
THE CURING LAW: ON THE EVOLUTION OF BABY-MAKING MARKETS

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ABSTRACT

The article offers a new paradigm to examine the legal regulation of reproductive technologies. The main argument is that a cure paradigm has shaped historical and current legal baby-making markets. Namely, reproductive technologies that have historically been understood as a cure for infertility (such as sperm donations and egg donations) have developed into market commodities, while others (such as full surrogacy) which have not been understood as a cure, have not. The article examines and critiques the cure paradigm. Specifically, the article challenges one current manifestation of the cure paradigm: the legal distinction between “full surrogacy” (where a surrogate is impregnated using her own ova) and “gestational surrogacy” (where an embryo is created in vitro and then transferred into the surrogate’s uterus). Gestational surrogacy has been established by many state courts and legislatures as a legitimate means of curing female infertility, while full surrogacy has generally been either prohibited or deemed unenforceable. This distinction is problematized in this article not only because it is based on contestable values, but also because it has produced serious market failures that have effectively excluded many potential participants from entering baby-making markets. Thus, the article argues that it is time to reevaluate the cure paradigm.

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INTRODUCTION

Attitudes of lawmakers toward some reproductive technologies have evolved over the latter half of the twentieth century from antagonism to approval. What happened in those moments of transition? Why have some reproductive technologies been granted legal recognition while others have not? This Article argues that among other possible explanations, a social, medical and legal understanding of certain reproductive technologies as medical cures for infertility has played a determinative role in those moments of transition. In particular, sperm donation was legalized by the late 1960s as a cure for male infertility, and egg donation and gestational surrogacy were

legalized beginning in the early 1990s as cures for female infertility.¹ Following those moments of legal recognition, baby-making markets developed.² The Article explores the evolution of a “curing law” in the realm of baby-making markets.³

Three baby-making markets have emerged: (1) a sperm market; (2) an egg market; and (3) a “gestational surrogacy” market. In “gestational surrogacy” an embryo is created *in vitro*, using the ova of another woman, whereas in “full surrogacy” the surrogate is impregnated using her own ova.⁴ In contrast with the three technologies that have so far been legally recognized, full surrogacy has not been granted legal recognition primarily because it has been understood as “baby-selling.”⁵ The surrogate’s role in full surrogacy has been viewed as *replacement of maternal labor* and not as a cure for female infertility.

Through the lens of the cure paradigm, the Article underscores two paradoxical characteristics of current baby-making markets. First, gestational surrogacy has been legally recognized as a legitimate form of curing female infertility,⁶ whereas full surrogacy has not.⁷ Second, there is a sex-based differentiation in the regulation of reproductive technologies: while the legal recognition of sperm donation has involved a full detachment of the paternal body from the process of reproduction through replacement of paternal sperm with donor sperm,

¹ The article uses two different methodologies to demonstrate the pervasiveness of the “cure paradigm.” First, it points to actual language and rhetoric of case-law, statutory law, and medical literature in the moments of legalization. Second, it offers the cure paradigm as an overarching logical explanation in instances where lawmakers do not explicitly draw on its logic. Namely, while in some cases the article points to explicit manifestations of the cure paradigm, in other instances, the article offers the cure paradigm as a possible explanation among others for understanding certain developments in baby-making markets.

² For general commodification debates see, for example, RETHINKING COMMODIFICATION (Martha M. Ertman & Joan C. Williams eds., 2005); MARGARET JANE RADIN, CONTESTED COMMODITIES (1996); Elizabeth S. Anderson, *Is Women’s Labor a Commodity?*, 19 PHIL. & PUB. AFF. 71 (1990); Richard A. Epstein, *Surrogacy: The Case for Full Contractual Enforcement*, 81 VA. L. REV. 2305, 2334 (1995) (concluding that the analogy to baby-selling “only strengthens the conclusion that surrogacy transactions should be legal”); Richard A. Posner, *The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood*, 5 J. CONTEMP. HEALTH L. & POL’Y 21 (1989) (arguing in favor of surrogacy contract enforcement); Elisabeth M. Landes & Richard A. Posner, *The Economics of the Baby Shortage*, 7 J. LEGAL STUD. 323 (1978) (urging the enforcement of baby-selling agreements).

³ I take the term “baby-making” from Carol Sanger, *Developing Markets in Baby-Making: In the Matter of Baby M*, 30 HARV. J.L. & GENDER 67 (2007).

⁴ To this day, most cases and literature refer to what I call “full surrogacy” as “traditional surrogacy.” Ironically, as this article demonstrates, it is “traditional” surrogacy that has been since the 1980s the most controversial reproductive technology. Therefore the article uses the term “full surrogacy,” which better captures the nature of this arrangement.

⁵ *In re Baby M*, 537 A.2d 1227, 1234, 109 N.J. 396, 411 (1988) (holding that a full surrogacy agreement is unenforceable because it conflicts with public policy and statutory law of New Jersey).

⁶ See, e.g., *Johnson v. Calvert*, 851 P.2d 776, 5 Cal. 4th 84 (1993) (enforcing a gestational surrogacy agreement against gestational surrogate).

⁷ *In re Baby M*, 537 A.2d at 1234.

the parallel full detachment of the maternal body from the process of reproduction through the use of a full surrogate has not been legally recognized.

The Article proceeds in three Parts. Part I describes the emergence of the medicalized cure paradigm in the 1950s and its consequent impact on the regulation of sperm donation, egg donation, and gestational surrogacy. This Part traces two legal-historical phases. In the first phase of the cure paradigm, which occurred in the 1950s and 1960s, sperm donation was gradually understood by medical experts and lawmakers as a cure for male infertility. In the second phase of the cure paradigm, beginning in the early 1990s, two components of *in vitro fertilization* (IVF) were recognized by lawmakers as cures for female infertility: egg donation and gestational surrogacy. Consequently, those three reproductive technologies (egg donation, sperm donation and gestational surrogacy) make up current baby-making markets.

Part II argues that full surrogacy, unlike egg donation and gestational surrogacy, has been legally understood as *baby-selling* and not as a cure for female infertility. This Part examines the ethical and moral objections to full surrogacy raised by lawmakers, feminists and medical experts in the 1980s, which provided the theoretical basis for the development of the baby-selling paradigm.

Part III critiques the cure paradigm drawing on two different theoretical perspectives. Section A examines the cure paradigm from a feminist/queer perspective, arguing that the cure paradigm has in fact masked cultural assumptions about sex, gender and reproduction. Section B examines current baby-making markets from an economic perspective, arguing that the cure paradigm has resulted in baby-making markets that exclude lower-income individuals and couples who cannot afford *in vitro* fertilization and embryo implantation. In conclusion, Section C argues that the distinction between gestational and full surrogacy should be eliminated and that full surrogacy should be legally recognized by lawmakers.

I. THE MEDICALIZED CURE PARADIGM

The cure paradigm appeared in two phases in the evolution of baby-making markets in the U.S. In the first phase (1950s-1960s), sperm donation was gradually understood by medical experts and lawmakers as a cure for male infertility, and consequently legalized. In the second phase (early 1990s and on), two components of IVF were legalized as a cure for female infertility: egg donation and gestational surrogacy. The following genealogies reveal that in both phases of the cure paradigm, a medicalized understanding of a specific reproductive

technology as a cure for infertility *replaced* a former understanding of the technology as immoral or unethical.

A. *First Phase: The Legalization of Sperm Donation*

The cure paradigm emerged around the mid-twentieth century as a new way of understanding donor sperm insemination. The shift in the legal classification of donor insemination involved a conceptual transition from a traditional view of donor insemination as an adulterous act, to a modern-scientific view of donor insemination as a medical cure for male infertility. This transition enabled the flourishing of the market for sperm that we have today.

1. The Previous Legal Classification of Sperm Donation as Adultery

Donor sperm insemination was historically treated as an act of adultery on the part of a wife who had been inseminated by sperm other than that of her husband. As articulated in *Gursky v. Gursky*, “heterologous artificial insemination by a third party donor, with or without the consent of the husband, constitutes adultery on the part of the mother, and . . . a child so conceived is not a child born in wedlock and is, therefore, illegitimate.”⁸ One of the main consequences of classifying donor insemination as adultery was illegitimacy of the child born of donor insemination. Thus, in *Gursky*, upon separation of husband and wife, the New York court ruled that there was no issue of the marriage because a child conceived through donor insemination was not the husband’s biological child.⁹ Likewise, in *Abajian v. Dennett*, a New York court ruled that an ex-wife wishing to deny her ex-husband visitation or custody was estopped from asserting that her pregnancy was a result of donor insemination because “to stigmatize them as children of an unknown father by means of artificial insemination of the mother is no more . . . than an attempt to make these innocents out as children of bastardy. And where a parent attempts such means, the law will still the lips of such a parent.”¹⁰ The court “stilled the lips” of a

⁸ *Gursky v. Gursky*, 242 N.Y.S.2d 406, 411 (Sup. Ct. 1963) (citation omitted).

⁹ The court emphasized the limited scope of *Strnad v. Strnad*, 78 N.Y.S.2d 390 (Sup. Ct. 1948), which held that children born of donor insemination are legitimate. *Gursky*, 242 N.Y.S.2d at 410-11 (“The view expressed by the court in that case, that such child was not an illegitimate child, is supported by no legal precedent.”).

¹⁰ *People ex rel. Abajian v. Dennett*, 184 N.Y.S.2d 178, 183 (Sup. Ct. 1958). Some courts, however, were less clear regarding the adulterous nature of the procedure. For example, in the first (unreported) case in the United States involving artificial insemination, *Hoch v. Hoch*, the court opined that donor insemination is insufficient evidence for adultery. *See* Charles E. Rice,

mother who wished to say the truth about the conception of her children because this truth would change the status of her children from “innocents” whose father had been the mother’s husband, to “children of bastardy” whose father had been the sperm donor.

This judicial language of stigma and bastardy reflects a widespread moral condemnation of donor insemination that was shared by various legal commentators, courts, medical experts, and religious authorities in the U.S., Britain and Canada in the mid-1900s. The American public was polled in the 1950s by social scientists who reported negative social attitudes toward donor insemination.¹¹ It was commonly thought that “[c]ouples who are involuntarily sterile may better satisfy their parental urge by adopting a child.”¹² As for others, marriage was “their solution rather than artificial insemination.”¹³ In Britain, a committee on donor insemination concluded that although the practice “is to be strongly discouraged, it should not be declared criminal or be regulated by law” because “it falls within the category of actions known to students of jurisprudence as ‘liberties’ which while not prohibited by law will receive no kind of support or encouragement from the law.”¹⁴

In essence, the moral unease with donor insemination had to do with the idea of it being a crime against the husband and the family that “should be condemned because it is contrary to the accepted standards of adultery and legitimacy.”¹⁵ Donor insemination was considered a moral threat to the husband and the family for three interrelated reasons. First, it was believed that the introduction of foreign sperm would weaken the existing social order that is “built on the nucleus of the family growing from the marriage of one man and one woman for life to the exclusion of all others.”¹⁶ Second, donor insemination was seen as a

A.I.D.—An Heir of Controversy, 34 NOTRE DAME L. REV. 510, 514 (1959); see also *Strnad*, 78 N.Y.S.2d at 392 (“Indeed, logically and realistically, the situation is no different than that pertaining in the case of a child born out of wedlock who by law is made legitimate upon the marriage of the interested parties.”).

¹¹ See, e.g., Glenn M. Vernon & Jack A. Boadway, *Attitudes Toward Artificial Insemination and Some Variables Associated Therewith*, 21 MARRIAGE & FAM. LIVING 43 (1959) (finding relatively little acceptance of donor insemination among college students, but that males evidenced greater acceptance than did the females); Joseph H. Greenberg, *Social Variables in Acceptance or Rejection of Artificial Insemination*, 16 AM. SOC. REV. 86 (1951) (finding that the identity of the donor appears to determine social attitudes concerning artificial insemination—while less than 10% rejected artificial insemination using the sperm of the husband, close to 50% rejected donor insemination).

¹² J.G.P., *Artificial Insemination Versus Adoption*, 34 VA. L. REV. 822, 829 (1948).

¹³ *Id.* at 828.

¹⁴ See Robert S.W. Pollard, *Report on the Departmental Committee on Human Artificial Insemination*, 24 MOD. L. REV. 158, 162 (1961) (internal quotation marks omitted).

¹⁵ J.G.P., *supra* note 12, at 824.

¹⁶ *Id.* The Catholic Church, for example, ruled out the legitimacy of donor insemination in 1949, 1951, and 1956, arguing that it reduces marriage and the conjugal act to a mere organic function, thus turning the family into nothing more than a “biological laboratory.” See Pius XII, *Allocution: Artificial Insemination* (Sept. 29, 1949), in 3 THE CANON LAW DIGEST: OFFICIALLY

direct threat to the husband's bloodline.¹⁷ Third, it was thought that the "increasing production of children by means of artificial insemination from unknown donors enhances the possibilities of incestuous marriages and incestuous relationships."¹⁸ In *The Enforcement of Morality*, H.L.A. Hart mentions that "speakers in the House of Lords urged that the practice should be prohibited by criminal law and Lord Denning indeed claimed that if the facts [regarding wife donor insemination] were concealed from the husband the practice was already illegal as a form of criminal conspiracy."¹⁹

2. The Shift to the De-Sexualized Cure Paradigm

The proposal to criminalize donor insemination in Britain was rejected, leading H.L.A. Hart to the conclusion that "today the conversion of deviation from accepted morality into criminal offences is not as easy as it once was."²⁰ From today's perspective we can see that it is not only that around the mid-twentieth century the "deviation" of sperm donation was not criminalized—it was converted into a new legal good. How did this flip happen?

By the 1950s, many medical fertility experts and physicians supported the proposition that donor insemination should be legitimized because it held out the possibility of curing infertility in the male.²¹

PUBLISHED DOCUMENTS AFFECTING THE CODE OF CANON LAW 1942-53, at 432-33 (T. Lincoln Bouscaren ed., 1953); Pius XII, *Allocution: Artificial Insemination Condemned* (Oct. 29, 1951), in 3 THE CANON LAW DIGEST: OFFICIALLY PUBLISHED DOCUMENTS AFFECTING THE CODE OF CANON LAW 1942-53, at 434 (T. Lincoln Bouscaren ed., 1953).

¹⁷ See J.G.P., *supra* note 12, at 825 (describing a Canadian case where the court stated in dicta that "the essence of the [donor insemination] offense was not in the immoral act of sexual intercourse, but in 'the voluntary surrender by the guilty person of the reproductive powers or faculties to one other than the husband or wife'" (quoting *Orford v. Orford*, 49 Ont. L.R. 15 (1921)); see also J.G.P., *supra* note 12, at 826 (explaining that the precise offense was introducing into the family of the husband a false stream of blood). Notably, some legal commentators at the time insisted that donor insemination was not adultery because there was no act of sexual intercourse. See, e.g., Comment, *Artificial Insemination: A Parvenu Intrudes on Ancient Law*, 58 YALE L. J. 457, 464 (1949) (noting that "the initial selection depends primarily on whether the judge feels more moral indignation against the evils of sterility than against the encroachment by science on the legal reserves of family life").

¹⁸ See, e.g., Morris Ploscowe, *The Place of Law in Medico-Moral Problems: A Legal View II*, 31 N.Y.U. L. REV. 1238, 1243 (1956) ("The incest taboo is one of the strongest in our society . . .").

¹⁹ H.L.A. HART, *The Enforcement of Morality*, in THE MORALITY OF CRIMINAL LAW: TWO LECTURES 31, 42 (1964) (discussing a recent divorce action where a judge ruled that artificial insemination of a wife by donor sperm did not constitute adultery).

²⁰ *Id.* at 42 (The Feversham Committee, appointed following this debate, rejected the proposal to criminalize the practice.).

²¹ See Gaia Bernstein, *The Socio-Legal Acceptance of New Technologies: A Close Look at Artificial Insemination*, 77 WASH. L. REV. 1035, 1079 (2002) (demonstrating how historically the medical profession mediated between the restraints imposed by legal uncertainty and the use of

This medical framework desexualized the previous understanding of donor insemination.²² This was manifested not only in the language but also in the physical re-location of the donor insemination procedure. In the 1930s, some medical practitioners, still operating under the assumption that a woman must be sexually aroused to allow upward movement of sperm, thought that intercourse must precede the procedure, and thus performed the process in the couple's bedroom.²³ In contrast, by the 1950s, medical literature detached the link between the appropriate timing for insemination and the woman's orgasm.²⁴ It was no longer thought that a woman could only become pregnant following her sexual arousal. The physician no longer had to perform the procedure in the bedroom, and it was moved to the physician's office.²⁵

But the legal classification of donor insemination as adultery posed a very concrete problem for courts: child support. If the husband is a legal stranger to the child, and the donor is in many cases anonymous, who is responsible for supporting the child? Although it still classified donor insemination as adultery, the *Gursky* court identified the problem of child support, and to overcome it, distinguished support from legitimacy, holding that "while the court is constrained to hold that the child of the defendant wife is not the legitimate issue of the plaintiff husband, it does not follow that the husband is thereby free of obligation to furnish support for the child."²⁶ Thus, "in the instant case . . . the husband is liable for the support of the child here involved, whether on the basis of an implied contract to support or by reason of application of the doctrine of equitable estoppel."²⁷

A conceptual and terminological shift in the assessment of donor insemination is evident in the transition from *Abajian* (1958) to *Gursky* (1963). While in both cases donor insemination was still understood as adultery, language of sexual virtue and traditional morality in *Abajian* shifts to language of social duty and responsibility for child support in *Gursky*. While in *Abajian*, the court focused on stigma, shame, innocence and bastardy, the court in *Gursky* based its decision on the husband's social obligation of child support. This shift is also embodied in the legal party who is the target of estoppel. While estoppel in *Abajian* was used to silence the wife (from relying on the adulterous nature of donor insemination to deny her ex-husband's custody or visitation), in *Gursky* it was utilized to silence the husband

the technology).

²² *Id.*

²³ *Id.* at 1064.

²⁴ *Id.* at 1075 (citation omitted).

²⁵ *Id.* at 1075.

²⁶ *Gursky v. Gursky*, 242 N.Y.S.2d 406, 411 (Sup. Ct. 1963).

²⁷ *Id.* at 412.

(from relying on the adulterous nature of donor insemination to deny his own obligation to support the child).

This conceptual transition from sexual virtue and stigma to cure and social responsibility was finalized in 1968 by the Supreme Court of California in *People v. Sorensen*.²⁸ The *Sorensen* court dismissed the adultery paradigm as “patently absurd.” Interestingly, in this case a new potential criminal identity emerged: that of a husband who fails to support *his* child born of donor insemination. The *Sorensen* court had to determine whether “the husband of a woman, who with his consent was artificially inseminated with semen of a third-party donor, [is] guilty of the crime of failing to support a child who is the product of such insemination, in violation of section 270 of the [California] Penal Code.”²⁹ The court concluded that the husband was indeed guilty.³⁰

The *Sorensen* court abandoned the adultery framework altogether:

Adultery is defined as “the voluntary sexual intercourse of a married person with a person other than the offender’s husband or wife.” It has been suggested that the doctor and wife commit adultery by the process of artificial insemination. Since the doctor may be a woman, or the husband himself may administer the insemination by a syringe, this is patently absurd; to consider it an act of adultery with the donor, who at the time of insemination may be a thousand miles away or may even be dead, is equally absurd.³¹

Given the definition of adultery as voluntary sex, various adulterous scenes were offered and dismissed by the court. First, the court raised the scene of insemination of the wife by the husband himself using a syringe. The notion of absurdity here comes from the latter part of the adultery definition—“with a person other than the offender’s husband or wife.” Because the husband cannot at the same time act as himself and as a person other than himself, this adulterous scene makes no sense. Second, the court sketches an adulterous sex scene of a female doctor with a female patient, which it then dismisses. It appears that (in 1968) the very idea of woman to woman sex seemed ridiculous to the court. A third adulterous scene takes place between the wife and the donor who may be a thousand miles away or even dead.

The court moved to a new understanding of the procedure. It is a contract to cure infertility that carries with it a heavy social responsibility. When a man, “because of his inability to procreate,” consents to his wife’s artificial insemination, he “knows that such behavior carries with it the legal responsibilities of fatherhood and

²⁸ *People v. Sorensen*, 68 Cal. 2d 280 (1968).

²⁹ *Id.* at 283.

³⁰ *Id.* at 283-84 (“The law is that defendant is the lawful father of the child born to his wife, which child was conceived by artificial insemination to which he consented, and his conduct carries with it an obligation of support with the meaning of section 270 of the Penal Code.”).

³¹ *Id.* at 289 (internal citations omitted).

criminal responsibility for nonsupport.”³² No longer perceived as sexual adultery, donor insemination is now the purchase of a donor’s sperm in order to cure male infertility. Or as put by the court, a man who “unable to accomplish his objective of creating a child by using his own semen, purchases semen from a donor and uses it to inseminate his wife to achieve his purpose.”³³

The donor was no longer perceived as selling a child to the couple. He was now “some other male” whose sperm is “utilized” for the conception of the wife.³⁴ The *Sorensen* court concluded that “within the meaning of section 270 of the Penal Code, defendant is the lawful father of the child conceived through heterologous artificial insemination and born during his marriage to the child’s mother.”³⁵ A new potential criminal liability emerged: the non-paying husband of a woman inseminated via donor insemination.

Focusing on the “best interest” of the child, the court emphasized that “no valid public purpose is served by stigmatizing an artificially conceived child as illegitimate,”³⁶ and that “the intent of the Legislature obviously was to include every child, legitimate or illegitimate, born or unborn, and enforce the obligation of support against the person who could be determined to be the lawful parent.”³⁷ The *Sorensen* court offered the following theory of punishment:

Rather than punishment of the neglectful parent, the principal statutory objectives are to secure support of the child and to protect the public from the burden of supporting a child who has a parent able to support him. Section 270d of the Penal Code provides that if a fine is imposed on a convicted defendant, the court shall direct its payment in whole or in part to the wife of the defendant or guardian of the child, except that if the child is receiving public assistance the fine imposed or funds collected from the defendant shall be paid to the county department³⁸

It seems important for the court here to stress that the defendant husband is not being punished for a crime. Instead, a social obligation is enforced upon him. Shame, stigma, bastardy and “stilled lips” no

³² *Id.* at 285.

³³ *Id.* at 286.

³⁴ *Id.* at 289 (“Nor are we persuaded that the concept of legitimacy demands that the child be the actual offspring of the husband of the mother and if semen of some other male is utilized the resulting child is illegitimate.”).

³⁵ *Id.* Notably, the problem that the New York Court in *Gursky* encountered when applying the adultery framework could not be solved here through the doctrines of implied contract and equitable estoppel. *Sorensen* was a criminal case, not a divorce action, and the husband had to be declared the legal father, convicted and punished for failing to support his child *or* acquitted as a legal stranger to the child. The court chose the former and no longer viewed itself as “constrained” like the *Gursky* court by the adultery framework.

³⁶ *Id.* at 288.

³⁷ *Id.* at 284-85.

³⁸ *Id.* at 287.

longer take center stage. There is now an inherent social obligation from the father toward the child, the mother and society at large which the statute seeks to “insure and facilitate . . . where necessary.”³⁹ Therefore, the fine paid by the convicted father is directed to the wife or the legal guardian.

The *Sorensen* understanding of donor insemination as a cure for infertility was adopted by later cases across the nation, and by the Uniform Parentage Act (UPA), as first promulgated in 1973, which provided that with the husband’s consent, donor insemination is legal, and that the donor shall not be perceived as the legal father.⁴⁰ In 1968, Georgia was the first state to legitimize donor insemination by a statute providing a conclusive presumption of legitimacy when a child is born through donor insemination performed with the written consent of both husband and wife, and permitting only licensed physicians to perform the procedure.⁴¹ In the following decade, many states followed with similar statutes.⁴²

The shift in the legal classification of sperm donations from adultery to a cure also involved a shift in authority. Physicians were granted the absolute authority to choose donor sperm, many times turning to doctors or medical students for sperm. Some were in fact alarmed that physicians were using medical technology to reproduce their own kind.⁴³ This “self breeding” raised the concern that physicians were engaged in euteleogenesis, an envisioned system of donor insemination that would use the sperm of genetically superior males, so that “the services of a prize male can be vastly multiplied and carried over wide areas.”⁴⁴

These social and legal debates about sperm donation at the time also involved broader concerns about social engineering and “improving” of the human species. The promise of eugenics appealed

³⁹ *Id.*

⁴⁰ UNIF. PARENTAGE ACT § 5 (repealed 2000); 9B U.L.A. 407 (2001).

⁴¹ GA. CODE ANN. § 19-7-21 (2008).

⁴² By the end of the 1970s at least fifteen states had statutes regulating donor insemination. All provided that the resulting child was the natural child of the recipient’s husband if the husband consented to the procedure. Five states required that the consent be filed with a state agency and six states, either directly or by implication, limited the practice of donor insemination to physicians. By 1981, this number had grown to twenty-three states, and by 1985 twenty-eight states had donor insemination statutes. Nine of the statutes were modeled after the UPA. See Bernstein, *supra* note 21, at 1090-91.

⁴³ See George J. Annas, *Artificial Insemination: Beyond the Best Interests of the Donor*, 9 HASTINGS CTR. REP. 14, 14 (1979) (“There can be little debate that physicians in all of these situations are making eugenic decisions—selecting what they consider “superior” genes for AID [donor insemination]. In general they have chosen to reproduce themselves (or those in their profession), and this is what sociobiologists would probably have predicted. While this should not be surprising, it should be a cause for concern.”).

⁴⁴ Note, *Eugenic Artificial Insemination: A Cure for Mediocrity?*, 94 HARV. L. REV. 1850, 1855 (1981) (citing A. SCHEINFELD, YOUR HEREDITY AND ENVIRONMENT 662 (1965)).

to some supporters of sperm donation. In medical and legal literature of the 1950s through the 1970s, donor insemination was explicitly celebrated as offering mankind a perfect eugenic opportunity.⁴⁵ Some believed that “the highly endowed have a genetic duty to bear large families in order to perpetuate a ‘better man.’”⁴⁶ The legitimization of artificial insemination was seen as a first and necessary step towards “controlled breeding.”⁴⁷ As noted by one legal commentator, “[m]edicine has included in its ground rules provisions capable of producing eugenically superior children in better homes more than is true in most instances where the child is biologically related to its mother’s spouse.”⁴⁸ Indeed, according to this legal commentator, scientists have so far been successful in this task, since there were no reported instances of “biologically inferior” children born via the technology.⁴⁹

This overall transition in legal, medical and societal values is summarized in the following chart.

⁴⁵ *Id.* at 1850 (1981) (claiming that in the United States as of 1980, “[e]ugenics is by no means dead”); George P. Smith, II, *Through a Test Tube Darkly: Artificial Insemination and the Law*, 67 MICH. L. REV. 127, 147 n.107 (1968) (defining eugenics as “a science that deals with the improvement of hereditary qualities in a series of generations of a race or a breed especially by social control of human mating and reproduction—race improvement”); James F. Crow, *Mechanisms and Trends in Human Evolution*, 90 DAEDALUS 416, 429 (1961); Roderic Gorney, *The New Biology and the Future of Man*, 15 UCLA L. REV. 273, 280 (1968); Hermann J. Muller, *Should We Weaken or Strengthen Our Genetic Heritage?*, 90 DAEDALUS 432, 439-42 (1961); William T. Vukowich, *Dawning of a Brave New World—Legal, Ethical, and Social Issues of Eugenics*, 1971 U. ILL. L. F. 189, 222-25.

⁴⁶ Smith, *supra* note 45, at 147 (citing Muller, *Human Evolution by Voluntary Choice of Germ Plasm*, 134 SCIENCE 643 (1961)).

⁴⁷ *Id.* at 149-50 (“Man is the last to breed selectively; rather than allow variant experimentation in this sensitive realm, he must devise appropriate procedures by which to isolate and perpetuate the most desirable human characteristics.”).

⁴⁸ Comment, *supra* note 17, at 466 & n.38 (“A variety of reports indicate the generally superior home conditions which medical screening provides children born via artificial insemination.”).

⁴⁹ *Id.* at 466 n.38.

MID-CENTURY DONOR INSEMINATION DEBATES

	<i>Attitude Toward Donor Insemination</i>	<i>Justifications</i>	<i>Consequent Status of Donor</i>	<i>Consequent Status of Sperm Donation</i>
<i>Before 1950s</i>	Rejection	Weakening of nuclear family; adulterous termination of paternal bloodline; incest	Parent	Adultery
<i>After 1950s</i>	Endorsement	Cure; child support; happy marriages; Eugenics	Legal Stranger	Cure for Infertility

3. The Development of a Sperm Market

The legal adoption of the cure paradigm has resulted in an open and free market for sperm. The four decades since the *Sorensen* decision have seen a rapid development of a market for sperm. Martha Ertman has observed that today the donor insemination market is a “literal market and a relatively free, open market,” in which “[b]anks and recipients demand sperm, and donors and banks supply it,” and that “lack of regulation and a relatively low price for the gametes mean that it is both an open market in which a large number of people can participate, and a free market that flourishes because of its comparative freedom from regulation.”⁵⁰

Indeed, commercial sperm banks have appeared in the fertility landscape since the 1970s, when the first for-profit bank opened its doors in Minnesota.⁵¹ By 1980, seventeen sperm banks across the nation were offering more than one hundred thousand sperm samples for sale.⁵² Those banks supplied sperm at roughly sixty-six dollars per

⁵⁰ Martha M. Ertman, *What's Wrong with a Parenthood Market? A New and Improved Theory of Commodification*, 82 N.C. L. REV. 1, 15-16 (2003) (questioning the assumption that privatization only benefits powerful players at the expense of everyone else, and proposing a new and improved theory of commodification that accounts for multiple valances of commodification in any particular context).

⁵¹ DEBORA L. SPAR, *THE BABY BUSINESS* 35 (2006).

⁵² *Id.* at 36 & n.10 (citing Anne Taylor Fleming, *New Frontiers in Conception*, N.Y. TIMES MAG., July 20, 1980, at 14).

specimen, resulting in the birth of twenty thousand babies.⁵³ Donors were typically young professionals chosen by the banks based on their physical and genetic characteristics. In 1980, the sperm bank “Repository for Germinal Choice” was set up to collect sperm from Nobel Prize winners and Olympic athletes.⁵⁴ By 1999, there were more than one hundred sperm banks in the United States,⁵⁵ and in 2000, the Wall Street Journal estimated the global market for sperm exports to be worth anywhere between fifty and one hundred million dollars per year.⁵⁶ Today, sperm customers in the United States want to know as much as possible about the donors,⁵⁷ and firms usually provide customers with information such as hobbies, family history, favorite foods, and handwriting samples.⁵⁸

In sum, in the transition of the legal status of donor insemination from adultery to legitimate cure, four significant things happened. First, the moral and legal condemnation of donor insemination was replaced by its legitimization as a “cure for infertility.” By the late 1960s, medical and social authorities offered an emergency supply of meaning that shaped a new legal understanding of donor insemination as legitimate curing treatment for infertility. In fact, the classification of sperm donation as a cure for infertility is apparent in medical literature to this day. A recent American Society for Reproductive Medicine (ASRM) publication indicates that “[c]urrently, therapeutic donor insemination . . . is appropriate when the male partner has severe abnormalities in the semen parameters.”⁵⁹ With the idea of a cure, donor insemination became legitimate and legal—it had legs. Second, social responsibility of fathers became a leading justification in the legalization of donor insemination. In *Sorensen*, the infertile man was not only understood to be cured by the sperm transaction, he was also held socially responsible for the child to whose birth he consented. In this new governance of the family, family law and criminal law jointly

⁵³ *Id.*

⁵⁴ See, e.g., *Eugenic Artificial Insemination: A Cure for Mediocrity?*, *supra* note 44, at 1850 (citing *A Bank for Nobel Sperm*, 207 SCIENCE 1326 (1980); *Breeding for IQ's—A Plan Under Fire*, U.S. NEWS & WORLD REP., Mar. 24, 1980, at 49; *Superkids? A Sperm Bank for Nobelists*, TIME, Mar. 10, 1980, at 49).

⁵⁵ SPAR, *supra* note 51, at 37-38 (noting that today the business of sperm banking, “tend[s] to be dominated by a small number of relatively large firms, each armed with a sizable donor base, highly specific technical expertise, and an inherent interest in expansion”).

⁵⁶ *Id.* at 38 (citing Pascal Zachary, *Family Planning: Welcome to the Global Sperm Trade*, WALL STREET J., Jan. 6, 2000, at B1).

⁵⁷ *Id.* at 37. In addition, federal regulation requires that all sperm must be kept in storage for a period of at least six months, during which the donor is tested for HIV, hepatitis and other sexually transmitted diseases. 21 C.F.R. § 1271.85 (2008).

⁵⁸ SPAR, *supra* note 51, at 39.

⁵⁹ AM. SOC'Y FOR REPROD. MED., THIRD PARTY REPRODUCTION: A GUIDE FOR PATIENTS 9 (2006), available at <http://www.asrm.org/Patients/patientbooklets/thirdparty.pdf> [hereinafter ASRM Guide for Patients].

“cure” the family from male infertility *and* from male irresponsibility. The law no longer stood to protect the husband from the “adulterous” act of donor insemination; instead the husband turned into a debtor of the child, the mother and the state.⁶⁰ Third, sperm was no longer understood as a necessary signifier of paternity. As the status of fatherhood was gradually becoming an issue of consent and social responsibility, the paternal body was detached from the material process of reproduction.⁶¹ Fourth—and this is where we stand today—a free market for sperm emerged.

B. *Second Phase: The Legalization of Egg Donation and Gestational Surrogacy*

The technology of IVF enabled the splitting of female contribution to the reproductive process into two parts: genetics and gestation. Unlike full surrogacy (discussed at length in Part II), over the past two decades egg donation and gestational surrogacy have generally been understood by medical experts and lawmakers as legitimate and desirable cures for female infertility.

⁶⁰ The decline in the legal status of the patriarch is discussed in Duncan Kennedy’s recent mapping of two overlapping periods of legal institutional and conceptual change in the West: *Classical Legal Thought* (CLT) between 1850 and 1914, and *Socially Oriented Legal Thought*, between 1900 and 1968. Duncan Kennedy, *Three Globalizations of Law and Legal Thought: 1850-2000*, in *THE NEW LAW AND ECONOMIC DEVELOPMENT: A CRITICAL APPRAISAL* 19 (David M. Trubek & Alvaro Santos eds., 2006). In the period of Classical Legal Thought, according to Kennedy, the issue of the “household” was conceived through the distinction, within private law, between the law of obligations and family law. In this “early modern” system of family law, “the patriarch was legally obliged to support his wife and minor children, entitled to their obedience, which he could enforce through moderate physical punishment, had arbitrary power with respect to many aspects of their welfare and property, and was protected against sexual and economic interference by third parties.” *Id.* at 32. In what Kennedy calls the “second globalization of legal thought” (1900-1968), individualism and will theory came under critique, giving rise to the idea of “the social.” The family became an institution *whose function is crucial for the social as a whole*. *Id.* at 51. No longer a private matter under the control of the patriarch, “[e]very aspect of family life had, given social interdependence, far-reaching consequences for all other social functions.” *Id.*

⁶¹ The Supreme Court’s unwed father jurisprudence in the second half of the century also echoes this transition in the status of the father. *See, e.g.*, *Michael H. v. Gerald D.*, 491 U.S. 110 (1989) (holding constitutional a statute preventing a biological father or child from challenging presumptive fatherhood of mother’s husband); *Lehr v. Robertson*, 463 U.S. 248 (1983) (holding that despite his having neither notice nor hearing, an unwed biological father’s rights to object to termination of his parental rights through adoption of his child by the mother’s new husband had been sufficiently protected by New York law).

1. Egg Markets

The first “test tube” baby was born in 1978 in England. By the spring of 1983, about one hundred and fifty babies had been conceived *in vitro*, but success rates for IVF were still slim.⁶² Between the years 1995 and 1998, there was a thirty-seven percent increase in the number of *in vitro* procedures performed in the U.S., from about 59,000 to about 81,000. The number of fertility clinics also grew from 281 to 360.⁶³

IVF enabled the retrieval of eggs from donors and implantation in intended mothers who could gestate a pregnancy but who could not produce viable eggs. In medical expert literature and patient guidelines, egg donation has been understood as a legitimate curing treatment for infertility. For example, in August of 2000, the ethics committee of the ASRM published its ethical approval of financial incentives for egg donations, stressing that egg donations will “in turn, allow[] more infertile persons to have children.”⁶⁴ Egg donation, according to ASRM, is desirable and should be compensable because it cures female infertility and allows women who otherwise could not bear children to do so.

The legal status of egg donation has generally been equated to that of sperm donation. Some states have enacted egg donation statutes to reflect this analogy. In Kentucky, for example, egg donation is named as an exception to the statutory prohibition of full surrogacy arrangements.⁶⁵ Likewise, a Colorado statute provides that “if, under the supervision of a licensed physician and with the consent of her husband, a wife consents to assisted reproduction with an egg donated by another woman, to conceive a child for herself, not as a surrogate, the wife is treated in law as if she were the natural mother of a child thereby conceived.”⁶⁶ In the past decade, Virginia, Texas, Florida, and Oklahoma have enacted statutes similarly clarifying that egg donation is a legitimate infertility treatment, and that an egg donor is *not* the parent

⁶² SPAR, *supra* note 51, at 28.

⁶³ *Id.* at 29.

⁶⁴ Ethics Comm., Am. Soc’y for Reprod. Med., *Financial Incentives in Recruitment of Oocyte Donors*, 74 FERTILITY & STERILITY 216, 218 (2000) (“First, providing financial incentives increases the number of oocyte donors, which in turn allows more infertile persons to have children. Second, the provision of financial or in-kind benefits does not necessarily discourage altruistic motivations Third, financial incentives may be defended on grounds that they advance the ethical goal of fairness to donors. From this perspective, women who agree to provide oocytes to others ought to be given the opportunity to benefit from their action.”).

⁶⁵ KY. REV. STAT. ANN. § 199.590(2) (2008) (“This section shall not be construed to prohibit *in vitro* fertilization. For purposes of this section, ‘*in vitro* fertilization’ means the process by which an egg is removed from a woman, and fertilized in a receptacle by the sperm of the husband of the woman in whose womb the fertilized egg will thereafter be implanted.”).

⁶⁶ COLO. REV. STAT. § 19-4-106(1) (2008).

of a child conceived through assisted conception.⁶⁷

A similar approach to egg donation has been expressed by courts in parental disputes where, upon separation, fathers sought declarations of sole paternity and full custody alleging that their wife, inseminated through the process of egg donation, had no genetic relationship to the child. Despite the lack of a genetic connection to the child in these cases, courts have recognized the status of the gestational parent as the natural and legal mother. In *McDonald v. McDonald*, for example, a New York appellate court used the cure logic, stressing that “[b]ecause the wife was unable to conceive naturally, she conceived through a process known as ‘in vitro’ fertilization.”⁶⁸ The court characterized the case as a “true ‘egg donation’” situation, in which “the wife, who is the gestational mother, is the natural mother of the children.”⁶⁹ The Supreme Court of Tennessee faced a similar dispute regarding triplets born of egg donation to an unmarried couple.⁷⁰ Echoing the cure logic, the court held that the birth-giver was the legal mother, because “[t]he egg donor is a surrogate insofar as she provides eggs in place of and on behalf of another woman who cannot produce viable eggs.”⁷¹ The egg donor, in other words, cures the woman who cannot produce viable eggs.⁷²

2. Gestational Surrogacy Markets

Gestational surrogacy is also regulated in a growing number of jurisdictions as a recognized and legitimate form of curing female

⁶⁷ VA. CODE ANN. § 20-158(3) (“A donor is not the parent of a child conceived through assisted conception, unless the donor is the husband of the gestational mother.”); *id.* § 20-156 (“Donor means an individual, other than a surrogate, who contributes the sperm or egg used in assisted conception.”); TEX. FAM. CODE ANN. § 160.702 (2008) (“A donor is not a parent of a child conceived by means of assisted reproduction.”); *id.* §160.102 (“‘Donor’ means an individual who provides eggs or sperm to a licensed physician to be used for assisted reproduction, regardless of whether the eggs or sperm are provided for consideration.”); FLA. STAT. § 742.14 (West 2008) (“The donor of any egg, sperm, or preembryo, other than the commissioning couple . . . shall relinquish all maternal or paternal rights and obligations with respect to the donation or the resulting children. Only reasonable compensation directly related to the donation of eggs, sperm, and preembryos shall be permitted.”); OKLA. STAT. ANN. tit. 10 § 554 (West 2008) (“Any child or children born as a result of a heterologous oocyte donation shall be considered for all legal intents and purposes, the same as a naturally conceived legitimate child of the husband and wife which consent to and receive an oocyte pursuant to the use of the technique of heterologous oocyte donation.”).

⁶⁸ 196 A.D.2d 7, 9 (N.Y. App. Div. 1994).

⁶⁹ *Id.* at 12.

⁷⁰ *In re CKG*, 173 S.W.3d 714 (Tenn. 2005).

⁷¹ *Id.* at 720.

⁷² *But see* *K.M. v. E.G.*, 117 P.3d 673, 37 Cal. 4th 130 (2005) (holding that an egg donor who donated an egg to her same sex partner is the genetic mother of the child who thus has two legal mothers because this was not a “true” egg donation situation).

infertility. The (1) medical necessity and (2) genetic contribution of the intended mother have repeatedly been underscored in the ongoing process of state-by-state validation of gestational surrogacy agreements. Accordingly, a distinction has emerged between “gestational carrier” and “surrogate mother.” The term “gestational carrier” has been designated for a woman who carries the genetic child of “another,” while the term “surrogate” or “surrogate mother” has been designated for a woman who carries a child of “her own” with the intention of giving “her” child up to another via adoption.

In *Johnson v. Calvert*, the Supreme Court of California set up the prevalent evaluation of gestational surrogacy agreements in its reading of the facts of the case:

Mark and Crispina Calvert are a married couple who desired to have a child. Crispina was *forced to undergo a hysterectomy* in 1984. Her ovaries remained capable of producing eggs, however, and the couple eventually considered surrogacy. In 1989 Anna Johnson heard about Crispina’s *plight* from a coworker and offered to serve as a surrogate for the Calverts.⁷³

This is the story of a married couple who (1) desires to have children; (2) is unable to procreate “naturally” due to a medical problem; and (3) is cured by medical science with the service of a “gestational carrier.” Based on this narrative of cure, the court held that the infertile intended mother who provided the eggs is the legal mother of this child.⁷⁴ The court clarified that the gestational surrogacy agreement does not constitute a pre-birth waiver of the surrogate’s parental rights because gestational surrogacy is not subject to the adoption statutes. Accordingly, “payments to [the surrogate] under the contract were meant to compensate her for her services in gestating the fetus and undergoing the labor, rather than for giving up ‘parental’ rights to the child.”⁷⁵

In the ongoing process of legal recognition of gestational surrogacy agreements that has followed *Calvert*, state courts, legislatures and medical experts have emphasized the medical necessity of the intended mother and the genetic contribution of one or both intended parents. For example, in *J.R. v. Utah*, a case involving the status of a gestational

⁷³ *Johnson v. Calvert*, 5 Cal. 4th 84, 87 (1993) (emphasis added).

⁷⁴ *Id.* at 93 (“[A]lthough [the UPA] recognizes both genetic consanguinity and giving birth as means of establishing a mother and child relationship, when the two means do not coincide in one woman, she who intended to procreate the child—that is, she who intended to bring about the birth of a child that she intended to raise as her own—is the natural mother under California law.”).

⁷⁵ *Id.* at 96, 100 (rejecting the gestational surrogate’s claim that her relationship with the child is constitutionally protected, and holding that “a woman who enters into a gestational surrogacy arrangement is not exercising her own right to make procreative choices; she is agreeing to provide a necessary and profoundly important service without (by definition) any expectation that she will raise the resulting child as her own”).

surrogacy agreement, a Utah court invalidated a broad statutory prohibition on all kinds of surrogacy. Like in *Calvert*, the court sympathized with a couple who was “unable for medical reasons to have children on their own,”⁷⁶ and held that the statute unduly burdened their fundamental liberty interest in conceiving and raising children without unwarranted government interference.⁷⁷ Likewise, the New Jersey Superior Court characterized a gestational surrogacy arrangement as one that “permits a woman who is *incapable of carrying a baby to term* to have a child who is genetically related to her,” and that “gives the wife of an infertile couple the opportunity to be biologically related to the baby and ensures that the woman who gives birth is not genetically linked to the child.”⁷⁸ A California appellate court also affirmed that gestational surrogacy is distinguishable from full surrogacy because the full surrogate is “without doubt, the ‘natural’ parent of the child, as is the father.”⁷⁹ Similarly, the Supreme Court of Massachusetts ruled that adoption laws do not apply in cases of gestational surrogacy because the gestational surrogate is a carrier and *not* a mother.⁸⁰

Medical necessity and genetic contribution of the intended mother is also determinative in infertility medical literature. The ASRM has recently defined gestational surrogacy as a “treatment option available to women with certain clearly defined medical problems, usually an absent uterus, to help them have their own genetic children.”⁸¹ The initial indication (qualification) for gestational surrogacy is when a woman “has normally functioning ovaries but . . . lacks a uterus.”⁸² The lack of uterus is understood as “cured” by the IVF treatment through the

⁷⁶ J.R. v. Utah, 261 F. Supp. 2d 1268, 1270 (D. Utah 2002) (emphasis added).

⁷⁷ *Id.* at 1296.

⁷⁸ A.H.W. v. G.H.B., 772 A.2d 948, 949-50, 339 N.J. Super. 495, 497-498 (2000) (emphasis added) (issuing an order permitting petitioner biological parents’ names to be placed on the birth certificate during the two day window between expiration of the statutory waiting period and the deadline for filing the certificate); *see also* P.G.M. v. J.M.A., No. A07-452, 2007 Minn. App. LEXIS 1189, at *18 (Minn. Ct. App. Dec. 11, 2007) (holding that gestational surrogacy agreements “do not violate any articulated public policy of this state”).

⁷⁹ *In re Marriage of Moschetta*, 25 Cal. App. 4th 1218, 1222 (1994).

⁸⁰ *Culliton v. Beth Israel*, 756 N.E.2d 1133, 1137-38, 435 Mass. 285, 290-91 (2001) (entering a judgment declaring the intended genetic parents to be the child’s parents, and ordering the hospital to identify them as the legal parents on the birth certificate); *see also* *Arredondo v. Nodelman*, 622 N.Y.S.2d 181 (Sup. Ct. 1994) (granting an uncontested post-birth petition of genetic parents of children born pursuant to gestational carrier arrangement, declaring genetic mother the legal mother of donor insemination children, and ordering issuance of new birth records so to reflect).

⁸¹ Peter Brindsen, *Gestational Surrogacy*, 9 HUMAN REPRODUCTION UPDATE 483, 483 (2003) (emphasis added).

⁸² ASRM Guide for Patients, *supra* note 59, at 13; *see also* Brindsen, *supra* note 81, at 489 (“The indications for treatment by gestational surrogacy are limited to a small number of women, most of whom have no uterus, suffer from recurrent abortion, or who have certain medical conditions, which would threaten their lives if they were to become pregnant.”).

use of the “gestational carrier.” The “gestational carrier” has no genetic link to the fetus, and this makes the arrangement, according to the ASRM, less controversial than full surrogacy “both legally and psychologically.”⁸³

Medical necessity and genetic contribution as prerequisites for a valid and enforceable gestational surrogacy agreement have also appeared in recent gestational surrogacy statutes enacted in Illinois, Florida and Texas. In the Illinois Gestational Surrogacy Act (2005), the intended parents satisfy the requirements of the Act if, in addition to receiving proper legal consultation, they meet all the following requirements at the time that the agreement was executed:

- (1) he, she, or they contribute at least one of the gametes resulting in a pre-embryo that the gestational surrogate will attempt to carry to term;
- (2) *he, she, or they have a medical need for the gestational surrogacy* as evidenced by a qualified physician’s affidavit attached to the gestational surrogacy contract and as required by the Illinois Parentage Act of 1984; [and]
- (3) he, she, or they have completed a mental health evaluation⁸⁴

The legislation explicitly leaves intact the unenforceable legal status of full surrogacy agreements by clarifying that “except as provided in this Act, the woman who gives birth to a child is presumed to be the mother of that child for purposes of State law.”⁸⁵

Similar conditions are found in the Florida Gestational Surrogacy Statute which requires that:

[T]he commissioning couple shall enter into a contract with a gestational surrogate only when, within reasonable medical certainty as determined by a [licensed] physician[.] . . . (a) the commissioning mother cannot physically gestate a pregnancy to term; (b) the gestation will cause a risk to the physical health of the commissioning mother; or (c) the gestation will cause a risk to the health of the fetus.⁸⁶

The statute also requires that the gestational surrogate become pregnant “without the use of an egg from her body,”⁸⁷ and that the child be conceived “by means of assisted reproductive technology using the eggs or sperm of at least one of the intended parents.”⁸⁸

The Texas statutory scheme, enacted in 2003, also instructs the court to validate gestational surrogacy agreements *only* if it finds that

⁸³ ASRM Guide for Patients, *supra* note 59, at 3 (“The gestational surrogate has no genetic link to the fetus she is carrying. Traditional surrogacy arrangements often are perceived as controversial with the potential to be complicated both legally and psychologically.”).

⁸⁴ Gestational Surrogacy Act, 750 ILL. COMP. STAT. 47/20 (2008) (emphasis added).

⁸⁵ *Id.* at 47/15.

⁸⁶ Gestational Surrogacy Contract, FLA. STAT. § 742.15 (2008) (emphasis added).

⁸⁷ *Id.* § 742.13(5).

⁸⁸ *Id.* § 742.13(2) (emphasis added).

“the medical evidence provided shows that *the intended mother is unable to carry a pregnancy to term* and give birth to the child or is unable to carry the pregnancy to term and give birth to a child without unreasonable risk to her physical or mental health or to the health of the unborn child.”⁸⁹ The statute also requires that “[t]he gestational mother’s eggs may not be used in the assisted reproduction procedure,”⁹⁰ and that the eggs must instead be retrieved from an intended parent or a donor.⁹¹ The intended parents must also be married to each other.⁹²

In comparison, the statutes in North Dakota and Nevada have focused more on genetic contribution of the intended parents and less on “curing” infertility. These legislatures as well have made clear that the legal status of full surrogacy remains unchanged. For example, the North Dakota statute, enacted in 2005, requires the genetic contribution of both intended parents.⁹³ The statute distinguishes gestational surrogacy from full surrogacy by defining a (full) “surrogate” as one who agrees to “bear a child conceived through assisted conception for intended parents,”⁹⁴ and a “gestational carrier” as one who agrees to “have an embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.”⁹⁵ The statute clarifies that whereas “a child born to a gestational carrier is a child of the intended parents for all purposes and is not the child of the gestational carrier,”⁹⁶ “any agreement in which a woman agrees to become a [full] surrogate . . . is void.”⁹⁷ Similarly, the Nevada surrogacy statute allows (only) married couples to enter an agreement for a “pregnancy resulting when an egg and sperm from the intended parents are placed in a surrogate through the intervention of medical technology.”⁹⁸

IVF baby-making markets for egg donation and gestational surrogacy have followed. It is now commonly accepted that gestational surrogates are and should be compensated. As of 2004, gestational surrogate compensation was between \$30,000 and \$120,000.⁹⁹ The U.S. commercial market for eggs is well developed. By 1997, seventy-

⁸⁹ TEX. FAM. CODE ANN. § 160.756(b)(2) (2008) (emphasis added).

⁹⁰ *Id.* at §160.754(c).

⁹¹ *Id.*

⁹² *Id.* at §160.754(b).

⁹³ N.D. CENT. CODE § 14-18-01 (2008).

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.* § 14-18-08.

⁹⁷ *Id.* § 14-18-05.

⁹⁸ NEV. REV. STAT. ANN. § 126.045 (2008) (the statute also provides that “[i]t is unlawful to pay or offer to pay money or anything of value to a surrogate except for the medical and necessary living expenses related to the birth of the child as specified in the contract”).

⁹⁹ *Id.* at 92.

eight percent of the 335 assisted reproduction programs reporting to the ASRM stated that they offered egg donation services for compensation.¹⁰⁰ By 1999, some IVF programs offered as much as \$5,000 per retrieval,¹⁰¹ and by 2004, most large fertility centers offered their own “in-house” egg programs with a catalog of potential donors and prices that typically range between \$3,000 and \$8,000.¹⁰² Centers recruit donors and provide their potential clients physical and social descriptions of the egg providers.¹⁰³ Because commercial selling of eggs remains illegal in most other industrialized countries, U.S. firms have risen to the top of the global egg trade.¹⁰⁴

In sum, the medical and legal understanding of sperm donation, egg donation and gestational surrogacy as cures for infertility can be seen as the birth-moments of those three baby-making markets. In contrast, the next Part will argue that full surrogacy has not been endorsed by medical and legal authorities as cure for female infertility, and has therefore not developed into a baby-making market.

II. THE BABY-SELLING PARADIGM

*While we recognize the depth of the yearning of infertile couples to have their own children, we find the payment of money to a “surrogate” mother illegal, perhaps criminal, and potentially degrading to women.*¹⁰⁵

Unlike gestational surrogacy, full surrogacy has rarely been understood as a cure for medical infertility. It has been classified as baby-selling. This Part discusses the critical influence of feminist-ethical positions on the exclusion of full surrogacy from baby-making markets.

¹⁰⁰ *Id.* at 216.

¹⁰¹ *Id.* Much higher sums, \$50,000 or more, have been offered in print and internet ads placed by individuals and couple seeking eggs from women with specific physical characteristics and intellectual abilities. *Id.*

¹⁰² *Id.* at 45.

¹⁰³ *Id.* (“At the center for egg donation, for example, clients from around the world searched an online database of donors, complete with name, SAT scores and glossy photos of both the donor and her own family . . . although the center’s Beverly Hills location led to an apparent cluster of blond and blue eyed eggs, it also offered harder to find types, including Jewish, red-headed, and South Asian prospects.”).

¹⁰⁴ *Id.* at 46 (“At the center for egg donations, 30 percent of the business in 2003 came from abroad, and the number was steadily rising.”).

¹⁰⁵ *In re Baby M*, 109 N.J. 396, 411 (1988).

A. *The Solidification of the Baby-Selling Paradigm in the Case of Baby M*

By the late 1970s, the implications of the legalization of donor insemination for full surrogacy were profound. While in the past the main way for surrogates to be impregnated was by sexual intercourse with the prospective father, now sex was removed. This made full surrogacy more attractive than in the past, enhancing both the demand for and the supply of surrogate mothers.¹⁰⁶ In 1976, Noel Keane, an attorney from Michigan was one of the first to recognize the potential of this market.¹⁰⁷ Keane, professed to have been moved by religion and compassion, sided with “the people who want to create life.”¹⁰⁸ He placed an ad in a local college paper seeking the services of a surrogate. By the early 1980s, Keane was described as “the undisputed father of surrogate motherhood.”¹⁰⁹ Due to strict Michigan laws, Keane eventually turned to Florida, a state with fewer restrictions on surrogacy at the time.¹¹⁰ Small competitors appeared in California and Kentucky,¹¹¹ and a market for full surrogacy was on the way.

Prior to the case of *Baby M* (1988), lawmakers were ambivalent about how to regulate agreements for full surrogacy.¹¹² Some legislatures, such as New York, considered the legalization of full surrogacy.¹¹³ Some courts equated sperm donation with full surrogacy, stressing that both sperm and full surrogacy are designed to cure infertility. These cases sometimes used the logic and language of the cure for infertility paradigm to explain full surrogacy. For example, one New York court reasoned that “the problem . . . caused by the wife’s infertility . . . is solved by artificial insemination [and] is not biologically different from the reverse situation where the husband is infertile and the wife conceives by artificial insemination.”¹¹⁴

¹⁰⁶ See, e.g., SPAR, *supra* note 51, at 74; Sanger, *supra* note 3, at 81-88.

¹⁰⁷ For further discussion of Keane and the role of intermediaries in the market for full surrogacy see *id.*

¹⁰⁸ *Id.* at 83 (citing NOEL P. KEANE & DENNIN L. BREO, *THE SURROGATE MOTHER* 256 (1981)).

¹⁰⁹ *Id.* at 83 (citing James S. Kunen, *Childless Couples Seeking Surrogate Mothers Call Michigan Lawyer Noel Keane—He Delivers*, *TIME*, Mar 30, 1987, at 93).

¹¹⁰ SPAR, *supra* note 51, at 76.

¹¹¹ *Id.* at 76-77.

¹¹² For further discussion see Elizabeth S. Scott, *Surrogacy and the Politics of Commodification*, *LAW & CONTEMP. PROBS.* (forthcoming), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1282330#.

¹¹³ See James Feron, *Testimony Is Given on Surrogates Bill*, *N.Y. TIMES*, April 12, 1987, at 39 (describing testimony by infertile parents and surrogates favoring new bill introduced in 1986).

¹¹⁴ See, e.g., *In re Adoption of Baby Girl L.J.*, 505 N.Y.S.2d 813, 817 (Sur. Ct. 1986) (holding that a full surrogacy agreement is not void but voidable); see also *Surrogate Parenting Assocs., Inc. v. Commonwealth*, 704 S.W.2d 209, 212 (Ky. 1986) (equating sperm donations to full

While in the early years of full surrogacy courts and legislatures still had no clear uniform position about the legal status of full surrogacy, commodification concerns appeared in social-legal debate on full surrogacy. In July of 1984, a committee appointed by the British government published a report regarding the legal, social and ethical implications of new developments in infertility treatments.¹¹⁵ The sixteen member committee was headed by Mary Warnock, a moral philosopher, and was composed of theologians, philosophers, philanthropists, scientists, lawyers, social workers and doctors. The committee condemned the practice of full surrogacy for profit, recommending that such agreements should be made unenforceable and that agencies that arrange such agreements should be made criminally liable because “even in compelling medical circumstances, the danger of exploitation of one human being for another” outweighs the interests and potential benefits of the parties.¹¹⁶

Many medical experts were also disturbed by full surrogacy. In contrast with sperm donation for male infertility, fertility experts found (full) surrogacy to be ethically problematic.¹¹⁷ From a technological standpoint, the identical technology used in donor insemination was not endorsed by fertility experts for the use of full surrogacy.¹¹⁸ The American Medical Association concluded in 1983 that surrogacy does not represent a satisfactory alternative for prospective parents,¹¹⁹ and in

surrogacy, and holding that full surrogacy agreements do not fall within statutory prohibitions against baby-selling and holding that surrogate parenting organization’s activities were not within the statutory prohibition against purchasing a child for the purpose of adoption). Notably while these decisions rejected the baby-selling paradigm (criminal law), they nonetheless insisted that the surrogate is the legal mother (family law) and thus left the surrogate the option to perform or renege as the agreements are voidable (contract law). For further discussion of choice of law in the case of Baby M see Carol Sanger, *(Baby) M is For Many Things: Why I Start with Baby M*, 44 ST. LOUIS U. L.J. 1443, 1448-1450 (2000).

¹¹⁵ See, e.g., Jacqueline Priest, *The Report of the Warnock Committee on Human Fertilisation and Embryology*, 48 MOD. L. REV. 73 (1985); Sylvia A. Law, *Embryos and Ethics: Report of the Committee of Inquiry into Human Fertilisation and Embryology*, 17 FAM. PLANNING PERSPECTIVES 140-44 (1985) (critiquing the Warnock committee for neglecting difficult and moral questions, such as whether work as a surrogate is inherently more exploitative than scrubbing floors or working with toxic chemicals, and whether criminalization of surrogacy is any more likely than the protective labor laws of the 1930’s to provide real protection).

¹¹⁶ Report of the Committee of Inquiry into Human Fertilisation and Embryology, HER MAJESTY’S STATIONARY OFFICE, at 46 (London 1984) (emphasis added). However, the committee approved the practice of egg donation through in vitro fertilization (IVF) carried out under the supervision of licensed medical practitioners. The committee equated this with the legitimate practice of fertilization by sperm donation performed by a licensed physician.

¹¹⁷ Notably, some medical practitioners and experts did support the practice of surrogacy, advancing cure rhetoric similar to that of the donor insemination context.

¹¹⁸ Bernstein, *supra* note 21, at 1117-18 (“The application of AI [artificial insemination] technology to surrogacy, has, thus at large, not significantly benefited from previous acceptance of the technology and was not assisted, as was the case with AID [artificial insemination by donor], from mobilization by the medical profession.”).

¹¹⁹ *Id.* at 1115-16 (citation omitted).

1986 the Ethics Committee of the American Fertility Association recommended greater scrutiny of full surrogacy.¹²⁰ The view that the practice of full surrogacy is not a cure for infertility was made explicit by fertility experts who emphasized that surrogacy is “neither curative nor palliative” and does not restore function”¹²¹

The case of *Baby M* solidified the legal classification of full surrogacy as commodification and baby-selling. As Elizabeth Scott has recently argued, “*Baby M*, the dramatic and emotional legal battle between a housewife who had dropped out of high-school and a couple with graduate degrees and professional careers who sought to have a child with her assistance, focused national attention on the issue and framed the practice as commodification.”¹²² In *Baby M*, the New Jersey Supreme Court held that a paid full surrogacy agreement is “illegal, perhaps criminal, and potentially degrading to women.”¹²³ The court clarified that a full surrogate is the “natural” and legal mother of the child,¹²⁴ and that under the terms of such agreements, she is “forever separated from her child.”¹²⁵ The intended mother was granted no parental rights or duties,¹²⁶ and the full surrogacy agreement was held to violate baby-selling and adoption statutes as well as the public policy of New Jersey.¹²⁷

A legal trend toward restrictions on full surrogacy agreements followed. Most legislatures at the time were unaware of the newly developed IVF technology, and thus framed their statutory limitations primarily as a response to full surrogacy agreements (such as the one in *Baby M*). As a result some statutes ended up with narrow statutes that restrict full surrogacy specifically (leaving gestational surrogacy unregulated),¹²⁸ whereas others (probably unintentionally) adopted

¹²⁰ *Id.* at 1115 (citation omitted).

¹²¹ *Id.* at 1116 (citation omitted).

¹²² Elizabeth S. Scott, *Surrogacy and the Politics of Commodification*, LAW & CONTEMP. PROBS. (forthcoming), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1282330# (arguing that the political and legal responses to the case of *Baby M* were a combination of moral panic and interest group politics; and that opinion leaders, primarily religious groups and feminists, reinforced the moral panic and formed an effective coalition that persisted for several years).

¹²³ *In re Baby M*, 109 N.J. 396, 411 (1988).

¹²⁴ *Id.* at 411 (“The contract providing for this is called a ‘surrogacy contract,’ the natural mother inappropriately called the ‘surrogate mother.’”).

¹²⁵ *Id.* at 410 (emphasis added).

¹²⁶ *Id.* at 413 (“Her anxiety appears to have exceeded the actual risk, which current medical authorities assess as minimal.”).

¹²⁷ *Id.* at 411. In 1981, ruling on one of the first constitutional challenges to governmental limitations on surrogacy arrangements, a Michigan appellate court upheld surrogacy restrictions, because “[i]n effect, the plaintiffs’ contractual agreement discloses a desire to use the adoption code to change the legal status of the child [and] [w]e do not perceive this goal as within the realm of fundamental interests protected by the right to privacy from reasonable governmental regulation.” *Doe v. Kelley*, 106 Mich. App. 169, 174 (1981).

¹²⁸ NEB. REV. STAT. § 25-21,200 (2008) (only full surrogacy agreements void and

broader restrictive language that theoretically could be applicable to gestational surrogacy agreements as well.¹²⁹

Since *Baby M*, courts in states with no surrogacy statutes have viewed full surrogacy agreements as unenforceable (void or voidable) and conflicting with adoption or baby-selling laws.¹³⁰ Most courts have viewed a commitment to be a full surrogate as substantially different from a commitment to provide sperm because a surrogate supplies a “life in being,” whereas a sperm donor provides “merely a gamete.”¹³¹

unenforceable); LA. REV. STAT. ANN. § 9:2713 (2008) (only full surrogacy agreements null, void and unenforceable); KY. REV. STAT. ANN. § 199.590 (2008) (full surrogacy contract void if compensation is involved). *But see* Surrogate Parenting Assocs., Inc. v. Commonwealth, 704 S.W.2d 209 (Ky. 1986) (surrogate parenting contracts are voidable, rather than illegal and void).

¹²⁹ WASH. REV. CODE ANN. § 26.26.240 (2008) (gross misdemeanor if compensation is involved); VA. CODE ANN. §§ 20-156 to 165 (2008) (any agreement for payment of compensation is void and unenforceable, but married couple with infertile wife can effectively contract for both types of surrogacy if no payment is involved); MICH. COMP. LAWS § 722.855 (2008) (both types of agreements are void, and are unenforceable as against public policy if involving compensation); N.H. REV. STAT. ANN. §§ 168-B:1 to 32 (2008) (limiting fees to pregnancy related expenses, lost wages, insurance, attorney’s fees and court costs, and setting infertility of intended mother as a condition for enforceable agreement); N.Y. DOM. REL. LAW §§ 121-123 (2008) (both types of agreement violate public policy, and are void and unenforceable regardless of compensation); IND. CODE ANN. §§ 31-20-1-1 to -3 (2008) (agreement void as against public policy regardless of compensation); ARIZ. REV. STAT. ANN. § 25-218 (2008) (both types of surrogacy contracts prohibited regardless of compensation). *But see* Soos v. Superior Court, 182 Ariz. 470 (Ct. App. 1994) (fundamental liberty interest affected and equal protection violated by statute); D.C. CODE ANN. §§ 16-401(4) to 402 (2008) (both types of surrogacy are prohibited and unenforceable regardless of compensation, with a civil penalty of up to \$10,000 or imprisonment up to a year or both).

¹³⁰ *See, e.g.*, R.R. v. M.H., 426 Mass. 501, 509 (1998) (holding full surrogacy agreement unenforceable because no private agreement regarding custody or adoption can be conclusive until a judge ruling on custody decides based on the best interest of the child); Decker v. Decker, No. 5-01-23, 2001 WL 1167475 (Ohio Ct. App. Sept. 28, 2001) (holding that the fact that birth mother may have signed a unilateral statement relinquishing custody does not constitute a contract); *In re* Marriage of Moschetta, 25 Cal. App. 4th 1218, 1231 (Ct. App. 1994) (declining to enforce a full surrogacy contract because “to do so would mean we would have to ignore both the analysis used by our Supreme Court in *Johnson v. Calvert*, and the adoption statute that requires a formal consent to a child’s adoption by his or her birth mother). *But cf.* *In re* Adoption of Baby A, 128 Or. App. 450 (Ct. App. 1994) (where evidence showed that birth-mother would have entered contract without compensation, and did not seek to withdraw her consent to adoption, trial court refusal to grant adoption was reversed despite the fact that surrogate was compensated in violation of statute).

¹³¹ *In re* Adoption of Paul, 550 N.Y.S.2d 815, 818 (Sup. Ct. 1990) (holding that a full surrogacy contract was void because under the clear language of the statutes governing adoption and the policy of the state, it provided for “the sale of the child, or, at the very least, the sale of a mother’s right to her child”); *see also* *In re* Baby M, 109 N.J. 396, 449-450 (1998) (holding that a sperm donor cannot be equated with a surrogate mother, even if the only difference was the amount of time necessary to provide sperm for artificial insemination and that necessary for a nine month pregnancy); R.R., 426 Mass. at 509 (full surrogacy “presents different considerations from surrogate fatherhood because surrogate motherhood is never anonymous and her commitment and contribution is unavoidably greater than that of a sperm donor”).

B. *The Role of Feminist Ethics in the Shaping of the Baby-Selling Paradigm*

An ethical feminist resistance to full surrogacy has played an important role in the shaping of the baby-selling paradigm. By the 1980s full surrogacy was viewed by many feminists as “the most controversial of the alternative reproductive technologies.”¹³² The feminist concern with full surrogacy focused on two realms of exploitation and commodification. First, as the practice of surrogacy was gaining public attention, some feminists expressed the concern that surrogacy may perpetuate male dominance over and objectification of women.¹³³ This exploitation, located on class and gender lines, may cause, as Margaret Jane Radin has emphasized, “even further oppression of poor or ignorant women, which must be weighed against a possible step toward their liberation through economic gain”¹³⁴ An individual woman’s choice to enter a surrogacy agreement was characterized as “an ironic self deception,” because “[s]urrogates may feel they are fulfilling their womanhood by producing babies for someone else, although they may actually be reinforcing oppressive gender roles.”¹³⁵ Second, the practice of full surrogacy embodied for some feminists the danger of a “capitalist baby industry,” which, “with all of its accompanying paraphernalia,” would lead to a society in which none of us, “even those who did not produce infants for sale, [can] avoid subconsciously measuring the dollar value of our children” and in which “our children [cannot] avoid being preoccupied with . . . their own dollar value.”¹³⁶

We can now see that in the regulation of full surrogacy lawmakers have taken up ethical feminist positions on commodification of women and babies. By the late 1980s, ethical feminist views were powerful in the governance of reproduction, emerging from *within* ethics

¹³² See, e.g., Patricia Donovan, *New Reproductive Technologies: Some Legal Dilemmas*, 18 FAM. PLANNING PERSPECTIVES 57, 59 (1986); Patricia A. Avery, *Surrogate Mothers: Center of a New Storm*, U.S. NEWS WORLD REP., June 6, 1983, at 76; Otto Freidrich, *A Legal, Moral, Social Nightmare*, TIME, Sept. 10, 1984, at 54; Jay Matthews, *Surrogate Motherhood Becoming an American Growth Industry*, WASH. POST, Jan. 24, 1983, at A2.

¹³³ See, e.g., G. COREA, THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL WOMBS 272-324 (1985); Norma Juliet Wikler, *Society’s Response to the New Reproductive Technologies: The Feminist Perspectives*, 59 S. CAL. L. REV. 1043, 1046-47 (1986).

¹³⁴ Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1936 (1987) (“Market-inalienability is an important normative category for our society. Economic analysis and traditional liberal pluralism have failed to recognize and correctly understand its significance because of the market orientation of their premises.”).

¹³⁵ *Id.* at 1930.

¹³⁶ *Id.* at 1926.

committees, legal briefs, court decisions, fertility expert opinions, and the media.¹³⁷ And although this ethical based resistance to full surrogacy has been frequently challenged,¹³⁸ its overall effectiveness in the shaping of surrogacy laws is an important manifestation of what Janet Halley has called “governance feminism”—that is, “the incremental but by now quite noticeable installation of feminists and feminist ideas in actual legal-institutional power.”¹³⁹

In sum, since the case of *Baby M*, full surrogacy has been understood by lawmakers as *replacement* of the intended mother *rather than a cure* for infertility, and therefore as baby-selling. Full surrogacy has become a de facto exception to the cure paradigm. At the same time, as shown in Part I, sperm donation, egg donation and gestational surrogacy have all been understood as cures for infertility and did not meet the same legal, medical, and feminist resistance.

The next Part will examine some problematic effects that the cure paradigm has had on baby-making markets.

III. TWO CRITIQUES OF THE CURE PARADIGM

In this Part, I critique the cure paradigm drawing on two separate

¹³⁷ It is important to clarify here that this feminist regulatory power is not necessarily (though sometimes is) voiced by what one may identify as a feminist speaker.

¹³⁸ For critique of moral objection to surrogacy from a feminist perspective see Marjorie Maguire Schultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 WIS. L. REV. 297, 323 (1990) (arguing that the principle of private intention must be given substantial deference and legal force, and that determining legal parenthood on the basis on intentional agreements has the potential to create more gender neutral avenues to parenthood). For a critique of moral objection to surrogacy from economic perspective see RICHARD A. POSNER, *THE PROBLEMATICS OF MORAL AND LEGAL THEORY* 247 (1999) (arguing that “given the benefits of the contracts to the signatories, the pragmatist judge would probably enforce such contracts regardless of what moral philosophers have to say about the issue”); Richard A. Epstein, *Surrogacy: The Case for Full Contractual Enforcement*, 81 VA. L. REV. 2305, 2330-34 (1995) (concluding that the analogy to baby-selling “only strengthens the conclusion that surrogacy transactions should be legal”); Elisabeth M. Landes & Richard A. Posner, *The Economics of the Baby Shortage*, 7 J. LEGAL STUD. 323 (1978) (urging the enforcement of baby-selling agreements); Richard A. Posner, *The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood*, 5 J. CONTEMP. HEALTH L. & POL’Y 21 (1989) (arguing in favor of surrogacy contract enforcement). For critique of moral objection to surrogacy from rights perspective see JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 99 (1994); John Robertson, *Assisted Reproductive Technology and the Family*, 47 HASTINGS L.J. 911, 932 (1996) (concluding that “although ART’s are unlikely to affect or change prevailing notions of family, they can nevertheless be seen as part of a larger set of developments affecting the autonomy of individuals to shape families and childrearing units to their needs”).

¹³⁹ Janet Halley et al., *From the International to the Local in Feminist Legal Responses to Rape, Prostitution/Sex Work, and Sex Trafficking: Four Studies in Contemporary Governance Feminism*, 29 HARV. J.L. & GENDER 335, 340 (2006) (noting that “[governance feminism] takes many forms, and some parts of feminism participate more effectively than others; some are not players at all”).

theoretical perspectives. First, from a feminist-queer perspective, I argue that the cure paradigm reflects and naturalizes certain assumptions about sex, gender and reproduction. Second, from an economic perspective, I argue that the cure paradigm has produced baby-making markets that are accessible only to higher income individuals and couples.

A. *The Gendered Cure Paradigm*

The focus on curing medical infertility has masked other societal values and assumptions. Specifically, cultural beliefs regarding (1) paternal and maternal roles in reproduction; and (2) the significance of biological sex in reproduction, have influenced the shaping of legal attitudes toward reproductive technologies.

1. Paternal and Maternal Gender Roles

Two cultural beliefs have so far been overlooked in the analysis of baby-making markets. First, a gendered assumption about men played an important role in the legalization of donor insemination. As discussed in Part I, around the mid-twentieth century lawmakers gradually became concerned with paternal obligations of child support. This is reflected in the *Gursky* and *Sorensen* decisions.¹⁴⁰ In the late 1960s, a growing judicial anxiety about paternal financial responsibility was an important consideration in the transition of lawmakers' attitudes toward donor insemination. Thus the *Gursky* court used the doctrines of implied contract and equitable estoppel to hold the husband liable for support.¹⁴¹ And the *Sorensen* court dismissed the adultery framework altogether, holding that a husband is the lawful father of a child born to his wife through the use of donor insemination, and that "his conduct carries with it an obligation of support within the meaning of section 270 of the Penal Code."¹⁴² So in the overall transition of legal and social attitudes toward approval of donor insemination, the "objective" paradigm of cure was *not* doing all the work—there was also the cultural conviction that male adults should be socially accountable for children for whose birth they were responsible. In that sense, the visible work of the cure paradigm was accompanied by the disguised work of other values that are not scientific or medical.

Second, a gendered assumption about women may also explain the

¹⁴⁰ See *supra* notes 8–28 and accompanying text.

¹⁴¹ See *supra* notes 22–26 and accompanying text.

¹⁴² *People v. Sorensen*, 68 Cal. 2d 280, 283–84 (1968).

distinction between full surrogacy and the IVF procedures of egg donation and gestational surrogacy. The assumption is that unlike men, women should physically participate in the process of reproduction. In the second phase of the cure paradigm (the legalization of egg donation and gestational surrogacy), regulatory trends have encouraged (and sometimes required) intended mothers to provide their own uterus or eggs. A woman who either hires a gestational surrogate *or* purchases an egg from another is seen in a growing number of jurisdictions as acting to cure her own infertility. She is a legal mother.

The notion that mothers should physically participate in the reproductive process may explain the current paradoxical distinction between full and gestational surrogacy traced in Parts I and II. Whereas in gestational surrogacy the intended mother usually provides her own eggs, and thus *participates in the physical process of reproduction*, in full surrogacy the intended mother provides neither eggs nor gestation, and the full surrogate provides *both*. And whereas arguably the rationale of the distinction is that full surrogacy is more exploitative than gestational surrogacy, this does not seem accurate today. Gestational “carriers” are indeed mostly lower income black women, and “[g]estational surrogacy invites the singling out of black women for exploitation not only because a disproportionate number of black women are poor and might possibly turn to leasing their wombs as a means of income, but also because it is incorrectly assumed that black women’s skin color can be read as a visual sign of their lack of genetic relation to the children they would bear for the white couples who seek to hire them.”¹⁴³

And because gestational surrogacy can be as exploitative as full surrogacy, it seems that among other factors, the conscious or unconscious preference that women physically participate in reproduction may have had an influence on the overall favoring of gestational surrogacy over full surrogacy by medical and legal authorities. When such participation is evident (by providing egg or gestation), the cure paradigm has emerged to legitimize the curing technology, but where such participation is not evident (such as in full surrogacy), the cure paradigm has not appeared. This demonstrates that the cure paradigm is not purely objective, and that the current preference of gestational surrogacy over full surrogacy is yet another instance in which scientific and medical truths incorporate less visible cultural norms.

Interestingly, this cultural premise that women should physically bear children and men should support them can be traced to the biblical account of the mythic expulsion of the first two humans from the

¹⁴³ Deborah R. Grayson, *Mediating Intimacy: Black Surrogate Mothers and the Law*, 24 CRITICAL INQUIRY 525, 540 (1998).

Garden of Eden. After condemning the serpent and its seed to eternal conflict with the woman and her seed, God says to the woman, “I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children.”¹⁴⁴ And to Adam, God says, “[I]n the sweat of thy face shalt thou eat bread.”¹⁴⁵ The woman now receives the name Eve (*Chava*), because she is the “mother of all living” [*chai*].¹⁴⁶ Eve is named in the biblical text only *after* she is condemned to sorrowful child bearing.

So while curing medical infertility has been the manifested goal of baby-making markets, cultural assumptions about men as breadwinners and women as the primary physical participants in “bringing forth children” have been pending in the background of twentieth century baby-making markets. Today the sperm of a man can be replaced by another’s, so long as the intended father provides financially for the child; whereas the law does not recognize the full replacement of a woman’s reproductive role by another.

2. Transgender Fathers

Another often overlooked cultural assumption disguised by the cure paradigm is that fathers are always male-born and mothers are always female-born. This bias is found in cases involving the parental status of female to male (FTM) transgender men whose female spouse was impregnated through donor insemination. The cure logic, as we saw in *Sorensen*, was historically set up to “cure” infertile male-born *husbands* in the context of marriage.¹⁴⁷ It was later extended to male co-habitants and to same sex partners, who have been obliged to pay child support¹⁴⁸ and have been granted parental rights.¹⁴⁹ Recently,

¹⁴⁴ *Genesis* 3:16 (King James).

¹⁴⁵ *Genesis* 3:19 (King James).

¹⁴⁶ *Genesis* 3:20 (King James).

¹⁴⁷ Today some states still specifically ban the use of artificial insemination by all but married couples. *See, e.g.*, OKLA. STAT. tit. 10, § 553 (1998). Other states adopted the 1973 UPA without later revision, thus limiting statutory coverage to married couples while not specifically prohibiting donor insemination to others. *See, e.g.*, ALA. CODE § 26-17-21 (1992); MINN. STAT. § 257.56 (2000); MO. REV. STAT. § 210.824 (2000); MONT. CODE ANN. § 40-6-106(2) (2001); NEV. REV. STAT. § 126.061(2) (1989); VA. CODE ANN. § 20-158(3) (West 2000); *Id.* § 32.1-257(D). Some states have enacted provisions that refer only to married couples. ALA. CODE § 26-17-21 (1992); ALASKA STAT. § 25.20.045 (2000); FLA. STAT. § 742.11(1) (2001); GA. CODE ANN. § 19-7-21 (1999); MD. CODE ANN., EST. & TRUSTS § 1-206 (LexisNexis 2001); MASS. GEN. LAWS ANN. ch. 46, § 4B (West 2005); MICH. COMP. LAWS ANN. § 333.2824(6) (West 1997); MINN. STAT. § 257.56; MO. REV. STAT. § 210.824; MONT. CODE ANN. § 40-6-106 (2001); N.Y. DOM. REL. LAW § 73 (McKinney 1999); N.C. GEN. STAT. § 49A-1 (1999); N.D. CENT. CODE § 14-18-03 (1997); OKLA. STAT. tit. 10, § 551-553 (1998); TENN. CODE ANN. § 68-3-306 (1996).

¹⁴⁸ *See, e.g., In re Parentage of A.B.*, 837 N.E.2d 965 (Ind. 2005) (reversing the trial court’s

some courts have taken the additional step of applying a gender neutral interpretation of donor insemination statutes to oblige a same-sex partner to pay child support,¹⁵⁰ and to recognize legal parenthood of same-sex partners.¹⁵¹

In the few cases addressing a sperm donation where the sperm “lacking” party was a transgender FTM man, courts have recognized paternity only as a punitive matter, but not as a matter of parental rights (to custody or visitation). While a FTM transgender man has been obliged to pay child support for a child conceived through donor insemination,¹⁵² similarly situated others were denied parental rights.¹⁵³

dismissal of the partner’s complaint and remanding the case to the trial court for further proceedings to determine the children’s best interest in these circumstances); *Chambers v. Chambers*, No. CN99-09493, 2005 Del. Fam. Ct. LEXIS 1 (Del. Fam. Ct. Jan. 12, 2005) (construing statutory law in light of children’s best interests, and clarifying that Delaware recognized de facto parenthood for certain purposes where a five-factor test was satisfied); *L.S.K. v. H.A.N.*, 813 A.2d 872 (Penn. Sup. Ct. 2002) (holding that in the absence of legislative action, court was obliged to apply equitable rules in the children’s best interest and since the partner had claimed the rights of a parent, she was equitably estopped from denying responsibilities of support incurred under 23 PA. CONS. STAT. § 4321).

¹⁴⁹ See, e.g., *In re Parentage of L.B.*, 155 Wash. 2d 679 (2005) (although former partner was not a biological or adoptive parent, she had standing under Washington law to petition the courts for a determination of co-parentage with regard to the child, based on common law theories of parenthood, but the former partner did not have standing to assert rights to visitation with the child because she is not a parent under the statute); *In re Custody of H.S.H.-K.*, 193 Wis. 2d 649, 659-63 (1995) (under Wisconsin law, the biological mother’s former female partner lacked standing to petition for custody or visitation, but the legislature did not intend to preempt the equitable power of the court so as to preclude a remedy outside of the statutory scheme); *E.N.O. v. L.L.M.*, 429 Mass. 824, 828-30 (1999) (equity jurisdiction governed resolution of the issue despite lack of statutory authority, and the best interests of the child require that the child’s de-facto parent be allowed visitation with the child); *Clifford K. v. Paul S.*, 217 W. Va. 625 (2005) (same sex parent had standing to pursue custody of the child under the “unusual or extraordinary” case section of W. VA. CODE § 48-9-103(b), because the parent raised the child from birth and had a strong maternal bond with him).

¹⁵⁰ *Elisa B. v. Superior Court*, 37 Cal. 4th 108 (2005) (applying a gender neutral reading of California statutory law to conclude that a child can have “two parents both of whom are women,” and that the former same-sex partner who agreed to raise children with the birth-mother, supported the birth-mother’s artificial insemination using an anonymous sperm donor, received the children into her home and held them out as her own, was a parent and had an obligation to support the children).

¹⁵¹ *In re Parentage of Robinson*, 383 N.J. Super 165 (2005) (granting a same sex couple’s request to declare the non-biologically related partner the second parent of a child conceived through artificial insemination, and concluding that it could not discern any state interest that would preclude the partner from the protection of the statute); *Charisma R. v. Kristina S.*, 140 Cal. App. 4th 301 (2006) (reversing a trial court finding that former same-sex partner lacked standing to bring action under the UPA); *Kristine H. v. Lisa R.*, 37 Cal. 4th 156 (2005) (ruling that a biological mother is estopped from challenging the validity of a stipulated judgment recognizing her same sex partner’s parenthood because under the California family Code a child can have two mothers and permitting a mother to attack the judgment’s validity would have been unfair to the child and the second mother).

¹⁵² *In re Karin T.*, 484 N.Y.S.2d 780 (Fam. Ct. 1985) (obliging transgender father to support children born of donor insemination during his marriage).

¹⁵³ *In re Marriage of Simmons*, 355 Ill. App. 3d 942 (2005) (ruling that because same-sex marriages are invalid under 750 ILL. COMP. STAT. ANN. 5/201 (2002), and the impediment of

Courts have narrowly interpreted statutes and contracts to apply to male-born husbands and co-habitants but not to female born transgender fathers. For example, in *Marriage of Simmons*, where a transgender man married a woman, and a child was conceived through donor insemination,¹⁵⁴ an Illinois appellate court denied all of the father's claims for legal rights with the child because "[a]ll the physicians testified that there were other surgeries which had to be done on petitioner before he could be considered completely sexually reassigned."¹⁵⁵ The transgender man was not yet fully "cured" from his Gender Identity Disorder (GID).¹⁵⁶ The court also dismissed the plaintiff's contract based argument, holding that the agreement that he had signed as a "husband" was invalid.¹⁵⁷

The legal exclusions of FTM fathers from donor insemination statutes and agreements illustrate that the seemingly objective cure paradigm is not value neutral. It has incorporated the cultural norm that only male-born individuals are potential fathers to children born of donor insemination. Other men have to provide medical-scientific

being female was never removed, the father could not claim status as a husband, and that this inability to prove status as either a "man" or a "husband" likewise deprived him of standing under either the Illinois Parentage Act, 750 ILL. COMP. STAT. ANN. 40/1 to 40/3 (2002), or the Parentage Act of 1984, 750 ILL. COMP. STAT. ANN. 45/1 to 45/28 (2002)).

¹⁵⁴ *Id.* (plaintiff was diagnosed as a transsexual man in his late teens and began taking testosterone when he was 21 years old).

¹⁵⁵ *Id.* at 948 (female to male transition surgeries include "vaginectomy, reduction mammoplasty, metoidioplasty, scrotoplasty, urethroplasty, and phalloplasty" and because he "still possesses all of his female genitalia," plaintiff is legally female). Notably, the court applied here a very narrow definition of sex, ignoring other sex determining factors such as chosen sex, hormonal sex, overall outer appearance, internal organs, etc.

¹⁵⁶ The diagnostic criteria for Gender Identity Disorder (GID), according to TASK FORCE ON DSM-IV, AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 537-38 (4th ed. 1994) is as following:

- A. A strong and persistent cross gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- C. The disturbance is not concurrent with a physical intersex condition.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

For further analysis of the problematic role of Gender Identity Disorder in the regulation of transgender and Intersex individuals see Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51 (2006); Noa Ben-Asher, *Paradoxes of Health and Equality: When a Boy Becomes a Girl*, 16 YALE J.L. & FEMINISM 275 (2004).

¹⁵⁷ The child's claim as a third-party beneficiary to the contract was also rejected by the court, based on the invalidity of the contract. *In re Marriage of Simmons*, 355 Ill. App. 3d 942, 955 (2005). In addition, petitioner's reliance on the Illinois Parentage Act which creates a presumption of parenthood under which a child born from donor insemination to two married parents retains his right with both even if the marriage is subsequently held invalid also failed. *Id.* at 952 ("That section, which confers a presumption of a 'man' to be the natural father of a child even after a marriage has been declared invalid, is based on the premise that the parties who are involved are a man and a woman. As we have previously determined, petitioner is not a man within the meaning of the statute, and that, therefore, the statute does not apply.").

proof that their transition from female to male has satisfied medical guidelines, and that they properly fit within the medically framed male/female, father/mother binaries.

B. *The Inaccessibility of Baby-Making Markets*

We should also consider how legal rules regarding reproductive technologies affect the bargaining process that occurs outside the courtroom.¹⁵⁸ The cure paradigm as applied by courts and by legislators has created markets in which, due to steep prices, lower income individuals and couples are often unable to participate.

1. The Absent Market for Full Surrogacy

The legal classification of full surrogacy as baby-selling and maternal replacement has had crippling effects on the formation of a market for full surrogacy.¹⁵⁹ And while the market for full surrogacy has effectively diminished, egg donations and gestational surrogacy, which have been legalized as legitimate curing treatments for infertility, are very costly.¹⁶⁰ The average cost for a cycle of IVF in the US was \$12,400 in 2003.¹⁶¹ Eggs cost more than sperm (\$4,500 versus \$300 on average), and as mentioned above, gestational surrogates are compensated between \$30,000 and \$120,000.¹⁶² Consequently, many potential buyers in the baby-making markets cannot afford to enter those markets. The demand is here, and the supply is as well, but “the price of this supply is still too high for many potential buyers, leaving supply and demand to meet at a point well below their full potential.”¹⁶³ The price constraint can theoretically be solved by folding fertility treatment into the national healthcare system,¹⁶⁴ or by mandating

¹⁵⁸ Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 997 (1979) (“The preferences of the parties, the entitlements created by law, transaction costs, attitudes toward risk, and strategic behavior substantially affect the negotiated outcomes.”).

¹⁵⁹ SPAR, *supra* note 51, at 78 (The full surrogacy market in the 1980s remained relatively small, with only about thirty commercial surrogacy agencies by 1988, making about one hundred matches a year.).

¹⁶⁰ Beyond the high cost of eggs, there may be medical risks to egg donors that have recently begun to emerge. For example, a link has been suggested between breast cancer and an elevated level of hormones induced in an in vitro cycle.

¹⁶¹ *Id.* at 29.

¹⁶² *Id.* at 92. According to the ASRM, however, the average is around \$20,000. Press Release, Am. Soc’y Reprod. Med., Highlights from the 62nd Annual Meeting (Oct. 24, 2006).

¹⁶³ SPAR, *supra* note 51, at 30.

¹⁶⁴ Such is the case in Denmark and Israel. *Id.*

insurance coverage.¹⁶⁵ But diverting the costs of infertility treatments to the state or insurance policies will not tackle the actual source of this market failure, which is that the expensive IVF technologies of egg donation and gestational surrogacy have been legalized and commodified whereas the much cheaper technology of full surrogacy has not.

2. The Impact on Lower Income Households

Thus a direct consequence of the cure paradigm is that the price of participation in baby-making markets is excessively high. Gestational Surrogacy involves the costly high-tech IVF technology, while full surrogacy is a low-tech (or no-tech) arrangement. Since the early 1990s, couples and individuals have been advised to pursue gestational surrogacy in order to avoid the legal complexities of full surrogacy.¹⁶⁶ Current medical guidelines and fertility expert literature direct couples and individuals to the legally safe procedures of gestational surrogacy and egg donation.¹⁶⁷ Those medical procedures involving IVF (egg donations and gestational surrogacy) are significantly more expensive than the fairly simple procedure of sperm fertilization involved in full surrogacy. As noted in *Marriage of Moschetta* by the California Court of Appeals:

Infertile couples who can afford the high-tech solution of in vitro fertilization and embryo implantation in another woman's womb can be reasonably assured of being judged as the legal parents of the child, even if the surrogate reneges on her agreement. Couples who cannot afford in-vitro fertilization and embryo implantation, or who resort to traditional surrogacy because the female does not have eggs suitable for in vitro fertilization, have no assurance their intentions will be honored in a court of law.¹⁶⁸

¹⁶⁵ As in the case of fourteen U.S. states. *See id.*

¹⁶⁶ Focusing on the role of the "middle man" in bargains for surrogacy, Carol Sanger has recently observed that as a consequence of the negative treatment of monetary compensation in cases of full surrogacy, brokers (middle men) had to go elsewhere in order to profit from such bargains, and that is what they did. Brokers transitioned to jurisdictions that permitted surrogacy, or to those in legal limbo. Thus, "couples can now choose from an array of surrogacy options. They can stay close to home if the local market satisfies, or they can forum shop in the global market of reproductive tourism." Sanger, *supra* note 3, at 95-96.

¹⁶⁷ ASRM Guide for Patients, *supra* note 59, at 3 ("Third Party Reproduction' also includes traditional surrogacy and gestational carrier arrangements The gestational surrogate has no genetic link to the fetus she is carrying. Traditional surrogacy arrangements often are perceived as controversial with the potential to be complicated both legally and psychologically. Despite the requirement for *in vitro fertilization* (IVF) to create embryos, the utilization of a gestational surrogate, legally, is a lower risk procedure and is the more common approach conducted in the United States.").

¹⁶⁸ *In re Marriage of Moschetta*, 25 Cal. App. 4th 1218, 1235 (1994).

The *Moschetta* court criticized the impact of the full-gestational surrogacy on “[heterosexual] couples who cannot afford in-vitro fertilization and embryo implantation, or who resort to traditional surrogacy because the female does not have eggs suitable for in vitro fertilization.”¹⁶⁹ These couples bargain in the shadow of the cure paradigm for reproductive technologies with no legal certainty. “For them and the child,” says the court, “biology is destiny.”¹⁷⁰

3. The Impact on Potential Gay Fathers

Current baby-making market conditions have also had a direct impact on the bargaining conditions for men looking to create motherless families. Review of current legal disputes reveals that the cure logic and its manifestation, the gestational/full surrogacy distinction, create complicated and costly bargaining conditions for males seeking to create motherless families. The current legal situation of single and gay men seeking to create families through the baby-making markets exemplifies how complicated bargaining in the shadow of the cure paradigm has become.

The complexity of these bargains involves two interrelated price increasing parameters: (1) the legalized separation of maternal labor into gestation and genetics through the legalization of IVF and (2) forum shopping. First, given the status of full surrogacy, men cannot hire full surrogates to bear their children. As shown above, the current state of the law, based on the cure paradigm, requires the separate and much more costly purchase of eggs and gestation from two different sources so that no potential woman will have a legal claim over the child. Second, the costs of these transactions increase dramatically because they often involve forum shopping for jurisdictions with clear statutory guidelines on egg donations and gestational surrogacy. As Carol Sanger has observed, “couples can now choose from an array of surrogacy options. They can stay close to home if the local market satisfies, or they can forum shop in the global market of reproductive tourism.”¹⁷¹

An example of such forum shopping took place in *P.G.M. v. J.M.A.*, where the Minnesota Supreme Court enforced a gestational agreement in a paternity dispute between a gay male from New York and a gestational surrogate from Minnesota. The child was conceived using the plaintiff’s sperm and a donor egg, and the parties agreed to be

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ Sanger, *supra* note 3, at 96.

governed by Illinois law.¹⁷² Ruling in favor of the intended father, the Supreme Court of Minnesota affirmed that the agreement was correctly enforced by the lower court because gestational surrogacy agreements “do not violate any articulated public policy of this state,”¹⁷³ and because under Illinois law, “there is clear-and-convincing evidence rebutting the presumption that [the gestational surrogate] is the child’s mother.”¹⁷⁴ Similarly, in *J.F. v. D.B.*, a man entered separate transactions with women from two different states for eggs and gestation. In a paternity dispute between the gestational surrogate and the intended father, the Supreme Court of Ohio held that “no public policy is violated when a gestational-surrogacy contract is entered into, even when one of the provisions requires the gestational surrogate not to assert parental rights regarding children she bears that are of another woman’s artificially inseminated egg.”¹⁷⁵ Likewise, in *Roberto*, the Court of Appeals of Maryland granted a joint petition of an intended genetic father and a gestational carrier asking to issue birth certificates that did not list the gestational carrier as mother of the born twins.¹⁷⁶

Although in all three cases contracts were enforced in favor of males seeking to create motherless families, the dissenting opinions in two of these cases reveal judicial anxiety about the formation of motherless families through the use of reproductive technologies. In *J.F. v. D.B.*, the dissent stressed that an agreement where a gay man pays for gestational surrogacy and egg donations violates the public policy of Ohio because “it would be necessary to legally declare that the children do not have a mother. Such a position is untenable.”¹⁷⁷ This contract, according to the dissent, “is no less than a contract for the creation of a child [and] this court should not be the unwitting instrument to opening the door of this state to such unregulated commercial enterprise.”¹⁷⁸ Likewise, the dissent in *Roberto* characterized the decision not to list the gestational carrier as a mother on the child’s birth-certificate as “in essence, stating that it is good public policy for the people of this State to permit the manufacturing of children who have no mothers—even at the moment of birth.” Thus,

¹⁷² P.G.M. v. J.M.A., No. A07-452, 2007 Minn. App. LEXIS 1189, at *18 (Minn. Ct. App. Dec. 11, 2007).

¹⁷³ *Id.* at *18.

¹⁷⁴ *Id.* at *21.

¹⁷⁵ *J.F. v. D.B.*, 116 Ohio St. 3d 363, 364 (2007).

¹⁷⁶ *In re Roberto*, 399 Md. 267, 292-93 (Ct. App. 2007) (“[The gestational surrogate] desires to relinquish parental rights, not assert them. There simply is no contest over parental rights. There is no issue of unfitness on the part of the father Accordingly the implication by the trial court that the BIC [Best Interest of the Child] standard should be used in the case sub judice is inappropriate. . . .”).

¹⁷⁷ *J.F.*, 116 Ohio St. 3d at 367.

¹⁷⁸ *Id.* at 368.

“there is to be no mother—just a Petri dish.”¹⁷⁹

In sum, far from serving as a friendly facilitator for the “formation of families on the basis of intent and function rather than biology and heterosexuality,”¹⁸⁰ current baby-making markets, shaped by the cure paradigm, have caused single men and same-sex male couples to enter costly and complex agreements in order to create families of choice.

C. *Some Normative Implications*

While a full articulation of an alternative paradigm is beyond the scope of this Article, lawmakers can begin to resist the cure paradigm by doing away with the full/gestational surrogacy distinction. The full/gestational surrogacy distinction should be eliminated for two reasons: (1) it is based on contested values, and (2) it has created serious market failures.

First, one of the driving forces behind the full/gestational surrogacy distinction is the idea that gestational surrogacy is a form of medical cure whereas full surrogacy is “baby-selling.” But the Article has argued that this legal classification of gestational surrogacy as medical cure is based on two related problematic assumptions. The first assumption, discussed in Part I.B., is about ownership of genetic material. Lawmakers typically view gestational surrogacy as an arrangement where a couple gives *their* child to a surrogate for gestation, whereas lawmakers view full surrogacy as an agreement where a surrogate gives *her* child to the couple. Accordingly, the former is seen as curing treatment and the latter as baby-selling. But medical cure of infertility should not depend on genetic ownership. If the logic of property law is running the full/gestational surrogacy distinction, lawmakers should be clear about it. Language and logic of a cure for infertility should not disguise premises about ownership of genetic material.

The second assumption underlying the gestational/full surrogacy distinction, discussed in Part III.A., is that women should *physically* participate in the process of reproduction. A snapshot of baby-making markets today reveals that lawmakers view women as “cured” from infertility when they enter arrangements in which they provide either their eggs or their uterus in the child bearing process. In that sense, the paradigm of cure is gendered and should be contested, and the gestational/full surrogacy distinction that depends on it can no longer stand.

¹⁷⁹ *In re Roberto*, 399 Md. at 301.

¹⁸⁰ Ertman, *supra* note 50, at 4.

The cure paradigm has also created serious market failures. As I argued in Part III.B., in the absence of the option to turn to full surrogacy, lower-income individuals and couples are de facto excluded from participation in baby-making markets, and gay males are likewise routed to the costly IVF procedures and costly forum shopping. A shift of paradigm should involve the legal recognition of full surrogacy. Opening up the market for full surrogacy seems promising for both ends of the baby-making markets. For parties wishing to create families, it would make baby-making markets accessible to more participants by dramatically reducing the costs of surrogacy. Full surrogacy is a low-cost, low-tech procedure that involves the simple injection of sperm into the uterus of the potential surrogate, while IVF is fancy, costly, and medically intrusive. The legal recognition of full surrogacy would enable single males and gay and heterosexual couples to contract with one surrogate (rather than an egg donor and a gestational surrogate) in their home jurisdiction, thus reducing the costs of creating families of choice. For potential surrogates, the legitimization of full surrogacy should result in higher compensation because the high costs of IVF will become optional rather than mandatory, and medical experts and technologies as costly intermediaries would potentially be removed from baby-making agreements, resulting in increased gains for the surrogate herself.

CONCLUSION

To believe in progress is not to believe that progress has already taken place. That would be no belief. —Walter Benjamin¹⁸¹

A medicalized notion of cure for infertility has been an important factor in the selective legal recognition of reproductive technologies. Reproductive technologies that lawmakers and medical experts have classified as medical cures for infertility have been recognized by lawmakers and commodified, while others have not. This selective legal validation is an instance of a troubling broader phenomenon in which lawmakers, medical experts, psychiatrists, social workers, and others collaborate to diagnose, cure, and manage populations. When law takes the form of a “curing law,” individuals are not merely oppressed by it, but they also (and perhaps more importantly,) come to understand themselves in light of its medicalized categories. The

¹⁸¹ Walter Benjamin, *Franz Kafka: On the Tenth Anniversary of His Death*, in *ILLUMINATIONS: ESSAYS AND REFLECTION* 111, 130 (Hannah Arendt ed., Harry Zohn trans., Schocken Books 1968).

“curing law” informs self-understanding and intelligibility. Thus it is not surprising that women and men who cannot “naturally” have children often view themselves as needing a medical cure.

Furthermore, because curing infertility is generally understood as a positive social goal, the underlying assumptions of this goal are often overlooked. There is a bind here. While lawmakers are truly concerned with the health and welfare of the population, they often end up reinforcing moral and cultural norms. Thus it is often difficult to criticize liberty restricting norms when those are backed up by medical-science and its ever growing body of experts. But we must. Moving conceptually away from “curing laws” toward notions of “liberating laws” may provide individuals with a broader range of views on “natural” and “assisted” reproduction and on what “health” can mean.

Access to reproductive technologies has so far depended on legal and medical understandings of cure for infertility. It should not be. To believe in the progress of reproductive technologies is not to believe that it has already taken place.