Assisted reproduction: Deciding what's best for the child, the family, and our society

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ASSISTED REPRODUCTION: DECIDING WHAT'S BEST
FOR THE CHILD, THE FAMILY, AND OUR SOCIETY

by

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ABSTRACT

Assisted Reproduction: Deciding Together What's Best for the Child, the Family, and our Society

by

Gayle R. Fisher

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The use of high-tech reproductive technologies to have children is widely practiced today in the United States. While state statutes regulate this industry to some extent, this field is largely self-governed, and disputes between individuals are usually resolved through the courts.

In my thesis, I examine the inadequacy of public policy formation in the three more controversial areas of assisted reproduction: artificial insemination, in vitro fertilization, and surrogate motherhood. Policy-making is mostly done indirectly and haphazardly through the courts and some state and federal legislation. There has been no organized national dialogue.

I recommend that moral consensus be sought on this issue through the formation of a national commission to study the current practice of assisted reproduction and to make recommendations for regulation, legislation, or further studies. The goal is to help build consensus on this important issue.
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CHAPTER I

INTRODUCTION

Will the real mother please stand up? Is she mother number one, the genetic mom; mother number two, the gestational mom; or mother number three, the adoptive mom? In today’s world, it is possible to have all three kinds of mothers. As for the fathers, there is the biological dad and the adoptive dad. However, the biological dad could also be a sperm donor without any intention of playing a role in a child’s life. He could be known or anonymous to the mother.

The technological possibilities are numerous, amazing and frightening at the same time. My thesis looks at three of the more controversial areas of assisted reproduction in terms of their potential effect on the changing role of the family. They include artificial insemination, in vitro fertilization and surrogate motherhood. All three areas, depending on the particular decision made, may involve the donation of gametes or the use of another woman’s uterus, which sets into motion a whole new potential for dispute and controversy. A general discussion of these three areas is made before launching into a closer look at the ethical issues that concern many people. Many of these assisted reproduction issues revolve around a person’s view of the family, which is part of a larger cultural debate taking place in America today.

In trying to decide what is the best approach for dealing with reproductive
technologies, one needs to look at several factors. First, who are making the decisions about these technologies today, and is that ethically acceptable to most people? Second, if most policy decisions are being made by judges, and to a lesser extent legislators and administrators, are they good decisions that take into account ethical dilemmas? Third, if laws are not the answer, or only part of the answer, what examples are available to use as a guide, and what works and doesn’t work about them? Fourth, is moral consensus the right thing to strive for, keeping in mind our need for personal autonomy? Fifth, would the establishment of a national commission fit in with this country’s style and tradition of decision making, and do precedents serve as good indications for the success of an ethical commission in this area? Sixth, does the establishment of a national commission on reproductive technologies fill a real need in this country? Finally, what would an ethics commission look like in terms of authority, scope, membership, and function? Answering these questions gives us guidance on what to do to fill this important need in this country.

Decisions about reproductive technologies, made every day by thousands of Americans and others around the world, usually remain private until there is a problem. Then it becomes a legal battle that is usually resolved in the courtroom and sometimes by state or federal legislation.

A study of common law cases involving reproductive technologies sheds only a dim light on the judicial and, to a lesser extent, societal response to assisted reproduction. At the present moment, however, for better or usually for worse, it seems to be the best indicator available of society’s response to these technologies.

This is due to an unwilling legislative and regulatory response to these technologies. This can be partly attributed to the U.S. Constitution, which protects a
person's right to privacy and a person's right to procreate and to have a family.

Many critics argue that resolving these complex, changing technological issues through the courts is the wrong approach. First, using common law cases in general to resolve broader societal issues is inadequate because of the attention paid solely to the parties involved. Second, using common law cases in technological and scientific areas invites criticism because judges and lawyers usually have a limited knowledge in these areas. Third, using common law cases in the area of assisted reproduction usually does not address the ethical issues underlying the disputes. Common law is not, by its nature, set up to be forward looking or far-reaching in its decision making.

While many people have written books and articles stressing the importance of our society grappling with the controversial issues involving reproductive technologies, state and local governments have remained uncommitted to resolving the complex issues raised by technological advances in the area of reproduction. A look at state and federal legislation shows wide disparity in the decisions that are being made about these technologies. Policy makers lack the time, the knowledge, the expertise and, some would say, the courage to enact thoughtful legislation. Still others say legislation is not needed.

Many experts have called for some kind of moral consensus on this issue in advance of legislation. The field of bioethics has looked at the issue of consensus for many years, and there is much disagreement about what kind of consensus is good, and whether it is achievable. A review of those findings reveals what has been done in this field, and what the experts say about moral consensus and how this might be undertaken on such complex topics as egg donors, donor insemination and surrogate motherhood.

One popular discussion in bioethics is the formation of ethics commissions to help
achieve consensus, not only in reproductive technologies but other topics as well. Other countries have moved much farther ahead in this area, choosing to delve into this arena through the formation of national boards or commissions, whose members study the issue and eventually make recommendations which have in some cases turned into national legislation. The formation of national commissions to study important technological and social issues is not new to the United States. These commissions have had mixed successes and an analysis of their work is shown in an effort to find how they have or have not achieved consensus, and how they have resolved controversial issues. A look is also taken at what has been done in the area of reproductive technologies in particular in terms of trying to achieve any degree of moral consensus. For such a consensus, the framework, scope, membership, authority, and deliberation process are important aspects. A number of authors have examined this and similar issues, and have as many opinions about the outcome of such a commission.

My thesis critiques the reproductive choices that are being made today and by whom, and what issues are being confronted and how. Decision making by judges, legislators and experts are examined with an eye toward how all this fits in with society's changing role of the family. The paper then looks at how other countries are dealing with reproductive technologies and how those models may be applied to the United States. A background look at national commissions and the concept of consensus is examined before recommending the framework, scope, and authority of such a commission and how it could be used to help all stakeholders for assisted reproduction.
CHAPTER II

INFERTILITY, CHOICE, AND ASSISTED REPRODUCTION

Infertility affects some 10 to 15 percent of all married couples in the United States. Infertility is defined as a failure to conceive after one year of regular coitus without contraception. A 1988 report of the Congressional Office of Technology Assessment said that Americans spent $1 billion in 1987 to combat infertility. More than 10 million Americans are struggling to have children; more and more women are waiting until the age of 35 or later to try to become pregnant, and more than 25 percent of those women are failing in that effort.\(^1\)

In 1991, at least five states required insurance carriers to cover infertility treatments, including in vitro fertilization. Insurance coverage is a continuing debate. The average cost of diagnostic and medical treatments for infertility in 1988 was more than $2,500 per couple. About 18 percent of the babies born in the United States in 1990 were expected to result from the benefit of infertility treatments, or about 200,000 babies. Less than half of the couples seeking treatment end up with babies.\(^2\)

Reproductive technologies also benefit those who are not infertile. Single women, couples with inheritable genetic disorders, gay couples, and older women are undergoing some of these procedures in order to have children. They choose to use these procedures, although some clinics have policies that discourage the use of reproductive...
technologies except in cases of infertility. Others have guidelines restricting assisted
reproduction to ineligible patients due to age, health, and other factors.

Artificial Insemination

In today's technologically advanced world, it is not only possible to have sex
without reproduction concerns, it is also possible to have reproduction without sex
concerns. The first recorded occurrence of this happened in 1984 in Philadelphia to a
woman who never knew what happened to her. Her doctor decided to perform the
procedure after discovering the husband was infertile. He used a medical student's sperm
to perform the procedure, and nine months later she had a son. Since then, artificial
insemination has evolved to the point where women can go to sperm banks, choose
desired characteristics from a selection of potential donors, and then inseminate
themselves, if they choose, with the donor semen. It is estimated that 400 commercial
sperm banks operate in the United States today, some 11,000 private physicians perform
the procedure, and about 80,000 women undergo artificial insemination by donor, called
AID, each year. Other estimates show 250,000 children being conceived by donor
insemination each year and about 30 sperm banks operating in the United States. This
discrepancy seems to indicate the low level of record-keeping practiced for these
procedures, particularly by doctors.

The world's largest sperm bank, in New York, holds more than 30,000 specimens
and has generated more than 11,000 babies since 1971. It is estimated that artificial
insemination by donor is a $164 million a year industry. It is also estimated there are
about 1,000,000 children born through donor conception in the United States.
Most sperm bank operators who work directly with women are not concerned whether or not the woman is married or heterosexual as is the case at some medical clinics. The donor, however, is screened for a history of family diseases, current hereditary or venereal diseases, and mental illness.⁶

Like other infertility procedures such as surrogate motherhood and embryo transfer, donor insemination is changing the traditional family structure. With donor insemination, the mother is the "real" parent but her husband, if she has one, isn't the "real" father. He could be the legal father, if he has adopted the child, or if the birth certificate lists him as the father. Many parents keeps this information secret, perhaps even from the obstetrician.⁷

Donor insemination, called AID, raises several moral issues for many people. As a result, those persons analyzing this subject have made a variety of recommendations including: halting the procedure entirely; regulating who is allowed to undergo donor insemination; counseling prospective participants as to their motivations; and screening donors on a psychological as well as medical level.⁸

Historically, donor insemination has been done in secrecy in doctors' offices. The secrecy occurred for several reasons. Mainly, many husbands did not want anyone to know they were infertile. Second, most donors did not want any legal responsibilities for children. Third, many doctors did not want any legal or other kind of complications resulting from the revelation of donor identities. Fourth, most women undergoing donor insemination wanted their own children, and many were often worried about the legality of the children.⁸ Birth records often named the husband as the father, and the child was considered the husband’s own. The procedure was used almost entirely for married
couples whose husbands were infertile. Almost all procedures were performed by doctors, who decided for medical and ethical reasons who should be inseminated. Many doctors turned away patients who were unmarried, non-heterosexual or too old.9

Record keeping was virtually nonexistent, and doctors still resist attempts to legislate mandated record keeping on donor-inseminated patients. A 1979 study showed that 36.9 percent of surveyed doctors kept records of donor insemination, and only 30.4 percent documented the procedure to protect the patient and guard against malpractice suits. In 1990, guidelines set by members of the American Fertility Society endorsed donor anonymity by stating that physician records must remain confidential and should become available to parents and children on an anonymous basis only.10

Secrecy still is a major part of the donor insemination process, particularly in doctors' offices. However, more options are available today to women, especially older, single and lesbian women. First, more doctors are opening their doors to a broader range of women. Second, sperm banks deal directly with women. These sperm banks often have more liberal policies. Because secrecy is still the preferred option, there aren't many parental advocates speaking out on this issue. Nor are donors or doctors doing much public speaking on this subject.11

In Vitro Fertilization

From the time the first test tube baby was born in England in 1978, more than 35,000 test tube babies have been born in the United States, and thousands more embryos have been frozen. Most of the babies were conceived by in vitro fertilization, a process in which the father's sperm is mixed with the mother's egg outside the body in a glass dish.
The resulting embryo is then intended to be transplanted into a uterus. It is estimated that more than 250 fertility clinics use in vitro fertilization and other techniques, with an estimated $2 billion a year spent to treat infertility. A single attempt can cost $6,000 to $12,000, with fertility drugs costing hundreds of dollars per dose.

The first successful use of in vitro fertilization resulted in the birth of Louise Brown, the world’s first test tube baby. Initially, IVF was used for a woman’s blocked fallopian tubes, but now is used for other reasons. For a few years after this birth, IVF was considered a magical, mysterious procedure largely because the scientists involved did not provide a lot of information due to competition among themselves. At this time, 60 percent of the general public polled approved of IVF for infertile married couples, and 53 percent said they would try IVF themselves if they were married and unable to have a child by any other means.

By 1981, only three more IVF births were reported around the world. Research continued, and scientists began reporting on expanded uses for IVF. While it was initially used for blocked fallopian tubes, the use evolved to abnormal semen, sperm antibodies, endometriosis, and so-called unexplained infertility.

Between 1978 and 1984, ethical and religious objections to reproductive technologies were discussed in virtually every journal article. During this same period, the need for IVF as a cure for the infertility problem reached “plague” proportions, particularly for white, affluent women who wanted to have it all.

Between 1984 and 1987, feminists started to vocally oppose new reproductive technologies. Many felt the new reproductive technologies were the ultimate control of women by male-dominated sciences. Before, many feminists felt that the new
reproductive technologies represented instruments of freedom for women. From 1987 to present, the public grew more and more accepting of routinely used techniques. Now, IVF has become more of an accepted product, the need of which is seemingly beyond dispute. The shift focused from the “need for” to the “right to” infertility treatments. The New England Journal of Medicine claims the “pool of patients” exceeds one million. In addition, Time Magazine said there are millions more undiagnosed patients. Now the debate often concerns the need for regulations and consumer protection.

In addition, the development of the technique of freezing and preserving embryos has created new uses for the procedure. Now, younger women can donate eggs to be used by older women, for example. Or embryos may be frozen for future use.

Surrogacy

Surrogate motherhood is the controversial practice in which a woman agrees to bear a child conceived by artificial insemination and to relinquish it at birth to others for rearing. The woman may or may not be genetically related.

Infertile couples seeking surrogates often hire attorneys and sign contracts with women recruited through newspaper ads. Presently, several hundred people probably have undergone this practice. What began with a few lawyers and doctors in Michigan, Kentucky and California is now national in scope. Surrogate mother centers exist in Maryland, Arizona, and several other states.

Phillip Parker, a Michigan psychiatrist who has interviewed more than 275 surrogate applicants, finds that the decision to be a surrogate springs from several motives. Most women willing to be surrogates have already had children, and many are
married. They choose the surrogate role primarily because the fee provides a better economic opportunity than alternative occupations, but also because they enjoy being pregnant and the respect and attention that it draws. Some surrogates may also feel pleased, as organ donors do, they have given the "gift of life" to another couple.\textsuperscript{22}

The couple must be willing to spend $20,000 to $25,000, depending on lawyers' fees and the supply of and demand for surrogate mothers.\textsuperscript{23} Others estimate fees as high as $125,000.\textsuperscript{24} The contract both sides enter into must deal with all sorts of contingencies such as the surrogate mother's unwillingness to surrender the child after birth, the claims of the husband of the surrogate mother, the birth of a malformed child, or even the death or divorce of the infertile couple prior to birth of the child. The contract may include provisions that the mother does not smoke, drink alcohol, take drugs, etc.

The surrogate motherhood issue came to light in the famed "Baby M" case in 1987 in New Jersey. In that case, the contracting parents and the gestational mother fought bitterly over the custody of the child.

The technique can also be used to provide single men or gay couples with babies or to allow women the opportunity to avoid the risk, discomfort and inconvenience of pregnancy.\textsuperscript{25}

Surrogate motherhood is not a new technique, although it is often considered so in discussions involving reproductive technologies. In biblical days, barren women were provided with sons by surrogate mothers. Sarah in the Old Testament said to Abraham: "Behold now, the Lord has restrained me from bearing; I pray thee, go into my maid; it may be that I may obtain children by her."\textsuperscript{26}

Many people are opposed to surrogacy because the practice involves the exchange
of money for a child. Others believe the practice exploits poor women who will become a surrogate mother solely for the financial benefits. Infertile couples desperate for a child of their own believe that it is better to have a child that is genetically related to at least one parent than no parent at all.

Summary

While infertility is a major reason to seek assisted reproduction, other reasons exist such as the lack of a male partner, the lack of a female partner, and so on. All those persons seeking assisted reproduction share a common goal: the desire to make a child part of the family, whether the family is a single parent, a married or unmarried couple, or a gay couple. While most people applaud a desire for children and a family, the controversy begins over the differing concepts of the family structure. The next chapter discusses some of the ethical issues surrounding the use of reproductive technologies, beginning with a discussion of the family in today's society.
Chapter Notes


2. Ibid., 3.


5. Ibid., 335-336.


8. Corea, 53-54.


10. Swanson, 155.


13. Ibid.


16. Van Dyck, 72.

17. Van Dyck, 83.

18. Van Dyck, 87-90.

19. Van Dyck, 121.


21. Ibid., 46.

22. Ibid., 47.

23. Ibid., 48.

24. Freedman, 46.


CHAPTER III

REPRODUCTIVE TECHNOLOGIES AND THE FAMILY

Ethical issues in reproductive technologies are being discussed today on many fronts. The stakeholders in these debates include the embryos, the children, the social parents, the siblings, the gamete donors, the surrogates, the surrogate’s family, the extended family, the friends, the co-workers, the doctors, hospital and clinic staff, researchers, judges, lawyers, legislators, congressmen, feminists, ethicists, theologians, journalists, students, and consumers. In short, millions of people have some sort of stake in the outcome of reproductive technologies, whether they are concerned for themselves, for others, or for future generations.

The discussions are both private and public, and range from how it should be done to if it should be done at all. Others prefer a guarded approach to these technologies while many exalt each new step along the researcher’s path. Some prospective parents approve of one method while disapproving of others, even though the result is a child for another infertile person or couple. While the private discussions continue, there is rarely any loud public outcry except on occasional instances when media attention is drawn to the postmenopausal grandmother giving birth, the surrogate mother demanding custody, divorced couples fighting over the disposition of frozen embryos, or a doctor at a fertility clinic using his own sperm without permission or disclosure.
This chapter discusses some of the major ethical issues that are of concern to various stakeholders. A discussion of the family initiates this discussion because many objections to these technologies are based on differing concepts of the family structure, concepts grounded in our society’s culture and religion.

The Family

Many of the ethical issues regarding reproductive technologies, but not all, stem from a particular person’s view of the family and marriage. Today, there is an upheaval in the family structure. Traditional families are competing with modern families for moral authority.

Until the last few decades, society understood the family as separate from other areas of life. By the 1970s, 50 percent of American marriages ended in divorce. About 25 percent of households consisted of one individual, and only 33 percent of families contained two parents and their minor children. Some 45 percent of mothers with preschool children worked in 1980 compared with 12 percent in 1950. By the late 1980s, 66 percent of children aged three and four were in day care or nursery school. Between the early 1960s and the early 1990s, the percentage of children born to unmarried parents increased 500 percent, from 5 percent of all births to 25 percent.¹

Many observers see a change in the social order with the breakdown of the family at the center of that change. Others see the change in the family as positive. In any case, an acute awareness about the family has grown throughout society.²

Author Janet Dolgin, in Defining the Family, states that the dilemmas posed by these reproductive technologies provide an opportunity to examine these social responses...
to the changing family. Assisted reproduction involves new choices for people both within and outside of traditional family structures. These choices, she claims, question the biological underpinnings of the traditional conception of family. They also encourage people to create families in contexts that depend upon the assistance of third parties and that usually involve money exchanges, areas traditionally outside the realm of family life. As a result, assisted reproduction is being acclaimed for “enabling the creation of enduring, affectionate families.” It is also being condemned for “manipulating the dimension of human reproduction and thereby contributing to the breakdown of traditional family life.”

This breakdown in the family is also seen as a larger cultural struggle. In the book, *Culture Wars*, author James Davison Hunter describes this country’s cultural conflict shift from a divide among religions to a divide among orthodox and progressive alliances within religions. He defines cultural conflict as “political and social hostility rooted in different systems of moral understanding.”

Hunter claims the cultural conflicts throughout most of American history have taken place within the boundaries of a larger biblical culture over religious issues. Underlying those disagreements, though, were basic agreements about life in the community and our country. He shows that the divisions taking place today are based on differences in world views rather than theological in nature. He then states that the discussions taking place today on such issues as abortion, child care, and gay rights can be traced to the question of moral authority. He defines moral authority as how people determine whether something is good or bad, right or wrong. Cleavages in differing world views cut across old lines of conflicts such as Protestants, Catholics and Jews.
The truth for orthodox advocates is that everything was created by God, that human life begins at conception, and from that moment on, it is sacred. Another truth is that the human species is male and female according to body, role, psyche and spiritual calling. Homosexuality is a perversion of the natural order. The nuclear family is the natural form of social structure and should remain inviolable from outside interference. The progressive view holds that there is no objective and final revelation directly from God, and scripture is, at best, a witness to revelation. Moral and spiritual truth can only be conditional and relative. It can come either from self-grounded rational discourse or personal experience. It is “this-worldly.” Personhood begins at or close to the moment of birth, male and female are differentiated solely by biology, and human sexuality is based on biological needs.

The author of *Culture Wars* believes the struggle over the family is at the heart of the culture war. And many issues such as abortion, homosexuality, and day care are family issues. Using this definition, reproductive technologies is also considered a family issue. The real issue is not whether the family is good or bad, but what constitutes a family.

The family as an issue of social concern began in the 1960s and continues today. In 1977, the Carnegie Council on Children recommended a comprehensive national policy on the family. In the 1980's White House Conference on Families, the difficulty in defining the American family was elevated permanently as part of a national policy debate. The conference only succeeded in polarizing the issue further.

The orthodox view of the family, according to Hunter, is a male-dominated nuclear family that both sentimentalizes childhood and motherhood, and celebrates
domestic life as a retreat from the harsh realities of industrial society. The author states that conservative Catholics, Mormons and evangelical Protestants view the survival of this type of family as essential because it was ordained by God, established by nature, and fosters social harmony.

For the progressives, the bourgeois family is the symbol and source of inequality and oppression for women in society. The demands of progressives, according to the author, are not just for civil rights, reproductive rights and equal opportunities for women, but a whole new conception of the family. To that end, progressive voices call for a change in the nuclear family structure and in society as a whole. The moderate view calls for the equal division of domestic and public labor. The more extreme view sees the oppression of women as rooted in their biological role in reproduction and demand the total abolishment of all forms of traditional and patriarchal authority. This is the radical feminist viewpoint expressed in articles and books against assisted reproduction because it keeps women oppressed. 10

The family struggle is divided over authority, or who has the final decision-making power. The orthodox view favors the husband, the male head of the household. The progressive view favors equal authority among men and women. This latter group favors such issues as equal rights for women. 11

Those holding the orthodox view believe that family obligation extends not only to the born and living but to the unborn as well. Progressives reject the idea that one can be obligated to potential persons. 12

Progressive activists have a difficult time shaking the image of being anti-family, but they insist their view is just more inclusive than traditional views. Progressives tend
to favor economic assistance for families in need and a coherent public policy.\textsuperscript{13}

The culture war is not just a debate about current social issues. The source of the conflict, according to Hunter, is competing moral visions. It is a struggle over the meaning of America - who we have been, who we are today, and who we will be in the future.\textsuperscript{14}

So where do the various stakeholders for assisted reproduction fit into this debate? Reproductive technologies change the entire baby-making process, involving individuals beyond the traditional mother and father (gamete donors, fertility specialists, lawyers, etc.). Assisted reproduction changes the very framework through which participants understand the family, their values, and themselves. Exactly what changes are made, and whether they are good or bad, is at the heart of the ethical debate about reproductive technologies. It is not only whether they are good for the persons directly involved, but whether they are good for others as well.

According to Kenneth Alpern, editor of \textit{The Ethics of Reproductive Technology}, three issues are essential when looking at assisted reproduction: prudence, morality, and policy. He states that prudence dictates what is good for a person directly involved in a particular action. Is it beneficial or harmful to a woman if she chooses to bear a child through surrogate contract? That, of course, depends on the person’s values and beliefs. However, sometimes what a person believes is good for her is not really the case at all. Morality, he continues, dictates what is good for all parties affected by an action and includes any relevant rights, principles, or values. Moral values indicate something that should be given weight in moral deliberations and preserved in action. Appeals to moral rights, principles, and values are constantly being made in the debates over reproductive
technologies. Finally, Alpern states that policy concerns the responsibility and policies of social institutions. Falling under this heading are questions about whether a certain practice should be made illegal and whether the government has the power to make it illegal.15

When addressing these issues, a person is asked to identify and decide among various interests, rights, principles and values. In the area of reproductive technologies this is difficult because our concepts and frameworks of family, for example, were developed without a view to the many possibilities that now exist. For example, Alpern explains that we may believe parents have certain rights and responsibilities regarding their children. All that is thrown into doubt, though, when there are questions about who is the “real” parent, as is the case with many of the reproductive technologies. Therefore, some of the more difficult problems raised by reproductive technologies are how to modify or replace our categories so that reproductive technologies may fit into our previous understanding of concepts such as family. This may call for the eventual abandonment of traditional ways of thinking in favor of a way that helps us to understand and accept these new technologies in the context of the family structure.16

One challenge, he claims, is how to look at cases when traditional concepts are insufficient for our understanding of them. In donor insemination, a married woman may have a child by a man who is not her husband. By this criterion, who is the child’s father? In the law, a husband who consents to his wife’s use of this procedure is deemed to be the legal father of any resulting children. Legally, artificial insemination by donor does not constitute adultery. However, decisions of this sort are more complex and difficult outside formal systems such as the law.17
He states reproductive technologies appear to split apart concepts that this society has traditionally treated as unified. The concept of motherhood is a good example. Traditionally, a mother is a woman who bears and raises a child. These new technologies make it possible for three women to share that role. Now we have to decide how to regard the three now separate relations and how the interests, rights, and responsibilities should be reallocated among them.

In the first two examples, there is the possibility of modifying traditional concepts to fit a new view of mother and father. At a certain point, however, applying a traditional concept to a new possibility may become too confusing or unilluminating. While some may try to apply traditional concepts to surrogate motherhood, others simply cannot do it and need to develop a new concept for understanding.  

Conceptual problems may also arise when one sort of framework is extended into the domain of another, as when economic, technological, or legal frameworks encroach on personal relationships, Alpern claims. When contracts are involved in parenting, for example, babies and reproductive relations are bought and sold, bringing about charges by some that these practices degrade persons to commodities and relationships to economic exchanges. When reproduction is conceived in technological terms of design, power, and manufacture, the consequence is that embryos are reduced to materials, and private personal intimacies are transformed into rational public ventures.

Traditional thinking may not be adequate for the new possibilities. What may be needed, according to Alpern, is a paradigm shift in our world view. In such revolutions, basic categories, methods and modes of explanation are completely transformed or abandoned and replaced. Reproductive technologies may be creating a condition in
which there is a continuing failure to resolve problems through the basic categories.\textsuperscript{20}

To help society’s understanding of reproductive technologies, ethicists have tried to identify issues that need resolution. There are many ethical issues in the area of reproductive technologies, and they are often divided differently. In this review, they are divided by stakeholders, and various kinds of ethical concerns are considered under each category. Some of the more important categories are discussed below.

The Embryo

One issue that concerns many people is what to do with embryos that are not implanted inside a woman’s uterus, either frozen or not. Some people believe that if an embryo is human and alive, it should not be deprived of a chance for development, and therefore should not be used for research. However, they would give moral approval to in vitro fertilization if each embryo produced were to be transferred to a uterus. Others believe that human embryos are not yet human persons and that if it could be decided when an embryo becomes a person, it could also be decided when it might, or might not, be permissible for research to be undertaken.

The central objection to the use of human embryos for research is that they are human. The human embryo is seen as having the same status as a child or an adult, by virtue of its potential for human life. The right to life is held to be the fundamental human right, and the taking of human life on this view is always wrong.

Those who favor the use of human embryos for research cover a wide range of views. At one end are those who believe that only human persons should be respected as persons, and that a human embryo is not a person. Others believe the embryo is entitled
to some measure of respect beyond that accorded to other animal subjects, that respect cannot be absolute, and may be weighed against the benefits arising from research.

The United Kingdom’s Warnock Committee report, for example, recommended that no live human embryo derived from in vitro fertilization, whether frozen or unfrozen, may be kept alive, if not transferred to a woman, beyond 14 days after fertilization, nor may it be used as a research subject beyond 14 days.²¹

Other questions arise over the disposition of frozen embryos, particularly when one or both parents no longer want them implanted for the later birth of a child. Who should be given priority consideration in this regard: the embryo, or the unwilling parent? Also, is it morally responsible to create more embryos than are needed for the birth of a child? This happens frequently during in vitro fertilization.

The Child

Some people think it is pointless to discuss whether it is fair to the child to be born through assisted reproduction techniques such as donor insemination or surrogacy. After all, without those techniques the child wouldn’t exist, so why discuss it? This is a major distinction from adoption, where the child is in this world already. An assisted reproduction child is planned because an individual or a couple want him to be a part of their family, for better or worse. This could be a married couple, a gay couple, or a single woman using donor insemination. The fact that the child is wanted is a positive sign for the child’s well-being. But what if something goes wrong with the plans? What if the surrogate mother changes her mind and sues for custody? What if something is wrong with the child and nobody wants to claim the child?
While one might argue that similar types of events happen to children who aren’t the result of assisted reproduction, does this justify the bad result? Fathers often abandon their children; and every day, some children are given up for adoption. Sometimes birth parents change their minds later. Other than a legal remedy, which is often inadequate, how does this society help protect the child of assisted reproduction? Even orthodox families approve of assisted reproduction within the confines of a marriage.

Who decides what is best for the child before it is too late? Do we say that 90 out of 100 successful outcomes is still a good percentage? What about that unsuccessful ten percent? Is that acceptable to this society? Almost all children born through donor insemination do not know about their true paternity. Is that right? Is this better for the family, even though studies show that the “secret” is always there, weighing down the parents? If it is more acceptable for a child to be adopted and to know about it than to be the child of donor insemination, isn’t that fact alone worth thinking about? If life cannot be lived within a mantle of truth, isn’t that a problem?

The law has taken some stands, identifying the married husband as the legal father of a child, thus protecting his legal rights and preserving his financial responsibility. But what about the child’s emotional well-being? A man the child thought was his father gets divorced from his mother. Now he’s fighting in court so that he won’t have to pay child support because he’s not the father. These court cases do not talk about the effect this has on the child. The same law protects the donor’s privacy and discourages record-keeping, a key mandatory element in adoption practice.

Embryo transfer is newer and records fewer, but the same goes for this child. Do the parents tell him his true maternal identity? What about the child with a 60-year-old
birth mother? Is it fair for a child to have an aging mother? It seems that reproductive rights for parents which are protected under the U.S. Constitution can inadvertently cause harm to the child of those parents. While legal protection may exist, the moral aspect must be taken into account.

On the positive side, a child that is born through assisted reproduction is related genetically to one or both social parents, unlike adoption. Most of these children are brought up in a welcome, loving environment. While progressives may argue that everyone is entitled to a family, and orthodox conservatives may argue that there are right kinds of families and wrong kinds of families, everyone applauds the notion of children being loved and welcomed.

However, questions are now being raised about whether in vitro fertilization and other technologies are creating serious illness and defects in a small but significant proportion of children who are born of them. While advocates of procreative liberty argue these children are better off being born with birth defects than not being born at all, others believe it is morally irresponsible to forge ahead with such possible risks to the child.22

The Parents

Discussing parents as stakeholders in this issue can mean many things. The parents could be the social parents, the genetic parents, the gestational mother, and so on. This could mean a single mom or dad, a gay couple, a married couple, or an unmarried couple. A sister or grandmother could be the gestational mother for a child, and a brother could be a donor.
It seems that a devoted couple seeking to have a child through in vitro fertilization would be applauded by just about anyone for their determination. But a gay couple using a surrogate mother to have a child is not entirely accepted by many parts of society. Is that fair? Legally it’s acceptable, but socially it may not be considered the right thing to do. That is a conflict between our values and the law. Both couples would love and cherish a child.

The surrogate mother is also a parent. She may be the gestational as well as the genetic mother. Is it right to force her to give up her rights to the child prior to her really understanding how she may feel about the baby once it is born? The law is divided on this issue. On the other hand, what about the father and his wife who have invested their emotional stock in this surrogate arrangement? Aren’t their needs and wants important? How does society resolve this issue for everyone concerned? An outright ban would protect all parties concerned from potential heartbreak, but it would also prevent the possibility of children for some families. Does the surrogate mother really know what is best for her? Is she vulnerable to exploitation? Is she selling her babies? What happens if her health is harmed as a result of the surrogacy?

As for donors, is there ever the possibility they may have paternal rights? Don’t donors deserve the same legal protection as married couples? Who do we as a society want to protect, the family or the donor?

When it comes to IVF procedures for the determination of characteristics such as sex, is this right? What about the color of the hair or eyes, or the shape of the nose? Are children lovable just as they are? If a 60-year-old woman wants to have a child, or an interracial couple want to have a white baby, should they be allowed to do it?
Siblings and Other Family Members

The use of reproductive technologies affects the rest of the family, too. How does a surrogate mother explain to her existing children that she plans to give away the child growing inside of her? What about the man who sells his sperm and later has his own family. Does he let them know that they have half brothers or half sisters somewhere in the world? Does a woman who donated her eggs to another couple tell her children what she has done? While all this may be legally acceptable, what are the moral implications for these sisters and brothers? How does the husband of a surrogate mother feel about the fact she is carrying another man’s baby? How does he react to her and the pregnancy?

The Doctors

In many cases, fertility specialists decide who may undergo certain procedures. It is possible for them to exclude older women and single women, for example. They also decide what to tell couples about their chances for success. It may be easier to make decisions when a life is threatened, or good health is at stake. However, infertility is not considered an illness by many, so this may be considered an elective or experimental procedure. Is it ethical to try an unproven procedure on a patient desperate to become pregnant? Doctors are deciding issues every day, and the outcome is different for each.

Judges and Lawyers

These stakeholders operate in an entirely different arena. They must consider the legal ramifications of an action, not the ethical ones. Lawyers work on behalf of their
clients, so they look at the law in terms of how it will benefit their clients' position. Judges, usually knowledgeable in this area, look at legal precedent and analogy in making their decisions. Their ethical views may differ substantially from their legal opinions.

Researchers

Extraordinary events are happening in assisted reproduction, and the role of researcher is extremely important to its success. However, many researchers privately worry about creating children with defects, something they don’t openly talk about because it creates fear. While the federal government cannot, by law, fund this type of research, it is still carried out by private institutions. Some critics wonder how safe these procedures are when desperate patients encourage eager researchers to push the envelope of what is biologically possible.

One researcher, for example, is now trying to improve the chromosomes of the eggs of older women so that they can have their own babies. However, this unproven procedure involving many risks should be tried first on embryo eggs, but this research is forbidden. So this researcher must receive permission from a patient who wants to have a child, but can’t do so through any other means. One researcher admitted that, upon reflection, that this was probably unethical, but would probably go ahead and do it anyway.23

Others

Other stakeholders include theologians, ethicists, consumers, students, and so on. Each has a stake in the outcome of reproductive technologies, either directly or indirectly.
The Catholic church, for example, believes assisted reproduction outside the confines of a marital relationship is not acceptable. Some ethicists believe surrogate motherhood is unacceptable but have no problems with in vitro fertilization. Radical feminists believe reproductive technologies exploit women, and consumers want laws and regulations that protect people from fraud and abuse.

Summary

While these brief descriptions do not give full justice to the various views, the point that is being made is that there are many different viewpoints about numerous aspects of assisted reproduction. Ethicists debate the issues among themselves while doctors and patients are doing whatever is necessary to safely bring another child into this world. What is right for one person is wrong for another. Is there any common ground for agreement? Should there be? Who should decide, and what should they decide upon in this burgeoning fertility arena? Is it better to let things go on the way they are now, with some legal intervention upon occasion, or should we as a society make some decisions about the future of the family and the role of assisted reproduction in determining the shape of that family?

The use of reproductive technologies challenge our society’s most established ideas about motherhood, paternity, biological inheritance, the integrity of the family, and the “naturalness” of birth itself. According to author Cris Shore, these debates tend to fall into three categories: ethical and practical problems about experiments on human embryos; questions that emphasize the problems posed for the structure of parenthood; and what effects these technologies will have on women’s health and lives.24
Whatever category is being discussed, the possibilities of assisted reproduction are astonishing to a society that has long understood human reproduction as the inevitable consequence of a natural biological process. While reproductive technologies are changing our view of the family, they are part of a change that already was taking place. These new technologies were not widely available until after society had accepted other changes in the family such as no-fault divorce, non-marital cohabitation, prenuptial agreements, and so on, according to Janet Dolgin, author of Defining the Family. These technologies, rather, have intensified questions about the dimensions of family life that were already being actively debated within the society.

Assisted reproduction provides a new context within which to consider the moral and social parameters of family. All stakeholders must be given a certain weight in any deliberations discussing the future of these technologies. With the various competing interests, it will be difficult to determine how we as a society will come to agreement on a shared set of values.

This confusion about society’s view of the family is clearly apparent in the courts. To date, most decisions about assisted reproduction have been made in common law cases. These decisions, in large part, have reflected the more conservative values of our society due to the nature of judicial decision making. An examination and review of those decisions is covered in the next chapter.
Chapter Notes


2. Ibid., 29-31.

3. Ibid., 30-31.


5. Ibid., 44.

6. Ibid., 122.

7. Ibid., 123-124.

8. Ibid., 176-177.


10. Ibid., 180-182.

11. Ibid., 183-186.

12. Ibid., 186-188.

13. Ibid., 194-196.


16. Ibid., 6-9.

17. Ibid., 7.

18. Ibid., 7-8.

19. Ibid, 8.


CHAPTER IV

REPRODUCTIVE TECHNOLOGIES AND THE LAW

Much debate in the area of reproductive technologies has centered around the effectiveness of decision making by the courts, and the paucity of laws made at the state and federal level. Society, it seems, has reached almost no consistent, generally accepted decisions about how to understand or regulate assisted reproduction. Ethicists disagree among themselves, and state legislatures have not “responded uniformly or comprehensively to the complexities of reproductive technology and surrogacy.”

This chapter takes a look at how artificial insemination, in vitro fertilization, and surrogacy are being seen through the eyes of the law, both through judicial decisions and legislative decisions. First, a look is taken at how society’s view of the family seems to be affecting judicial decisions. Then a closer look is taken at what actually has been occurring in the specific areas of artificial insemination, in vitro fertilization, and surrogacy. Finally, there is a brief analysis of why these methods may not be sufficient for the kinds of decisions that are being made today.

Most experts would agree that the right to have children and a family is protected under the U.S. Constitution. A number of court cases reaching the Supreme Court have reaffirmed the view that the U.S. Constitution protects a person’s right to have children and a family. In Meyer v. Nebraska (1923), the U.S. Supreme Court said constitutional liberty included the right of an individual to “marry, establish a home and bring up
children.” In *Skinner v. Oklahoma*, (1942), the Supreme Court said marriage and procreation were among “the basic civil rights of man.” In *Stanley v. Illinois*, (1972), the Supreme Court observed that “the rights to conceive and raise one’s children have been deemed essential basic civil rights of man...more precious than...property rights.”

John Robertson, a Princeton University Professor, cites *Skinner v. Oklahoma* in concluding that almost every practice necessary to procreate should receive constitutional protection. He finds a constitutional right to reproduce technologically, to purchase sperm, eggs and gestational services, and even to enforce preconception agreements to rear offspring. In *Skinner v. Oklahoma*, the Supreme Court struck down an Oklahoma statute authorizing forcible sterilization of thrice-convicted chicken thieves. Robertson argued that if fertile persons possess a constitutional right to reproduce, then infertile persons must possess a right as well. Critics argue that Robertson’s global constitutional principles are ill-suited to resolve the problems posed by the new reproductive technologies. Nevertheless, reproductive technologies are seldom challenged on a constitutional basis.

While the U.S. Constitution seems to protect a person’s right to have children, some unsettling questions remain about the use of reproductive technologies. For example, how are competing rights settled between two persons in a dispute over reproductive technologies? Are those consumers desperate to have children adequately protected from profit-minded fertility clinics? Are we as a society really taking care of the best interests of the children, or are we making decisions based on what is good for one parent or another at the child’s expense?

Many experts seem to agree that most decision making in this area is being made
by judges in common law cases that are often limited in scope and vision. Artificial insemination, surrogacy, and in vitro fertilization cover some of the more controversial aspects of modern day baby making. The swirl of controversy surrounding these technologies is also part of a larger debate on the future of the family.

In 1990, four women from Yale University and Kent State University published a report analyzing judicial opinion on reproductive technologies in the United States up to February 1990. After eliminating irrelevant cases, they examined 31 cases. These cases dealt mostly with child support in reproductive technologies, conflicts with existing statutes, paternity rights in artificial insemination and surrogacy, and adoption and custody in reproductive technologies. In their conclusion, they said their analysis confirms the social nature of reproductive technologies. They also said that court decisions reflect an "unwavering commitment to the nuclear family structure."\(^5\)

As part of my thesis, information was obtained using the same terms and the same source (Lexis-Nexis) for the period from 1990 until September 1998. This search reveals a slight shift in the types of cases being brought before the state and federal courts. First, there were about 80 cases dealing with such issues as insurance coverage for in vitro fertilization, artificial insemination, surrogacy, and liability for in vitro fertilization procedures. About 20 cases involved surrogacy arrangements revolving around custody issues and contractual violations. Some 15 cases involved artificial insemination by donor. Some donors wanted paternity in cases dealing with unmarried women and/or lesbians, and others involved child support and paternity issues between formerly married couples. A couple of cases involved artificial insemination and procreation rights of prisoners. One case involved the disposition of the frozen sperm of a dead person. A
couple of cases involved the disposition of frozen embryos. More than a dozen cases involved a dispute between an individual and an insurance company, or an individual’s company. A few cases involved liability issues between an IVF patient and a clinic or hospital. Mostly, the search reveals that issues revolving around surrogacy, IVF procedures, and artificial insemination are still around in the 1990s. In addition, there has been an increase in the number of consumer issues such as insurance coverage and liability of physicians and hospitals.  

Artificial insemination has been around for many decades, and many believe that some form of consensus has emerged on the use of this procedure although some ethical issues remain, such as whether or not to protect the privacy of semen donors and whether or not to require mandatory record keeping. Some donors are demanding paternity rights if the review of recent court cases are any indication. In vitro fertilization and surrogacy emerged as society began to acknowledge and openly accept changes that departed from the traditional understandings of family. Options about how and when to create children, about which gamete should be used to create them, about which woman should be used to gestate them, etc, dramatically complicate society’s ongoing debate about the family.  

The Courts Dominate Family Debate  
The choices presented by assisted reproduction can be defined as conforming to traditional models of family, as when technology is used to create children for desperate, infertile couples. However, these choices can also be perceived as destroying traditional families and everything those families represent, as when the technology is viewed as turning women and children into commodities and parents into business partners. Society
and the law must decide not only who is a mother, the father, or the baby, but what is a "mother," a "father," or a "baby." It becomes more difficult to argue that biology is fate. Hence, the fate of children and families becomes more variable and uncertain.8

Author Janet Dolgin states the law is being asked to respond to the disruptions presented by reproductive technology, just as traditional assumptions about the social dimensions of family and the character of kin relations are being questioned and eroded more generally. For the most part, the task has fallen to the judiciary. Courts are responding by settling particular disputes, but that is not all they are doing. They are beginning to erect a set of frames within which to think about and to develop the family of the future. They are, in short, being asked to develop a new social and moral vision of families so that they can determine the appropriate response to the social and moral dilemmas created by the new reproductive technologies.9

Dolgin adds that courts may be seen as providing a potential laboratory that legislators may review if and when states respond to the new reproductive technologies and surrogacy with comprehensive statutory rules. State legislatures have hesitated to respond to the complex, volatile questions raised by assisted reproduction, but courts do not have that option because judges deal with real people who demand resolution of their problems. As a result, courts have become the primary arena in which the society is constructing its response to assisted reproduction.10

Courts, unlike legislatures, cannot delay or limit responses to reproductive technology and surrogacy until a social consensus emerges or until the absence of regulation becomes disastrous for the society. Parties to specific, unresolved disputes occasioned by assisted reproduction seek judicial resolution, and the judiciary must
respond. Some come out of divorce actions. Others concern such matters as custody battles between a surrogate mother and the intending parents, or between a woman anxious to use her dead lover's frozen sperm and his grown children, or disputes between gamete donors and fertility clinics.

Dolgin states court decisions, however, are characterized by bewilderment and inconsistency. In many cases, trial courts' opinions are turned over on appeal or are affirmed but, as illustrated in Johnson v. Calvert (1993), McDonald v. McDonald (1994), and Davis v. Davis (1992), are made on the basis of an analysis entirely at odds with the first court. Judges have tended to preserve traditional conceptions of the family in cases occasioned by surrogacy and the new reproductive technologies, while at the same time rendering decisions that threaten traditional understandings of family.¹¹

Two court cases, Johnson v. Calvert, and McDonald v. McDonald, illustrate the complexities of dealing with reproductive technologies. The Johnson case involved a couple, each of whom provided a gamete to be joined and then gestated in another woman's uterus. The McDonald case involved a wife who gestated an embryo formed from the fertilization of a donated ovum with her husband's sperm.¹²

In the Johnson case, the two lower courts and the California Supreme Court awarded the baby to Mark and Crispina Calvert, but on different grounds. The state supreme court relied on the notion of parental intent rather than biology or the state statute's definition of mother. However, the Calverts and Johnson both based their appeals to the court on alternative interpretations of the reproductive process that led to the birth of baby Christopher. Previously, gestation was long understood as the symbol and essential instance of biological maternity.
In her court case, Anna Johnson stressed that nature creates a bond between a woman and a baby that she gestates and bears, and that bond establishes the mother-child connection. The Calverts emphasized their biological link to the child as conclusive of their parentage.

In the McDonald case, the woman who intended from the start to be the social mother provided the gestational, but not the genetic component, of biological maternity. The case was between a man and a woman rather than a couple and a woman. In this case, donor eggs were planted into the wife’s uterus, and twins were born. The couple later divorced, and the father fought for sole custody because he was the biological father, and the woman wasn’t. In the McDonald case, the court determined Olga McDonald to be the natural mother because she was the intentional mother, just as the Johnson case.13

In both cases, the judges decided on “intent” to establish the parentage of a baby with two biological mothers. As used by the court in the Johnson case, the concept of intent represents a contractual and a traditional view of family. The egg donor became the legal mother because of intent. In McDonald, the gestational mother was identified as the mother because she intended to be the social mother. The presumption in the Johnson case that an intending parent will be a good parent is arguably stronger than the comparable presumption about biological parents in other cases.

In Davis v. Davis, a Tennessee court bowed to traditional understandings of the family by demanding that special respect be paid to the embryos, defined as valuable because of their potential to become children. However, the court bypassed the interests of the embryos and focused on those of the progenitors. The court explained that ideally such disputes should be resolved by effecting the preferences of the progenitors.14
In this case, Mary Sue and Junior Lewis Davis fought over custody of seven frozen embryos following their divorce. The wife wanted to save them for future implantation, and the husband wanted them discarded because he did not want to become an unwilling father. Three Tennessee courts heard the case, each basing its opinion on a view of the embryos' existential condition radically different from that of the other two courts. One judge said the embryos were children and awarded custody to Mary Sue Davis. The Court of Appeals of Tennessee reversed that decision, stating the decision rested solely on who is entitled to control the embryos. The court stated both parties shared an interest in the embryos and should jointly control them. The state supreme court upheld the appellate court's decision about sharing an interest but on different grounds. The court weighed the "relative interests of the parties in using or not using the pre-embryos." The court stated that because Mary Sue Davis no longer intended to use them to get herself pregnant, but planned to donate them to an infertile couple, that the person who wanted to avoid procreation should then prevail. In June 1993, Junior Davis announced he had the embryos destroyed.15

The varied response of the courts to these two cases illustrates the depth and significance of the social and legal transformation of the family now occurring. The legal system is reacting with uncertainty and confusion, concludes Dolgin. The essential task of the courts, she adds, has become that of mediating between the modern views of family characterized by choice, individuality and autonomy versus the traditional family characterized by "inexorable truth, holism and hierarchy." Courts have employed a variety of legal strategies, but mostly fall into two categories -- the best-interest of the child principle, and parental intent, a new concept for family law.16
Courts relying on intent to resolve disputes engendered by reproductive technology have failed to delineate the parameters and implications of intent, explains Dolgin. Several law review articles, suggesting that intent should become the central tool through which to settle disputes involving reproductive technology, have delineated the contours of the concept. In each case, intent has been equated with choices made through contract negotiations. Thus, the articles urge courts to recognize and enforce contractual agreements concerning the creation of families and children. However, courts have generally not been willing to do that. Although they have relied on intent, courts have failed to address the obvious questions raised by that reliance. Courts have explicitly distinguished a party's intent from the same party's contractual agreements.\(^{17}\)

Disputing parties tend to rely on biological facts to present their arguments in court. Opposing litigants rely on essentially the same biological facts, but dispute the moral and existential implications of the facts.\(^{18}\)

The U.S. Constitution is no help in this regard, either. The right to privacy offers no guidance in selecting among disputants' conflicting rights to procreational privacy posed by the right to procreate against the right to avoid procreation. Rights of equal significance do not help in considering the emotional stress and physical discomfort, the joys of parenthood, or the anguish of a lifetime of unwanted parenthood.\(^{19}\)

Artificial Insemination

Artificial insemination has been around since the early 19th century. About 65,000 children are born annually in the United States due to artificial insemination. This practice shows how the law has regulated this practice following an assimilation period.\(^{20}\)
First, artificial insemination using the husband’s unfrozen sperm has never been an issue with the law. This is a straightforward procedure that does not deal with custody or biological issues. However, the same cannot be said about insemination by donor. Traditionally, artificial insemination by donor was used in marriage when the male was infertile. More recently, it has been used for reducing the risk of genetic disease and gives single women and lesbian couples a chance to have children.

In the first half of the century, disputes involved questions about the paternity of the donor and of the mother’s husband. Courts responded variously and intensely. Some equated artificial insemination with adultery and defined the child as illegitimate. Others defined the relation between the mother’s husband and the child produced from artificial insemination as one of quasi-adoption. Others refused to consider the mother’s claim of artificial insemination because the children would be considered illegitimate. No legislation specifically guided courts in these cases until the mid-1960s.

Early common law cases centered around divorce. In MacLennan v. MacLennan (1958), a Scottish case, the court actually deliberated whether artificial insemination by donor constituted adultery. Lord Wheatley, the judge, said adultery involves sexual intercourse and therefore artificial insemination by donor cannot be adultery. The husband was looking for a reason to divorce prior to the age of “no fault” divorce. Since the wife was unwilling to disclose any details of her artificial insemination, the court granted the husband a divorce due to the wife’s adultery.21

Other cases involved the husband’s obligation of custody and financial support to a child born through donor insemination following a divorce. Most cases decided the husband must support the child, that he is entitled to visitation, and that no other man
may adopt the child without his consent. Only one case considered the child illegitimate.

In *C.M. v. C.C.*, New Jersey Superior Court (1977), a couple was dating and planned to marry. They didn’t want to have sex before marriage, but they wanted a child. They had a child through artificial insemination, but never got married. The man paid child support and wanted visitation. The woman denied visitation. A New Jersey court said the man was entitled to visitation. The court stated: “C.M. has grown a genuine interest in the child; he is a teacher and educationally able to aid his development, and is financially capable of contributing to his support.”

In *Doornbos v. Doornbos* (1956), an Illinois county court ruled that donor insemination was adulterous even if the husband consented because it was “contrary to public policy and good morals.”

In *People v. Sorenson*, California Supreme Court (1968), the court ruled that it would be “patently absurd” to say that donor insemination constituted adultery. In that case, a woman who had received her husband’s written consent to artificial insemination subsequently obtained a divorce and declined support under the divorce decree. When she became ill and began receiving public support, the state sued her husband for support. The court held the husband liable for support because he was the lawful father, thereby preventing the “obvious injustice that would result if a child artificially conceived was excluded from the protection of the law intended to benefit all minors, legitimate or illegitimate...In the absence of legislation prohibiting artificial insemination, the offspring of defendant’s valid marriage to the child’s mother was lawfully begotten and was not the product of an illicit or adulterous relationship.”

In *Gursky v. Gursky*, New York Superior Court (1963), a lower court in New
York stated that the legislature's failure to pass a statute legitimizing a child by donor insemination evidenced the legislature's intent that the courts continue to apply the historical concept of illegitimacy. Another, In re Adoption of Anonymous, New York Superior Court (1973), the court criticized this ruling, stating that the child was not born out of wedlock, that the wife did not have an affair outside of marriage, and legislative intent is not a basis for court rulings. In general, most courts have held that the husband is responsible for child support in artificial insemination cases.

In 1964, Georgia enacted the first statute directly responsive to the questions raised by artificial insemination. This statute stated that children born through artificial insemination using donor sperm would be considered the legitimate children of their mother's husbands if both spouses have consented in writing. The statute provided that only licensed physicians may perform the procedure. Anyone else is guilty of a felony and may be imprisoned for one to five years. Within a short period of time, a majority of the states promulgated statutes that regulated artificial insemination. A similar statute in Oregon makes it a misdemeanor for a woman to inseminate herself.

Many physicians are unwilling to provide such basic infertility treatments as artificial insemination to women who are poor or unmarried. A few states have simply declared artificial insemination performed without the aid of a physician illegal (Connecticut, Georgia, Oklahoma, Idaho, and Oregon).

More commonly, the states allow only those women who use physicians to avail themselves of statutory protections that prevent the semen donor from seeking parental rights, so that women who choose to become pregnant outside the health care system do so at their own risk.
Several states have enacted laws providing that men who have a disease or defect know by them to be transmissible by genes may not be donors. Screening of donors, however, is relatively untouched by statutes or by administrative rulings.  

The Uniform Parentage Act has been adopted by several states with variations in language. This Act guarantees equal protection under the law for all children born of artificial insemination. A child whose mother was so inseminated will not be deprived of a right to a legal father. The California version goes further, shielding the donor of semen from any legal-paternal responsibility, but only for married women. Section 5 of the Uniform Parentage Act provided that if, under the supervision of a licensed physician and with the consent of her husband, a wife is artificially inseminated with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of that child. This means that the semen donor is treated in law as if he were not the natural father of the resulting child. As an aside, the word "donor" is not entirely accurate because the person providing semen usually gets paid.  

The Commissioners on Uniform State Laws have now taken a second try at the donor insemination question. The Commissioners drafted the Uniform Status of Children of Assisted Conception Act in 1988, which corrects some of the problems of the Uniform Parentage Act. The new act defines donor to include an individual who produces sperm for assisted conception, regardless of whether payment is made. The Act declared the husband of a married woman to be the child’s father unless a court finds he didn’t consent to the procedure. A donor is not a parent of a child conceived through assisted conception. The Act also takes a strange position in the case of lesbians who become pregnant through donor insemination. If the woman’s lover seeks some sort of parental
rights in the child, the statute is silent about whether or not she can prevail and gain full custody.\textsuperscript{32}

In \textit{Jhordan C. v. Mary K.}, California Court of Appeals (1986), a donor and a mother’s female friend each sought parental rights for the child. Under the Assisted Conception Act, the father would have been denied because the donor could not be considered the legal father. However, California’s statute did not include artificial insemination outside of marriage. So the court ruled the donor could have visitation rights, and the mother’s friend was also granted visitation.\textsuperscript{33}

In the \textit{Interest of R. C.}, Colorado Supreme Court (1989), the court placed considerable weight on the preconception intentions of the parties and indicated what would constitute evidence of such intent (the recipient’s promise the donor would be treated as a father, the donor’s purchase of baby equipment, setting up of a college trust fund, assistance at the birth and daily child rearing). However, the court would have disallowed any preconception agreement between a donor and a married woman whose husband consented to her AID.\textsuperscript{34}

In Oregon, a donor seeking parental rights forced the court, in \textit{McIntyre v. Crouch} (1989), to declare that the state statute enacted there didn’t apply because the semen was not provided through a doctor, which is a misdemeanor under that statute because the woman inseminated herself.\textsuperscript{35}

The disposition of frozen sperm was argued in \textit{Hecht v. Superior Court}, California Court of Appeals (1993). In this case, a man wrote in a suicide note that he wanted his girlfriend, Deborah Ellen Hecht, to have his child and willed to her 15 vials of his sperm, which he had deposited in a sperm bank a month before his death. Despite
William Kane’s dying wish, Hecht was unable to use the sperm because she was fighting Kane’s two grown children for the right to the sperm. Kane’s children wanted the sperm destroyed, arguing the court should prevent the birth of a child who would never know his father and prevent further emotional stress on Kane’s family members. They also feared an heir who could claim Kane’s estate.36

The trial court ordered the sperm destroyed, but the California Court of Appeals vacated the order in 1993. The appellate court held Kane could bequeath an interest in the sperm, just as he could bequeath an interest in stock. Still, the court remanded the case to the probate court to determine the validity of Kane’s will. The court case is the first to address the issue of whether to recognize property rights in sperm, and could have implications for other reproductive material such as embryos.37

In Vitro Fertilization

In vitro fertilization, or IVF, is a technique that involves fertilizing an ovum outside of a woman’s body and transplanting the resulting embryo into a women to carry the child to term. The woman who gestates the child may or may not be the woman who provided the ovum, and any man may be the sperm provider. When a husband’s sperm is used to fertilize his wife’s ovum and the wife bears the child, the only problems that are likely to arise involve negligence in performing the technique and the question of what to do with any unused embryos. Additional issues arise when a third party is involved as a provider of the sperm, ovum, or womb.

IVF is also considered by many to be an experimental technique that should be controlled. Many of the court cases have dealt with custody of the child or embryos.
liability of the physician or clinic, and insurance coverage for the procedure, as well as other related issues.

The recent use of frozen embryos has created a whole new round of litigation and legislation dealing with custody issues. There are many unanswered legal questions about embryos. Can there be ownership of embryos? Can they be bought or sold? Can embryos be the subject of experimentation? What is the status of the embryos when it develops? Who should have the custody of the embryos in the event of the couple's divorce?

It seems the legal relationship among donors of eggs, recipients, and offsprings should parallel the relationship of sperm donation. However, sperm donation statutes do not generally apply to egg donation since the “sperm” literally came before the “egg” historically in terms of development and practice. Just as the husband’s consenting to the use of donor sperm assumes the donor’s rearing rights and duties, so does the consenting wife (who may be the gestational mother) take on rearing rights and obligations, terminating those rights of the donor of the egg.38

These advances in medical technology are forcing courts to consider the scope of the right to procreate. In particular, questions that need to be answered are whether women are entitled to the aid of medicine and of the state in furtherance of their desire to procreate. IVF is expensive. Some insurance companies pay for it, others don’t. Courts increasingly are accepting insured persons’ arguments that infertility is a health or medical problem and that IVF is no longer experimental. As a result, courts are requiring insurers, who have not made specific exclusions, to pay for such treatments. This is what happened in the case of Reilly v. Blue Cross and Blue Shield of Wisconsin (1988).39
Health insurance coverage for infertility procedures has been relatively little discussed, although in recent years several appellate courts have faced that issue. In *Witdraft v. Sundstrand*, Iowa Supreme Court (1980), the court initially determined that an infertility condition was an illness.\(^{40}\)

Reproductive technologies also raise interesting questions as to the liability of the person of persons performing the process. In *Smith v. Hartigan* (1983), the physician determined that Mary Smith was unable to conceive because of irreversibly damaged fallopian tubes, and that IVF was the only possible solution for a baby. However, the state of Illinois apparently prohibited the procedure and all parties were fearful of the legal consequences. The statute in question stated that “any person who intentionally causes the fertilization of a human ovum outside the body of a living human female shall be deemed to have the care and custody of a child.” Plaintiffs argued the statute was unconstitutional. The federal district court for the Northern District of Illinois found no case or controversy because the doctor refused to perform the procedure based on his own personal interpretation of the statute, and the prospective parents agreed not to prosecute the doctor for refusing to perform the procedure.\(^{41}\)

Couples who are vulnerable need to be informed of the risks and benefits of IVF procedures. In 1992, Congress passed a law directing fertility clinics to report success rates. However, that law has not been enforced due to lack of funding.\(^{42}\)

The federal district court in Virginia in *York v. Jones Institute* (1989) ruled that the frozen embryo was property belonging to the couple whose genetic material created it. The couple moved the frozen embryo from a Virginia clinic to one in California where the couple planned to have it implanted.\(^{43}\)
The process of freezing embryos appears to be banned in certain states, including Minnesota, Michigan, and Illinois. Minnesota forbids experimentation on a living human conceptus, including those conceived ex utero, unless the experimentation is necessary to protect the health or life of the conceptus or unless scientific evidence has proven the experimentation to be harmless.  

In the United States, the use of embryos is not regulated, and different fertility centers use different rules. This contrasts with a country such as Sweden, where the government ruled that an embryo may be gestated only by the woman who produced the egg, thereby prohibiting embryo donation. Frozen embryos may not be stored more than three years. In the United Kingdom, the Warnock Committee recommended that the human embryo be treated with “respect” and be afforded some protection in law.

The courts generally deal with disputes among the various parties, and the routine IVF procedure continues unobstructed by legal roadblocks. Very few statutes have dealt with this issue, even though ethical objections are heard regarding the use of such procedures on older women, single women, lesbian women, and so on. Also, ethical objections are heard regarding the recent use of such procedures to determine the sex of the child, but there are no laws preventing these types of procedures.

Surrogate Motherhood

Surrogate motherhood has gotten most of the attention regarding the use of different means to have a child. Although surrogate motherhood is not officially a new reproductive technology, it is generally included in discussions about the impacts of reproductive technologies on society, the law, and the family structure. State legislatures
have responded more readily on this issue than IVF procedures. Most of the concerns and disputes have centered around contractual agreements, custody issues, adoption parallels, and payment for gestational mothers. Other concerns center around the surrogate mother, whom some see as vulnerable to exploitation due to poverty.

The presence of two mothers, gestational and genetic, is forcing judges to reconsider how far they are willing to push reliance on the best interests of the child as a standard in court disputes. These disputes are not difficult to imagine. The surrogate may not want to surrender the child; the father and his wife may not want to accept the child; the surrogate may want an abortion, or she may refuse prenatal care, and so on.

Recently, the law has begun to recognize that persons other than biological parents may raise claims to custody and visitation. Grandparents and stepparents, as well as “psychological” parents may be granted visitation, showing that the law has already deviated from a simple biological determinism in deciding who is to be treated as a parent.46

Most third parties have claims due to established social relationships which would create instability in a child’s life if they were to discontinue. This can’t be said about third party gestational mothers. However, a physical relationship exists. Should the absence of a genetic tie prevent the consideration of a gestational mother’s claims? In many surrogate cases, the gestational mother is also the genetic mother but not the intended social mother.

In a 1987 New York Times article, it was reported that a Michigan surrogate mother had refused to surrender the twins whom she bore for an Arkansas couple under contract, and a Michigan court had temporarily permitted her to retain custody but
authorized the infertile couple to see the newborns twice a week. The surrogate mother claimed she had been coerced. In Re Baby Girl, the Kentucky circuit court denied the request of the husband of the surrogate mother to terminate parental rights and to transfer custody of the newly born child to the biological father. The biological father was not the legal father, for a child born in wedlock is presumed to be the legitimate child of the surrogate mother and her husband. The father had not filed the proper application for permission to place or receive the child for adoption.

In Syrkowski v. Appleyard, Michigan Supreme Court (1983), a semen donor filed an action alleging that he had reason to believe that the defendant who had been artificially inseminated was pregnant with his child. He wanted to be declared the natural father and get custody. The defendant surrogate mother did not oppose the petition, but the attorney general of Michigan intervened, saying that the court had no jurisdiction over the matter because it involved a surrogate mother contract that was of doubtful validity. The Michigan Court of Appeals agreed with the State that the defendant's husband who had consented to the AID should be deemed the child's father. "Family living and, more specifically, interest in the welfare of the child must continue to be of paramount importance to the people of this state, the court stated."

The validity of the surrogate mother contract was recently upheld in the New York decision in Matter of Baby Girl L.J. (1980). The case involved a natural father and his wife, who wanted to adopt a child born of a surrogate mother. The court admitted moral and ethical reservations, but acknowledged the reality of the child's need to be reared by parents and not by the surrogate mother. The adoption was granted.
Opinions in these cases also demonstrate disagreement over the role of financial coercion in the use of reproductive technologies. The court in the Baby Girl L.J. case explained that laws prohibiting payments in connection with adoption were designed to keep baby brokers from coercing expectant mothers or parents with financial inducements to give up their child. Courts held that surrogacy does not violate these laws. According to the courts, surrogacy and adoption differ because surrogate arrangements are entered into before conception, whereas adoption is agreed to afterward. Financial considerations may shape a woman’s choice to give up her child for adoption, but the “essential consideration is to assist a person or couple who desperately want a child but are unable to conceive one in the customary manner.”

In the most famous case, Matter of Baby M, New Jersey Supreme Court (1988), the court granted custody to the father, David Stern. However, the court refused to terminate the parental rights of the surrogate and biological mother, Mary Beth Whitehead. The court declared surrogate motherhood contracts void because the contract conflicted with New Jersey law and public policy. The court also said it would consider visitation because it was in the best interests of the child.

The court looked at the two family situations. The Sterns’ family life was stable, their financial and employment situations were secure. They were committed to the baby’s education and well suited to nurture and protect Baby M while encouraging her wholesome, independent psychological growth and development. Contrast that situation with that of Mary Beth Whitehead, who was unhappily married, financially insecure, dishonest, unopen to professional help, and uncommitted to the baby’s education.

In another case, Noel Keane, a surrogate broker and Michigan attorney, had a deal
go bad when the baby was born with severe defects. The parents refused the child, and the surrogate mother sued. The child turned out to be the child of the surrogate mother’s husband, but was infected by the contracting man’s sperm. The United States Court of Appeals for the Sixth Circuit resolved the case in favor of the plaintiff. The court found that Keane and the other defendants had a special relationship to the mother based on their participation in the surrogacy program and their use of the mother in that program. Because of that special relationship, she was entitled to compensation from them.53

The California Supreme Court, in Johnson v. Calvert, relied on parental intent to distinguish between two women claiming to be a child’s biological mother. The court was interested in the intentions of the disputing parties prior to the birth of the child and decided accordingly.

The Baby M case relied on the best interest standard. In deciding the case, the court stated that “we grant custody to the father, the evidence having clearly provide such custody to be in the best interests of the infant.” However, the court declared the surrogacy contract invalid because of the “coercion” contract: the natural mother’s irrevocable agreement, prior to birth, even prior to conception, to surrender the child to the adoptive couple. Such a contract is totally unenforceable in private adoption.”54

If other states followed the New Jersey Baby M case decision, surrogacy contracts would be a thing of the past. The major stumbling block is not the receipt of payment by the surrogate mother but the fact that she cannot agree irrevocably before conception to terminate her maternal rights and surrender her baby at its birth.55

The U.S. Supreme Court, in Griswold v. Connecticut (1965) and Eisenstadt v. Baird (1972), had strongly stated that a state statute could not constitutionally prohibit a
couple desiring to have a child, which would include barring them from entering a surrogate parenting arrangement. Some believe that allowing a surrogate mother to violate her contract may be unconstitutional because it infringes upon the procreative liberty of the infertile couple providing the embryo.

In *Surrogate Parenting Inc. v. Commonwealth of Kentucky*, Kentucky Supreme Court (1986), the court held that the surrogate contract did not violate the Kentucky statute against baby selling.\(^5^6\)

In *Gray v. Maxwell*, Nebraska Supreme Court (1980), the court held an adoption agreement to be unenforceable because an agreement to pay a mother more than the "legitimate expenses of confinement and birth" was against public policy.\(^5^7\)

In *Doe v. Kelly*, Michigan Court of Appeals (1981), the court had taken a similar view that payment should not be allowed because "the primary purpose of this money is to encourage women to volunteer to be surrogate mothers."\(^5^8\) State statutes have differed on this subject. A Michigan statute, effective in 1988, made surrogacy contracts illegal and also made the arranging of such contracts to be a felony with penalties up to five years in prison and a $50,000 fine. However, the contract would be permitted if the surrogate mother did not have to decide until after the birth whether she wanted custody of the baby or whether she wanted to waive custody and receive payment for giving birth.\(^5^9\)

Nevada has made commercial surrogacy possible by exempting surrogate contracts from the state adoption laws that prohibit payment to natural parents for their adoption of the child. Other states have passed the Uniform Parentage Act that deals with surrogate motherhood. Under the Act, court-monitored surrogacy would amount to filing
all surrogacy agreements with the state, undergoing mandatory counseling, conducting evaluations of the participants' ability to handle the process, and proving that the wife of the intended couple was infertile or that pregnancy poses a significant risk to her health.\textsuperscript{60}

Some people believe surrogate motherhood is not a good candidate for legislative treatment because it affects a very small percentage of the population. Others see surrogacy, at least paid surrogacy, as baby selling, which should be prohibited. Surrogate mothers are prohibited in many states from receiving compensation for their services. Only Arkansas had enacted a specific statute on surrogate mothering. Otherwise, state statutes relating to adoption practices have been used in the attempted regulation of surrogacy. Florida, for example, allows the mother to receive actual medical, hospital, confinement, and living expenses. California prohibits payments in excess of medical expenses to the mother or adoption agency. Indiana allows payment and receipt of attorney's fees, medical expenses, reasonable charges by a licensed adoption agency, and other court-approved charges. Ohio authorizes the mother to receive payment for medical and legal expenses. Utah allows receipt of actual, reasonable medical, hospital, and confinement expenses.\textsuperscript{61}

Surrogacy has been regulated by many states under statutes dealing primarily with fetal experimentation, particularly where the fertilization was in vitro as opposed to artificial insemination of the natural parent without surrogacy.\textsuperscript{62}

Nebraska has legislatively declared that surrogate motherhood contracts are void, as have Indiana, Kentucky, and Louisiana. Only Arkansas and Nevada appear to accept such contracts as valid subject to judicial review.\textsuperscript{63}
Summary

As shown, this review of court cases and state statutes reveal conflicts over how best to regulate reproductive technologies. This includes conflicts over the relationship between reproductive technologies and existing statute statutes, child support, paternity rights, and adoption and custody policies.

Reproductive technologies have entered the U.S. courts and state legislatures in a variety of different legal contexts, according to the authors of “Reproductive Technologies and the U.S. Courts.” Their survey revealed that the courts’ main task has been to decide whether these technologies conflict with existing statutes. Next, courts have dealt with questions of responsibility for child support in conjunction with reproductive technologies. Presently, most state laws indicate that the husband of a woman who consents to artificial insemination by donor is the father of the child so conceived, but whether he should pay child support following a divorce has not been clear. These laws do not deal well with issues surrounding the paternity of a child of an unmarried women. Other frequent court cases involving paternity revolve around surrogate arrangements. The courts also deal with questions related to adoption and custody. Their decisions have varied widely in this regard. Finally, consumer issues such as insurance coverage and liability issues are prevalent today in court cases.

Reproductive technologies are popularly viewed by many as expanding the reproductive choices available to women and men. However, other groups such as feminists argue that reproductive choice is meaningful only if the conditions under which women make these choices are addressed. They cite a number of factors that may influence women’s choice to use reproductive technologies such as the social
stigmatization of infertility, the high costs of these technologies, and women’s lack of knowledge of the risks associated with them.65

In general, law provides a powerful commentary on the life it regulates. The actions of legislatures and courts provide different vantage points on that life, however. According to author Roger Dworkin, legislative statutes usually signal social agreement far more than court opinions. Legislation suggests the resolution of debate while courts suggest the terms of debate. Courts often make decisions quickly.66

Decisions about reproductive technologies are made mostly in the courts, where there is debate without social agreement. In addition, decisions about these technologies are being made without thoughtful consideration or a vision of the society as a whole. Court decisions, then, reflect the confusions and uncertainties of reproductive technologies and society’s inability to provide any broad, consistent response. Cases about surrogacy and reproductive technologies reveal, for instance, that courts apparently at odds over the resolution of disputes involving assisted reproduction may predicate their conflicting decisions on a shared vision of family. According to author Dolgin, most judges have mounted a seemingly unconscious defense of the traditional view of the family.67

She explains that some courts have accepted surrogacy contracts and recognized intending parents because the correlates of contract seemed to ensure the preservation of tradition, at least within specific families. It seems that the confusion centers around a general, social ambivalence regarding the expansion of individual choice in the creation and operation of families.68

The responses of the law have been challenged dramatically by reproductive
technologies and surrogacy arrangements, according to Dolgin. First, they challenge the
notion that the parent-child tie should be founded in love, not in money. In every state of
the United States, adoption laws prohibit the exchange of money for a baby. Yet,
commercial surrogacy arrangements and infertility markets involve the exchange of
money for gametes, embryos and babies, pursuant to a variety of contractual agreements.

These new technologies disturb assumptions about parent-child relationships, and the fast pace of these technological changes make it difficult for society and the law to adapt. Whether a consensus will eventually emerge remains to be seen.69

Achieving some form of broad consensus has been the aim of several other countries. These countries have taken a fairly comprehensive approach in trying to resolve the difficult issues related to reproductive technologies. The next chapter discusses the various approaches and how they have worked.
Chapter Notes


7. Ibid.

8. Dolgin, 8-10.

9. Ibid., 174-175.

10. Ibid., 7-10.

11. Ibid., 138-168.

12. Ibid., 139.

13. Ibid., 152-155.

14. Ibid., 156-158.

15. Ibid., 158-162.

16. Ibid., 180.
17. Ibid., 180-183.
18. Ibid., 139.
19. Ibid., 179.
21. Ibid., 63.
25. Freedman, 36.
27. Freedman, 28-33.
29. Freedman, 30-33.
30. Freedman, 205.
32. Ibid., 67-68.
34. Ibid., 21.
35. Ibid., 18.
37. Ibid., 663.
38. Freedman, 45.

39. Ibid., 46.

40. Ibid., 48.

41. Ibid., 56.


43. Freedman, 11.

44. Ibid.

45. Ibid.

46. Dworkin, 79.

47. Freedman, 47.

48. Ibid., 80.

49. Ibid., 47.

50. Ibid., 86.

51. Ibid., 87.

52. Ibid.

53. Ibid., 82.

54. Ibid.

55. Ibid., 83.

56. Ibid., 48.

57. Ibid., 80-81.

58. Ibid., 83.

59. Ibid., 84.

60. Ibid.
61. Ibid., 85-86.
62. Ibid., 86.
63. Ibid., 84.
64. Blankenship, 29-31.
65. Ibid., 27-29.
66. Dworkin, 9-10.
68. Dolgin, 250-252.
69. Dolgin, 253.
CHAPTER V

THE USE OF COMMISSIONS IN OTHER COUNTRIES

Other countries such as France, the United Kingdom, Australia and Canada have taken close looks at the impact of artificial reproductive technologies on their societies. Each country's approach has been different but has been fairly comprehensive in its outlook. The United States, one of the largest users of the new reproductive technologies, has been much less comprehensive in its approach and outlook. Rather, the United States has dealt with complicated reproductive technology issues on a piecemeal basis, preferring to use litigation and, to a lesser extent, legislation, rather than discussion and decision on a nationwide basis. This chapter examines what other countries have done and whether various approaches could be used as a model for the United States.

France

When France first started the use of infertility treatments, it was regarded as a private matter. The National Health Service even paid for them. The introduction of surrogacy and posthumous insemination, however, made it difficult for public authorities to maintain a neutral position. Government officials, therefore, decided that a national debate was needed. The debate was promoted in two ways: the organization of a national colloquium and a report providing views of experts and members of the public.¹

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The colloquium, titled “Genetics, Procreation, and the Law,” was held in Paris in January 1985. The debate during these two days centered largely on the question of whether legislation was needed. Scientists, lawyers, philosophers, sociologists, and members of the public participated. Four panels discussed different topics: the donation and use of gametes; the freezing of embryos; in vitro fertilization and surrogacy; and predictive medicine.

No conclusions were reached following this gathering except that decisions should not be left solely to scientists. The requirement for legislation was not felt to be great at that time, and a moratorium was proposed. During this period of legislative abstention, however, it was felt that a study should be conducted to find out which issues were controversial to French society. This led to a study done by two lawyers and three biologists. They were asked to give a “snapshot” of opinions from religious and political fields as well as the professionals involved. The research showed that reproductive medicine brought some real advantages, but it also carried some risks and potential drawbacks. To find an adequate balance, specific rules would be required. These rules should not come from the medical community, but should also include legal and moral opinions. The time and diversity needed to define these ethical principles could be carried out by a forum such as a National Ethical Committee.²

By presidential decree in 1983, a National Ethical Committee for Life Sciences and Health was created. This advisory body was designed to consider major social issues which were limited to ethical questions posed by the development of research. The committee is supposed to work as a moral authority, and its advice may be accepted by
scientists, and may also be influential in the courts and public policy making. The committee also serves as a forum of discussion for both professionals and members of the public. The 37 members of the committee — consisting of 25 doctors and scientists, four lawyers, three theologians and philosophers, and five persons of different professions — are appointed for two years. Before an issue is discussed before the committee, a permanent technical staff prepares two reports: one on the state of science and the other on legal and ethical issues.

The committee was widely respected in France because of its multi-disciplinary approach. The committee also found that a common position on artificial reproduction could be reached because of an existence in the national culture of general principles on which many people could agree. One such principle is that every person is entitled to have human rights because he or she is physically a human being. This implies that the body is the central point of respect due to the dignity of the human person. The integrity of the body, therefore, should not be violated without the consent of the individual concerned.

Some decisions the committee made about assisted reproduction include: the birth mother is always considered the legal mother, even in cases of surrogacy; sperm donors should not receive payments nor can any paternal rights or responsibilities be established; no use can be made of frozen gametes and embryos when the members of the couple are divorced or separated, or when one of them is dead.

Using the principles as a guide, the committee decided that legal conclusions could be drawn in accordance with the French legal system. For this reason, the
government decided to proceed further by launching a study to see how it might be possible to translate into law the general principles of common morality identified by the National Ethical Committee.³

A working group of lawyers was set up to examine the committee’s work under the auspices of the Cancel d’Etat, the permanent legal advisory council of the government. The working group held hearings and made visits to research institutes and hospitals. In 1988, they concluded that legal regulation was a necessity in this field. Their four main conclusions were: statute law is better than case law; law is necessary to clarify family relationships and to secure public health; the power over man that biology gives to scientists is not legitimate and legal; and these matters are of international concern which require the adoption of a national law.

The report insisted on some fundamental principles which include: reproductive medicine should be considered as a way to remedy infertility; the child has an interest to be brought up in a two-parent family; the right to individual autonomy should be recognized but cannot be absolute; the legal status of the resulting child should be as similar as possible to the general status of children in general; prenatal diagnosis should be limited but the consequences of a diagnosis should be left up to the physician and to the couple; and a law is necessary to protect a potential human being from the possible risks of scientific manipulation which could become a new form of eugenics.

The working group drafted a bill containing 89 sections and six chapters proposing to introduce law reform. The text constantly refers to the general principles which govern the human in the Civil Code system and to the concept of human rights.
The French approach in dealing with reproductive technologies took different steps: the encouragement of social debate, the development of ethical considerations, the setting of principles which could commonly be accepted as a basis for future legislation, and the writing of appropriate statutes. As a result, there was no major social opposition and a new independent authority was allowed to define what was possible social agreement in the field of bioethical issues. However, it looks like no legislation has been enacted to date due to the sensitivities of this kind of legislation.

Australia

The Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization was formed in 1982 in the state of Victoria in Australia. The committee was established by the Attorney General and Minister of Health. The committee consisted of five men and four women. Three were from the medical profession, two from the legal profession, two from the religious community, one a schoolteacher and another a social worker. The committee was formed due to public awareness of the issue following the births of "test tube babies" in Australia. The committee members interviewed a number of experts in the areas of reproductive medicine, infertility counseling, moral philosophy and child psychiatry. The committee also held public hearings, solicited comments from the community, and read material from a variety of sources. After three months, the members produced an interim report which focused on husband and wives supplying their own gametes for the laboratory production of an embryo or embryos. The members unanimously agreed this form of
procedure was acceptable to the Victorian community. They proposed legislation be enacted to provide a system for approval or licensing of hospitals to undertake IVF programs. Counseling for prospective patients was mandatory.5

The committee published two other reports, one in August 1983 and another in August 1984. The Report on Donor Gametes included some of the following recommendations: the use of donor gametes and donor embryos in IVF programs was acceptable; donors of gametes should not receive payment other than expenses; counseling should be mandatory for donors as well as for infertile couples; comprehensive information about donors should be stored in a government-controlled Central Registry; legislation should be enacted to establish clearly the relationship of father and child, or mother and child, or father and mother and child, when donor gametes or donor embryos were used to establish the child, provided it was with the consent of the spouse who made no genetic contribution to the child; and non-identifying information should be offered to recipients of gametes or embryos, and to donors about recipients and successful pregnancies and live births.

The third report dealt with the freezing and storing of embryos, embryo experimentation and surrogate motherhood. The committee recommended that freezing should be permitted, but only for the couple seeking to establish a family. Each couple agreeing to storage was obligated to decide what would happen in the event of an accident, death, or divorce. A majority of committee members decided that embryo experimentation of a non-therapeutic kind might be conducted, but only on spare or excess embryos produced from patients in an IVF program. All members agreed that
such experimentation be scrutinized by the Health Commission or by a standing review and advisory body that the committee recommended should be established. The committee opposed surrogate motherhood of any kind. 6

After allowing for three months of public comment, the Attorney General introduced two legislative measures based on the committee’s recommendations. As a result, the Infertility Act of 1984 was passed and the Standing Review and Advisory Committee on Infertility was formed to advise the Minister of Health. The eight-member committee was formed in 1985 and represents medicine, social work, law, philosophy, teaching, and religious communities. The committee has held many formal meetings, including consultations with embryologists, clinicians, counselors, and infertile couples. The committee has met with many government officials and has held various symposiums.

The Victorian legislation has served as a model for other states in Australia. However, the nation has not adopted any uniform legislation, although a National Bioethics Consultative Committee was established in 1988.7

Canada

In 1982, the Attorney General of Ontario asked the Ontario Law Reform Commission to study the legal issues related to the practices of artificial reproduction, including surrogate motherhood. The commissioners, all lawyers, decided the best way to tackle this project was to appoint an advisory body to study the issue and make recommendations to the commission. The advisory body was made up of doctors,
philosophy professors, a social worker, a family court judge and a tax accountant. The commission solicited comments from the public through the newspaper and had numerous meetings with religious organizations, hospitals, medical schools, IVF practitioners in Canada, and other medical practitioners.

The commissioners discovered that three general orientations might be applied in developing legal responses to artificial reproduction and surrogate motherhood. One approach basically facilitates non-judgmental laws through which individuals may plan, negotiate and complete their reproductive activities according to their own goals, confident that the legal consequences they intend will actually follow. A regulatory approach establishes one of several levels of regulations of the ways in which individuals may act to achieve their own and other people’s reproductive preferences. The third approach legally prohibits, denies or frustrates any pursuit of a reproductive deviation from procreation within marriage or a stable domestic union. Following a study of the two-volume, 390-page report prepared by the advisory board, the commissioners favored a hybrid approach. They found that different techniques of assisted reproduction warranted different legal approaches. The commissioners decided that surrogate motherhood warranted a high level of regulation.

The commissioners were guided by a basic governing principle that “there should be no intervention, in any form, unless the public interest is likely to be threatened or frustrated by the absence of some form or degree of regulation.”

The commissioners decided many artificial reproduction matters were already subject to regulation through the College of Physicians and Surgeons of Ontario. They
also decided that comprehensive new legislation was unnecessary since many recommendations could be implemented under existing legislative structures affecting public hospitals, child welfare, and birth registration. Surrogate motherhood was the exception. Surrogate motherhood was seen as an option that could not be eliminated or suppressed, but controlled. Their approach was to have participants in surrogacy arrangements go before a family court judge. The judge would look at a number of issues and then decide whether to approve the arrangement. The judge would have to be satisfied that all parties acted freely, with complete information and counseling.

Although the report has never been legislated, it has been influential. For example, birth registration no longer requires the paternity of a child. Also, IVF clinics can now act with legal confidence to treat patients.

Some women's groups, fearful that Ontario would be a "mecca" for those seeking artificial reproduction, recommended that a Canada-wide study be conducted. The federal government of Canada appointed a Royal Commission on New Reproductive Technologies in 1982. The commission was headed by a leading geneticist at the University of British Columbia.

The commission, representing diverse groups of society, spent a few years gathering information and discussing how new reproductive technologies should be used in Canada. They held public hearings, read briefs, set up toll-free telephone lines, and conducted surveys. In all, more than 40,000 people were involved in this work in some fashion. More than 300 researchers at institutions across the country conducted research projects in many disciplines, including the social sciences, ethics, law, and medicine.
The Commission issued a final report called “Proceed With Care.” The report cites three main considerations: a set of explicit ethical principles, the values of Canadians, and a conviction that a medical procedure that is offered as a service must be proven safe and effective.

The report criticizes some of the standards and guidelines recommended by various professional associations. It stated that some practices are even dangerous, such as donor insemination using sperm from donors who have not been tested for HIV. Some are harmful to the interests of the children born through the use of various technologies, such as the lack of records kept on their origins. “We found insufficient emphasis on the prevention of infertility. We found some discriminatory practices in access to services, some clinics preparing to carry out procedures to allow surrogacy, and some commercial clinics existing to treat sperm to allow sex selection.” The report stated that some procedures are being offered as treatments without good evidence that they are effective, when they should be offered only in research trials.\textsuperscript{10}

The report notes:

It is clear that the situation with regard to the use of new reproductive technologies needs to be addressed: the issues will not go away -- in fact, the field is growing, and potential uses are expanding...We conclude that government, as the guardian of the public interest, must act to put boundaries around the use of new reproductive technologies, and must put in place a system to manage them within these boundaries, not just for now, but, equally important, in an ongoing way.\textsuperscript{11}

The first recommendation is to enact legislation that prohibits, with criminal sanctions, several aspects of new reproductive technologies, “such as using embryos in research related to cloning, the fertilization of eggs from female fetuses for implantation,
the sale of eggs, sperm, zygotes, or fetal tissues, and advertising for, paying for, or acting as an intermediary for preconception (surrogacy) arrangements.” The second recommendation is to establish a regulatory and licensing body called the National Reproductive Technologies Commission that will be responsible for the licensing of new reproductive technologies. This commission would be composed of 12 members, representing a broad range of experiences and perspectives. Women would make up at least half, and would also include the perspectives of those with disabilities, those who are infertile, and those who are members of racial minorities. A range of expertise would be represented, including reproductive medicine, ethics, law, and social sciences.¹²

The five areas of responsibility for such a commission would deal with the following areas: sperm collection, storage, and distribution, and the use of assisted insemination services; assisted conception services, including egg retrieval and use; prenatal diagnosis research involving human zygotes; and the provision of human fetal tissue for research or other specified purposes.

License hearings would be open to the public, and the commission would have the following regulatory authority: license, set standards and monitor practice; collect, evaluate, store, and disseminate information; consult, help coordinate, and facilitate intergovernmental cooperation in the field; and monitor future technologies and practices and set policies for them. A subcommittee would deal with infertility prevention.

The report states that a central goal of the recommendations is to enable individual Canadians to make personal decisions about their involvement with the technologies, confident in the knowledge that mechanisms are in place to assess their
safety and effectiveness and to consider their ethical, legal, and social implications.

"Individuals have a responsibility to inform themselves as fully as possible before making such decisions, but government, on behalf of citizens, has a responsibility to ensure that inappropriate and unethical use of technology is prohibited and that the procedures and support necessary for informed decision making are in place."\(^{13}\)

The report notes that the proposed framework would be a beginning, but leadership and cooperation among all members of society, particularly government officials and professionals involved with reproductive technologies, would be needed.

In the report’s conclusion, it states:

The reasons for such action are compelling: the potential for harm to individuals and the need to protect the vulnerable interests of individuals and society. Adopting our recommendations will enable this protection, but will also allow scientific knowledge to be used to better the lives of many Canadians. Implementing the blueprint will demonstrate that we care about each other’s well-being and recognize collective values with respect to the importance people attach to having children. At the same time, it will ensure only ethical and accountable use of technology is made, and demonstrate that Canadians have wisdom, humanity, and compassion in the way they choose to use technology.\(^{14}\)

In July 1995, the Canadian government announced a moratorium on highly questionable reproductive practices. In early 1996, the government announced the membership of the Advisory Committee on the Interim Moratorium on Reproductive Technologies. The goal of the committee is to track the development of emerging new reproductive and genetic technologies and identify other highly questionable practices that warranted inclusion in the moratorium. The committee is composed of 13 members with expertise in women’s health, bio-ethic, reproductive medicine, minority rights and religion as well as consumer, children and ethno-cultural issues. The moratorium is the
first step in the development of a permanent regime for managing the application of new reproductive and genetic technologies.15

On June 14, 1996, Canadian Health Minister David Dingwall introduced legislation prohibiting 13 unacceptable uses of new reproductive and genetic technologies and released a position paper setting out the federal government’s proposed policy on the management of new reproductive technologies, including a proposed regulatory component.

Under the proposed Human Reproductive and Genetic Technologies Act, the following practices would be prohibited: sex selection for non-medical purposes; buying and selling of eggs, sperm, and embryos, including their exchange for goods, services or other benefits, but excluding the recovery of expenses incurred in the collection, storage, and distribution of sperm, ova, and embryos for persons other than a donor; germ-line genetic alteration; ectogenesis (maintaining an embryo in an artificial womb); cloning of human embryos; creation of animal-human hybrids; retrieval of sperm or eggs from cadavers or fetuses for fertilization or implantation, or research involving the maturation of sperm or ova outside the human body; commercial preconception or “surrogacy” arrangements’ transfer of embryos between human and other species; the use of human sperm, eggs or embryos for assisted human reproduction procedures or for medical research without the informed consent of the donor; research on human embryos later than 14 days after conception; creation of embryos for research purposes only; offer to provide or offer to pay for prohibited services. The rationale used to prohibit these practices is that they pose serious risks to human health and safety. They included
practices that commercialize reproduction and are contrary to the principles of human
dignity, respect for life and protection of the vulnerable.

The federal government, following consultations with stakeholders, also plans to
propose legislation on governing acceptable practices of the new reproductive
technologies. This would include in vitro fertilization, donor insemination, use of fetal
tissue, storage and donation or zygotes, and embryo research.

The proposed regulatory component would permit any province or territory that
wishes to do to develop its own regulatory regime on an equivalency basis.16

The United Kingdom

Responding to the public’s deep concern over the lack of control of reproductive
technologies, the British government set up the Committee of Inquiry into Human
Fertilization and Embryology (the Warnock Committee) in 1982. The committee’s
mandate was “to consider recent and potential developments in medicine and science
related to human fertilization and embryology; to consider what policies and safeguards
should be applied, including consideration of the social, ethical, and legal implications of
these developments; and to make recommendations...”17

In June 1984, the committee reported back to the government. Those
recommendations included the following: IVF should continue to be available subject to
licensing and inspection, and within the National Health Service; that the placing of a
human embryo in the uterus of another species for gestation should be a criminal offense;
that no live human embryo derived from IVF may be kept alive beyond 14 days after
fertilization; that a proposed licensing body promulgate guidance on what types of research would be unethical under any circumstances.

Following the publication of two government papers on the committee's findings, the Human Fertilization and Embryology Bill was introduced in 1989 and received approval in 1990.

The Human Fertilization and Embryology Act is one of the most comprehensive statutes concerning reproductive technology anywhere in the world. The statute further abolishes the status of illegitimacy for a child and provides that a husband or unmarried partner be considered the father of a child born from a woman who underwent donor insemination. Abolishing the illegitimacy provision of previous laws was a major step forward for British law. The law also states that the woman who carries the child is to be treated as the mother of the child. As for surrogacy, the act renders criminal any act designed to establish a surrogacy arrangement if that arrangement is made on a commercial basis. Advertising for surrogacy arrangements also is a criminal offense. This provision is designed to impact agencies who make a profit by bringing together infertile couples with women willing to act as surrogate mothers.19

The statute also set up the Human Fertilization and Embryology Authority, known as the Licensing Authority. Its function is to oversee embryo research and infertility treatment in the United Kingdom, to grant licenses to those working in the field, and to withhold or revoke licenses from those who do not uphold the standards mandated by the Licensing Authority.

The statute also provides for controlled embryo research. One major provision,
for example, bars any research or destruction of any embryo created in vitro to take place after 14 days from the completion of the process of fertilization. If any embryo exists at that stage it must either be implanted into a woman for gestation or immediately be destroyed. Research before 14 days will be permitted only if it is necessary to use a human embryo for the proposed research.20

One criticism of the report and the statute is that no consideration is given to resource allocation. This has been seen as a way to avoid a controversial aspect of the new technologies, the discussion of which would have created considerably more controversy because tougher decisions would have to be made.21

Italy

Reproductive technologies are not regulated by law in Italy. Due to large differences of opinion concerning the nature of the family and of reproductive liberty, all of the bills introduced to address these matters have failed to pass the Italian Parliament. However, the discussion among bioethicists has grown, particularly on such issues as procreative rights and the status of the embryo.

The National Committee for Bioethics has been considering reproductive technologies since 1991, and issued recommendations in 1994. Those recommendations include: practices of artificial reproduction inspired by racial prejudices should be banned; the practice of using gametes or embryos for artificial reproduction without the interested parties’ consent should be prohibited; any commercial or industrial exploitation of gametes, embryos, of fetal tissues should be banned; embryo splitting, cloning, and
ectogenesis with the object of procreation should be forbidden; producing embryos solely for scientific purposes should be forbidden.

These recommendations were unanimous but did not follow from a common understanding of the nature of the human embryo. Some members believe the human embryos should be treated as a person from the moment of conception while others believe the embryo cannot be a person, at least until the 14th day of its development.

There has been general agreement that it is best for the baby to be conceived and raised by a heterosexual couple in a deep and loving relationship, but not all members believe that is always the case. Most members believe that access to artificial reproduction should be denied to women who are postmenopausal, to homosexual couples, and to single women or widows. Others prefer to ban donation or sale of gametes. A third group suggested a moratorium on postmenopausal pregnancies until more is known about their psychosocial consequences. All members agree that contract pregnancy is inadvisable.

The commission also recommends that all centers practicing artificial reproduction should be regulated, have consistent policies, and publish their rates of success and the inherent risks for each technique. Every new protocol for artificial reproduction should be subjected to approval by an independent ethics committee.22

Summary

Each of these countries has acknowledged to some extent the importance of grappling with this important topic on a societal level. While the United States
understands the importance of the topic and its potential impact on society, it is unwilling, for whatever reason, to take the important step of forming a national response to these issues.

One problem cited in the United States is the difficulty in achieving consensus on these issues and whether consensus is desirable in the first place. Some say it is preferable to live in a society where each person can do what he or she wants within reason while others argue that more control is needed for consumer protection and other reasons. The next chapter looks at the concept of consensus and how it might be achieved.
Chapter Notes


2. McLean 135-137.

3. McLean 140-142.

4. McLean 147-149.


11. Ibid., 3-5.

12. Ibid., 4-5.

13. Ibid.

14. Ibid.


16. Ibid.


18. Ibid., 496-501.


CHAPTER VI

A LOOK AT CONSENSUS AND COMMISSIONS

Many of the books and articles on assisted reproduction emphasize the need to achieve consensus on this issue before moving ahead with more permanent techniques such as the adoption of legislation or regulations. However, many agree that consensus on controversial issues is difficult to achieve. All one needs to do is take a close look at the abortion issue to see that proven. So the question is whether consensus is necessary and appropriate to move forward on this issue. This question has intrigued many scholars, some of whom believe consensus is neither desirable nor achievable.

Some scholars question whether it is possible to achieve moral consensus on such an issue as artificial reproduction or even whether it is necessary. One subject expert has written:

Consensus is usually valued and preferred because it is psychologically comforting and politically useful. However, from a philosophical point of view its benefit to individuals or groups should not be examined, but its moral authority...Consensus has a claim to moral authority only when it is the result of a rational communicative process aimed at inter-subjective understanding and a just balancing of interests.¹

H. Tristam Engelhardt, Jr., from the Center for Ethics, Medicine and Public Issues at the Baylor College of Medicine in Houston, Texas, argues in the same book, The Concept of Moral Consensus, that if a person can live with rights to privacy, that person
can live without a moral consensus regarding the use of human reproductive technologies. He claims it is useful to have as much common agreement as possible to avoid social discord, and there will be many areas in which the use of commissions for public discussions will allow a significant majority to be established. He also adds there will be a significant scope of issues with respect to fraud, failure to make proper disclosures, etc., to which societies should turn to protect individuals, whatever their moral interests or concerns with reproduction might be. However, he argues that individuals should be free to use or not use these technologies as long as those who disagree are not constrained to collaborate with them. Also, individuals should be allowed to voice their opposition to these technologies as they see fit.2

Bioethics and Consensus

In bioethics, there is a history of skepticism regarding the authority of experts. Many believe experts should not be given free rein on important issues. Therefore, the idea of consensus is the solution to ensure the constraint of expert opinion on moral questions. Consensus implies a common or shared sense of things. The scientist, or expert, may have a vote but it is a group decision. Consensus then becomes the moral authority, meaning no individual can have moral authority. Western culture, however, denies that consensus on moral questions has any validity in itself. 3

According to Jonathan D. Moreno, author of Deciding Together: Bioethics and Moral Consensus, consensus processes have an important role in bioethics. American society as a whole relies heavily on panels composed, in large part, of technical experts.
Emerging questions of values in the life sciences have been treated in the same way. As a result, both the institution of bioethics and the individuals who are considered experts in the field have become closely identified with consensus in the formulation of societal responses to ethical issues in medicine and the life sciences. Policy-making commissions include government bodies such as the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.\(^4\)

In a pluralistic society such as the United States, consensus is generally regarded as highly desirable. Frequently, there are appeals to consensus in controversial matters. The Western philosophical tradition, however, is divided on this issue. While this tradition is highly skeptical of the tendency of consensus to curb criticism and dissent, it also relies on consensus to help strike the balance between individual self-expression and societal functioning, according to Moreno.\(^5\) Those who strive to find a common ground between individualism and socialism often call themselves communitarians, emphasizing the importance of common interests and responsibilities as a basis for novel means to manage difficult social problems, says Moreno.\(^6\)

Since the early 1970s, “there has been a consensus about bioethical methodology in that one can infer a discrete set of principles from various moral theories.” Those principles, which can be applied to particular cases, are autonomy, beneficence, nonmaleficence, and justice. This set of principles is one in which most participants in bioethical debate have found they can rally.\(^7\)

Criticism of these principles comes from various sources. Some say they are too
broad or even too narrow. Others prefer a case-based approach, and still others prefer a unified theoretical approach. Insisting on a particular moral theory has been by far the least popular option in bioethics. One of the features that distinguishes moral philosophy and applied ethics is the latter's rejection of any single theory, according to Moreno.8

Some feminists reject the "principles" approach in addressing human problems because it is too rigid and masculine. Rather than using principles and rules, some feminists argue that it would be better to look to procedures that will yield the arrangement that is most satisfactory to all those who stand to gain or lose by the outcome.

Moreno then discusses the various distinctions made regarding various views of consensus. For example, there are those who distinguish between procedural and substantive consensus. Procedural consensus is when there is agreement about the rules or methods that will be followed in resolving actual or possible conflicts about substantive matters. Substantive consensus is agreement with one of a number of alternative and conflicting points of view.

Others distinguish between descriptive and prescriptive consensus. Descriptive consensus is a sociological account of the moral views of a particular group, and prescriptive consensus is in a philosophical or theological text that commends a particular point of view on a moral question. In either case it is sensible to ask whether there is merit in the view that is held by a large number of people or that is defended by argument or appeal to authority. Consensus ethics is usually thought to be a variation of descriptive ethics.9

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There is also a distinction made between process and product in consensus, although this is not as big a distinction now because many believe the process by which a belief is attained is commonly used in defense of the project, which is the belief itself.\textsuperscript{10}

Finally, there are the distinctions made between consensus and compromise, an important point for philosophers who object to products resulting from negotiation between fixed views. Consensus involves reaching agreement on one of a number of theoretically available compromises. Compromise suggests that parties to a controversy have started with fixed preferences. Consensus suggests an openness to points of view. At a deeper level, consensus has the potential for participants to change as a result of the process, achieving perspectives unknown to them before. By contrast, compromise implies at most a deeper appreciation of one’s pre-existent concerns.

Moreno cites abortion as an issue in which consensus seems beyond grasp, and the best that can be done is to achieve a stable compromise. This is because the parties have entered the situation with fixed views that are amenable to modification only at the margins. This is what is meant when it is said that an ethical issue has become politicized, since individuals are wedded to their positions. Many bioethical issues, while containing some political elements, have not been captured by those elements in the public debate.\textsuperscript{11}

A Liberal, Diverse Society and Consensus

Bioethics relies on the nexus of autonomy and consensus, according to Moreno. In American society individuals are free to pursue their own vision of the good life
(autonomy) and to enter into common agreements about such a vision (consensus).

The government may not dictate any particular vision of the good life, nor may it use its police power to enforce it. The moral authority of consensual arrangements derives from the rightful autonomy of the individual, which is an ethical value that deserves to be respected. So long as a group respects the general principles of liberalism, its view of the good life is entitled to respect. This is the essence of the political rationale for the authority of consensus in a liberal society.¹²

In a diverse society, this allows subgroups the freedom to pursue their own view of particularized substantive moral consensus, and each of them must in turn grant that freedom to other groups. However, differences do arise in practice, and those must be ameliorated for a complex, modern society to function, states Moreno.¹³

Some argue that the liberal state is not a level playing field since the government has an interest in the citizenry. The question of the neutrality of the government is important in the discussion of national ethics commissions because the group could be seen as a mere manifestation of state interests, which would reduce moral consensus to political consensus.

Another kind of criticism is that liberal neutrality may be genuine, suggesting that no principled view of the good life is possible, and hence no consensus is achievable. Because any conception of the good life is as valid as another, consensus can only be a fleeting association with no foundation, observes Moreno. Since liberal society cannot validate a particular substantive moral consensus, there is no basis for explaining why the rest of society should accept this consensus from a group such as an ethics panel.¹⁴
John Rawls is concerned with the idea of achieving “overlapping consensus,” which means the combination of two ideas that are central to his idea of justice as fairness, “of society as a fair system of cooperation over time, from one generation to the next.” The first idea is that of citizens cooperating as free and equal persons. The second is that of a society regulated by a political conception of justice, a well-ordered society. A framework that includes opposing doctrines of the good can be the object of an overlapping consensus so long as the regime is just, which means ensuring the fair treatment of individuals.15

John Rawls invokes the idea of overlapping consensus to suggest that the members of a pluralistic society will agree on some ideas and values but will not all agree on the same ones. Rawls believes it is often prudent to refrain from attempts to gain social agreement on certain intractable controversies, such as abortion.16

To that end, Moreno states that bioethical principles can be the enduring objects of an overlapping consensus. The exact principles that are the objects of an overlapping consensus, and the extent to which they are more or less articulate, depends to a great extent on the context in which they are being entertained.17

Ethics Commissions and Moral Authority

Ethics commissions must produce decisions or recommendations that are valid expressions of moral consensus in a pluralistic society. Is it possible for these panels’ conclusions to have moral authority? It is possible if the group’s consensus upholds liberal values such as respect for the personal autonomy of those who disagree, and a
willingness to consider alternative points of view. If that occurs, some believe the panel’s consensus has all the moral authority that a deliberative process can be accorded in a liberal society. Liberalism does not require that a small group of decision makers agree with the society in detail, but it does demand agreement with the general conditions that govern the conduct of this process.

To understand whether this has been achieved, one needs to look at how consensus-based panels operate. Do panel members value mutual respect, openness to alternative points of view, and a willingness to entertain unpopular views? The principles that are the objects of an overlapping consensus are in a continual tug with judgments about the ethical issues with which panels are confronted. Each undergoes continual modification in light of the other. At some point they reach a balance.

Extending moral consensus into new and controversial territory opens up problems about values being less stable than is desirable from the standpoint of overlapping consensus. A panel’s interpretation of a principle beyond what was precisely intended by the society’s moral consensus is often an important facet of a panel’s mission. Since society as a whole cannot be expected to consider each new case or problem, some subset of members of the society must do so. This social need is exactly the reason why many practices in the institution of bioethics exist, including review by individual ethics panels as well as consultants. There must be some systematic effort to extend the consensus of a pluralistic and technologically innovative society. Diversity of representation is normally thought to be an essential feature of ethics panels. Ethics panels represent society in a deliberative sense rather than in legislative sense.
They do not represent the views of constituents, but they do have value disposition reasonably similar to those of the community. Deliberations about issues should represent the more general and abstract value consensus of the wider community while guarding against the uncritical embrace of its more specific values. The panel should be willing to gather facts, hear from concerned parties, consider the wisdom of relevant extant policies, and willingly entertain reasonable appeals, according to Moreno.¹⁹

The force of a panel’s deliberations is persuasive, which is the point often made by proponents of ethics commissions. Some panels are empowered for a consultative role. The results of those deliberations will only have force if they help to forge an institutional consensus, according to Moreno.²⁰

Government Commissions

Government commissions have played an important role in public policy. The Royal Commission on Poor Laws is seen as the first ethics commission. The British commission, which ran from 1832-34, proposed reforms in the British welfare system. In the 20th century, several U.S. presidents have favored presidential commissions. President Theodore Roosevelt appointed six, including a Country Life Commission that investigated the needs of farm families. President Herbert Hoover appointed several commissions to bring scientific knowledge to bear on matters of government. In the 1960s and 1970s, the National Advisory Commission on Civil Disorders and the President’s Commission on the Assassination of President Kennedy were formed.²¹

The United States has a history of forming advisory boards, commissions and
ethical committees to look at tough, controversial issues. Often, though, their scope is limited. Ethics committees at hospitals, for example, often look at specific cases, not general issues. The federal government, since the early 1970s, has assigned panels, task forces and commissions to look at difficult issues, particularly scientific and medical advances. Their effectiveness is often debated. One person, who has served on several of these panels, says these commissions, boards, or panels offer several advantages over courts, legislatures, and regulatory agencies, including greater flexibility and more extensive analysis in approaching complex social dilemmas. Many also have successful track records of reaching consensus in their advice and recommendations in many instances.\textsuperscript{22}

James F. Childress, a University of Virginia professor, has analyzed a panel assigned to look at whether the U.S. government should provide federal funds to pursue research on the treatment of various diseases such as Parkinson’s Disease, by using tissue from deliberately aborted fetuses. Although the Human Fetal Tissue Transplantation Research Panel eventually concluded that the government should use federal funds, the Secretary of the Department of Health and Human Services decided to uphold the moratorium in 1989. Some researchers at the federally-funded National Institute of Health (NIH), in the late 1980s, wanted to experiment with the use of aborted fetal tissue on patients with Parkinson’s Disease. The NIH had experimented with these tissues in the past, until a moratorium was placed on the use of federal funds for this purpose until an advisory panel looked into the issue.\textsuperscript{18}

The Assistant Secretary of Health and Human Services assigned to the panel ten
legal and ethical questions that had to be addressed. The panel, headed by a retired federal judge, met in 1988 to hear testimony from more than 50 invited speakers and more than 15 representatives of public interest groups. The panel concluded that it is "acceptable public policy" for federal funds to be used for this purpose as long as some appropriate guidelines or safeguards are in place. They particularly noted the need to separate as much as possible the pregnant woman's abortion decision from her decision to donate fetal tissue. They also recommended that women could not be paid for donating fetal tissue, nor could a woman designate a certain patient as a recipient of this tissue. This report was submitted to the Advisory Committee to the Director of NIH and representatives of the National Advisory Council to NIH. The Advisory Committee unanimously accepted the report and recommended the Secretary of Health and Human Services lift the moratorium. At the same time, four out of 21 members of the panel published dissenting reports.

One question that needed to be answered was whether an induced abortion is of moral relevance to the decision to use human fetal tissue for research. Would an answer to this question provide any insight on whether and how this research should proceed? After much debate, the panel answered 18 yes and 3 no. Childress concludes that the ten questions posed by the Assistant Secretary constrained the discussions and linked them too closely to the question of abortion. While observers noted the panel took a consensual approach, this professor states in his analysis that this effort may have been costly in terms of the quality and richness of the report. Too much time was spent trying to find words that everyone could agree with, at least for most of the panelists.
Public opinion was not considered by the panel members to any great extent, although these panels are often seen as reflecting the views of society as a whole. Childress concludes that the appeal to consensus may have stifled a richer debate on the issue, which could have been more meaningful in the long run. In the end, the report was rejected, a rare occurrence.

Carl Wellman, a philosophy professor from Washington University in St. Louis, Missouri, disagrees that some form of consensus is not achievable, but he believes that absolute consensus is too much to hope for in this country. "The best we can reasonably hope for is a widespread, fairly weak acceptance of a few low-level moral principles applicable to technical interventions in human reproduction." The 14-day rule for experiments on embryos is an example. He believes that this level of agreement is sufficient for the purposes of legislation, adjudication, and the law as a whole.

Regarding legislation, he believes it should reflect a compromise between the diverse preferences and interests of members of a democratic society. He argues that the legal validity of any statute does not depend upon moral grounding; its enactment will require a compromise between the legislators and their constituents. He recognizes, however, that compromise is not consensus. Typically, it involves trade-offs between what one wants and undesirable alternatives. However, he argues that legislation may be preferable to judicial decisions because of the tendency for judges to interject their own beliefs and attitudes into the decision-making process without benefit of public input.

He says legal reasoning can succeed if it is part of larger moral discourse which can lead to modest moral consensus. This requires rational argumentation in which
different moral viewpoints are confronted with each other, resulting in a better understanding of different points of view.²⁹

Some social scientists say a commission could give added legitimacy to social action, could sanction a delay in government action on a controversial matter, and could recommend unpopular policies or build public support for new policies.

In 1979, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research issued an important document, popularly referred to as The Belmont Report. The commission was formed five years earlier by an act of Congress. The commission, in its report, articulates three ethical principles intended to provide an "analytical framework that will guide the resolution of ethical problems arising from research involving human subjects. The principles -- respect for persons, beneficence and justice -- each represents the essence of long-standing moral traditions. These principles were part of an evolution of moral thought from various quarters.³⁰

This integrated and cooperative group pursued its work in a spirit of mutual respect, while at the same time its members did not shrink from identifying and defending points of disagreement, according to Moreno. However, it was not always able to exert its authority on the agency it was created to advise, the Department of Health, Education and Welfare. On several occasions, the Secretary either delayed his response to several regulations proposed by the Commission or ignored them entirely.

Consensus building often requires more than crystallizing professional opinion; it also must galvanize public opinions in order to put pressure on public officials to respect the commission's authority, according to Moreno.³¹
The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has been very influential. This commission completed its work in 1983. The membership of the commission rotated and had a strong drive toward consensus. The Executive Director, Alexander Morgan Capron, said that only abortion was so laden with fixed positions that the Commission’s consensus process would have been frayed by an effort to select a barely acceptable compromise, if one were available.

Capron noted: “Rather than having harmful effects, the drive for consensus seems to have had a beneficial effect - it encouraged the commissioners to seek the common ground that best expresses the moral insights and values of Americans today, in light of our shared, albeit not uniform, religious and philosophical traditions.” One of the commission’s volumes of work, “Securing Access to Health Care,” has had little impact on the public debate. Some have criticized this as a good example of the futility of superficial consensus. By the time the commission members started discussing this issue, eight members of the commission were replaced, requiring the “process of reasoning together to be restarted with newcomers.” Also, there seemed to be disagreement among staff members and commission members, resulting in a compromised conclusion.

The interests of political leaders and society dovetail in the work of national ethics commissions. Both are served when a previously unrecognized consensus can be established as part of social policy. Also, there are few risks involved in forming a panel to deal with morally problematic areas. Although a delayed response might aggravate the situation, the purpose of building consensus is hard to criticize.
In 1993, the U.S. Congress’s Office of Technology Assessment published a report called “Biomedical Ethics in U.S. Public Policy.” Working with an advisory panel of bioethicists, the Office of Technology Assessment summarized the historic experience of government ethics commissions with an eye toward the question of whether another one should soon be established and if so, how it should be organized.

The report states: “Successful commissions were relative free of political interference, had flexibility in addressing issues, were open in their process and dissemination of findings, and were comprised of a diverse group of individuals who were generally free of ideology and had wide ranging experience.”

The report emphasizes that commissions should not be burdened with a mandate that includes issues likely to be a priori divisive, such as abortion, and that suitable funding would enable a staff of professional bioethicists to assess particular points of view in a detached manner. It also urged that the structure of a commission should follow from its scope and issues, since a standing body would be suitable for some purposes, a term-limited body for others.

The report encourages Congress to appoint another commission noting: “For nearly four years — the longest period of time since bioethics burgeoned as a discipline - the federal government has been without a formal forum that addresses bioethical issues. In fact, a full operational body has not existed in over a decade.”

In reviews of ethics commissions, some observations and criticisms have been made. One person notes that morality requires the presentation of disparate views. Consensus renders dissent less obvious. Others disagree, stating that consensus among
commission members is essential because a commission has only the power of persuasion. In any case, many agree that the public should have access to information about how consensus is reached. Some believe the primary function of commissions is to preserve social peace, not to serve disinterested intellectual goals. Ethics commissions are at least a mechanism for reducing conflict about moral questions, and perhaps achieving a social consensus. The diversity of viewpoints within the society must be recognized in some way by the commission, also. “The justifiability of a commission’s conclusions depend, at a minimum, on whether they can be sanctioned by principles that are objects of a broad consensus. These conclusions also demand attention to the informal political, sociological, and psychological factors that condition them. Consensus in and of itself is not desirable,” concludes Moreno.35

Private Sector Commissions

The National Advisory Board on Ethics in Reproduction is a private sector panel which has members from the fields of ethics, theology, law, medicine, genetics, and public policy. It was established in 1991 to provide a forum for “reasoned discussion of ethical and policy issues raised by the new reproductive technologies, fetal and embryo research, and fetal tissue use; and to make recommendations about these issues.”36 The work is designed to assist policy makers, physicians and nurses, and members of the public.

The board was established to step into a vacuum in American public life created by the lack of a national body to initiate and stimulate debate about ethical and policy
issues arising in reproductive practice and research. According to the board’s book, *New Ways of Making Babies*, officials in this country have been anxious to avoid developing guidelines on such politically explosive subjects, and only physicians who provide these procedures have developed standards for employing them.

The American Fertility Society, now known as the American Society for Reproductive Medicine, has been developing guidelines for the use of assisted reproduction since 1986. These guidelines are prefaced by overviews of ethics and the law, and provide a sense of current practice in reproductive medicine. Practitioners themselves, however, recognize the need for some guidance from an interdisciplinary group that functioned independently of physician organizations. The American Fertility Society, along with the American College of Obstetricians and Gynecologists, provided seed money to establish the board as a “disinterested external organization” that could begin to develop comprehensive guidelines for use of methods of assisted reproduction and provide advice on research in this area. This board is now funded by private foundations.37

After considering a variety of viewpoints, the board has made the following recommendations regarding egg donation: a wider range of information should be offered to potential egg recipients and donors; counseling should be an essential element in all programs; screening of recipients and donors should be kept distinct from counseling; the practice of egg donation in women of advanced reproductive age should be pursued only with extreme caution; single women should be granted access to this procedure with counseling about special considerations; egg donation programs should offer standard
measures of reimbursement; arrangements in which poor women donate eggs to those who are well-to-do in exchange for coverage of their own in vitro fertilization procedure should be discouraged; donors should be screened for voluntariness with special review in cases of intra-familial donation; programs should purchase insurance to compensate donors who suffer injury or disability due to their participation; donors and recipients should be matched on the basis of whether they want to relate as known persons or as non-identified persons; a broadly constituted task force should develop inter-center guidelines for many facets of egg donation; a centrally coordinated network of registries should be established in this country with permanent records containing medical, genetic, and certain social information about donors in either identifiable or coded form.38

The board also reviewed the policies of four fertility clinics. It found that the policy concerning the age of an egg recipient is different at each clinic, ranging from 43 years to no limit. The age for egg donors was pretty much the same — under 35. All these clinics had various policies for counseling, donor and recipient screening, and donor anonymity.

In their report, the board states: “There are significant moral issues surrounding egg donation about which NABER members were able to reach consensus, even though they disagreed about the weight of the moral values involved.” The report’s contents are not designed to give legal guidance, although they take account of current legal findings and scholarship. They tried to build a consensus about the issues that reflected a broad societal consensus whenever possible.39

Their report states that even though egg donation is an established practice, many
of the most fundamental questions about its moral acceptability have been bypassed. Board members believe it is important to consider the underlying question of whether this practice is ethically unobjectionable in principle and to inquire about how it affects, for good or ill, our culture and religious understandings of procreation, marriage, parenthood, children and women. The arguments fall into two categories: questions about the meaning of marriage, parenthood, and procreation, on one hand, and the consequences of the practice for the resulting children, or for the donors, on the other hand. Their principles include respect for personal autonomy, informed consent, privacy, non-commodification of human beings and their bodies, the moral significance of the family as a basic social unit, equal respect and concern for all human beings, and the fair and appropriate distribution of societal resources. This framework of values is relevant to board members in questions raised by the technique of egg donation. They plan to investigate the way in which these values apply to the use of other techniques of assisted reproduction in future reports. Their ultimate plan is to develop a comprehensive ethical framework that can be used to guide the development of current and future reproductive technologies that is grounded in careful case studies of these technologies. They believe more discussion is needed among societal members before that step is taken.40

In a section on public policy and the use of egg donation, the board states there is no explicit public policy in the United States directed toward some of the pressing ethical and social questions raised by egg donation. Legislation regulating the procedure is virtually non-existent and courts are hearing a few cases. No national commission has been established to consider its ethical, social, legal, and policy implications, and to craft
guidelines for its use. This is largely left to infertile people, egg donors, and health care professionals. As a result, practices vary from center to center, and information is not readily available outside the clinic.

Egg donation is a way of creating children and families and touches basic issues about the sort of society in which we live and will create for future generations. It is among the new reproductive technologies that raise fundamental policy questions about the appropriate means for setting social priorities, and ultimately who decides and controls the use of genetic and reproductive technologies in a democratic society.

Board members considered four ways in which a greater degree of societal direction could be addressed: a framework of laws and regulations; common law cases; policies developed through a national forum in the public or private sector; and guidelines crafted by health care professionals through their professional groups or through inter-egg donation center committees. Legislation is needed to assign parenthood and to ensure record-keeping about egg donors and to assign parenthood to the egg recipient, the board concludes. Also, state legislatures should pass laws clarifying the legal status and rights of all those involved in this procedure. Serious and timely consideration should be given to establishing a federal regulatory body to license infertility centers.42

Summary

While some argue whether consensus on reproductive technologies is desirable, others say it is desirable but not achievable. Still others say consensus is achievable, but differ on how to achieve it. Commissions have successfully dealt with other
controversial social issues, and serve as an example for the formation of a similar commission to resolve issues related to assisted reproduction. Some commissions have even grappled with some of these issues but not with the kind of objectivity and scope the subject deserves. The next chapter, the conclusion, shows why a national commission should be formed and how it could work to develop consensus.
Chapter Notes


2. Bayertz, 34-35.


4. Ibid., 7-8.

5. Ibid., 12-13.

6. Ibid., 14.

7. Ibid., 20.

8. Ibid., 21.

9. Ibid., 43.

10. Ibid., 44.

11. Ibid., 45-46.

12. Ibid., 56.

13. Ibid., 56-57.


16. Ibid., 246.


18. Ibid., 63-66.

19. Ibid., 67-68.

20. Ibid., 69-71.

21. Ibid., 74-75.

22. Bayertz, 163-175.
23. Ibid., 175-180.
24. Ibid., 163-165.
27. Ibid., 120.
29. Ibid, 116-120.
30. Moreno, 76-80.
31. Ibid, 81-85.
32. Ibid., 83-86.
33. Ibid, 83.
34. Ibid.
35. Ibid, 85-86.
37. Ibid., xiii.
38. Ibid., xviii.
39. Ibid., 236.
40. Ibid, 246-248.
41. Ibid, 293.
42. Ibid, 297-302.
CHAPTER VII

CONCLUSION

The use of reproductive technologies, according to one author, wears two faces.

To some, the technique brings with it the capacity to carry society down a slope of increasingly negative applications. To others, it is a simple medical technique offering hope to people in need. Andrea Bonnicksen writes in her book: “We have upon our backs the weight of unresolved polarity about basic in vitro fertilization, and we have failed to take account of the areas of consensus that lie hidden beneath the headlines and flamboyant symbols.”¹ This author claims the government has not gotten involved in the issue because it is too controversial.

Another author states public consensus has been reached: “The trophy of a public policy is to turn a particular interpretation into an accepted fact which seems beyond the stage of negotiation.” This is crucial because it guides legal rulings concerning the right to motherhood and reproductive freedom.²

In many parts of the country, there are no standards about who can open a fertility clinic, what should be done with frozen embryos, or who owns them. Arthur Caplan, an ethicist at the University of Pennsylvania, questions whether the United States can create a moral and legal framework that keeps an eye out for the best interests of the children. He agrees that legislation should cover the legal ownership of reproductive materials and
patient consent regarding the donation of embryos. He also thinks there should be some kind of standards regarding age, income or marital status for patients wishing to use reproductive technology.

It seems that every person who gives some serious thought to the issue of reproductive technologies comes up with a different conclusion about its moral acceptability, even if it's slightly different. While one person believes surrogacy is acceptable under any condition, others say it is only acceptable if the surrogate is not paid; still others say it is not an acceptable practice under any circumstances. Surrogacy has been banned in some countries. In the United States, the practice is legally acceptable in most states if the surrogate mother is reimbursed only for certain expenses and other costs, similar to adoption.

In trying to decide the best approach for dealing with reproductive technologies, this paper has looked at several questions, which were mentioned in the introduction. First, who are making the decisions about these technologies today, and is that ethically acceptable to most people? Second, if most policy decisions are being made by judges, and to a lesser extent legislators and administrators, are they good decisions that take into account ethical dilemmas? Third, if laws are not the answer, or only part of the answer, what examples are available to use as a guide, and what works and doesn't work about them? Fourth, is moral consensus the right thing to strive for, keeping in mind our need for personal autonomy? Fifth, would the establishment of a national commission fit in with this country's style and tradition of decision making, and do precedents serve as good indications for the success of an ethical commission in this area? Sixth, does the
establishment of a national commission on reproductive technologies fill a real need in this country? Finally, what would an ethics commission look like in terms of authority, scope, membership, and function? Answering these questions gives us another answer to what may play an important, necessary role in this country.

The Decision Makers

Who are making the decisions about these technologies today, and is that ethically acceptable to most people? Depending on who one talks to in this area, the answers vary. However, most people would agree, I believe, that preliminary decisions about whether to find out about a reproductive technique is made by those who want a child and have the money to pay for any procedures or transactions in order to get an offspring. This could be a married or unmarried couple, a single woman, an older woman, a gay couple, and so on. For some reason, usually infertility, these persons cannot have a child by themselves and need third party assistance. In the case of surrogacy, contractual agreements are made, often with a lawyer and the surrogate mother. If a visit is made to a fertility clinic, the prospective clinics must abide by clinic policies, which vary from clinic to clinic. Some doctors are reluctant to administer procedures to single women, lesbians, and older women due to their own personal beliefs. Some legislation forbids surrogate contracts, or forbids artificial insemination outside of a doctor's office. After the procedure is underway, or the child is born and there is a dispute for whatever reason, judges often determine what is in the best interest of the child or the parent's intent prior to the pregnancy. Judges also are deciding cases concerning frozen embryos, child support and
child custody, and clinic fraud and abuse. Legislators, in some cases, have determined limits on some of the procedures, and who is considered the legal parent in some instances, but not all.

So, in summary, prospective parents decide if they’re interested in the procedure. Doctors and clinic policies decide if they can undergo the procedure, and judges decide any disputes arising from these initial decisions. Almost nobody disputes the decisions that are made by infertile couples wishing to have a child, except those wishing to have a child through a surrogacy contract. Others would like to place limits on those who do not represent traditional families because they sincerely believe, correctly or incorrectly, that it is not in the best interest of the child involved. There are disputes back and forth about what is best for a child, and many believe that a child raised in a loving, secure environment, regardless of the exact parental arrangements, has a chance for a good life. This debate is at the heart of the “culture war” between orthodox conservatives and progressives. Where reproductive technologies fit into the larger picture of the changing role of the family deserves thoughtful scrutiny.

I believe doctors control too much of the decision making, and I am concerned about the role that courts play. Judges have fashioned most of the public policy in this area while legislators have played a much smaller role. Federal policy makers, with a few minor exceptions, have played little or no role.

I would like to take some of the ethical decision making from doctors, judges and politicians, and place it with some diverse, thoughtful persons who can help guide new policy in this arena, and even provide advice to the courts and legislatures as appropriate.
Flaws in the Laws

If most public policy decisions are being made by judges, and to a lesser extent legislators and administrators, are they good decisions that take into account ethical dilemmas? While many people believe the law is part of the answer to questions about reproductive technologies, one has to keep in mind what law is and what it isn’t.

According to Roger Dworkin, author of Limits, law is not the same as science. While a scientist describes a person’s state of mind in agonizing detail, a lawmaker determines whether society will be better off to send a convicted criminal to prison or to a mental hospital. The scientist has no special claim to expertise about considerations such as expense, impact on others, the moral sense of the community, or ease of administration.

Law is not ethics, either, and this is an important point. Ethics is a branch of philosophy about how persons ought to behave. Some ethicists argue that ethics involves primarily questions about what ought to be done rather than about how to decide what ought to be done. Law is temporal and involves sanctions, but can also embody ethics.

Law is what allows a society to reach conclusions on difficult problems without knowing in advance what the solutions to the problems should be. A careful look at the different kinds of lawmaking -- common law, legislation, constitutional adjudication, and administrative rule-making -- reveal the strengths and weaknesses of each.

All federal and state legislation is drafted on a background of common law. Common law adjudication is a legal system in which judges get their information from
lawyers and make law mostly on a state-by-state basis through the resolution of real, existing disputes one case at a time. Decisions are based largely on analogy and precedent. The backward-looking nature of the common law is still another reason to doubt the common law's ability to deal with new problems posed by rapid changes in science and technology.

In common law, remedies are limited. The most common remedy is to order one person to pay money to another. Common law courts usually award money because they don’t have the staff ability or authority to regulate behavior in detail or to supervise ongoing activities. Many problems posed by biomedical advance seem to call for relatively detailed regulation and supervision.⁴

Common law is made by judges who sit in state supreme and appellate courts. Most judges are appointed and many serve for life. Most have expertise in law but not in medicine or science. They are inexpert, undemocratic lawmakers who get their information from lawyers, litigants, and law clerks. They have no large staffs such as legislators, and do not hold investigative hearings.

Most common law is made by state courts, which means that common law development is unlikely to provide uniform, national resolution of issues. The common law is ill-suited to comprehensive, systematic lawmaking.

Processing scientific and technical information is one of the jobs that many judges do with the least skill and the greatest impatience, according to David Horowitz, author of Courts and Social Policy.⁵ In a court case, judges look at whether one party has a right while legislators and administrators, in contrast, look at alternatives. Adjudication, then,
is narrow. The format of decision-making inhibits the presentation of an array of alternatives and the explicit matching of benefits to costs, states Horowitz.7

In court cases, the judge’s power to decide extends, in principle, only to those issues that are before him. Related issues, not raised by the instant dispute, must wait for later litigation. The focused, piecemeal quality of adjudication implies that judicial decisions tend to be abstracted from social contexts broader than the immediate setting in which the litigation arises. The potentially unrepresentative character of the litigants makes it hazardous to generalize from their situations to the wider context, according to Horowitz.8

In court cases, judges do not initiate action; they hear disputes brought to them by parties. Judicial decisions become a chance occurrence with no guarantee that the litigants are representative of the scope of problems their case represents.9

In a court case, historical facts are events that have transpired between the parties to a lawsuit. Social facts are the recurrent patterns of behavior on which a policy must be based. Social facts are nothing new in litigation. Courts have always had to make assumptions or inferences about general conditions that would guide their decisions. As the courts move into new, specialized policy areas, they must deal with human behavioral problems that are beyond their ability to answer on the basis of their own experience or through expert testimony, he explains.10

If a judge or a jury make a mistake of fact relating only to the case before it, the effects of the mistake are limited. But if those facts are used to make general policy, the consequences cannot be so confined. This is one reason some favor common law.
In general, the parties can be depended upon to elicit all of the relevant historical facts, through the ordinary use of testimony and documentary evidence, and the judge or jury can be presumed competent to evaluate that evidence. Social facts, on the other hand, may not be elicited at all by the parties, and the competence of the decision maker in this field cannot be taken for granted. These deficiencies of the adversary process have led to proposals for the employment of outside experts as consultants to the courts.\textsuperscript{11}

Expert testimony is the conventional way for the litigants to prove social facts, but its deficiencies are considerable. Rules of evidence are geared toward the search for truth between the parties, not to the search for truth in general.

Horowitz states that issues dealing with social facts have been handled poorly by the courts because they are not future-minded. Usually, adjudication makes no provision for review of a policy. Judges base their decisions on antecedent facts, on behavior that antedates the litigation. Consequential facts -- those that related to the impact of a decision on behavior -- are equally important but much neglected. Litigation is geared toward rectifying the injustices of the past and present rather than planning for some change to occur in the future.\textsuperscript{12}

Legislation, in contrast, is law made by elected representatives, who may be informed by a large number and wide variety of sources. It can deal with problems prospectively and offers greater speed and more certainty than the common law. Legislation is more democratic and more political. Legislators have access to a large amount of information, have large staffs, and hold hearings.

However, legislators are also too busy to become experts on many topics.
Legislative information comes primarily from lobbyists and other persons with personal
agendas, not from objective experts. Legislation is the product of inexpert decision
makers using biased, partial, and ill-understood information to form the bases for their
actions. While legislators can act in advance, they often don’t. Legislation could be
faster, but the passage of bills is often a slow process, and legislation may freeze science
and technology in a certain moment.

Regulations made by government agencies also play a role. Although no
regulations have been made by any federal government agency on the use of reproductive
technologies, it is instructive to note the character of this type of law-making as a
potential future remedy for issues related to reproductive technologies. Administrative
law is made by appointed officials who are not directly accountable to the public. These
persons, usually civil servants, must be experts in the area being regulated. This kind of
lawmaking is designed to proceed informally and can engage in both rule making and
adjudication. This is supposed to be fast, responsive, expert decision making. However,
administrative lawmaking is highly formalized, remarkably technical, and extremely
complex. Administrative agencies are often created and overseen by legislatures.

Constitutional adjudication is law made by judges, who get their information from
lawyers. It involves the national imposition of solutions, sweeping in its analogical and
geographic impact, and difficult to change. It is made through case-by-case adjudication
with real, existing disputes serving as vehicles for lawmaking.

Only Supreme Court decisions are definitive. Supreme court judges are
nondemocratic, inexpert decision makers who have enormous power. The only way to
change constitutional decisions are to amend the constitution or to convince the Supreme Court to reverse itself. Since the Bill of Rights, the Constitution has only been amended 17 times.\textsuperscript{13}

People want speedy answers to questions about reproductive technologies. In many cases, a concern for medical ethics often has become a plea for medical law. The law is a primary vehicle for resolving disagreements about public policy and the treatment of real persons. To suggest that law has no role to play would be wrong and unrealistic. Yet the law can’t solve everything. Much of the law that exists today is ill advised. Law is a collection of tools of limited utility, according to Dworkin.\textsuperscript{14}

Even if lawmakers were able to understand and keep pace with scientific change, however, they would be unable to effect wise, principled, or across-the-board responses to the social issues posed by biomedical advances. Every serious social question posed by biomedical advance seems to involve conflict between right and right, according to Dworkin. Assisted reproduction pits the desires of infertile couples to achieve parenthood and of individuals to capitalize on their physical resources against concerns about demanding and imposing on women and irresponsible treatment of children.

Administrative agencies can be helpful when they restrict their lawmaking to their spheres of expertise and try to regulate as non-disruptively as possible, but they can go off the political deep end, can exceed their competence, and are non-accountable, he adds.\textsuperscript{15}

Currently, judges have the most say in the direction of reproductive technologies. As can be seen, though, those decisions are not the most representative of society.
However, it is about the only snapshot of society we have to determine any kind of broad-based consideration on these issues. While legislation exists, mostly at the state level, it is not consistent and revealing enough for policy makers as a whole.

Also, laws and regulations are not designed to deal with the ethical issues facing this country. A judge may interpret a dispute according to analogy and precedent, but that doesn’t mean there will be any consideration given to moral values. In that area, there is indeed a vacuum.

Examples of Other Countries

If laws are not the answer, or only part of the answer, what examples are available to use as a guide, and what works and doesn’t work about them? One can begin by analyzing the models of other countries. Recognizing that these countries are not necessarily the same in character or legal framework, they are nevertheless faced with the same concerns about how to deal with the rapid advance of new technologies that help so many people, yet force new definitions of parenthood and family that are confusing and troublesome to many.

In attempting to reach a consensus, governments have identified various approaches. In France, the state of Victoria in Australia, and Canada, considerable time was given by the government to provide an opportunity for public debate. In the United Kingdom, a more limited format was adopted by creating an evidence-gathering committee whose terms of reference probably were vague to the general population.

Italy has taken limited measures.
At the very least, the public has an interest in obtaining accurate information about the risks, benefits and costs of this technology. Most countries have gone too far in the area of reproductive technologies to forbid its use now. Thus, they are making attempts through licensing bodies to monitor and control these technologies. Examples can be found in the United Kingdom and Canada with the establishment or proposed establishment of licensing authorities to regulate clinics and monitor new technological advances.

The French model is a good example to follow in terms of approach. The government encouraged a broad public debate before considering ethical issues. Then the panel set principles which they consistently used to make recommendations which could be turned into statutes. Unfortunately, the panel's work has not been tested in the French parliament. However, I don't believe the lack of eventual outcome detracts from its attractiveness as a model.

In the United States, the debate is centered mainly on the autonomy of service consumers and providers. Government is placed against the individual, and debates occur about the degree to which moral teachings ought to be imposed upon the population in the name of good order and morale. This generates a rights-based discussion, in which competing interests argue about the principles embedded in the U.S. Constitution and Bill of Rights. Any bioethics commission created for the U.S. government would have to be responsive to this political reality.16

The Canadian government follows a principles-based approach. The commission completed its work in a comprehensive fashion with modern methods of gathering public
input. They used toll-free telephone numbers, public surveys, public hearings, and other means to get public opinion on this subject. In all, they said more than 40,000 people were involved. That is an impressive number of people. Many of these people were researchers, who studied various issues. The commission issued a report, leaving it up to the government to introduce legislation, which eventually happened.

The title of the Commission's report, "Proceed with Care," shows that progress is good if tempered with thought and consideration. The commission urged a two-part approach. They made recommendations about which technologies and practices should be banned, such as human cloning research and payments for gametes. These recommendations should be turned into national legislation. The commissioners also recommended a licensing board to govern new technologies and regulate clinics using acceptable practices.

A look at these groups in general brings several points to mind: public debate and discussion is essential to a commission’s work; the development of underlying ethical principles guides the commission’s work more clearly; legislation is often considered as part of the recommendations that are made; a permanent licensing body is also considered necessary to keep the commission’s work alive; and extreme caution must be used when attempting to impose restrictions on personal autonomy.

Most important, these countries are faced with the same kinds of decisions about reproductive technologies as in America. In this country, however, the use of these technologies is more prevalent. Each country, at separate times but for similar reasons, decided to study these issues in order to determine what is acceptable and unacceptable.
from a moral viewpoint. This hasn’t happened in the United States. While many ethicists call for such a stand, it hasn’t reached the turning point. It seems that some positive steps should be taken in this area before the issue becomes too divisive, as the abortion debate has done.

As has been shown, the United States has formed national commissions on various topics, especially in the past century, and most have been considered a success. While a national commission has not been formed in this area specifically, other commissions have been formed to study areas of controversial research. The best example is the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research Studies, which made policy recommendations about many bioethical issues during the late 1970s and early 1980s.

A look at moral consensus and the use of ethics commissions in general shows that valuable work has been done in this arena. This work has not been without its critics, however. Some people question the usefulness of commissions while others question their moral authority. Ethics commissions can help to inform and guide the rest of society on difficult issues, particularly when there isn’t enough time devoted to these issues by the general public. The important point is that a commission respects the general principles of a liberal society, accommodating and respecting divergent viewpoints. Also, representation of a broader society is essential as well as a general agreement on basic moral principles that can guide the deliberations on each difficult case or issue. Also, there must be broad agreement that consensus is needed on an issue before setting up a commission. Consensus for the sake of consensus is without value.
Moral Consensus

Is moral consensus the right thing to strive for, keeping in mind our need for personal autonomy? Many bioethicists and others have debated this issue. It seems that the alternatives are no decisions being made and no consensus being reached, or one expert moral authority determining what is good and bad for society. These new technologies are not like the invention of the telephone or the airplane. While those innovations had a dramatic effect on society, these technologies are changing the core of the family, long thought to be the major component of our social structure. The very reason it cuts to the heart of our personal, private lives is the reason there is a resistance to regulate these new technologies. Family life has always been considered somewhat sacred. So how does someone convince people that taking a look at these technologies with an eye toward monitoring and controlling them is good for them?

The bottom line is that decisions are made every day on behalf of society. It seems that if there is significant discussion and input about the principles that are important in the area of reproductive technologies, then some decisions may be made that respect personal autonomy and improve society as a whole.

However, any discussion about assisted reproduction would inevitably include deliberations about the family. The changing role of the family already is affecting the courts and the legislatures through the passage of laws that tend to reflect traditional views of the family. Before attempting any kind of consensus, though, a group of persons would have to study the issues and how they affect the various stakeholders: the
parents, the children, the embryos, doctors, lawyers, judges, consumers, and so on. Because assisted reproduction deals with a larger issue that affects everyone, any kind of consensus would need to reflect the larger discussion.

If there is no attempt to achieve moral consensus, what we are left with are judges and doctors who decide what is best for society, in effect. They are the ones who are making decisions in these areas now. Prospective parents may decide whether or not to undergo treatment, but doctors may turn down patients, and judges determine child support, custody and other related issues in court cases. This will continue to be the case to some extent, but the debate can be broadened to include all stakeholders by the establishment of a mechanism for achieving a form of moral consensus.

The Canadian government commission states the importance of placing boundaries around the new reproductive technologies, and to guide and control them within those boundaries. Otherwise, some of these technologies could harm individuals and society as a whole.

Filling a Void

Does the establishment of a national commission on reproductive technologies fill a real need in this country? The National Advisory Board on Ethics in Reproduction was established to "step into a vacuum in American public life created by the lack of a national body to initiate and stimulate debate about ethical and policy issues arising in reproductive practice and research."

The industry's viewpoint is that officials in this country have been anxious to avoid developing guidelines on the subject. Practitioners
themselves, however, recognize the need for some guidance from an interdisciplinary group that functions independently of physician organizations. Throughout this paper there have been citations from bioethicists, writers, feminists, and others that some form of guidance is needed, whether it is from legislation, regulations, commission recommendations, or the like.

While attempts to form recommendations by the National Advisory Board on Ethics in Reproduction may be considered thoughtful, courageous, and praiseworthy, it is not distant enough from the medical community to have the credibility and moral authority needed by our society. That would involve the formation of a national ethics commission.

Formation of a National Commission

What would an ethics commission look like in terms of authority, scope, membership, and function? While consensus may be difficult to reach, and despite negative comments about the effectiveness of achieving any group consensus, I believe it is feasible to form a panel, commission or board to examine reproductive technologies.

First and foremost, this panel should seek a diversity of viewpoints throughout the country, widely publicizing meetings and hearings to allow for sufficient input. Toll-free telephone numbers, faxes, and web sites could be useful, also. Special invitations should be sent out to those involved in this issue as well as those who aren’t.

This commission should consist of members representing medicine, philosophy, sociology, law, bioethics, religion, women’s groups, voters’ organizations, political
parties, government agencies such as the Department of Health and Human Services, infertility patients, fertility clinics, and the general public. At least half should be women. This commission should report to the President, the findings of which could be turned into legislation for consideration by Congress, or into regulations to be considered by the Executive Branch, as appropriate.

I believe it is important that the judicial branch continue to decide cases on an individual basis, but I believe it is more important to establish a consistent and coherent regulatory and/or legal framework which protects and informs infertility patients about their choices, risks and chances for success. This type of work would have the most far-reaching impact on the greatest majority of persons. More difficult philosophical questions are important and must be discussed, but I believe it is important to take a hard look at the infertility business from a consumer protection standpoint.

There is much justification for regulations to protect consumers. Consumer Reports called infertility treatments a “crapshoot,” one that costs $8,000 to $10,000 a roll. There’s no way for a couple to know how a particular clinic performs, according to their researchers. Many patients don’t realize the cost versus success ratio. It is estimated that about one in eight women who undergo the procedure will conceive. One article states that clinics market themselves by their success rates. The competition for patients has led to exaggerated claims and renewed appeals by some medical ethicists to regulate the clinics. These clinics take in about $2 billion a year.18

Another factor coming to light is the long-term health effects on the mother. Preliminary findings based on a 1993 study by Stanford University epidemiologists...
indicate that women who took fertility drugs were three times as likely to develop ovarian cancer as women who didn't.\textsuperscript{19}

There are other stories about fertility clinics taking eggs from mothers without their knowledge and giving them to other women. The issue seems to be how to best regulate the industry, not whether it should be regulated. A Presidential commission could seek out this answer in its deliberations.

The commission could also look at whether the enactment of regulations should be left up to the courts, the medical profession, state legislators, federal regulators or congressional legislation. State legislatures already have made some decisions; many judges already have listened to debates on this issue; and the federal government already has looked at some aspects. However, no entity has taken a comprehensive look at the infertility issue and made comprehensive recommendations. Other countries have managed to do this with varying degrees of success such as the United Kingdom. It seems odd that the United States, one of the largest users of reproductive technologies in the world, has not taken a comprehensive stand on this issue.

The piecemeal approach taken by the courts is unacceptable because it doesn't consider the whole issue. For example, if access to reproductive technology is available, should it be available to everyone? While arguments are made that access is restricted in the best interests of the prospective children, is that really the case? Is prejudice or justice really being served when single mothers, lesbians and older women are not allowed to undergo infertility treatments? A closer look at adoption practices could be applied in this instance. Legislation may be far more preferable than abiding by the
discretionary practices of those controlling the technologies. While many persons studying the issue believe we have moved too far forward to turn back the clock in the area of reproductive technologies, it may be worthwhile to examine whether this is really the case. This would be another primary task of the commission, which could be a permanent body unless the members decide to establish another commission after their work is completed. This group should not forget that it represents the broader public in its deliberations.

It is time for our country to decide where it wants to go on this issue. The only way to do this is to decide on a specific course of action. Any course of action has its merits and faults, but the decision to do something is what’s important. We need to find out where we want to go as a country and what is the most prudent course to take. Consensus may not be reached, but it could be strived for thoughtfully and thoroughly.

First, information and protection are needed to help those who already are involved in infertility treatments. Second, we need to feel comfortable knowing that infertility treatments are acceptable to the majority within certain guidelines. Those who have discomfort with this issue might feel better knowing that we have carefully considered this issue, and it is under control. We should not allow extreme or experimental practices to be used on patients or allow them to be manipulated by greedy clinics.

Some people will never accept a supposed infringement on their fundamental rights, but that is an issue debated about many issues. All we can hope for is that some fair legal decisions are made which benefit the majority of the people most of the time.
We ought to be looking at how these new families fit into society, either through education, counseling, or regulation. Children’s educational programs, for example, are extremely sensitive to different family structures such as single parent homes, grandparent homes, etc. If reproductive technologies are here to stay, why not institute some kind of educational program for society? There is a general lack of knowledge and, some might say, interest in this subject by those who are seemingly unaffected by it. But these technologies affect everyone in society, and there should be an assimilation process.

First, though, acceptable technologies should be safe and effective. Second, some technologies may be unacceptable. Third, acceptable technologies should be considered in light of the changing role of the family. A Presidential commission could tackle one or more of these areas, depending on the information members receive from the active, thorough, and thoughtful solicitation of views.
Chapter Notes


5. Ibid., 7.


8. Ibid., 34.

9. Ibid., 35-42.

10. Ibid., 46-48.

11. Ibid., 49.


15. Ibid., 10-18.


BIBLIOGRAPHY

Books


**Journals**


Magazines


Newspapers


Reports


Other

1. Lexis-Nexis Express Service. Dayton: 1998. Information sources are full-text articles from newspapers, business, government, trade and technology publications, federal and state cases and regulations.


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