

ACCESSING REPRODUCTIVE TECHNOLOGIES: INVISIBLE BARRIERS, INDELIBLE HARMS

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I. INTRODUCTION

At the height of the Second World War, Justice William O. Douglas penned an observation so self-evident, it was a virtual truism. “Procreation,” he declared “involves one of the basic civil rights of man...fundamental to the very existence and survival of the race.”¹ At the time, procreation through means other than sexual intercourse were unknown,² thus Justice Douglas’ world view of human conception entailed a single scenario in which one man and one woman melded their gametes inside the woman’s body to produce a child. By the end of the twentieth century, this world view had shifted dramatically with the birth of reproductive medicine – a medical specialty devoted to helping patients overcome infertility through various methods of assisted conception. A mere three score years after Justice Douglas spoke of the import of procreation, human offspring could be conceived in a test tube,³ with the aid of an egg donor,⁴ or a sperm

¹ *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). The case involved a challenge to the Oklahoma Habitual Criminal Sterilization Act which permitted state officials to sexually sterilize those convicted two or more times for felony crimes involving “moral turpitude.” *Id.* at 536. Writing for a unanimous court in overturning the law, Justice Douglas described the case as “touch[ing] a sensitive and important area of human rights...the right to have offspring.” *Id.* In his 2003 biography of Justice Douglas, Bruce Allen Murphy analyzes the import of the *Skinner* decision, concluding that it marked a jurisprudential turning point in constitutional law. The language discussing procreation as a basic liberty and the consequences of its state-sponsored deprivation, Murphy writes, “would one day be credited as a cornerstone for the “fundamental rights” line of cases, by which any legislation dealing with these areas would be subjected to a higher level of judicial scrutiny than the prevailing standard, which afforded great deference toward legislatures.” Bruce Allen Murphy, *WILD BILL: THE LEGEND AND LIFE OF WILLIAM O. DOUGLAS* 203 (2003).

² The first report of a child conceived by means other than sexual intercourse can be traced to Dr. John Hunter (1782-1793), a Scottish surgeon who collected the sperm from a patient who had been unable to impregnate his wife. In 1785, Dr. Hunter used a syringe to inject the man’s sperm into the wife’s reproductive tract, resulting in the birth of a child nine months later. See Judith F. Daar, *REPRODUCTIVE TECHNOLOGIES AND THE LAW* 25-29 (2006) (detailing the history of assisted conception). Over the next 150 or so years, isolated cases of “artificial insemination” were reported, but it wasn’t until the mid-1950s that the technique gained recognition from the medical community as a treatment for infertility, due largely to published reports documenting pregnancies using stored frozen semen. See R. Bunge & J. Sherman, *Fertilizing Capacity of Frozen Human Spermatazoa*, 172 *Nature* 767 (1953).

³ The world’s first “test tube” baby, Louise Brown, was born outside London on July 25, 1978. See Peter Gwynne, *All About That Baby*, *NEWSWEEK*, Aug. 7, 1978, at 66. Louise was conceived using in vitro fertilization (IVF), a medical technique in which the egg and sperm are introduced under the glare of a laboratory petri dish, instead of in the dark quiet recesses of a woman’s fallopian tube. Once the sperm fertilizes the egg, the resulting embryo is nurtured in the lab for several days and then transferred into a woman’s uterus where it will, hopefully, implant and

donor,⁵ or a gestational carrier,⁶ wreaking havoc on traditional notions of reproduction and parenthood. These procreative aids, commonly referred to as assisted reproductive technologies (ART),⁷ inject third parties into what was heretofore considered an intimate and closed two-party relationship. The presence of third parties in the reproductive process, be they ART providers or purveyors of human gametes,⁸ calls into question the durability of Justice Douglas' averment that procreation is a basic civil right of man. With reproduction in the modern era trending toward the technical,⁹ one wonders

develop until birth. See generally, Peter R. Brinsden, A TEXTBOOK OF IN VITRO FERTILIZATION AND ASSISTED REPRODUCTION (1999).

⁴ The world's first birth resulting from egg donation was reported in 1984 by scientists in Australia. The first known birth using AID was reported in 1884, but the practice became popularized in the 1950s with the discovery of effective methods for cryopreservation of sperm. See Daar, *supra* note __ at 28, 220.

⁵ The first known birth of a child conceived using donor sperm took place in 1884 with the aid of Dr. William Pancoast of Jefferson Medical College in Philadelphia. According to a later published report, Dr. Pancoast aided a childless couple by inviting them into his classroom where an audience of medical students sat in observation. He anaesthetized the woman and then obtained semen from the "best looking member of the class." Nine months later, a baby boy was born. The mother is reputed to have gone to her grave none the wiser as to the manner of her son's provenance. The husband was informed and was reputedly delighted. The son discovered his novel history at the age of 25 when enlightened by a former medical student who had been present at his conception. See A.D. Hard, *Artificial Impregnation*, 27 *Medical World* 163 (1909).

⁶ A gestational carrier refers to a woman who agrees, generally for compensation, to carry a child in her womb for another person or couple. Though this practice of "surrogate motherhood" has biblical origins, recall the story in *Genesis* in which the handmaid Hagar, gives birth to Abraham's son Ishmael for the childless Sarah, surrogacy in the modern era became popularized in the 1980s following the publicity surrounding the case of Baby M, a child born of a surrogacy contract gone awry. See *In re Baby M*, 109 N.J. 396, 537 A.2d 1227 (1988).

⁷ Throughout this article I use the term ART to refer to the medical techniques used to achieved pregnancy other than through sexual intercourse. By admission, this definition of ART is broader than that adopted by prominent authorities such as the Centers for Disease Control (CDC), which produces an annual report on the use and success of certain reproductive technologies. The CDC report defines ART as "all fertility treatments in which both egg and sperm are handled. In general ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman. They do NOT include treatments in which only the sperm are handled (i.e., intrauterine, or artificial, insemination) or procedures in which a woman takes drugs only to stimulate egg production without the intention of having eggs retrieved." 2003 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 3 (December 2005) (hereafter 2003 ART Report).

⁸ Human gametes refer to the cells that participates in fertilization and development of a new organism, also known as germ cells or sex cells. The male gamete is the spermatozoon (sperm) and the female gamete is the oocyte (egg). See McGraw-Hill Dictionary of Scientific and Technical Terms (4th ed. 1989, at 2087).

⁹ The interaction between reproduction and technology first took shape in the 1960s and 70s in the form of prenatal testing. Increasingly, obstetricians offered patients the opportunity to test or visualize the developing fetus, often for the purpose of reassuring the prospective parents that the pregnancy was proceeding to produce a healthy child. The most commonly used prenatal screening methods include ultrasound to visualize structural abnormalities in the fetus, amniocentesis and chorionic villus sampling (CVS) to detect fetal chromosomal abnormalities, and maternal serum screening to measure biochemical markers associated with several conditions in the fetus, including neural tube impairments such as spina bifida and anencephaly, and Down Syndrome. According to the Center for Disease Control and Prevention (CDC), in 2003 (the most recent year for which statistics are available), 67% of women who had live births in the U.S. received ultrasound, a steady increase from 47.6% in 1989. See Joyce A. Martin, et al., Center for Disease Control and Prevention, National Vital Statistics Reports, *Birth: Final Data for 2003*, Vol. 54, No.2, at 13 (Sept. 8, 2005). The rate of amniocentesis for 2003 was 1.7%, a decline from the 3.2% reported in 1989, due in large measure to the increased use of noninvasive screening tests such as ultrasound and measurement of maternal serum markers. *Id.* At 14. The use of maternal serum markers to assess fetal health, commonly referred to as a "triple screen," looks for three types of biochemical markers in a pregnant woman's blood during the second trimester of pregnancy. Elevated and low levels of certain markers can be associated with certain neural tube and genetic defects, and often prompt women to follow up an abnormal finding with ultrasound or amniocentesis. See Erik Parens and Adreine Asch, PRENATAL TESTING AND DISABILITY RIGHTS 45-49. Parens and Asch suggest the use of maternal serum markers is very high, noting that "[b]y the 1980s, most women were being offered serum AFP [alpha-fetoprotein, a marker for neural tube impairments] screening during pregnancy." *Id.* at 46.

whether the protections and respect accorded the traditional procreation of yesteryear apply en masse to today's amalgam of conception methodology.

The most obvious difference between natural and assisted conception lies in their ease of use. The basic requirements for traditional procreation are undeniably slight – a man and a woman with functional reproductive systems helped along by an instruction manual written by Mother Nature herself, with perhaps a touch of tutoring by a cadre of high school biology teachers. Assisted conception, on the other hand, is axiomatically complicated by its necessary introduction of third parties into the reproductive process. Whether these third parties are physicians specializing in infertility care, or strangers willing to provide the missing ingredients for the conception and birth of a child, the addition of one or more actors to the traditional two-party procreative process increases its complexity exponentially. The necessity of third parties in assisted conception means that reproduction is no longer purely internal, but rather is externalized, forcing prospective parents to seek out and procure services essential to their procreation. This article explores the accessibility of these reproductive technology services.

The notion of access to reproduction in the aftermath of Justice Douglas's broad mid-century pronouncement was, in the main, a negative right.¹⁰ Declaring procreation a "basic civil right of man" meant the state was prohibited from interfering with a person's *natural* ability to procreate. This article ponders the limits of state and private conduct when a person lacks the natural ability to reproduce. Whether the contemporary notion of access to reproduction likewise embraces a prohibitory stance toward interference with a person's ability to procreate *with assistance*, is best revealed by a study of the current provision and denial of assisted reproductive services. Part II describes the rising use of reproductive technologies in the United States, marching steadily from a rare oddity in the 1980s to a downright common form of procreation in the 21st century, responsible for 2 in every 100 births nationwide. By tracking the panoply of existing reproductive technologies and the demographics of those who seek out ART services, the potential for barriers to access comes clearly into view. Studying who needs, who buys and who supplies assisted conception is foundational to understanding the obstacles that ART consumers face. While Part II extols the technical successes reproductive medicine has wrought, it correspondingly suggests these successes have sown a pent up demand for reproductive services that our society either cannot, or will not, accommodate.

Part III herein discusses the limitations on access to reproductive technology services, setting forth the four major categories from which barriers arise. The first, and most far-reaching barrier, is the limitation based on cost. As Part III explains, ART services are costly and are largely excluded from coverage under most private health insurance policies. Thus, the population who can access such services tend to display homogeneous wealth and employment characteristics. Relatedly, a second barrier to access separates prospective patients along racial and ethnic lines. As in access to health care generally, access to reproductive technologies is diminished for racial and ethnic minorities as compared to non-minority populations. Statistically, while minority men and women are more likely to suffer from infertility compared to their non-minority

¹⁰ Procreative liberty as a negative right is ably discussed by John A. Robertson in his book, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 23 (1994).

counterparts, they are less likely to have and avail themselves of access to treatment. The reasons for this disparity are explained in both historic and contemporary social terms, with neither explanation yielding a satisfactory justification for the continuing barrier. Third, reproductive services can be limited based on a patient's marital status. Despite the fact that a third of all children in the U.S. are born to unmarried women, negative attitudes toward single parenthood create barriers for single individuals and same sex couples who must look to reproductive medicine for family formation. Recent efforts on the part of some private physicians and public lawmakers display an unabashed desire to deny ART services to unmarried individuals. Though the merits of such attempts seem constitutionally dubious, the mere foray into a system that assesses the worthiness of a prospective parent based on marital status is dangerously out of step with modern family life.

The fourth and final barrier to reproductive services discussed in Part III focuses on limitations based on domicile. It turns out that where one lives, either country or state of residence, can significantly impact one's access to reproductive technologies, causing those with more limited access to travel abroad for ART services. This phenomenon of fertility tourism is on the rise, creating myriad legal and ethical dilemmas in its wake. While the impetus for fertility tourism is basically threefold – domestic limitations based on cost, access to services, or legal restrictions – the flow of fertility patients across state and national borders has produced both anticipated and unexpected results. Part III concludes by introducing the harms now associated with fertility tourism, making the case that such harms are inevitable when a person's natural inclination to reproduce is artificially repressed by legal and other structural barriers.

Part IV examines in more detail the potential harms that can be expected if access to reproductive technologies is limited on the basis of the host of factors discussed in Part III, including wealth, race, ethnicity, marital status or domicile. The harms will likely be visited on four distinct groups, each suffering unique damages from the various laws and practices that provoke involuntary childlessness. The first group, infertility patients, suffer in a number of ways from denial of services, arguably the most problematic of which is harm to dignity. The dignitary harm to patients is explored in the greater context of the debate over the viability of intangible harm claims as a legal remedy. While acknowledging that recovery for dignitary harm carries burdens in terms of measurement, an argument is made that practitioners are uniquely positioned to serve the infertile and thus may take on special obligations to avoid imposing such harms on the patient population.

Second, harms from limited access can befall ART providers, both in terms of economic as well as reputational damages. If treatment denials are voluntary, physicians and ancillary health care workers will suffer loss of potential revenue, as well as loss of confidence from eligible patients who may demonstrate solidarity with their shunned sisters by forsaking the withholding provider in favor of one with a more inclusive policy. Even if treatment denials are involuntary, providers face harms to their pocketbooks and reputations from a potential pool of patients who will seek services elsewhere, perhaps casting blame on the profession for failing to prevent construction of the treatment barriers. Third, children of assisted conception can be harmed by limitations on access to reproductive services. Already born children may face stigma as

a result of the now-banned method of their conception, while never born children are harmed in more theoretical, yet important, ways. Finally, limiting access to reproductive technologies harms society by expressing an attitude that stigmatizes those who are unable to achieve parenthood the old-fashioned way. This expressivist argument is advanced as the primary rationale for opposing limitations on access to safe and effective methods of assisted conception, urging instead recognition and operationalization of Justice Douglas's view of procreation as a basic human right.

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