, she has a right to abort the fetus.).

407. See *infra* text accompanying note 422.

408. See Baruch Brody, *Abortion and the Sanctity of Human Life: A Philosophical View* 30 (1975) (arguing that "Thomson has not established the truth of her claims about abortion primarily because she has not sufficiently attended to the distinction between our duty to save [a] life and our duty not to take it"); John Finnis, *The Rights and Wrongs of Abortion: A Reply to Judith Thomson*, 2 *Phil. & Pub. Aff.* 117, 141 (1973) (indicating that the distinction between killing and letting one die may be the primary reason why abortion cannot be analyzed under a Good Samaritan theory and why Thomson's arguments are merely a novelty); see also Michael Tooley, *Abortion and Infanticide* 43-44 (1983). Tooley characterizes Finnis's argument as hinging on the difference between direct and indirect killing. *Id.* A killing is direct if the death is either one's desired end or a means to one's end. *Id.* If, however, the killing is only a foreseen consequence of one's action, and neither desired in itself nor a means to something which is desired, then the killing is said to be indirect. *Id.* While indirect killing of the innocent is sometimes justified, direct killing never is. *Id.* Therefore, abortion differs from the unplugging of the violinist in that abortion is a direct killing while unplugging the violinist is indirect. *Id.*

409. See Tooley, *supra* note 408, at 42-45; Finnis, *supra* note 408, at 117-45.

410. See David Boonin-Vail, *A Defense of "A Defense of Abortion": On the Responsibility Objection to Thomson's Argument*, 107 *Ethics* 286, 287-88 (1997) [hereinafter Boonin-Vail, *A Defense of "A Defense of Abortion"*].

411. *Id.* at 290.

412. *Id.* (quoting Bonnie Steinbock, *Life Before Birth: The Moral and Legal Status*

woman voluntarily engages in the act of intercourse, she should be understood as having tacitly consented to something that results in a fetus developing inside her body.<sup>413</sup> She is also deemed to have tacitly consented to the fetus's having the right to remain alive.<sup>414</sup> It is at least arguable that the notion of tacit consent seems reasonable, if tacit consent assumes that one acts voluntarily, there is a causal link between the act and the result, and the result is foreseeable.<sup>415</sup> If a woman becomes pregnant from voluntary intercourse, her act is voluntary; if intercourse is the proximate cause of the pregnancy that temporarily impedes her right to control her body, it is the cause of her circumstances which were foreseeable to her, assuming that she understood that intercourse could lead to pregnancy.<sup>416</sup> This claim of "tacit consent" is compelling if the elements are not only necessary, but also sufficient.<sup>417</sup>

Those who reject tacit consent as a means of holding a woman responsible for carrying a pregnancy to term reason that if the elements comprising tacit consent do not constitute a waiver of rights in a non-pregnancy context, then they are insufficient in the context of abortion rights.<sup>418</sup> Instead, their argument is that even if deliberately creating a situation amounts to consenting to the burdens it imposes, it does not follow that being partly responsible for the state of affairs counts as consent.<sup>419</sup>

A second responsibility objection, the "Negligence Version," rejects tacit consent as necessary for the voluntary nature of the woman's intercourse in order to deny the woman her right to refuse to help the fetus.<sup>420</sup> Rather, the woman is akin to a person who is partially responsible for the accident that leaves an innocent bystander in need of her assistance.<sup>421</sup> A simple response to the "negligence version" is that while the innocent bystander has options other than relying on the one causing the accident—and whose assistance may be impossible—the fetus has no options other than relying on the pregnant woman for survival.<sup>422</sup> Neither the tacit consent nor the

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of Embryos and Fetuses (1992)).

413. *Id.* at 290-91.

414. *Id.*

415. *Id.*

416. *Id.*

417. *Id.*

418. *See id.* at 300.

419. *Id.* at 301.

420. *Id.* at 300.

421. *See Tooley, supra* note 408, at 45; Boonin-Vail, *A Defense of "A Defense of Abortion," supra* note 410, at 300.

422. *See Tooley, supra* note 408, at 45. *But see* Boonin-Vail, *supra* note 410, at 300-01. Boonin-Vail argues that Tooley's argument and other similar arguments rely on a negligence analogy to support a pregnant woman's duty to support the fetus and carry it to term. *Id.* He asserts that most would agree that people have a right not to be injured by another's negligence and that the one causing the injury should be held

negligence version of the responsibility objection satisfactorily justify a gestator's responsibility not to abort the fetus, primarily because both objections seem to treat the woman's pregnancy as emanating from a voluntary act leading to an "accident" for which the woman is at least partially responsible. As will be discussed below, however, in the gestational carrier context, the gestator is not merely passively yet partially responsible for being pregnant. She has not engaged in intercourse knowing that pregnancy *might* be a possible outcome as a result of her voluntary act, an outcome she does not necessarily desire. The gestator's actions are more deliberate and more direct. She expressly submits herself to medical procedures; she knows that these procedures are designed to result in her pregnancy; she, in effect, agrees to serve as trustee for the intended parents with the concomitant duties of care and loyalty to carry the fetus to term if a pregnancy results.

### C. *The Good Samaritan As Stranger: The Right Not to Render Aid*

At the heart of Thomson's attack on the notion that a woman must provide life to the fetus is that people do not normally view an individual's right to life as imposing obligations upon others to provide whatever is necessary for his survival.<sup>423</sup> While Thomson addresses her arguments to the right to abort in general, these arguments clearly extend to the question of whether a gestational carrier, who assumes the position of trustee, may abort when she has expressly agreed to carry a fetus to term for the intended parents.

As a means of demonstrating that people are not normally viewed as having to provide whatever is needed for another's survival, Thomson relies on the parable of the Good Samaritan<sup>424</sup> as an underpinning for her analysis of a woman's right to abort.<sup>425</sup> She notes

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liable. *Id.* But this is not analogous to the case of an intended pregnancy. *Id.* The question continues to be whether or not a fetus has a right not to be aborted. *Id.* The issues are not the same.

423. See Thomson, *supra* note 398, at 61-64.

424. The parable of the Good Samaritan is recounted in the Book of Luke as follows:

A certain man went down from Jerusalem to Jericho, and fell among thieves, who stripped him of his clothing, wounded him, and departed, leaving him half dead. Now by chance a certain priest came down that road. And when he saw him, he passed by on the other side. Likewise a Levite, when he arrived at the place, came and looked, and passed by on the other side. But a certain Samaritan, as he journeyed, came where he was. And when he saw him, he had compassion on him, and went to him and bandaged his wounds, pouring on oil and wine; and he set him on his own animal, brought him to an inn, and took care of him. On the next day, when he departed, he took out two denarii, gave them to the innkeeper, and said to him, "take care of him; and whatever more you spend, when I come again, I will repay you."

Luke 10:30-35 (New King James).

425. See Thomson, *supra* note 398, at 62.

that the Good Samaritan went out of his way, at some expense to himself, to help a man in need, while a priest and a Levite did nothing.<sup>426</sup> Assuming that the priest and Levite could have helped by doing something less than the Good Samaritan, the fact that they chose to do nothing shows that they were not even minimally decent.<sup>427</sup>

But they did not have to be. Thomson argues that as a general rule, people are not compelled to be good or even minimally decent citizens. In support of this point, she relies on the story of Kitty Genovese who was murdered while thirty-eight people watched or listened but did nothing to help her.<sup>428</sup> She reasons that a Good Samaritan would have given direct assistance; a minimally decent Samaritan would have at least called the police.<sup>429</sup> Instead, the thirty-eight people chose to do nothing.<sup>430</sup> Clearly, she argues, it was not morally required of any bystander to rush to the aid of the victim at the risk of her own life.<sup>431</sup> From this example she concludes “[t]hat it is not morally required of anyone that he give long stretches of his life—nine years or nine months—to sustain the life of a person who has no special right . . . to demand it [sic].”<sup>432</sup> If Thomson is correct, then there is no moral obligation to the fetus whether the fetus is present due to rape or voluntary acts. It may be callous or indecent to refuse to help, but it is neither immoral nor illegal.

Judith Jarvis Thomson is correct, but only for a limited and narrow set of facts. People are not required to be minimally decent.

426. *Id.*

427. *Id.*

428. *Id.* at 62-63. For an explanation of why no help was offered or calls made by bystanders, see J.M. Darley & B. Latane, *Bystander Intervention in Emergencies: Diffusion of Responsibility*, 8 *J. Personality Soc. Psychol.* 377, 377 (1968) (stating the more people who share the ability to help another in need, the less likely help will be given by any one person); see also David G. Myers, *Exploring Psychology* 528-29 (4th ed. 1999) (examining the “bystander effect,” a phenomenon where people are more likely to offer help when people perceive themselves to be the only source of assistance).

429. See Thomson, *supra* note 398, at 62-3.

430. *Id.* at 63.

431. *Id.* Thomson’s characterization of the thirty-eight people who watched or listened but did nothing to help Kitty Genovese is overly simplistic. Thomson asserts that their actions can be seen as being neither those of a Good Samaritan or of those who are even minimally decent Samaritans, and there is no law under which they could be charged for standing by while Ms. Genovese died. *Id.* However, the other argument is that the law would not have protected them had they wrongfully intervened. They would have intervened at their own physical and legal peril. See Shelby A.D. Moore, *Doing Another’s Bidding Under a Theory of Defense of Others: Shall we Protect the Unborn with Murder?* 86 *Ky. L.J.* 257, 276 nn.100-105 (1997) (quoting *Alexander v. State*, 447 A.2d 880 (Md. Ct. Spec. App.), *aff’d* 451 A.2d 664 (Md. 1982) (reasoning that “[t]he onlookers hesitated to become involved in the fracas at their legal peril. Even if their hearts had been stout enough to enter the fray in defense of a stranger being violently assaulted, the fear of legal consequences chilled their better instincts.”)).

432. Thomson, *supra* note 398, at 63.



Certainly, they are not compelled to be Good Samaritans, for with few exceptions, American jurisprudence does not compel one to aid another, particularly a stranger.<sup>433</sup> While one may be held responsible for misfeasance for committing an act leading to liability, there is no such liability for nonfeasance for failure to act when there is no duty to do so.<sup>434</sup> In fact, strong public policy considerations have supported

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433. See generally John Adler, *Relying Upon the Reasonableness of Strangers: Some Observations About the Current State of Common Law Affirmative Duties to Aid or Protect Others*, 1991 Wis. L. Rev. 867, 867-71 (arguing that bystanders should be held to act reasonably under the circumstances when determining if a duty to rescue exists); James A. Henderson, Jr., *Process Constraints in Tort*, 67 Cornell L. Rev. 901, 928-43 (1982) (asserting that the no-duty-to-rescue rule is justified due to the process constraints of tort law); Saul Levmore, *Waiting for Rescue: An Essay on the Evolution and Incentive Structure of the Law of Affirmative Obligations*, 72 Va. L. Rev. 879, 879-81 (1986) (asserting that as the law develops a duty to rescue will be imposed); Jay Silver, *The Duty to Rescue: A Reexamination and Proposal*, 26 Wm. & Mary L. Rev. 423, 428-45 (1985) (arguing that there should be a duty to render aid and explaining how it would apply); Ernest J. Weinrib, *The Case for a Duty to Rescue*, 90 Yale L.J. 247, 249-51 (1980) (asserting that courts have refused to impose a general duty to rescue primarily because it would be unmanageable); Jennifer L. Groninger, Comment, *No Duty to Rescue: Can Americans Really Leave a Victim Lying in the Street? What Is Left of the American Rule, and Will it Survive Unabated?*, 26 Pepp. L. Rev. 353, 353-56 (1999) (indicating that although most civil law countries impose a duty to rescue, America imposes no such responsibility upon its citizens); Robert Justin Lipkin, Note, *Beyond Good Samaritans and Moral Monsters: An Individualistic Justification of the General Legal Duty to Rescue*, 31 UCLA L. Rev. 252, 254 (1983) (noting that while one may be liable for negligent conduct, "he is not required to be a Good Samaritan"); Marcia M. Ziegler, Comment, *Nonfeasance and the Duty to Assist: The American Seinfeld Syndrome*, 104 Dick. L. Rev. 525, 528 (2000) (noting that in both the civil and criminal law, a bystander's failure to assist at either an accident or a crime scene is completely nonactionable). But see Peter F. Lake, *Bad Boys, Bad Men, and Bad Case Law: Re-examining the Historical Foundations of No-Duty-To-Rescue Rules*, 43 N.Y.L. Sch. L. Rev. 385, 385-87 (1999) (stating that the assertion that there is no duty to rescue is an over generalization, and that the more accurate statement is that there is no general non-statutory law duty to rescue a stranger).

American courts recognize several basic exceptions to the no-duty-to-rescue rule. See John L. Diamond et al., *Understanding Torts* 117-20 (1996) (including creating the peril, special relationship, undertaking to act and reliance, and contract between parties); see also Restatement (Second) Tort § 314 cmt. a, § 314A-324A (1965) (including special relationships, landowner's duty, supervisor of dangerous or helpless persons, and undertaking dangerous acts or rendering services). The Restatement indicates that a

[s]pecial relation[ship] may exist between the actor and the other . . . which impose upon the actor the duty to take affirmative precautions for the aid or protection of the other. The actor may have control of a third person, or of land or chattels, and be under a duty to exercise such control. . . . The actor's prior conduct, whether tortious or innocent, may have created a situation of peril to the other, as a result of which the actor is under a duty to act to prevent harm. . . . The actor may have committed himself to the performance of an undertaking, gratuitously or under contract, and so may have assumed a duty of reasonable care for the protection of the other, or even of a third person . . . .

*Id.* at § 314, cmt. a.

434. See Francis H. Bohlen, *The Moral Duty to Aid Others as a Basis of Tort Liability*, 56 U. Pa. L. Rev. 217, 219-20 (1908). Professor Bohlen explains:

American courts' consistent "refus[al] to require a stranger to render assistance,"<sup>435</sup> even when the nonfeasance seems egregious, and where the stranger or acquaintance could have helped another with very

There is no distinction more deeply rooted in the common law and more fundamental than that between misfeasance and nonfeasance, between active misconduct working positive injury to others and passive inaction, a failure to take positive steps to benefit others, or to protect them from harm not created by any wrongful act of the defendant. . . . In the case of active misfeasance the victim is positively worse off as a result of the wrongful act. In cases of passive inaction plaintiff is in reality no worse off at all. His situation is unchanged, he is merely deprived of a protection which, had it been afforded him, would have benefited him.

*Id.*; see also Restatement (Second) Torts § 314 cmt. a (1965); Diamond et al., *supra* note 433, at 113-20 (explaining "the well-established distinction between misfeasance, for which a duty is typically found, and nonfeasance, for which a duty is not"); W. Page Keeton et al., *Prosser & Keeton on Torts* 373-85 (5th ed. 1984). The Restatement indicates that:

The origin of the rule lay in the early common law distinction between action and inaction, or "misfeasance" and "non-feasance." In the early law one who injured another by a positive affirmative act was held liable without any great regard even for his fault. But the courts were far too much occupied with the more flagrant forms of misbehavior to be greatly concerned with the one who merely did nothing, even though another might suffer serious harm because of his omission to act. Hence liability for nonfeasance was slow to receive any recognition in the law. It appeared first in, and is still largely confined to, situations in which there was some special relation between parties, on the basis of which the defendant was found to have a duty to take action for the aid or protection of the plaintiff.

Restatement (Second) Torts § 314 cmt. a.

435. Diamond et al., *supra* note 433, at 115 (noting that the no-duty rule embodies "the value placed on individualism in American society"); Keeton et al., *supra* note 434, at 373 (indicating that the defendant whose misfeasance endangers the plaintiff has "created a new risk of harm to the plaintiff, while by 'non-feasance' he has at least made [the plaintiff's] situation no worse, and has merely failed to benefit him by interfering in his affairs")

Another justification for the existence of the no-duty rule is that because rescue is morally right, rescue will be devalued if it is required. Diamond et al., *supra* note 433, at 115. Others oppose an obligation to rescue because there is absolutely no causal connection between the defendant's conduct and the plaintiff's peril. See Richard A. Epstein, *A Theory of Strict Liability*, 2 J. Legal Stud. 151, 151-52 (1973).

A practical reason upholding the no-duty rule is that the legal system would not be able to manage a rule imposing liability for the failure to rescue. See Henderson, *supra* note 433, at 935-36; Ziegler, *supra* note 433, at 536-37. For powerful arguments rejecting the no-duty rule, see Diamond et al., *supra* note 433, at 116 (indicating, in part, that other policy reasons for imposing the duty to rescue include the belief that the law should not only shape but also reflect society's moral values; it encourages the timid to get involved because it would be the right thing to do; it simplifies a judicial system that has become burdened by the complicated exceptions to the duty-to-aid cases; and the value of the savings accrued in a cost-benefit formula from encouraging rescues which small societal and personal sacrifice that avert great potential losses); see also James Barr Ames, *Law and Morals*, 22 Harv. L. Rev. 97, 98-100 (1908) (indicating that the law should impose liability on people who fail to aid others when they could do so with little or no inconvenience to themselves); Leslie Bender, *A Lawyer's Primer on Feminist Theory in Tort*, 38 J. Legal Ed. 3, 36 (1988) (arguing, in part, that the rule results from a legal system devoid of care and responsiveness to the safety of others).

little effort or risk to himself.<sup>436</sup> Indeed, it seems both outrageous and immoral that an Olympic swimmer is free to disregard a drowning child or that one can ignore a child who is being sexually assaulted and murdered in a public restroom.<sup>437</sup> To encourage humanitarianism, every jurisdiction has enacted "Good Samaritan" laws aimed at limiting liability for those who come to the aid of others, particularly in an emergency.<sup>438</sup> Nonetheless, in most instances, a would-be Good Samaritan can still choose to ignore one in need of her assistance.

### 1. Foregoing the Right Not to Assist Another

Only under certain circumstances does one have a responsibility to help strangers. For example, one must aid another with whom he has a special relationship, where one has created the peril, and where one has contracted to help another.<sup>439</sup> The landscape changes, however, when one voluntarily chooses to forego the anonymity of the priest and Levite, who ignored the man in need, and to assume the burdens of being a Good Samaritan. As Prosser eloquently states "[t]he result of all of this is that the Good Samaritan who tries to help may find himself mulcted in damages, while the priest and the Levite who pass by on the other side go on their cheerful way rejoicing."<sup>440</sup>

Clearly, then, once a person who has no initial duty to do so gratuitously takes charge of another who is helpless to adequately assist or protect himself, she creates in herself a duty and must accept responsibility for the obligation she has undertaken.<sup>441</sup> She becomes liable for the person now in her charge if she does not exercise care to secure his safety,<sup>442</sup> or if she discontinues assistance or protection,

436. See Keeton et al., *supra* note 434, at 375-76.

437. Diamond et al., *supra* note 433, at 115; Ziegler, *supra* note 433, at 525-26. Sherrice Iverson was sexually assaulted and murdered in a bathroom stall by Jeremy Strohmeyer as her father played slot machines in a Las Vegas casino. Ziegler, *supra* note 433, at 525-26. Even more reprehensible, Strohmeyer's best friend, David Cash, stood on the toilet seat in the next stall and watched the brutality but did nothing to stop it. *Id.* While his inaction was deplorable, Cash did nothing for which he could be civilly or criminally liable. *Id.*

438. Diamond et al., *supra* note 433, at 119; Justin T. King, Comment, *Criminal Law: "Am I My Brother's Keeper?" Sherrice's Law: A Balance of American Notions of Duty and Liberty*, 52 Okla. L. Rev. 613, 617-18 (1999) (noting that every State and the District of Columbia have Good Samaritan laws which exempt rescuers from liability for their rescue attempts); Danny R. Veilleux, Annotation, *Construction and Application of "Good Samaritan" Statutes*, 68 A.L.R.4th 294, 300 (1989). *But see* Frank B. Mapel, III & Charles J. Weigel, II, *Good Samaritan Laws—Who Needs Them?: The Current State of Good Samaritan Protection in the United States*, 21 S. Tex. L.J. 327, 329-30 (1981) (arguing that Good Samaritan Laws do not really provide an incentive for rescue); Groninger, *supra* note 433, at 365-66 (noting that studies reveal that Good Samaritan legislation has had little, if any, beneficial impact).

439. Diamond et al., *supra* note 433, at 114.

440. Keeton et al., *supra* note 434, at 378.

441. Diamond et al., *supra* note 433, at 118-19.

442. *See id.*

leaving her charge in a worse position than when she came to his aid.<sup>443</sup>

Similarly, even if we view the gestational carrier and the fetus as strangers wherein the gestator selflessly sacrifices her autonomy for the fetus, the argument that the gestator maintains responsibility for the fetus remains the same. She must still carry the fetus to term. For if one can become liable to a stranger for coming to his aid but subsequently failing to secure his safety or by discontinuing aid and leaving him in a worse position, then there is an even stronger argument to be made in the case of a gestational carrier who willingly agrees to serve as trustee for the fetus. The gestator takes responsibility for a fetus who, arguably, as a stranger with absolutely no genetic connection with the gestator, had no initial right to and did not demand the gestator's assistance—although its very existence depends on the gestational carrier—but to whom the gestator nonetheless commits to exercise the duties of care and loyalty. Based on the duties that envelop her as trustee, she must carry the fetus to term.

## 2. Beyond Good Samaritanism and Strangers: Enforcing the Gestational Carrier's Fiduciary Responsibilities to the Fetus

Thomson's premise of pregnant woman as Good Samaritan is based upon what she believes is the tenuous relationship between two alleged strangers: the pregnant woman and the fetus. The pregnant woman makes promises and sacrifices that she may discontinue by aborting the fetus if those promises interfere with her autonomy beyond what she finds acceptable. But Thomson's argument is faulty in large part because it treats the fetus as a stranger who just happens to be inconveniently placed proximate to the mother or because she has taken responsibility for the fetus by default.<sup>444</sup> The gestational carrier and the fetus are not strangers, however. The fetus is not being carried merely by happenstance or mistake.<sup>445</sup> Rather, the

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443. *See id.*

444. *See* Philip Bobbitt, *Constitutional Fate: Theory of the Constitution* (1982); *see also* Rosalind Hursthouse, *Beginning Lives* 191-93 (1987) (questioning Thomson's argument that a pregnant woman is a Good Samaritan simply because she carries a fetus to term); David A. Strauss, *Abortion, Toleration, and Moral Uncertainty*, 1992 *Sup. Ct. Rev.* 1, 10-14 (1993). Strauss rejects the argument that the pregnant woman is a Good Samaritan. Strauss, *supra*, at 10-14. He notes that neither *Casey* nor any other decision relies on this argument. *Id.* at 11. He notes that the argument is problematic in that it depends on two libertarian premises: "[F]irst that obligations must be in some way commensurate with voluntary undertakings; and second, that there is a sharp distinction between bodily invasions and other impositions on individuals. These libertarian premises are not obviously true, are difficult to justify, and conflict with strongly held institutions." *Id.*

445. *See supra* notes 168-70 and accompanying text (stating that there is a lengthy medical procedure which is required before any embryos are transferred to the gestational carrier).

intended couple who is unable to conceive endures considerable monetary, physical and emotional strain<sup>446</sup> to produce an embryo to be entrusted to the gestational carrier.<sup>447</sup> In fact, some argue that infertile couples pursue the desire to have a child as if their very lives depend on it.<sup>448</sup> Gestational carriers are well aware of their role in helping the intended couple achieve this goal.<sup>449</sup> Whether for economics, altruism or other reasons, gestational carriers willingly and knowingly submit to the procedures necessary to assist intended parents in their quest for a child.<sup>450</sup>

If a woman chooses to become a gestational carrier, she knows that apart from her own monetary considerations,<sup>451</sup> if any, the primary purpose of the relationship is to produce a child for the intended parents. To this end, she must choose to endure procedures that she may find invasive to her personal autonomy. These procedures are not forced upon her. She must agree to submit to a full medical and psychological evaluation.<sup>452</sup> To facilitate her ability to carry the fetus, the gestational carrier must receive injections to prevent normal endocrine activity,<sup>453</sup> followed by estrogen and progesterone to prepare the fetus for transfer.<sup>454</sup> Thereafter, the fetus is transferred to the gestator's uterus by one of the methods previously described.<sup>455</sup> Even after the transfer has been completed, however, there are no guarantees that the gestator will produce a live birth. Less than 18.5%

446. For monetary considerations, see text accompanying notes 38 (estimating the cost of one IVF cycle to be between \$8000 and \$10,000), 43 (the costs are normally not covered by insurance) and 164 (payments to gestational surrogates range from \$10,000 to \$50,000 for a successful pregnancy). On the physical requirements of IVF, see notes 96-1268 and accompanying text. On the emotional strain on a couple, see Stewart, *supra* note 151 ("The dream of bearing a baby is costly, in dollars, in time, and most of all, in wildly veering emotions, in hope and fear and disappointment."); *supra* note 38; see also Rothenberg, *supra* note 373, at 350 ("[T]he couple . . . after investing so much time, emotional energy, and money in achieving a [gestational carrier] pregnancy, may feel they have no other recourse than to go to court to attempt to protect their genetic material from any negative behaviors of the [gestational carrier].").

447. See *supra* Part I.G (describing the procedures necessary to use a gestational carrier).

448. See Applegarth, *supra* note 276 (suggesting that infertility patients pursue treatment with a tenacity equal to that of cancer patients).

449. See *supra* text accompanying notes 169-71, 200.

450. See *supra* text accompanying notes 169-71, 200.

451. See *supra* text accompanying notes 164-65 (noting that gestational carriers typically receive payments between \$10,000 and \$50,000 for a successful pregnancy, but payments can be as little as ten percent of the agreed amount if a live birth is not achieved).

452. See *supra* text accompanying notes 161-62; see also Ethics Committee of the American Fertility Society, *supra* note 25, at 60S (stating that the screening of the gestational carrier is required since there is a risk of the gestational carrier being less concerned for the child than a pregnant woman who will rear the child).

453. See *supra* text accompanying note 170.

454. See *supra* text accompanying note 170.

455. See *supra* notes 138-50 and accompanying text.

of gestational carriers actually become pregnant.<sup>456</sup> Of this number, about one-third of these pregnancies end in miscarriage during the first trimester.<sup>457</sup> Because the likelihood of a full-term pregnancy is not great, the intended parents must rely on the gestational carrier not to commit any intentional acts to cause the death of the fetus, including abortion.

It is clear that both the intended parents and the gestational carrier must endure substantial physical invasion, as well as emotional tumult, for the intended parents to have even a possibility of conceiving or delivering a child with their complete genetic makeup.<sup>458</sup> It is also undisputable that neither the intended parents nor the gestational carrier are forced into the relationship that binds them together.<sup>459</sup> And because the gestator willingly agrees to carry the fetus, she has invited it in and she becomes the host.<sup>460</sup> Prior to submitting to the medical procedures necessary to receive and carry the fetus, the gestational carrier has absolutely no moral or legal obligation to provide security and, ultimately, life to the fetus.<sup>461</sup> In this sense, she is no different from any other woman in society who can freely refuse to be burdened by the needs of another unless she is legally obligated to assume the burden. But once she identifies herself as one willing to undertake the arduous task of bearing a child for another, including the intended risks, her status changes. Her right to exist as an anonymous member of society, who in this context is not accountable, temporarily ceases and gives way to a duty to the fetus.<sup>462</sup> The

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456. See *supra* text accompanying notes 172-73.

457. See *supra* note 177 and accompanying text.

458. See Utian et al., *Preliminary Experience*, *supra* note 25, at 634 (detailing that couples were accepted into gestational carrier programs only if the female had ovaries and either no uterus or a severely abnormal uterus, over five recurrent abortions, or some other medical problem with conceiving (e.g., DES exposure, severe heart disease, diabetes mellitus)).

459. See Epstein, *Full Contractual Enforcement*, *supra* note 167, at 2326.

460. See John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 Va. L. Rev. 405, 438 (1983) [hereinafter Robertson, *Procreative Liberty*] (indicating that in the context of abortion in general, a woman is under no obligation to invite the fetus in, however, once she does, she assumes obligations to the fetus that limit her freedom over her own body). If this is true in cases of pregnancy in general, then an even stronger argument can be made where the gestational carrier agrees to carry the fetus and subsequently invites it "in."

461. *Id.*

462. See James Denison, Note, *The Efficacy and Constitutionality of Criminal Punishment for Maternal Substance Abuse*, 64 S. Cal. L. Rev. 1104, 1127 (1991) (asserting that while a person is not required to take any action to help another, once she does take this role, other obligations may arise. A woman who does not wish to help a fetus does not have any obligation to do so, but once she accepts the role of "mother" she owes certain duties to the child.); see also *In re A.C.*, 533 A.2d 611, 614 (D.C. 1987) (holding that as a matter of law the woman's right to abort is separate from her obligations to the fetus once she decides to carry the fetus to term); Keeton et al., *supra* note 434, at 376-77 (noting that the law has limited any tendency to depart from the rule that there must be some special relationship between the parties before a duty is created between the parties).

gestational carrier can be seen as having created a "special relationship" with the fetus whose care and safety clearly have been entrusted to her.<sup>463</sup> In essence, she is the trustee, and the fetus, as a beneficiary of the fiduciary relationship between the intended parents and the gestator, depends upon her to act in good faith by fulfilling her duties of loyalty and care.<sup>464</sup>

Even if one is unwilling to concede that the fetus and the gestational carrier share a special relationship, another basis for imposing a duty emerges. An equally forceful argument is that the gestational carrier becomes liable like anyone else who has no initial obligation to help another yet decides to intervene.<sup>465</sup> Extending responsibility under these circumstances is logical. If, for example, one can be held liable for failing to obtain medical aid for another based primarily on his promise to do so,<sup>466</sup> it is not a stretch to find that a woman has a duty to the fetus not only for her promise, but also for her undertaking direct responsibility for its safety and security. She cannot leave the fetus in a worse position than it would be in had she not assumed the duty.<sup>467</sup> The following hypothetical based on one created by Rosalind Hursthouse helps to demonstrate this position:

"Suppose I am living in a house in France in 1944. As I happen to know, its earlier occupiers had run it as a link in a chain smuggling Jews out of Germany and—as I happen to know—the simple signal they use to show that the hiding places were free was to leave a window open. If all the windows were shut it meant 'Danger, keep away'. . . . I allowed myself to open the occasional window when it was very hot. Suppose one night a Jewish refugee climbs in, . . . interpreting the open window" to mean he was free to enter. "His survival depends on my sheltering him, as I knew the survival of anyone who interpreted the open window . . . would." Nevertheless, I tell the Jewish refugee he cannot stay, knowing that expelling him from my home will result in his death.<sup>468</sup>

Clearly someone's survival depends on what is done.<sup>469</sup> Under these circumstances, can I legitimately argue that I am not responsible for

463. See Diamond et al., *supra* note 433, at 118; Keeton et al., *supra* note 434, at 376-77.

464. See *supra* notes 273-301 and accompanying text.

465. See Restatement (Second) Torts § 323 (1965); Diamond et al., *supra* note 433, at 118 n.20 (discussing duty to act once police have taken a person into custody); Keeton et al., *supra* note 434, at 378-82. Keeton argues that one does not have a general duty to help another in peril. *Id.* at 378. But if one does attempt to help, taking charge and control of the situation, one is regarded as entering into a relationship with its attendant responsibilities. *Id.* at 378. For example, a doctor who accepts a charity patient will be liable for failure to use reasonable care for the protection of the plaintiff's interests. *Id.*

466. Diamond et al., *supra* note 433, at 118.

467. *Id.*

468. Hursthouse, *supra* note 444, at 189.

469. See *id.*

the refugee's being in my house and dependant upon me for his survival?<sup>470</sup> The Jewish refugee had no right to enter my house short of my giving him permission to enter.<sup>471</sup> But once I have invited him in, I cannot reasonably argue that my right to bodily integrity, which is not absolute, and my right to be free from physical intrusion permit me to expel him from my home, knowing that I have created a situation where he justifiably has become dependant upon me because I agreed to be responsible for his care and safety.<sup>472</sup> Indeed, it is likely that the refugee has lost the opportunity to have someone else secure his safety. Under these circumstances, I cannot now refuse to give assistance whether I have encountered a stranger or one with whom I have previously established a relationship. In either case, the person has a right to depend on me. I can neither act unreasonably nor leave him in a worse position than before his reliance.<sup>473</sup>

The same argument can be made in the context of the gestational carrier and the fetus. Like the Jewish refugee, neither the intended parents nor the fetus could insist that anyone provide for its care and safety. It is only after one takes some positive steps signifying that another can depend upon him that anyone can assert a right of reliance.<sup>474</sup> The fetus has an even stronger argument than does the refugee. Whether one believes the fetus is a human being or property,<sup>475</sup> prior to being transferred to the gestator's uterus, the embryo has no functional existence. This means that, standing alone, the embryo has no ability to progress beyond its current status, but the possibility still exists that someone might carry it to term so that it can be transferred to the intended parents. Once the gestational carrier accepts care and responsibility for the fetus, she forecloses this opportunity for any other woman. The fetus is worse off in two critical ways. First, it must now depend upon the gestational carrier for its very survival. Second, once the gestator is permitted to abort, she eliminates any possibility for the fetus to be carried to term, born alive and delivered to the intended parents.

One can argue that this is true in all cases of abortion, whether or not there is a gestational carrier since, in either case, the fetus must depend upon the woman for survival. However, the disequilibrium between these two situations occurs because the gestator has knowingly and voluntarily suspended her abortion rights—agreeing to subordinate them for the fetus—and has undertaken a specific duty to

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470. *Id.*

471. *Id.*

472. *See id.*

473. *See* Diamond et al., *supra* note 433, at 119 (noting that one can be held liable for negligence or intentional acts for preventing a rescue, and also can be held liable where an unfinished rescue effort has dissuaded others from helping).

474. *See* Denison, *supra* note 462, at 1127 (arguing that once a woman elects to carry a fetus to term, she has a duty to the fetus).

475. *See supra* note 301.



both the fetus and the intended parents. There is a confidential, fiduciary relationship of trust which results because the fetus and the intended parents justifiably rest their trust in the gestator for the benefit of the fetus.<sup>476</sup> While they could not have demanded that anyone be the fetus's source of refuge, they have the right to depend upon it once the gestator agrees to accept responsibility for the fetus. Otherwise, the intended parents lose the opportunity to realize the birth of a child by relying on the gestator's promise not to abort. For this loss, there can be no monetary compensation.

Returning to the violinist hypothetical,<sup>477</sup> we employ a scenario more intimate than the one involving the Jewish refugee, which similarly supports these propositions. Rather than being kidnapped, the woman voluntarily agrees to relinquish her kidney to the violinist. Relieved, the violinist justifiably discontinues his search for another donor. Unfortunately, immediately after the transplant, the woman changes her mind and demands the return of her kidney, knowing that without it the violinist will die. Surely, one cannot reasonably argue that the woman has the right to the return of her organ, even if it results in the death of the violinist who has justifiably relied to his detriment on the woman's willingness to give him her kidney.

### 3. Implied Recognition of a Trust Relationship between the Mother and the Fetus

Unfortunately, those who champion the gestator's right to abort even when she has knowingly and voluntarily agreed to temporarily waive this right seem to forget that the fetus also has rights which must be protected. Even under *Roe v. Wade*,<sup>478</sup> a woman does not have an absolute right to abort.<sup>479</sup> Rather, the Supreme Court in *Roe* clearly recognized that the State has an important and legitimate interest in potential life which exists throughout a woman's pregnancy.<sup>480</sup> Further, in *Webster v. Reproductive Health Services*,<sup>481</sup> the Supreme Court erased the "viability" line pronounced in *Roe* that designated when the State's interest in potential human life became compelling.<sup>482</sup> In a minority opinion, Chief Justice Rehnquist stated, "we do not see why the State's interest in protecting potential human

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476. See *supra* note 276.

477. See Thomson, *supra* note 398, at 48-52.

478. 410 U.S. 113 (1973).

479. See *supra* text accompanying notes 22425-26 and 264-65.

480. *Roe*, 410 U.S. at 162-63 (indicating that the State has an "important and legitimate interest" in potential life that exists throughout a woman's pregnancy, and that such interests increase substantially as a woman approaches the time to give birth). *Roe* also held that the State's interests become "compelling at the point of viability." *Id.*

481. 492 U.S. 490 (1989).

482. See Christine Hunt, *Criminalizing Prenatal Substance Abuse: A Preventative Means of Ensuring the Birth of a Drug-free Child*, 33 Idaho L. Rev. 451, 466 (1997).

life should come into existence only at the point of viability. . . . '[T]he State's interest, if compelling after viability, is equally compelling before viability.'"<sup>483</sup> *Planned Parenthood v. Casey*<sup>484</sup> also recognized that a woman's freedom to terminate her pregnancy is not so unlimited "that from the outset, the State cannot show its concern for the life of the unborn."<sup>485</sup>

In this context, when the gestational carrier assumes responsibility for the fetus, she has limited her right to complete bodily integrity.<sup>486</sup> Indeed, the very nature of her decision to become a gestational carrier brings her rights into conflict with the rights of the fetus.<sup>487</sup> Just like a trustee, she assumes a duty to avoid acts or omissions that will injure the corpus of the trust, the fetus, and ultimately the child.<sup>488</sup> Her responsibilities are not different from those required to protect the child's welfare from the time the child is born until the mother transfers the duty to someone else.<sup>489</sup> The fetus acquires the right to have the gestator exercise a duty of care and conduct herself in a manner that does not cause injury,<sup>490</sup> as well as the right to be brought into the world as healthy as reasonably possible.<sup>491</sup> Recent medical developments support the legal concept that "a fetus has the right to begin life with a sound mind and body."<sup>492</sup>

483. *Webster*, 492 U.S. at 519 (quoting *Thornburgh v. American College of Obstetrics and Gynecologists*, 476 U.S. 747, 795 (1986) (White, J., dissenting)); see also Hunt, *supra* note 482, at 466-67 ("The Supreme Court in *Webster* did not hold that the State's interest is 'compelling' throughout a woman's pregnancy, but rather, it held that the State's interest becomes 'compelling' not at the rigid line of viability, as determined by *Roe*, but some time before viability.").

484. 505 U.S. 833 (1992).

485. *Id.* at 869; see also Hunt, *supra* note 482, at 466-67 (indicating that *Roe* and its progeny support a limited state right to regulate abortion).

486. See Robertson, *Procreative Liberty*, *supra* note 460, at 438. See also Hunt, *supra* note 482, at 468-69. Hunt notes that some scholars have argued that once a pregnant woman chooses to forego an abortion, she acquires both a legal and moral duty to give her fetus the best care possible. *Id.* at 468. In addition, Hunt notes that one judge held that there was "no reason to treat a child *in utero* any differently from a child *ex-utero* where the mother has decided not to abort or where the time allowed for abortion has passed." *Id.* at 469.

487. Robertson, *Procreative Liberty*, *supra* note 460, at 437-38.

488. *Id.* at 438. Robertson notes that

[t]he mother has . . . a legal and moral duty to bring the child into the world as healthy as is reasonably possible. She has a duty to avoid actions or omissions that will damage the fetus and child, just as she has a duty to protect the child's welfare once it is born until she transfers this duty to another. In terms of fetal rights, a fetus has no right to be conceived—or, once conceived, to be carried to viability. But once the mother decides not to terminate the pregnancy, the viable fetus acquires rights to have the mother conduct her life in ways that will not injure it.

*Id.* at 438.

489. *Id.* at 437-38.

490. *Id.*

491. *Id.*

492. James A. Filkins, *A Pregnant Mother's Right to Refuse Treatment Beneficial to Her Fetus: Refusing Blood Transfusions*, 2 DePaul J. Health Care L. 361, 361 (1998);

This right of the fetus to be born free from harm is not speculative. The choice of fetal interests over maternal rights is deeply rooted in the criminal law tradition<sup>493</sup> as well as recent tort law.<sup>494</sup> American criminal law jurisprudence reveals that a person who performs acts before fetal birth that result in the death of the fetus after birth commits homicide.<sup>495</sup> While a prenatal act causing a fetus *in utero* to be stillborn is not homicide, it has been traditionally punished as either feticide or even abortion.<sup>496</sup> The fetus's mother is also subject to liability under the same theories.<sup>497</sup>

For well over a decade, great focus has been placed on the pregnant woman's responsibility for the prenatal welfare of her fetus.<sup>498</sup> One issue which has resulted in considerable controversy and heated

see Robin M. Trindel, *Fetal Interests vs. Maternal Rights: Is the State Going Too Far?*, 24 Akron L. Rev. 743, 743 (1991).

493. See, e.g., Wayne R. Lafave & Austin W. Scott, Jr., *Criminal Law* 607-09 (2nd ed. 1986).

494. See, e.g., Keeton et al., *supra* note 434, at 367-70; Regina M. Coady, *Extending Child Abuse Protection to the Viable Fetus: Whitner v. State of South Carolina*, 71 St. John's L. Rev. 667, 672 (1997) (noting that the decision in *Bonbrest v. Kotz* marked a major advancement in the development of fetal rights because fetuses gained the right to recover for tortious injuries inflicted upon them *in utero*); Trindel, *supra* note 492, at 745-46 nn.14-19. See generally Michelle D. Mills, Comment, *Fetal Abuse Prosecutions: The Triumph of Reaction over Reason*, 47 DePaul L. Rev. 989, 992-93 (1989) (discussing development of fetal tort law and noting that many state laws allow pregnant women to recover for injuries resulting in the death of a fetus).

495. See Lafave & Scott, *supra* note 493, at 609; Trindel, *supra* note 492, at 744.

496. Lafave & Scott, *supra* note 493, at 609; Robertson, *Procreative Liberty*, *supra* note 460, at 438 & n.99.

497. Robertson, *Procreative Liberty*, *supra* note 460, at 438.

498. For articles which discuss fetal rights, see Rebekah R. Arch, *The Maternal-Fetal Rights Dilemma: Honoring a Woman's Choice of Medical Care During Pregnancy*, 12 J. Contemp. Health L. & Pol'y 637 (1996); Katherine Beckett, *Fetal Rights and "Crack Moms": Pregnant Women in the War on Drugs*, 22 Contemp. Drug Probs. 587 (1995); Arthur S. DiDio, *The Right to Refuse Treatment During Pregnancy: Where Maternal and Fetal Rights Conflict*, 45 Med. Trial Tech. 225 (1999); Julia Epstein, *The Pregnant Imagination, Fetal Rights, and Women's Bodies: A Historical Inquiry*, 7 Yale J. L. & Human. 139 (1995); Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 Harv. Women's L.J. 9 (1987); Nova D. Janssen, *Fetal Rights and the Prosecution of Women for Using Drugs During Pregnancy*, 48 Drake L. Rev. 741 (2000); Dawn E. Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 Yale L.J. 599 (1986); Robyn M. Kaufman, *Legal Recognition of Independent Fetal Rights: The Trend Towards Criminalizing Prenatal Maternal Conduct*, 17 Child. Legal Rts. J. 20 (1997); Beth Driscoll Osowski, *The Need for Logic and Consistency in Fetal Rights*, 68 N.D. L. Rev. 171 (1992); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 Harv. L. Rev. 1419 (1991); Barbara Shelley, *Maternal Substance Abuse: The Next Step in the Protection of Fetal Rights?*, 92 Dick. L. Rev. 691 (1988); Elizabeth S. Brown, Note, *Constitutional Considerations Underlie Missouri's Expansion of Fetal Rights Within Its Wrongful Death Statute*, 61 Mo. L. Rev. 473 (1996); Michael Lee, Note, *The Wisconsin Court of Appeals Introduces a Dangerous New Weapon in the Battle over "Fetal Rights,"* 30 Ga. L. Rev. 1183 (1996); Note, *Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse,"* 101 Harv. L. Rev. 994 (1988).

debate centers on whether pregnant women can be prosecuted under state criminal statutes for ingesting illegal substances during pregnancy resulting in injury to the child after its birth.<sup>499</sup> Beginning with *Reyes v. Superior Court*,<sup>500</sup> the great weight of authority consistently held that women cannot be prosecuted for harm to the unborn under these circumstances.<sup>501</sup> *Reyes*, the first appellate case to

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499. See Janssen, *supra* note 498, at 741; Lisa M. Noller, *Taking Care of Two: Criminalizing the Ingestion of Controlled Substances During Pregnancy*, 2 U. Chi. L. Sch. Roundtable 367 (1995); Kellam T. Parks, *Protecting the Fetus: The Criminalization of Prenatal Drug Use*, 5 Wm. & Mary J. Women & L. 245 (1998); James G. Hodge, Jr., Annotation, *Prosecution of Mother for Prenatal Substance Abuse Based on Endangerment of or Delivery of Controlled Substance to Child*, 70 A.L.R.5th 461, 461 (1999) (arguing that in cases recognizing a pregnant woman's duty to the fetus, these courts implicitly recognize that the pregnant woman has committed a wrong against the child and must be held responsible). Those jurisdictions that do not impose such responsibility do not do so primarily due to lack of legislative authority. See Hunt, *supra* note 482, at 454 (indicating that by statute courts have the authority to involuntarily civilly commit a pregnant woman where it has been demonstrated that she poses a danger to her unborn child or herself). However, since criminal statutes did not include the word "fetus," women did not have fair notice and warning that harm to the fetus *in utero* could result in criminal prosecution under law. Denison, *supra* note 462, at 1104 (arguing that great controversy and heated debate centers around the abuse of illegal drugs by pregnant women and the impact on their children after birth); Hunt, *supra* note 482, at 454-55.

500. 141 Cal. Rptr. 912 (Cal. Ct. App. 1977).

501. While most jurisdictions have been reluctant to hold mothers criminally responsible for prenatal substance abuse, it has not been because they find these sorts of prosecutions inherently wrong. See Hodge, *supra* note 499, at 470-72. Rather, these women have been able to avoid prosecution because these courts believe they lack specific legislative authority to charge mothers with child abuse or child endangerment for delivering drugs to a fetus. *Id.* at 470-72; see also *U.S. v. Foreman*, 1990 WL 79309, at \*2 (A.F.C.M.R. 1990) (holding that an unborn fetus is not intended as a potential victim of criminal neglect under a military statute covering child abuse and neglect); *Reinesto v. Superior Court*, 894 P.2d 733 (Ariz. Ct. App. 1995) (indicating that child abuse statute did not include fetuses); *Reyes v. Superior Court*, 141 Cal. Rptr. 912 (Cal. Ct. App. 1977) (holding the ingestion of heroin during pregnancy was not subject to criminal prosecution since the word "child" in the applicable statute did not include fetuses); *State v. Gethers*, 585 So. 2d 1140, 1142 (Fla. Dist. Ct. App. 1991) (holding that the statute did not include the criminal prosecution of mothers whose prenatal substance abuse harms their infants); *Commonwealth v. Welch*, 864 S.W.2d 280, 281 (Ky. 1993) (noting that a fetus is not included in the definition of a "person," and if the legislature had wanted to include it they would have expressly done so); *People v. Hardy*, 469 N.W.2d 50, 52-53 (Mich. Ct. App. 1991) (holding that while the existing state statute clearly proscribed the possession and use of cocaine, nothing evidenced an intent to prosecute women for delivery of cocaine to a fetus while *in utero* and concluding the court was not at liberty to create a new crime); *Sheriff v. Encoe*, 885 P.2d 596, 598 (Nev. 1994) (holding that a mother cannot be prosecuted for the delivery of a controlled substance to her child through the umbilical cord due to the lack of clear statutory language); *People v. Morabito*, 580 N.Y.S.2d 843, 846 (Geneva City Ct. 1992) (holding the delivery of cocaine to a fetus *in utero* is not within the scope of the statute since a fetus is not included in the statutory definition of "child"); *State v. Gray*, 584 N.E.2d 710, 711 (Ohio 1992) (holding that a mother cannot be prosecuted for substance abuse during pregnancy under the child endangerment statute because the "parent-child" relationship is not established until birth); *Collins v. State*, 890 S.W.2d 893, 898 (Tex.

consider this issue, clearly sets the tone for similar decisions in other jurisdictions by holding that the state's criminal child abuse statutes did not intend to include the unborn in its definition of "child."<sup>502</sup>

Despite the overwhelming majority of cases refusing to allow any prosecutions or criminal sanctions against pregnant women solely because of their prenatal substance abuse, one state has been willing to hold to the contrary.<sup>503</sup> In a bold move for fetal rights, *Whitner v. State* held that, in South Carolina, a pregnant woman who causes pre-birth injuries to her fetus can be held criminally responsible for the child's post-natal injuries.<sup>504</sup>

The decision in *Whitner* was not a stretch, however. South Carolina law had for many years recognized that in the context of civil law, viable fetuses are persons with certain rights and privileges.<sup>505</sup> In *Hall v. Murphy*,<sup>506</sup> the South Carolina courts previously held that there was no medical or other basis for holding that a viable fetus was not a person for purposes of its wrongful death statute.<sup>507</sup> Following *Hall*, the South Carolina Supreme Court in *Fowler v. Woodard*<sup>508</sup> reaffirmed that a viable fetus need not be born alive to bring an action for wrongful death of the fetus.<sup>509</sup> *Fowler* made clear that the decision in *Hall* was based upon its view of a viable fetus as a person with legal rights.<sup>510</sup>

The South Carolina Supreme Court subsequently held in *State v. Horn*<sup>511</sup> that a viable fetus is a person even under state criminal statutes.<sup>512</sup> The Court concluded that it would be "grossly inconsistent for us to construe a viable fetus as a 'person' for the purposes of imposing civil liability while refusing to give it a similar classification in the criminal context."<sup>513</sup> The Court reasoned that its holding in

App. 1994) (holding that a mother could not be prosecuted for giving birth to a drug-addicted child since it was not possible under the statute to prosecute the results of the mother's conduct, but rather only the conduct itself).

502. See *Reyes*, 141 Cal. Rptr. at 913-14.

503. See *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997) (upholding the prosecution of a mother who abused drugs during her pregnancy and was charged with child abuse and endangerment); see also *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (holding that drug tests on urine samples of maternity patients suspected of using cocaine was in violation of the Fourth Amendment).

504. *Id.*

505. See *Hall v. Murphy*, 236 S.E.2d 257, 262-63 (S.C. 1960) (finding that a fetus is a person and a child may maintain an action for injuries inflicted during the prenatal period).

506. *Id.*

507. *Id.*

508. 138 S.E.2d 42, 44 (S.C. 1964).

509. *Id.* at 44.

510. *Whitner v. State*, 492 S.E.2d 777, 780 (S.C. 1997).

511. 319 S.E.2d 703, 704 (S.C. 1984).

512. *Id.*

513. *Id.*

*Whitner* was consistent with existing medical information,<sup>514</sup> precedent<sup>515</sup> and the statute's public policy.<sup>516</sup>

In light of these cases, *Reyes* was incorrectly decided. The interpretation of the statute was erroneous because it overlooked the fact that the abused child really is not the fetus.<sup>517</sup> Rather, it is the child who is born alive and suffers from injuries occurring before its birth.<sup>518</sup> Indeed, *Reyes* was inconsistent with California homicide law which, at the time of the decision, imposed liability for prenatal actions that cause death post-natally.<sup>519</sup> Those decisions following *Reyes* also appear to have ignored that the child born alive after the mother has exposed it to illegal drugs is in need of protection.<sup>520</sup>

Even if *Reyes* and its progeny got it wrong, *Whitner* and subsequent similar decisions have gotten it right.<sup>521</sup> As one commentator notes, "[t]he timing of the *Whitner* decision was critical; as the first state high court to criminalize maternal drug use, it sent a prominent message that abuse of the unborn child will not be tolerated."<sup>522</sup> While the ground-breaking decision resurrected the balancing of a woman's

514. See *Whitner*, 492 S.E.2d at 780; see also Coady, *supra* note 494, at 669 (arguing that the South Carolina Supreme Court based its decision primarily upon existing medical information regarding fetal development); Joseph Wharton, *Domestic Relations: Drugs in Pregnancy Amount to Abuse*, 82 A.B.A. J., Nov. 1996, at 43 (asserting that the decision in *Whitner* was based on medical knowledge rather than the relationship between mother and child).

515. See *Whitner*, 492 S.E.2d at 780-81.

516. *Id.*; see also *Whitner v. State*, 70 A.L.R.5th 723, 732 (1998) (noting that a Massachusetts case, *Commonwealth v. Pellegrini*, was similar to the facts in *Whitner* but reached a different result, primarily due to different public policies). In *Pellegrini*, the court held that a viable fetus could only be accorded the rights of a person for the sake of its mother or its parents. *Id.* at 733. This means that the viable fetus does not have rights of its own that deserve vindication. *Id.* To the contrary, the policy underlying South Carolina's body of law was the protection of the viable fetus, a policy radically different from that underlying the law of Massachusetts. *Id.* See generally *Commonwealth v. Pellegrini*, 608 N.E.2d 717 (Mass. 1993) (holding that a mother of a newborn could be criminally prosecuted based on a statutory theory of possession of cocaine, where drugs were found in the child's urine as a result of prenatal drug abuse by the mother).

517. See Robertson, *Procreative Liberty*, *supra* note 460, at 439.

518. *Id.*

519. See Cal. [Penal] Code § 187 (West 1999); see also *Keeler v. Superior Court*, 470 P.2d 617, 622 (Cal. 1970), *superseded by statute as stated in People v. Carlson*, 112 Cal. Rptr. 321, 327 (Cal. Ct. App. 1974) ("When the child is born . . . it becomes a human being, [sic] within the meaning of the law; [sic] and if it shall then die . . . it would be murder." (citation omitted)); *People v. Chavez*, 176 P.2d 92, 95 (Cal. Dist. Ct. App. 1947).

520. See Hunt, *supra* note 482, at 468 (noting that the child who is born alive but who has been damaged by the mother's prenatal drug abuse will require costly neonatal care, and those children who are born mentally impaired will require special education). For these reasons and others, the state has a compelling interest in protecting the fetus. *Id.*

521. See Coady, *supra* note 494, at 676 (noting the number of recent decisions which have held pregnant women accountable for prenatal injuries to their fetuses).

522. *Id.* at 678 n.50.

rights with those of her fetus, it did so consistent with advances in medical technology.<sup>523</sup> Such technological advances lend increasing support for the fetus's legal rights.<sup>524</sup> As society recognizes the need to extend fetal rights, however, there is, of necessity, a compromise of a pregnant woman's freedom.<sup>525</sup>

By strong implication, *Whitner* recognizes that a pregnant woman holds the fetus in trust and has responsibilities to it, including the duty of care. This is so even if she has not willingly agreed to serve as trustee for the child to whom she will ultimately give birth. It is important to emphasize that in prenatal substance abuse cases, the duty of care is not willingly assumed by the pregnant woman. Instead, the court recognizes that in such cases, the woman's right to bodily integrity has to give way to the rights of the fetus.

In the case of a gestational carrier, the argument supporting a gestator's duty to the fetus is less difficult. She is the trustee who has a fiduciary responsibility to the fetus. She has not been forced to assume the duty of care. She willingly accepted the responsibility for the fetus knowing that she agreed to make sacrifices. Short of extraordinary circumstances, there is no unexpected burden to her bodily integrity. As a result, even if she grows weary of the task she has undertaken, she must be held to the promise she made for the benefit of the intended parents and ultimately the fetus: to protect the fetus and to conduct her life in a manner that does not injure it,<sup>526</sup> and to deliver a child as healthy as is reasonably possible.<sup>527</sup>

#### CONCLUSION

With the help of modern medicine, some infertile couples are able to achieve the dream of bearing a child of their own through *in vitro* fertilization. This medical miracle affords couples the ability to have a 100% genetically related child, even where the female is incapable of gestating a child. This is achieved through a gestational carrier. The intended parents provide the embryo which is then turned over to another woman for the period of gestation. However, the amount of time, money and emotion that it takes to reach this goal is daunting.

Most legal and medical professionals believe, under the current state of the law, that a gestational carrier can freely abort the entrusted embryo at any time, and for any reason, without recourse for the intended parents. This is wrong. The gestational carrier should be treated as a fiduciary, the trustee of the embryo she is carrying. Her responsibilities as a fiduciary are to protect the subject

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523. *Id.* at 676.

524. *Id.* at 677.

525. *Id.* at 677 n.49.

526. Robertson, *Procreative Liberty*, *supra* note 460, at 438.

527. *Id.*

of the trust, to defend the trust corpus from attack, to make the subject of the trust productive, to satisfy her duty of loyalty to all beneficiaries and to not engage in self-dealing. Any one of these duties alone would preclude the gestational carrier from getting and abortion unless her own life or physical health were at stake.

While there have been numerous objections to the limitation of the right to abort, these should not apply to limiting abortions in the context of a gestational carrier. The commodification arguments must fail since they are nothing more than neo-Marxist rhetoric that would preclude women's freedom of choice. The arguments proposed by Judith Jarvis Thomson, that of the violinist and Good Samaritan, also fail in the gestational carrier context since the gestational carrier is responsible for the welfare of the fetus and is not just passively carrying a stranger to whom she has no responsibility. The gestational carrier is a trustee who knowingly and willingly enters into a trust-type relationship in which she assumes responsibility for the welfare of the fetus.

There is no easy answer when considering the right of a gestational carrier to abort the fetus she is carrying. On the one hand, are the intended parents who desperately want a child of their own and have paid a high monetary, physical and emotional cost to provide embryos to the gestational carrier. On the other, is the gestational carrier who could be required to endure the pains of gestation and childbirth. However, since the burden was freely and knowingly taken, and the gestational carrier owes a fiduciary duty to the intended parents and the fetus, the scales should tip in the balance of restricting the gestational carrier's right to abort.