

Alternative Birth Technologies: Legal Challenges*

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This lecture examines the legal issues in human reproduction. Had it been delivered as recently as fifty years ago, it would have been quite brief. Basically, there was only one method in use—the method the average layperson would, I suppose, be inclined to term the “natural” one, namely intercourse. Of course, its use was supposedly regulated by the state in a crude way through the criminal prohibitions on adultery and fornication. This regulation aimed at the act itself, on the ground of morality, rather than the product, though here, too, the law was prepared to step in with the label “bastard” and the not inconsiderable legal baggage it carried until recent years. Since medical personnel were not involved in the creation of their patients’ offspring—beyond simple, home remedies for infertility—the notion of regulating the field for reasons of safety or professional standards did not exist. The only other important state involvement was the role played by the courts and state agencies in arranging and formalizing adoptions.

In less than half a century, that simple picture has changed rather dramatically—and, of course, the most dramatic changes are those that are occurring right now. For example, so-called “surrogate motherhood”¹ may have a Biblical precedent,² but only in the past few years has it been openly practiced by any appreciable number of people. Moreover, despite the attention now being paid to surrogate motherhood in the *Baby M* case in New Jersey,³ other alternatives to traditional human reproduction that have been around for many years, such

* This Article is adapted from the Bodenheimer Lecture delivered at the King Hall School of Law, University of California, at Davis, on Feb. 19, 1987.

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¹ The term “surrogate mother” is inaccurate because in ordinary parlance a woman who raises another woman’s offspring would be called their surrogate mother, but the term has come into general usage to designate a woman who gives up the child she has borne to be raised by another woman and her husband, the child’s biological father.

² *Genesis* 16:19 (King James).

³ See *infra* text accompanying notes 61-73.

as artificial insemination by donor (AID), affect a much larger number of people. Still others, though not yet in widespread use, come closer to being alternative “technologies” for reproduction. Their adoption has created complications beyond imagination only a few years ago. The development of this field has been so rapid that a leading textbook on gynecology and obstetrics published in 1981 contains, for example, only one paragraph on *in vitro* fertilization in its 1300 pages!⁴

I. REPRODUCTIVE TECHNOLOGIES

In order to suggest some of the problems with which the law must cope in the field of alternative birth technologies, let us consider some of the more likely “reproductive possibilities.” I will then analyze the goals and values involved, and finally turn to the subject of recent headlines — namely, surrogate motherhood — as a test case for society’s legal response.

When we think about reproductive possibilities, what are the variables we ought to consider? First, who will be the source of the gametes — that is, the “genetic” aspect of parenthood? (In the table, I use X for female participants and Y for male.) Next, how and where does “fertilization” take place? Is it by the natural method of human intercourse, or by artificial insemination (AI)? After fertilization, does the embryo stay in the uterus, or is it flushed out? Or perhaps, are egg and sperm united in the laboratory, through *in vitro* fertilization (IVF)?

Next, we must ask, where will gestation occur? The question “where?” thus far signifies only “in what woman?,” though perhaps someday an extracorporeal gestator—that is, an artificial placenta or neonatal intensive care unit for fourteen-day old embryos—may give the question “where?” new implications. Finally, who will raise the product of reproduction—that is, who will be its “social” or rearing parents?

To orient ourselves, let us see how old-fashioned reproduction between a husband and wife would look in these categories. In this first possibility, we see lots of “M”s, the symbol that indicates a member of a married couple. The table shows the wife’s egg and husband’s sperm uniting in her fallopian tubes following intercourse, with the fetus then coming to term in her uterus, and finally the couple rearing the resulting child.

⁴ See S. ROMNEY, M. GRAY, A. LITTLE, J. MERRILL, E. QUILLIGAN & R. STANDER, *GYNECOLOGY AND OBSTETRICS: THE HEALTH CARE OF WOMAN* (2d ed. 1981).

Moving down the table, technology begins to enter the picture. For many years, people in the animal husbandry field have been using a technique called artificial insemination (AI) as part of programs for selective breeding. Although the first use of the technique with human patients was in the 19th century, it has only come into wide use in the past several decades.⁵ Let us first consider its usage with the gametes of a married couple. In this circumstance, all the factors remain the same as in Method No. 1, except that AI permits overcoming a male fertility problem (by concentrating the sperm before insertion), or a female fertility problem (when the cervix or tubes pose a barrier to normal insemination). The technique is also used when a husband anticipates damage to his testicles (as, for example, because of workplace hazards) and freezes semen deposits in a "sperm bank." Artificial insemination by husband (AIH) need not involve anyone other than the couple—since insemination is a simple technique that in many cases can be accomplished with a turkey baster or a drinking straw. But when it is performed for the sorts of indications I have mentioned, it will typically involve a physician and other medical personnel. The presence of physicians and medical personnel does not appear on the table, but their involvement is felt and will bear attention.

What if the primary infertility problem is female rather than male—for instance, a blocked fallopian tube—which prevents the egg from descending from the ovaries to become fertilized? In the late 1960's, researchers—led by Patrick Steptoe and R.G. Edwards of Cambridge University—began experiments with laboratory fertilization of eggs removed from the ovaries of women with fertility problems.⁶ Their efforts resulted in the birth in 1978 of the first "test tube baby," as Louise Brown was dubbed.⁷ Here again, from genetic, gestational, and social viewpoints, reproduction aided by a Petri dish looks just like conventional reproduction. Several thousand babies have been born through this technique by now, and "*in vitro* clinics" are a growth sector in the medical industry, even though most of them are not yet capable of routinely producing pregnancies for their clients.

⁵ Jacobson, *Up 400%: Artificial Insemination*, in *SEXUAL MEDICINE TODAY* (1976).

⁶ Biggers, *In Vitro Fertilization and Embryo Transfer in Human Beings*, 304 *NEW ENG. J. MED.* 336 (1981).

⁷ *Id.* at 337.

TABLE

REPRODUCTIVE POSSIBILITIES						
No.	Name of Method	Genetic Source	Fertilization	Gestation	Social Parents	
1	Traditional Reproduction	X _M & Y _M	Natural	M	M & M	
2	Artificial Insemination, Husband	X _M & Y _M	AI	M	M & M	
3	Test Tube Baby	X _M & Y _M	IVF	M	M & M	
4	Artificial Insemination, Donor	X _M & Y _D	AI	M	M & M	
5A	Donated Egg	X _D & Y _M	IVF	M	M & M	
5B	Transferred Egg	X _D & Y _M	AI with embryo flushing	M	M & M	
6	Surrogate Motherhood	X _D & Y _M	AI	D	M & M	
7A	Test Tube Baby in Rented Womb	X _M & Y _M	IVF	D	M & M	
7B	Transfer to Rented Womb	X _M & Y _M	Natural or AI w/embryo flushing	D	M & M	
8	Postnatal Adoption	X _D & Y _D	Natural, AI, or IVF	D	M & M	
9	Substitute Father	X _M & Y _D	IVF	M	M & M	
10	Brave New World	X ₁ & Y ₂	IVF or Natural/AI/ w/embryo flushing	3	4 & 5	
Abbreviations:						
X = female, Y = male, AI = artificial insemination, IVF = <i>in vitro</i> fertilization, D = donor,						
M = member of married couple						

Perhaps it would be a good idea to pause for a moment and say a word about the issue of growing demand for medical services aimed at overcoming infertility: what is it, and why is it occurring? As we are all well aware, a general decline in the birthrate has occurred since the peak of the post-War "baby boom" in 1957—at least through the mid-1970's when it bottomed out.⁸ Just as the "baby boom" arose mostly because of a great decrease in the percentage of women who remained childless or had only one child (rather than any huge increase in family size), so the decline occurred as more women had only a single child or remained childless, at least for a longer time.⁹

Women's choices in these matters were greatly increased by the wider range of contraceptive methods and the general availability, from 1973 onwards, of elective abortion. But women's "liberation" from the dictates of reproductive biology and their entry into the mainstream workforce have also had a price. The exercise of choice has had a dramatic effect on involuntary infertility. First, couples have delayed having children, and fertility decreases with age. Second, the methods used to prevent reproduction, such as "the pill," IUDs, and abortions, all carry some risk of infertility. Third, protection against pregnancy has led to more premarital sexual activity, with a resulting increase in infertility caused by sexually transmitted illness, such as pelvic inflammatory disease.¹⁰ At the same time, one traditional alternative for childless couples—adoption—has become less available due to a decrease in the number of "adoptable" babies relative to the demand.¹¹ For this reason, a large and eager—one might even say desperate—public exists for each new reproductive possibility, such as IVF.

At this point our review of reproductive alternatives begins to move beyond simply aiding men and women who have some difficulty generating children of their own. The major issues thus far are simply the relative safety and efficacy of the procedure: will it harm the prospective parents or child, and is it effective enough to qualify as medical practice rather than research, and thus to warrant health insurance coverage, and so forth? From here on, the situation grows more complex.

⁸ Aral & Cates, *The Increasing Concern with Infertility*, 250 J.A.M.A. 2327, 2329 (1983).

⁹ *Id.*

¹⁰ *Id.* at 2330.

¹¹ American Fertility Society, Ethics Committee, *Ethical Considerations of the New Reproductive Technologies*, published as 46 FERTILITY AND STERILITY 37S (Supp. 1 1986).

Suppose we alter Method No. 2, and make the source of the semen a third party, here labelled D for "Donor." The term "donor" is a misnomer, for the traditional source of semen for artificial insemination has been male medical students, who are persuaded to submit their sample in exchange for fifty dollars or the like; the proper term would be "vendor."¹² Donor semen is used when the husband lacks adequate sperm or carries a genetic trait that he does not want to pass on to offspring. The donor could inseminate the woman through intercourse, but for moral and psychological reasons, insemination is usually performed artificially by a physician. As mentioned a moment ago, the technique itself is not very complicated, and non-physician-assisted AID certainly occurs. In the opinion of some feminists, the ease of use provides a valuable means for women—especially single women, or lesbian couples—to control this reproductive alternative and to use it without needing medical approval and control. When used by women themselves, AID often involves a donor whose identity is known to the woman; when administered by a physician, typically it does not. Fresh semen is still widely used, but the increase in the number of semen banks and improvement in techniques for freezing semen has led to greater reliance on frozen samples,¹³ selected from catalogues that provide basic information on donor characteristics. If the results are pleasing to the couple, the physician may be able to arrange the use of the same donor for future inseminations.

When the situation is reversed and the wife either has no viable eggs or wishes to avoid passing on her own genes, the germinal material can be obtained from another woman. This leads to two possibilities, which are variations on Method No. 3. In the one I've labelled 5A, a donor would be hormonally stimulated (to coincide with Mrs. M's own fertility cycle) and a number of "ripe" ova removed; these would then be fertilized *in vitro* with Mr. M's sperm, after which some of the fertilized eggs would be inserted into Mrs. M's uterus (apparently three to four is the number that optimizes the chance of at least one fetus resulting).¹⁴

¹² L. ANDREWS, *NEW CONCEPTIONS* 160 (1984). The wider use of frozen sperm samples has resulted in a broader range of donors—without eliminating the practice of payment for the use of their samples.

¹³ The risk that AIDS (acquired immune deficiency syndrome) will be transmitted during artificial insemination has led to greater use of frozen semen; a sample is frozen for 90 days, at which point the donor is retested for AIDS (since several months are sometimes required between infection with the human immuno-deficiency virus and the production of a detectable level of AIDS antibodies).

¹⁴ Jones, Acosta, Andrews, Garcia, Jones, Mayer, McDowell, Rosenwaks, Sandow,

A newer technique, 5B, uses *in vivo* fertilization of the donor's egg in the donor's body, through artificial insemination with Mr. M's sperm. Before the fertilized egg can implant in the uterus, however, it is flushed out and transferred to Mrs. M. Although this technique is more difficult from some angles, it avoids the need for a laparoscopy—a surgical procedure by which the eggs are harvested for IVF.¹⁵

Suppose that Mrs. M's problems go beyond having no viable ova and include factors that make it dangerous or impossible for her to bear a child—or perhaps she is simply unwilling to go through the inconvenience of a pregnancy. If the couple wishes to have a child with the genes of one of them, another woman could be fertilized artificially with Mr. M's semen, bear the child, and then give it to Mr. and Mrs. M to raise: the technique that, oddly enough, has been labelled “surrogate motherhood.”

There are other circumstances in which a couple might want to borrow—or rent—a womb (remembering that a vendor for pay rather than a volunteer donor is likely to be involved). First, a method parallel to Method 5A could be used, in which the eggs are harvested by laparoscopy from Mrs. M, fertilized *in vitro*, and then transferred to the rented gestator. Alternatively, if a woman has healthy eggs but cannot, or does not want to, carry the fetus to term, the couple could employ natural intercourse or artificial insemination, followed by embryo flushing and transfer to the donor for gestation (No. 7B on the table).

To return to the familiar, Method No. 8 represents what happens with post-natal adoption. Such pregnancies usually follow traditional intercourse, but a baby that resulted from artificial insemination, or even from IVF, might be put up for adoption—for example, if its parents were to die. Moreover, the timing of the decision by the male and female Ds to give up the child to Mr. and Mrs. M may vary a great deal; usually this is a decision made near the time of birth, and it may or may not involve a male D, depending upon whether his identity is known and he is claiming paternal rights. But the decision might be made earlier—indeed, even before fertilization.

Many more lines could be added to the table. For example, Methods No. 3 and 4 could be combined—*in vitro* fertilization because Mrs. M has blocked tubes, with AID because Mr. M has sperm problems. This

Veeck & Wilkes, *Three Years of In Vitro Fertilization at Norfolk*, 42 FERTILITY AND STERILITY 826 (1984); Lopata, Sathanathan, McBain, Johnston & Speirs, *Concepts in Human In Vitro Fertilization and Embryo Transfer*, 40 FERTILITY AND STERILITY 289 (1983).

¹⁵ L. ANDREWS, *supra* note 12, at 251.

is the “substitute father” method shown as Method No. 9. The ultimate extension of this process of variation and combination would be the involvement of five different people—plus the medical personnel—the germinal material coming from Nos. 1 and 2, the fetus gestating in the uterus of No. 3, and Nos. 4 and 5 being the parents who raise the child after birth. Nor do these variations by themselves exhaust the currently available “reproductive possibilities.” In looking at this final possibility, one cannot presume that all the participants were alive at the time. One would probably expect No. 3 to be alive—unless, of course, she is “brain dead” and supported for months by mechanical ventilators and drugs while the fetus reaches viability.¹⁶ Likewise, one might expect Nos. 4 and 5 to be alive, or how could they raise the child? Yet might the child not still be considered their legal offspring if they “acknowledged” the child as theirs before its birth but died before the child was born (to another woman)? Most obviously, however, Nos. 1 and 2 need not be alive, because about fifteen percent of artificial inseminations already use frozen semen, and methods are being developed to freeze ova. Already, births have been reported of embryos that were frozen after fertilization and then later thawed and implanted, as for example, when more eggs are harvested and fertilized than can be implanted in a single cycle.¹⁷ Of course, before the era of the new technologies, when a pregnant widow died in childbirth, her baby was *born* an orphan — but today a child can be born who is an orphan *at the moment of conception!*

II. ISSUES, VALUES, AND GOALS

In the past several decades, medicine has managed to give us sex without reproduction—and now, as these examples show, it is managing to give us reproduction without sex. The latter sounds a lot less enjoyable than the former—and it will raise issues of much greater complexity. This lecture turns now to two sets of such issues: first, those raised by the techniques in which human germinal material is possessed (and manipulated) outside the body; and second, those issues that arise from the separation of genetic, gestational, and social parenthood. I will then turn to an examination of the goals and values that I believe should guide society in resolving issues of this sort.

¹⁶ *Baby Born Prematurely to Brain-Dead Woman*, N.Y. Times, Aug. 15, 1986, at 8, col. 6.

¹⁷ Wash. Post, June 5, 1985, at A16, col. 2.

A. *Extracorporeal Germinal Material*

As the review of the techniques showed, there are a number of circumstances in which eggs and sperm are removed, stored, and manipulated outside their human source; moreover, they can be combined to create an embryo, or an embryo can be removed from a woman before it implants in the uterus.

The first issues raised by these facts are those of injury and safety. In many ways, these issues are no different from the issues that arise with all new biomedical developments. The novel aspect is that medicine usually intervenes to attempt to correct an existing problem in an *existing* individual, but in this field, the problem of infertility exists separate from the existence of the particular child, so that harm might be done in the very act of *creating* the victim. This metaphysical conundrum was cited by the courts in the early "wrongful life" cases, such as *Gleitman v. Cosgrove*,¹⁸ but it is my belief that the whole tangled web of rulings in this corner of tort law will eventually be set straight precisely because judges will be willing to allow recovery for injuries caused by physicians' negligence in treating the unborn—for example, in prenatal surgery.¹⁹

The second issue raised by the extracorporeal location of germinal material is the issue of control. This question did not arise so long as the materials that went into making a human being were either in a human body or in the process of being transferred from one body to another during sexual intercourse. Once the eggs, sperm, or embryo is outside the body, it becomes a matter that is possessed. Can we apply conventional property law and deny the full meaning of such possession? Or should we treat the germinal material merely as quasi-property, like a human body, over which certain people may exercise control but in which they do not have a full-fledged property interest? Or should we confine this limitation to fertilized embryos, and go on allowing semen and ova to be treated like blood and other bodily products that are bought and sold?

To answer questions such as these, we must decide the values that are implicated. Is the primary value possessory? That is, because of the expense, effort, and risk that various individuals have undergone to produce the particular germinal material, they should be entitled to a property right in the product of their work. Or are the claims psycho-

¹⁸ 49 N.J. 22, 227 A.2d 689 (1967).

¹⁹ See Capron, *Wrongful Life: Will Common Sense Ever Prevail?*, 1985 BIOETHICS REPORTER 23.

logical and emotional, and thus, control should lodge with the source of the germinal material because he or she has a special attachment to it? Alternatively, if the primary value is the protection of human life, then control should be given to the party most likely to ensure the well-being of the genetic material and to treat it with appropriate respect.

The issue of control involves not only values but also process. How ought the issue be resolved? Should arrangements about the "ownership" of germinal material be left to private agreements, or does the public have legitimate interests in restricting people's freedom to do as they please with extracorporeal germinal material? In 1984, Congress adopted the National Organ Transplant Act,²⁰ section 301 of which makes it "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce." Would a similar prohibition on the sale of embryos be advisable? Legitimate?

For myself, I believe that the special sanctity of human life is a legitimate concern of the state and that preservation of this value would justify regulation to prevent actions that are unnecessarily disrespectful of this special status. The Supreme Court has, of course, held that a human being before birth is not a person in the constitutional sense, but the Court also recognized that the unborn have interests that the state may protect.²¹ In the present context, those nascent human interests are arrayed not against the interests of a pregnant woman who wishes to rid her body of the unborn embryo but of a physician or scientist who has possession of the material outside of any body. What is the basis of the control over the embryo that *Roe v. Wade*²² gave to pregnant women and their physicians? Is it termination of the woman's pregnancy, or termination of the life of the unborn being? And at whose command—only the woman, or others?

In suggesting that I would answer the question of control by recognizing a broader social interest in protecting a fertilized extracorporeal embryo against its parents' insistence that it be destroyed, I do not mean to imply an absolutist position. As I stated, the sanctity value is violated by actions that are unnecessarily disrespectful. If the *use* of an embryo—for example in a biomedical experiment—is *necessary* for a particular advance in *important* medical knowledge, the use of an embryo (obviously, without its consent) as a means to a broader benefit

²⁰ Pub. L. No. 98-507, 98 Stat. 2339 (1984).

²¹ See *Roe v. Wade*, 410 U.S. 113 (1973).

²² *Id.*

does not necessarily violate a moral principle because an embryo is not yet a full human being in my view. Yet the fashion in which the research is conducted remains a matter of importance and ought to be subject to very rigorous scrutiny.

In this, I find very agreeable the conclusions about research reached by the Ethics Advisory Board (EAB) in its report on the subject to the then-Secretary of Health, Education, and Welfare in May 1979.²³ This report's recommendations have never been acted upon. This is part of the reason that the leading research in IVF has gone on abroad because the major source of funding for biomedical research in the United States, the National Institute of Health (NIH), cannot support such research.²⁴ I should note, however, that my enthusiasm for the EAB report rests on a sense that it is a good document from a prudential viewpoint, not that I believe its restriction of research to the first fourteen days after fertilization enjoys any special constitutional status.

Perhaps what should be the matter of greatest concern for the moment is that the technology that raises such issues—and will certainly continue to do so with greater frequency—has advanced as far as it has without the development of any real social consensus or well-developed body of law on the moral and legal status of the embryo in the laboratory prior to implantation. Even if one places heavy reliance on “private ordering” to handle such questions, cases will arise that fall outside the arrangements made by the involved parties. For example, several years ago, a couple died leaving several embryos in a physician's deep-freeze in Australia, without instructions on what should happen to the embryos in such circumstances.²⁵ The state legislature insisted that an attempt be made to defrost the embryos and implant them in a volunteer gestator.²⁶

²³ Ethics Advisory Board, U.S. Dept. of Health, Education, and Welfare, Report and Conclusions: HEW Support of Research Involving Human *In Vitro* Fertilization and Embryo Transfer (1979).

²⁴ See also Health Research Extension Act of 1985, Pub. L. No. 99-158, 99 Stat. 820 (1985).

²⁵ See Saltarelli, *Genesis Retold: Legal Issues Raised by the Cryopreservation of Preimplantation Human Embryos*, 36 SYRACUSE L. REV. 1021, 1030 (1985); TIME, July 2, 1984, at 68-69; see also STATE OF VICTORIA (AUSTRALIA), REPORT ON THE DISPOSITION OF EMBRYOS PRODUCED BY IN VITRO FERTILIZATION (1984).

²⁶ Infertility (Medical Procedures) Act, No. 10,163 (Vict., Austl. 1984).

B. *Separations of Aspects of Parenthood*

The second set of issues raised by the alternative birth technologies, namely, those of separating aspects of parenthood, are at least as complex and unresolved. Ironically, one of the reasons for the complexity is that a larger body of law exists that is arguably relevant to this set of issues. For example, there are state laws on child custody and adoption, and now in many states also laws on AID.

As far as I can tell, most of the debate in this field has been framed in terms of the interests of the adult participants—that is, when parenthood is separated along genetic, gestational, and social lines, who has what rights? This way of framing the issue ignores what ought to be the strongest value to be served, namely, protecting the interests of the child. Perhaps this failure is changing. The media do refer to the New Jersey situation as “The Baby M” case, rather than the “Stern-Whitehead” case, which may signify a recognition of the primacy of the interests of the child.²⁷

The *Baby M* case is not the first one in which the risks to the well-being of a child of the new technologies became apparent. In 1982, Judy Stiver, a Michigan woman, entered into a surrogate mother contract with the Alexander Malahoffs. Noel Keane, the attorney also involved in the *Baby M* case, drafted the contract that Mrs. Stiver and Mr. Malahoff signed. When a child was born on January 10, 1983, he suffered from a strep infection and from microcephaly, meaning that his head was very small, usually a sign of mental abnormality. Mr. Malahoff, by this point separated from his wife, allegedly denied physicians permission to treat the infection, pursuant to a clause in the surrogate parenting contract that gave him custody of the child. Hospital officials, questioning his authority to decide, obtained a court order allowing them to treat the boy.²⁸ Thereupon, Malahoff denied paternity of, and responsibility for, the baby. Mrs. Stiver and her husband disputed his claims and denied their responsibility. Blood tests were taken and—as Harry Golden used to say, “only in America”—the results were revealed to the Stivers and Mr. Malahoff on the *Phil Donahue Show*.²⁹ The tests proved that Malahoff could not be the father and that Ray Stiver was the probable father, at which point he told his startled wife that in a previous marriage he had fathered a child whose head

²⁷ See, e.g., N.Y. Times, February 24, 1987, § 1, at 14, col. 1.

²⁸ See *id.*, Jan. 23, 1983, § 1, at 19, col. 1.

²⁹ *Phil Donahue Show*: “The Case of the Layaway Baby” (NBC television broadcast).

had stopped developing in infancy and who then died. With millions of people watching expectantly, Mr. Donahue extracted a promise from the Stivers that they would accept responsibility for the baby.

Nor has the issue of the welfare and interests of the offspring arisen only in the context of surrogate motherhood. In 1973, Dr. Raymond Vande Wiele, Chair of Obstetrics and Gynecology at Columbia University's College of Physicians and Surgeons, interrupted an experiment in which Dr. Landrum Shettles was attempting the *in vitro* fertilization of ova and sperm from a Mr. and Mrs. Del Zio. The couple then brought suit for wrongful conversion of personal property and infliction of severe emotional distress, and collected \$50,000 on the latter count.³⁰ Whatever the merits of the case, the important thing is that the state was not exerting its efforts as *parens patriae* for the vulnerable party but was merely providing the means to sort out the competing interests of the adults—patients, physician-investigator, and medical administrators.

Lest it seem that the goal of protecting the vulnerable has become an issue only for a few babies at the outer edges of the reproductive frontier, we should remember what has been true in the area of AID for many years—namely, the absence of accurate information of paternal lineage for most children born by AID. Perhaps in response to the early court cases, which labelled the process adultery and its products bastards,³¹ and perhaps out of deference to the sensibilities of the young men whose services were being used for a small fee, or perhaps based on a desire to avoid complicating the lives of the couple—for whatever reasons, physicians have generally followed a practice of not recording the identity of semen donors.³² This not only frustrates children who want to know something about their “natural” fathers—a desire that has led some of them to undertake very public national searches—but it may also create health problems for AID children and their own offspring, especially when medical data or test samples from both parental lines are needed for diagnosis or treatment. Remember, it is estimated that 20,000 babies are born through AID each year in the United States.³³

³⁰ *Del Zio v. Presbyterian Hosp.*, 74 N.Y. Civ. Ct. 3588 (S.D.N.Y. Nov. 14, 1978) (memorandum decision).

³¹ *See, e.g., Gursky v. Gursky*, 39 Misc. 2d 1083, 242 N.Y.S.2d 406 (Sup. Ct. 1963).

³² *See* L. ANDREWS, *supra* note 12, at 171; Curie-Cohen, Luttrell & Shapiro, *Current Practice of Artificial Insemination by Donor in the U.S.*, 300 NEW ENG. J. MED. 585, 588 (1979).

³³ L. ANDREWS, *supra* note 12, at 160.

To review: looking at two sets of issues—those raised by the existence of human germinal material outside the body, and those raised by the separation of aspects of parenthood—I have identified three primary values that may need protection.³⁴ They are: first, the sanctity of human life; second, personal well-being (sometimes associated with duties of nonmaleficence and of beneficence); and third, autonomous decisionmaking, which may be described in terms of freedom from interference in medical decisions, and in terms of the expectations of control that are embodied, for example, in property or tort rights.

Each of these values is complex and has numerous possible manifestations in the context of the alternative birth technologies. For example, in the context of state regulation, the third value—autonomous decisionmaking—may carry primarily the implication of a *negative* freedom because under the constitutional doctrine of “privacy,” the government is limited in the regulations and prohibitions it may place on medical choices but it is not obliged to make possible the use of particular techniques.³⁵ In a private context, however, autonomous decisionmaking may have broader implications, including creating affirmative duties on the part of physicians to inform their patients of options and even to make those options available.

As if the three values I have already discussed did not raise sufficient complications, there are two other values that are too important in our society to go unmentioned in the present context; both are aspects of “justice,” namely the values of equal treatment and of procedural fairness. The first of these arises when technologies to meet reproductive wishes are differentially available to men and women; arguably, it also arises when those who are capable of reproducing without the assistance of third parties are treated differently from those who need such aid. The second aspect, procedural fairness, arises when people lack means to assert their interests—or have these interests asserted by a guardian—in a timely fashion before an appropriate decisionmaker.

³⁴ See generally T. BEAUCHAMP & J. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (2d ed. 1983) (citing four principles—autonomy, nonmaleficence, beneficence, and justice—which themselves reflect the sanctity of life, and which lead to other derivative rules, such as informed consent, veracity, privacy, fidelity, etc.).

³⁵ See, e.g., *Maier v. Roe*, 432 U.S. 464 (1977) (state’s refusal to pay for nontherapeutic abortions did not violate equal protection clause); *Beal v. Doe*, 432 U.S. 438 (1977) (state need not fund nontherapeutic abortions to receive federal Medicaid funds).

C. Goals for Public Policy

Pulling these interests together, what goals do I believe should be set for public policy on alternative birth technologies? As a matter of strategy, let me express a preference for policies that minimize the extent to which the technologies disappear from regulatory oversight—the last thing we need are “back alley *in vitro*-ists” or “black market surrogates.” Too much harm to the child as well as the adult participants would result. What, then, should be the goals?

At the outset, the safety of reproductive interventions should be established. Plainly, the goal of safety requires appropriate biomedical testing before the techniques come into general use, a result that is achieved through medical and facilities licensure, tort law, and governmental regulations on research with human subjects. But it means more than that; it also necessitates appropriate procedures for the *use* of proven techniques, such as AID, to ensure adequate genetic and other medical screening of all sources of germinal material and to provide for confidential recordkeeping.³⁶ Amazingly, most of the legislation in the thirty or so states that have enacted AID statutes makes no provision on either score.³⁷ Instead, such legislation (for example, section 7005 of the Uniform Parentage Act of 1979) seems aimed primarily at protecting the interests of a husband in not being saddled with the results of a medically induced pregnancy to which he has not consented, and at relieving semen donors of any of the usual obligations of fatherhood.³⁸

Beyond these concerns about physical well-being, the second goal of

³⁶ The problem is illustrated by a Pennsylvania statute that apparently aims to improve the safety of IVF (and to prevent fraudulent clinics from operating) by requiring quarterly reports to be filed with the state Department of Health. 18 PA. CONS. STAT. ANN. § 3213(e) (Purdon Supp. 1985). The statute does not, however, require recording or reporting of the names of the donors or recipients of eggs and sperm.

³⁷ See ALA. CODE § 26-10-8 (1977); ARIZ. REV. STAT. ANN. § 8-126(c) (1974); CAL. PENAL CODE § 273(a) (West 1970); COLO. REV. STAT. § 19-4-115 (1986); DEL. CODE ANN. tit. 13 § 928 (1981); FLA. STAT. ANN. § 63.212(1)(b) (West Supp. 1983); GA. CODE ANN. § 74-418 (Supp. 1984); IDAHO CODE § 18-1511 (1979); ILL. REV. STAT. ch. 40 §§ 1526, 1701, 1702 (1981); IND. CODE ANN. § 35-46-1-9 (West Supp. 1984-85); IOWA CODE ANN. § 600.9 (West 1981); KY. REV. STAT. § 199.590(2) (Supp. 1986); MD. ANN. CODE § 5-327 (1984); MASS. ANN. LAWS ch. 210 § 11A (Law Coop. 1981); MICH. COMP. LAWS ANN. § 710.54 (West Supp. 1983-84); NEV. REV. STAT. § 127.290 (1983); N.J. STAT. ANN. § 9:3-54 (West Supp. 1986); N.Y. SOC. SERV. LAW § 374(6) (McKinney 1983); N.C. GEN. STAT. § 48-37 (1984); OHIO REV. CODE ANN. § 3107.10(A) (Baldwin 1983); S.D. CODIFIED LAWS ANN. § 25-6-4.2 (1984); TENN. CODE ANN. § 36-1-135 (1984); UTAH CODE ANN. § 76-7-203 (1978); and WIS. STAT. ANN. § 946.716 (West 1982).

³⁸ See UNIFORM PARENTAGE ACT § 7005, 9A U.L.A. 587, 592-93 (1979).

public policy in this field should be to protect the social and financial well-being of the children produced. To achieve this, explicit rules may be needed concerning the financial and other obligations of those who use the new techniques (especially relevant when the results are not as anticipated); moreover, I would urge restricting the use of frozen germinal material from identified persons to the lifetime (or perhaps even to the period of normal reproduction) of such persons, not only to avoid the difficulties otherwise created for family and estate law but also for psychological reasons, to avoid the intentional creation of orphans.³⁹

Third, for a variety of reasons having to do with individual and collective well-being, a limitation should be placed on the number of offspring from any single donor. Some women are already "donating" (for a fee) five to ten ova a month (which is possible with superovulation drugs); likewise, some semen donors have been used repeatedly.⁴⁰ Beyond the increased risk of unwitting incest among the offspring of such a "super-Mom" or "super-Dad," the adverse genetic effects are very disturbing. Furthermore, the *voluntary* use of such a pattern may set the stage for mandated use (perhaps on eugenic grounds) of certain "prime specimens" as super-breeders, as is done in animal husbandry.

Finally, the laws should preserve the special status of human life to the extent possible in the face of new technical capabilities. Clearly, some of the mysteries and wonders of life have been altered by scientific discoveries and technological capabilities in a way that the law cannot and should not even try to alter. But limitations on the commercialization of the process—in order to insist on a difference between babies and bath water (not that anyone typically *buys* bath water)—and on the manner in which human germinal materials are treated outside the body are desirable and could be formulated in a fashion that did not violate constitutional dictates. Some commentators have argued that the

³⁹ The discussion draft of a statutory proposal, entitled simply "Status of Children of the New Biology," under consideration by the National Conference of Commissioners on Uniform State Laws at its summer 1987 meeting, offers a more permissive alternative on this point. Section 6 eliminates the status of parent for the donor of egg or sperm used after the donor's death or when conception has occurred during the donor's life but the embryo was not implanted for gestation until after the donor's death. Optional language in the section, however, would allow a donor in the latter situation to provide to the contrary by will so long as the embryo is implanted within 21 years after the testator's death. This optional language suggests that the main concern of the section is with certainty in the disposition of estates, not protection of children against the misfortune of being intentionally created as orphans.

⁴⁰ See American Fertility Society, *supra* note 11; Curie-Cohen, Luttrell & Shapiro, *supra* note 32, at 588-89.

protection given by the Supreme Court to reproductive decisions in the contraception and abortion contexts as “fundamental” rights means that the state may not restrict what they term “noncoital reproduction.”⁴¹ Yet even in the context of conventional reproduction, the Court has held the rights not to be absolute.⁴² Regulation of the sort I have recommended—to protect the well-being of the defenseless or to preserve order regarding a matter of general interest (such as lineage and genetic fitness), for example—would, I believe, be found to aid the sufficiently compelling state interests to be upheld. Already, several courts have upheld limitations on the new technologies.⁴³ Likewise, a state may restrict its adoption procedures to preclude the selling of babies without violating constitutional rights of privacy or property.

III. SURROGATE MOTHERHOOD

As stated at the onset, having examined a range of reproductive possibilities and having sketched the values and goals that ought to guide public policy in responding to the issues raised by these possibilities, I turn now to a specific application of these points to surrogate motherhood. Although not presently covered by statutory law in any state, surrogacy—as it is sometimes termed—is on the legislative agendas in more than a dozen states. Most are considering bills that would legalize the procedure, although legislation has also been introduced to ban it and invalidate surrogacy contracts.⁴⁴

A. Present Legal Status

What is the legal status of the procedure in the absence of legislation? First, there appears to be no barrier to the parties entering into the agreement itself, although if the surrogate is married her husband would need to be a party to the contract. The payment of money, beyond certain enumerated expenses, is illegal under the adoption laws of about half the states,⁴⁵ and the Michigan Supreme Court has inter-

⁴¹ American Fertility Society, *supra* note 11, at 2S-6S.

⁴² *Roe v. Wade*, 410 U.S. 113 (1973).

⁴³ *Syrkowski v. Appleyard*, 122 Mich. App. 506, 333 N.W.2d 90 (1983), *modified*, 420 Mich. 367, 362 N.W.2d 211 (1985) (per curiam) (holding that Michigan Paternity Act applies in surrogacy cases); *Doe v. Kelley*, 106 Mich. App. 169, 307 N.W.2d 438 (1981), *cert. denied*, 459 U.S. 1183 (1983).

⁴⁴ *State Proposals Vary Greatly*, L.A. Daily J., Apr. 1, 1987, at 23.

⁴⁵ See, e.g., ALA. CODE § 26-10-8 (1977); ARIZ. REV. STAT. ANN. § 8-126(c) (1974)(exempts stepparents); CAL. PENAL CODE § 273(a) (West 1970)(exempts stepparents); COLO. REV. STAT. § 19-4-115 (1986); DEL. CODE ANN. tit. 13 § 928 (1981);

preted its "baby selling" statute to ban payment to a surrogate.⁴⁶ Last year, however, the Kentucky Supreme Court reached the opposite conclusion—on constitutional grounds.⁴⁷

The forbearance of society in permitting people to voluntarily organize their lives to achieve a "surrogate child" is not the same as saying the contracts are "legal" in the sense of being enforceable through specific performance or a suit for damages. Attempts to enforce a surrogate mother contract during the surrogate's pregnancy would face both common law and constitutional impediments. As a contract for personal services, a surrogate arrangement would not be subject to specific performance—as, for example, by an injunction to force the pregnant woman to abort a fetus that the father and his wife no longer wanted to have born (perhaps because of the results of prenatal tests). If the action sought by the couple did not involve such a protected decision as the choice whether or not to abort, it would be possible to assess damages after the fact, in contract or in tort. For example, assume the contract required a specific dietary regime or series of medical examinations during pregnancy, which the surrogate failed to perform, leading to provable damage to the child. This action might void the contract for nonperformance or lead to an assessment of damages to compensate the couple for their added expense in caring for the child.⁴⁸

FLA. STAT. ANN. § 63.212(1)(b) (West Supp. 1983) (exempts stepparents); GA. CODE ANN. § 74-418 (Supp. 1984); IDAHO CODE § 18-1511 (1979); ILL. REV. STAT. ch.40 §§ 1526, 1701, 1702 (1981); IND. CODE ANN. § 35-46-1-9 (West Supp. 1984-85); IOWA CODE ANN. § 600.9 (West 1981); KY. REV. STAT. § 199.590(2) (Supp. 1986); MD. ANN. CODE § 5-327 (1984); MASS. ANN. LAWS ch. 210 § 11A (Michie/Law. Coop. 1981); MICH. COMP. LAWS ANN. § 710.54 (West Supp. 1983-84); NEV. REV. STAT. § 127.290 (1983); N.J. STAT. ANN. § 9:3-54 (West Supp. 1984-85) (exempts stepparents); N.Y. SOC. SERV. LAW § 374(6) (McKinney 1983); N.C. GEN. STAT. § 48-37 (1984); OHIO REV. CODE ANN. § 3107.10(A) (Baldwin 1983); S.D. CODIFIED LAWS ANN. § 25-6-4.2 (1984); TENN. CODE ANN. § 36-1-135 (1984); UTAH CODE ANN. § 76-7-203 (1978); WIS. STAT. ANN. § 946.716 (West 1982).

⁴⁶ *Doe v. Kelly*, 106 Mich. App. 169, 307 N.W.2d 438 (1981), *cert. denied*, 459 U.S. 1183 (1983).

⁴⁷ *Surrogate Parenting Assocs., Inc. v. Kentucky*, 704 S.W.2d 209 (Ky. 1986). The decision is curious because the court rested its finding that surrogacy was not baby selling on the ground that surrogacy cannot involve adoption because the biological father already has a legal relationship with the child. But that begs the question: may the state forbid a man's wife to pay another woman to transfer the latter's parental rights to her without violating the "privacy" rights of the parties?

⁴⁸ I doubt, however, that the contract would allow the child to seek any damages for its breach. *See, e.g.*, Cal. Civ. Code § 43.6 (Immunity from Liability; Actions Against Parents in Childbirth Claims) (West 1984).

B. Is Legislation Desirable?

Should we remedy this problem by legislating a framework for surrogate contracts? On the one hand, to do so may well increase the frequency of such arrangements—not a salutary development in my view. On the other hand, the primary interest in protection of the offspring is not well-served by the absence of a statutorily established system. What ought such a statute encompass? At a minimum, I would suggest the following.

First, careful medical screening should be performed for all participants in “surrogacy” to prevent avoidable illness. Granted, this does not exist for ordinary reproduction—but, then, surrogacy is not ordinary. The result may well be achieved through the threat of sanctions on the professionals (physicians, social workers, lawyers, etc.) who superintend the arrangements; their failure to screen could be a basis for liability. The risk of eugenic controls being exercised by the state places this aspect of a statute into a difficult balancing act, but the interest in protecting the child is strong enough to compel a hard effort to find a solution that stops short of state control of reproduction.

Second, surrogacy should be regarded as a form of prenatal adoption of the child of one parent by the other parent and provisions for state supervision, including confidential recordkeeping, should parallel those applicable to postnatal adoption. The harder question is whether standards of “fitness” ought to be applied to the couples; it may be enough to achieve this indirectly through medical supervision. There may, of course, be some issues that cannot be well resolved by the law but must be left to the development of social norms. For example, should the procedure be limited to infertile couples and those with medical reason (genetic or gestational risks) for not reproducing themselves? Rather than trying to develop clear rules on what qualifies as sufficient “infertility” or “medical contraindication,” it may be sufficient to leave the question to physicians and potential surrogates: “Is this couple’s problem serious enough to warrant surrogacy?”

Third, and perhaps most important, the parties to the contract should each be bound by their normal parental obligations of care and support, regardless of the breach or alleged breach of the contract by the party. The Malahoff case indicates the potential for abandonment of the child if the parties are free to regard the situation as one of a contract for delivery of a product.

All of the suggestions made thus far aim to protect the interest of the child, which I view as the primary aim of public policy in this field. Other provisions in a statute would expand on this goal, while also

attempting to promote additional values.

Fourth, the law should provide that the child is the legal child of the surrogate mother. This was the position of the Warnock Committee in England in 1984.⁴⁹ Such a legal rule would do three things. First, it would reinforce the child's interest in having a legally responsible mother at birth. Second, it would place the surrogate in the same position as other women who decide to allow a child to be adopted, which includes having the right to change her mind within a specified time period. Third, it would also discourage surrogacy by exposing the biological father to the risk that he might end up with a financial obligation to the child but without any guarantee of other paternal rights (which would lodge instead with the surrogate's husband).

The rule I suggest regarding maternity raises the more difficult issues of the presumption of paternity. Under the law in the thirty or so states with AID statutes, a child born after AID is presumed to be the legal offspring of her husband if he has consented to the insemination.⁵⁰ Applying that rule to surrogacy would make the child the legal offspring of the surrogate's husband if he consents, or would open the physician (and others) to suit if the husband "non-consented" and later became dissatisfied with the situation. A Michigan decision declining to allow the paternity act to be used to declare prenatally the paternal status of a contracting father was revised on appeal,⁵¹ while a Kentucky

⁴⁹ *Report of the Committee of Inquiry Into Human Fertilization and Embryology*, London, Department of Health and Social Security, July, 1984.

⁵⁰ ALA. CODE § 26-17-21 (1986); ALASKA STAT. § 25.20.045 (1983); ARK. STAT. ANN. § 61-141(c) (1971); CAL. CIV. CODE § 7005 (West 1983); COLO. REV. STAT. § 19-6-106 (1986); CONN. GEN. STAT. §§ 45-69f to 69n (1985); FLA. STAT. ANN. § 742.11 (West Supp. 1984); GA. CODE ANN. §§ 74-101.1, 74-9904 (Supp. 1984); IDAHO CODE § 39-5401 to 39-5407 (Supp. 1984); ILL. ANN. STAT. ch. 40 § 1453 (Smith-Hurd Supp. 1987); KAN. STAT. ANN. §§ 23-128 to 23-130 (1981); LA. REV. STAT. ANN. 188 (West Supp. 1984); MD. EST. & TRUSTS CODE ANN. § 1-206(b) (1974); and MD. GEN. PROV. CODE § 20-214 (1982); MICH. COMP. LAWS ANN. § 333.2824 (1980) and § 700.111 (1980); MINN. STAT. ANN. § 257.56 (West 1982); MONT. REV. CODE ANN. § 40-6-106 (1985); NEV. REV. STAT. § 126.061 (1986); N.J. STAT. ANN. § 9:17-44 (West Supp. 1986); N.M. STAT. ANN. § 40-11-6 (1986); N.Y. DOM. REL. LAW § 73 (McKinney 1977); N.C. GEN. STAT. § 49A-1 (1984); OKLA. STAT. ANN. tit. 10, §§ 551-553 (West Supp. 1987); OR. REV. STAT. §§ 109.239, 109.243, 109.247, 677.355, 677.360, 677.365, 677.370 (1985); TENN. CODE ANN. § 53-446 (Supp. 1983); TEX. FAM. CODE ANN. § 12.03 (Vernon 1975); VA. CODE § 64.1-7.1 (1980); WASH. REV. CODE ANN. § 26.26.050 (1986); WIS. STAT. ANN. § 767.47(9) (West 1985), § 891.40 (West Supp. 1982-1983); WYO. STAT. § 14-2-103 (1978).

⁵¹ *Sykowski v. Appleyard*, 420 Mich. 367, 362 N.W.2d 211 (1985) (per curiam), *modifying* 122 Mich. App. 506, 333 N.W.2d 90 (1983).

court declined to allow a "mere affidavit" to rebut the presumption of the paternity of the surrogate's husband.⁵²

A fifth control that a statute might exercise would be to regulate the amount of payment made. Obviously, such agreements are notoriously difficult to supervise. The major risk that a person runs in going outside the terms permitted in the regulation is the same risk as already exists—namely, holding an unenforceable contract—and that has not deterred hundreds of people so far. Moreover, besides difficulties of enforcement, the question arises, which way should the regulation tend—to hold down payments to the level of actual out-of-pocket expenses (including life and health insurance premiums), which would lead to surrogacy only by true altruists, or to push the price up to a level commensurate with the values of the service and the time and effort involved? The latter would doubtlessly lead to a flood of eager surrogates, but without at least some control, more cases are likely to arise like the one now being litigated in San Diego, in which a Mexican woman is trying to retain custody of the child she bore under a surrogate contract for \$1500.⁵³

Suppose that the legal regulations adopted are seen as disadvantaging surrogacy compared to AID. Is this unfair discrimination because it treats couples differently based on male versus female infertility? I do not believe that the claimed objection based on "procreative freedom"⁵⁴ is persuasive, for several reasons. First, there is a substantial difference between the role of the "donor" in AID (merely contributing the germinal material, which is obtained in a risk-free procedure) and the "donor" in a surrogate contract (who not only contributes the germinal material but carries the child for nine months and gives birth to it).⁵⁵ These differences—in time, in risk, in attachment,⁵⁶ and in effects on fetal development—implicate the values of well-being and of exploita-

⁵² *In re Baby Girl*, No. 83 AD (Jefferson Cir. Ct., 6th Div., March 8, 1983).

⁵³ Scott, *Pair Duped Her on Surrogate Mother Pact, Woman Tells Court*, L.A. Times, Feb. 20, 1987, § I, at 22, col. 1.

⁵⁴ See, e.g., Robertson, *Embryos, Families and Procreative Liberty: The Legal Structure of the New Reproduction*, 59 S. CAL. L. REV. 939 (1986).

⁵⁵ See Elias & Annas, *Social Policy Considerations in Noncoital Reproduction*, 255 J.A.M.A. 62 (1986).

⁵⁶ The Ethics Committee of Britain's Royal College of Obstetricians and Gynaecologists recommended against the use of surrogates because women cannot predict the distress they will experience when they have to relinquish a child. ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, REPORT OF THE RCOG ETHICS COMMITTEE ON IN VITRO FERTILISATION AND EMBRYO REPLACEMENT OR TRANSFER § 7.3 (1983).

tion set forth earlier. Second, the legal rule in question—that a child born to a woman is legally hers until she gives the child up for adoption—is facially neutral between the situations of AID and surrogacy. In both instances, it vests parental rights and obligations in the woman who is inseminated and her husband. Third, the analogy between AID and surrogate motherhood is inexact; the correct analogue to AID is egg donation (No. 5A on the table). In that case, the “adoptive mother,” who gestates the donated egg (fertilized by the sperm of her husband or another donor) would be the legal mother.⁵⁷

The development of alternative birth technologies is seemingly pushing back the limits of human biology, and in the process sorely testing the limits of human law. The *Baby M* case in New Jersey reminds us of these limits, since it involves at its core the interest of a child who is not a party to the contract. My sense is that, in the absence of a statute that clearly establishes the rules I have recommended in this essay, the *Baby M* court should rule on grounds of the child’s “best interests” in a custodial sense, not on the basis of the contract. Moreover, in so ruling there must be no presumption that wealth or social class is determinative. As the California Supreme Court recently ruled, in a custody dispute over an out-of-wedlock child whose father was seeking custody based on the greater financial means and better home environment he and his new wife could offer compared with the child’s working (and still unwed) mother, “the purpose of child support awards is to ensure that the [parent] otherwise best fit for custody receives adequate funds,” and not to use the poorer parent’s position as a ground for denying custody.⁵⁸ At the heart of best interests—or “beyond” it⁵⁹—is stability and continuity for the child.⁶⁰ In the *Baby M* case, that consideration could lead custody to be awarded to Dr. Stern and his wife (who have

⁵⁷ In its discussion draft of a statute on the Status of Children of the New Biology, the drafting committee of the National Conference of Commissioners on Uniform State Laws defines a mother as “the woman who gives birth to a child . . . whether or not she is the genetic parent” (Sec. 3). However, it also offers an optional Section 7 under which a couple who has arranged for a surrogate to bear them a child can establish a binding legal relationship with the child even before its birth, even to the point of being listed on the birth certificate as the legal parents, though information on the true biological parents would be kept confidentially by the court that had reviewed the case and approved the prenatal adoption.

⁵⁸ *Burchard v. Garay*, 42 Cal. 3d 531, 536, 724 P.2d 486, 488, 229 Cal. Rptr. 800, 802 (1986).

⁵⁹ See J. GOLDSTEIN, A. FREUD & A. SOLNIT, *BEYOND THE BEST INTERESTS OF THE CHILD* (1973).

⁶⁰ See *In re Marriage of Carney*, 24 Cal. 3d 725, 730-31, 598 P.2d 36, 37-38, 157 Cal. Rptr. 383, 384-85 (1979).

had primary custody of most of the child's first year), even if the physician who performed the insemination were now to announce that he had used semen from a man other than Dr. Stern.

IV. POSTSCRIPT: THE "BABY M" CASE

Six weeks after this lecture was delivered, New Jersey Superior Court Judge Harvey R. Sorkow, presiding judge in the Family Part for Bergen County, handed down his much-awaited decision *In the Matter of Baby M*.⁶¹ With its drama of a baby passed out a window and later seized by police from a nursing mother's arms, and with all the titillating details of the disputants' private lives, this case fascinated the nation more than any custody battle since Gloria Vanderbilt was a child.

Rather than limit his holding to a resolution of the custody issue, however, Judge Sorkow issued a far-reaching, 121-page opinion on the legality of surrogate mother contracts and based his decision in favor of the adoption of Baby M by William and Elizabeth Stern in part on the enforceability of the contract signed by Mary Beth Whitehead, the surrogate mother, and her husband Richard. It is surprising, and in my view regrettable, that the judge did not limit his ruling to what he termed the primary issue, "the best interests of the child." This is the somewhat vague standard used to resolve custody disputes, and most of the testimony had concerned this topic.

Had he given custody to the mother, Mary Beth Whitehead, he would have been criticized for depriving Baby M of the greater material benefits available in the home of her biological father. Moreover, giving Mrs. Whitehead custody would have gone against the view—relentlessly cultivated by the Sterns' attorney—that she was a liar and psychologically unstable. So Judge Sorkow apparently agreed, probably fueled by his displeasure that Mrs. Whitehead had flouted his initial custody order and fled with her family to Florida for several months in spring 1986.

On the other hand, the decision in Dr. Stern's favor also has its critics, who see in it a form of class prejudice. Many working class lives are marked by poor education, unattractive jobs, and financial difficulties—all factors claimed against the Whiteheads. Such couples are always going to lose out when judged by middle class standards. Indeed, in view of Judge Sorkow's negative description of Mrs. Whitehead's

⁶¹ *In re Baby M*, No. FM-25314-86E, slip op. (N.J. Super., Ch. Div., Family Part Bergen Co., March 31, 1987).

abilities as a mother, it seems almost surprising that she was allowed to maintain custody of her other children.

It is, of course, too soon to know the effects of Judge Sorkow's decision. The case itself is now on appeal to the Supreme Court of New Jersey; until that court resolves the questions of surrogacy, the *Baby M* decision is unlikely to have great effect on other courts. Beyond the factual issues that relate solely to the Stern-Whitehead dispute (on which the views of the trial judge, although rather extraordinary in their characterization of one of the parties, are likely to be given considerable weight on appeal), there are several grounds on which the lower court's ruling seems very dubious.

The heart of the issue is the manner in which the law treats surrogate arrangements compared with ordinary adoptions; of particular importance is the role of commercial activity. The fact that the man in the adopting couple is the genetic father of the child sets the surrogate situation apart from most ordinary adoptions, though the adoption of an illegitimate child by his or her father is not an unknown event. In such circumstances, the usual rules about maternal rights—including the change-of-heart provisions that allow a parent to revoke consent to the adoption for a period of time—would apply.

Judge Sorkow's argument for treating surrogate arrangements differently than adoptions is unconvincing, particularly since he cited the existence of court review of adoption petitions as a safeguard in surrogate arrangements.⁶² Adoption statutes must be strictly construed, according to the judge, because adoption did not exist at common law. Yet "a review of the adoption statute's legislative history reveals" that surrogacy "was not a viable procreation alternative and was unknown when the laws of adoption were passed."⁶³ From this Judge Sorkow concludes that "the only concept of law that can presently attach to surrogacy arrangements are [sic] contract law principles and *parens patriae* concepts for the benefit of the child."⁶⁴ The problem with this conclusion is simply that the adoption statute and its procedures are at the heart of the surrogate mother contract, for a person like Mrs. Whitehead (and her husband) agrees to sign over her legal rights to the child after its birth, and the person in Dr. Stern's position agrees to make the payment (in that case, \$10,000) once the adoption has taken place.

Equally peculiar is the judge's acceptance of the payment of money for the adoption. Although he found that New Jersey adoption law

⁶² *Id.* at 69-70.

⁶³ *Id.* at 71.

⁶⁴ *Id.*

“does prohibit the exchange of any consideration for obtaining a child,”⁶⁵ this provision was held not to prevent the Sterns’ adoption of Baby M because the payment was for the surrogate’s “willingness to be impregnated and carry his child to term.”⁶⁶ Yet the payment is made only after the adoption, and if the surrogate miscarries, she gets either no payment or only a partial payment, despite her good-faith attempt to be impregnated and to carry the child.

Judge Sorkow’s reasoning on the nonapplicability of adoption law appears also to be based on his belief that because the social father is biologically related to the child, “[h]e cannot purchase what is already his.” But one joint tenant to property can indeed pay the other to give up rights in their property. Looking at the contract, it is apparent that Dr. Stern planned to pay the Whiteheads for the equivalent of a quit-claim to their interests in the baby, who was thus treated like property.

The issue of dehumanization through commercial transactions in lives is dismissed too quickly in the *Baby M* opinion. In arguing against allowing sale of human embryos, Dr. Sherman Elias and Professor George Annas observe that “we know intuitively that the human embryo is more valuable than a kidney [which cannot be sold⁶⁷] and of much more symbolic importance regarding human life: that is why we believe embryos should not be the subject of commerce.”⁶⁸ The same applies—even more forcefully—to payments made for rights in actual babies, with all the implications of a product—made up to certain specifications, like any other item of trade—rather than of a person.

Furthermore, to the related objection that surrogacy will “undermine traditional notions of the family,”⁶⁹ Judge Sorkow replied that this cannot be true because people like the Sterns desperately want to have families—though that would not, of course, justify their snatching a child from another family. Because at one time, when the contract was signed and before the baby was conceived, both sides must agree, the judge concluded that surrogacy arrangements will not undermine the family even when enforcement of the contract is manifestly upsetting to the woman who bore the child and perhaps to her other children. The fact of the agreement on the contract seems to be a *non sequitur* in terms of this objection.

⁶⁵ *Id.* at 70.

⁶⁶ *Id.* at 71.

⁶⁷ *See supra* note 20.

⁶⁸ Elias & Annas, *supra* note 55, at 67.

⁶⁹ *In re Baby M*, No. FM-25314-86E, slip op., at 72 (N.J. Super., Ch. Div., Family Part Bergen Co., March 31, 1987).

Equally puzzling is the judge's attempt to dismiss the concerns apparently presented to the court that legalization of surrogacy will permit "an elite upper economics group" to use "the lower economic group of woman [sic]" as breeders. Rather than deal with this risk of exploitation, Judge Sorkow simply reiterates the very real and understandable drive on the part of people like Dr. Stern "to procreate naturally and when that is impossible, to use what lawful means are possible to gain a child."⁷⁰ Of course, this begs the question whether surrogate contracts are legal and enforceable—the very issue before the court. Moreover, the fact that the "intense desire to propagate the species" exists "within the soul of all men and women regardless of economic status"⁷¹ does not change the fact that only people with considerable economic means will be capable of paying for a surrogate contract (which with medical and legal expenses costs two to four times the direct payment of \$10,000 to the surrogate mother that now seems to be typical) and that women attracted to bearing and giving up a child for pay are likely to be of modest means.

This leads to the final objection to surrogacy that Judge Sorkow dismisses, namely, "that the surrogate mother will be exploited."⁷² The judge is surely correct in observing that women in other circumstances may be even more at risk for exploitation. But the greater pressures toward giving up a child for adoption felt by a poor, pregnant woman who may not be able to get any financial support from her child's biological father does not refute the potential for exploitation. The judge believes there will be none because the woman "is not yet pregnant," as though pregnancy is the only pressure a person might feel.

The facts of the *Baby M* situation made it a hard case, and the aphorism that hard cases make bad law has proven right once again. With luck, the worst aspects of the decision will be reversed on appeal, and in the meantime the legislatures around the country will not rush to prove true a related aphorism, namely that hard cases propel legislators into adopting bad laws. The welfare of children is more likely to be protected if the law does nothing to facilitate surrogacy and instead leaves open the uncertainty that has attached to this particular contract. At the very least, we should follow the lead of the British and place prohibitions on brokering such arrangements for a fee or other commercial activities by "surrogacy agencies."⁷³

⁷⁰ *Id.* at 72.

⁷¹ *Id.* at 73.

⁷² *Id.* at 70.

⁷³ Surrogacy Arrangements Act 1985, United Kingdom, ch. 49.