

**ACCESSING REPRODUCTIVE TECHNOLOGIES:
INVISIBLE BARRIERS, INDELIBLE HARMS**

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I. INTRODUCTION

At the height of the Second World War, Justice William O. Douglas penned an observation so self-evident, it was a virtual truism. “Procreation,” he declared “involves one of the basic civil rights of man...fundamental to the very existence and survival of the race.”¹ At the time, procreation through means other than sexual intercourse were unknown,² thus Justice Douglas’ world view of human conception entailed a single scenario in which one man and one woman melded their gametes inside the woman’s body to produce a child. By the end of the twentieth century, this world view had shifted dramatically with the birth of reproductive medicine – a medical specialty devoted to helping patients overcome infertility through various methods of assisted conception. A mere three score years after Justice Douglas spoke of the import of procreation, human offspring could be conceived in a test tube,³ with the aid of an egg donor,⁴ or a sperm donor,⁵ or a gestational carrier,⁶ wreaking havoc on traditional notions of

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

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

³ The world’s first “test tube” baby, Louise Brown, was born outside London on July 25, 1978. *See* Peter Gwynne, *All About That Baby*, *NEWSWEEK*, Aug. 7, 1978, at 66. Louise was conceived using in vitro fertilization (IVF), a medical technique in which the egg and sperm are introduced under the glare of a laboratory petri dish, instead of in the dark quiet recesses of a woman’s fallopian tube. Once the sperm fertilizes the egg, the resulting embryo is nurtured in the lab for several days and then transferred into a woman’s uterus where it will, hopefully, implant and develop until birth. *See generally*, Peter R. Brinsden, *A TEXTBOOK OF IN VITRO FERTILIZATION AND ASSISTED REPRODUCTION* (1999).

⁴ The world’s first birth resulting from egg donation was reported in 1984 by scientists in

reproduction and parenthood. These procreative aids, commonly referred to as assisted reproductive technologies (ART), inject third parties into what was heretofore considered an intimate and closed two-party relationship. The presence of third parties in the reproductive process, be they ART providers or purveyors of human gametes,⁷ calls into question the durability of Justice Douglas' averment that procreation is a basic civil right of man. With reproduction in the modern era trending toward the technical, one wonders whether the protections and respect accorded the traditional procreation of yesteryear apply en masse to today's amalgam of conception methodology.

The most obvious difference between natural and assisted conception lies in their ease of use. The basic requirements for traditional procreation are undeniably slight – a man and a woman with functional reproductive systems helped along by an instruction manual written by Mother Nature herself, with perhaps a touch of tutoring by a cadre of high school biology teachers. Assisted conception, on the other hand, is axiomatically complicated by its necessary introduction of third parties into the reproductive process. Whether these third parties are physicians specializing in infertility care, or strangers willing to provide the missing ingredients for the conception and birth of a child, the addition of one or more actors to the traditional two-party procreative process increases its complexity exponentially. The necessity of third parties in

Australia. The first known birth using AID was reported in 1884, but the practice became popularized in the 1950s with the discovery of effective methods for cryopreservation of sperm. *See Daar, supra* note 2 at 28, 220.

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

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

⁷ Human gametes refer to the cells that participate in fertilization and development of a new organism, also known as germ cells or sex cells. The male gamete is the spermatozoon (sperm) and the female gamete is the oocyte (egg). *See McGraw-Hill Dictionary of Scientific and Technical Terms (4th ed. 1989, at 2087.*

assisted conception means that reproduction is no longer purely internal, but rather is externalized, forcing prospective parents to seek out and procure services essential to their procreation. This article explores the accessibility of these reproductive technology services.

The notion of access to reproduction in the aftermath of Justice Douglas' broad mid-century pronouncement was, in the main, a negative right.⁸ Declaring procreation a "basic civil right of man" meant the state was prohibited from interfering with a person's *natural* ability to procreate. This article ponders the limits of state and private conduct when a person lacks the natural ability to reproduce. Whether the contemporary notion of access to reproduction likewise embraces a prohibitory stance toward interference with a person's ability to procreate *with assistance*, is best revealed by a study of the current provision and denial of assisted reproductive services.

Part II describes the rising use of reproductive technologies in the United States, marching steadily from a rare oddity in the 1980s to a downright common form of procreation in the 21st century, responsible for nearly 3 in every 100 births nationwide.⁹ By tracking the panoply of existing reproductive technologies and the demographics of those who seek out ART services, the potential for barriers to access comes clearly into view. Studying who needs, who buys and who supplies assisted conception is foundational to understanding the obstacles that ART consumers face. While Part II extolls the technical successes reproductive medicine has wrought, it correspondingly suggests these successes have sown a pent up demand for reproductive services that our society either cannot, or will not, accommodate.

Part III herein discusses the limitations on access to reproductive technology services, setting forth the three major categories from which barriers arise. The first, and most far-reaching barrier, is the limitation based on cost. As Part III explains, ART services are costly and are largely excluded from coverage under most private health insurance policies. Thus, the population who can access such services tend to display homogeneous wealth and employment characteristics. Relatedly, a second barrier to access separates prospective patients along racial and ethnic lines. As in access to health care generally, access to reproductive technologies is diminished for racial and ethnic minorities as compared to non-minority populations. Statistically, while minority men and women are more likely to suffer from infertility compared to their non-minority counterparts, they are less likely to have and avail themselves of access to treatment.¹⁰ The reasons for this disparity are explained in both historic and contemporary social terms, with neither explanation yielding a satisfactory justification for the continuing barrier. Third, reproductive services can be limited based on a patient's marital status. Despite the fact

⁸ Procreative liberty as a negative right is ably discussed by John A. Robertson in his book, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 23 (1994).

⁹ See *infra* text accompanying notes 29-32.

¹⁰ See *infra* text accompanying notes 75-78.

that a third of all children in the U.S. are born to unmarried women,¹¹ negative attitudes toward single and same sex parenthood create barriers for unwed individuals who must look to reproductive medicine for family formation. Recent efforts on the part of some private physicians and public lawmakers display an unabashed desire to deny ART services to unmarried individuals. Though the merits of such attempts seem constitutionally dubious, the mere foray into a system that assesses the worthiness of a prospective parent based on marital status is dangerously out of step with modern family life.

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

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

¹¹ See *infra* note 96.

Third, children of assisted conception can be harmed by limitations on access to reproductive services. Already born children may face stigma as a result of the now-banned method of their conception, while never born children are harmed in more theoretical, yet important, ways. Finally, limiting access to reproductive technologies harms society by expressing an attitude that stigmatizes those who are unable to achieve parenthood the old-fashioned way. This expressivist argument is explored, ultimately yielding that stigmatizing would-be parents by depriving them the opportunity to reproduce is dangerously reminiscent of our eugenics past, an era in which wrong-headed judgments about parental fitness culminated in the involuntary sterilization of thousands of Americans. The need to recognize and avoid the negative eugenics of yesteryear serves as the primary rationale for opposing limitations on access to safe and effective methods of assisted conception. Only by insisting on access for all can we begin to operationalize Justice Douglas' view of procreation as a basic human right.

II. THE RISE OF REPRODUCTIVE TECHNOLOGIES

Rooted in the use of reproductive technologies is the condition of infertility, defined broadly as the inability to conceive or carry a child to term.¹² To my mind, infertility can be functional or structural. Functional infertility occurs when either the woman or the man, or both, experience a malfunction in their reproductive tract. Women can experience infertility if their ovaries fail to produce eggs, or their fallopian tubes fail to allow eggs to pass through to the uterus, or their uterus fails to allow a developing embryo to implant for the 40-week gestational period. Men can experience infertility if their sperm are absent from the seminal fluid, or present in insufficient numbers, or if they lack the ability to effectively deliver sperm into the female reproductive tract.¹³ Likewise both men and women can experience infertility if their reproductive organs have been surgically removed or rendered inoperative by medical treatment such as radiation therapy or chemotherapy used for the treatment of cancer.¹⁴

¹² The Centers for Disease Control (CDC) considers a couple infertile if they not used contraception and not become pregnant for 12 months or more. *See* 1995 National Survey of Family Growth, conducted by the National Center for Health Statistics, available at www.cdc.gov/nchs/data/series/sr_23.

¹³ For a discussion of the causes of infertility, *see supra*, ASSISTED REPRODUCTIVE TECHNOLOGIES: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY, THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW 8-10 (1998).

¹⁴ Today both men and women can take steps to preserve their fertility prior to undergoing surgical or medical treatment that would otherwise render them infertile. Sperm and eggs can be extracted prior to treatment and frozen for later use. While the ability to freeze and thaw viable sperm dates back to the 1950s, egg cryopreservation is just now emerging as a method of fertility preservation for women. *See* R. Bunge & J. Sherman, *Fertilizing Capacity of Frozen Human Spermatazoa*, 172 NATURE 767 (1953) (reporting the first successful human pregnancy with frozen sperm); Sally Wadyka, *For Women Worried About Fertility, Egg Bank Is A New Option*, N.Y. TIMES, Sept. 21, 2004, at 5 (describing Extend Fertility, a new business offering egg banking to women with offices in major metropolitan areas).

Structural infertility occurs when an individual or couple desires to reproduce but must do so through means other than sexual intercourse because of the social structure in which they self-identify. Single individuals and same sex couples comprise this group of the structurally infertile. Partnerless single individuals and gay couples who wish to reproduce and rear their children within their existing social milieu, lack the necessary structures to achieve parenthood on their own. Thus they must access assistance in reproduction in order to conceive and carry a child to term.¹⁵

The data surrounding the incidence of infertility focuses largely on functional infertility, detailing the prevalence of involuntary childlessness among heterosexual, mostly married, couples. According to the CDC, approximately 7.1%, or 2.1 million married couples in the U.S. are infertile.¹⁶ In 2003, the most recent year for which statistics are available, this rate of infertility translated into 1.2 million women of reproductive age seeking infertility-related medical services annually.¹⁷ The incidence of structural infertility – perhaps best measured by the number of single and same sex couples who desire to reproduce – is largely unknown, as no government surveys report such figures. Perhaps the only surrogate marker for the incidence of structural infertility comes from anecdotal reports about the use of one type of ART – artificial insemination by donor (AID) – by single women. Recent newspaper accounts suggest that one

¹⁵ Single individuals and same sex couples can achieve biologic parenthood in a variety of ways, each of which requires participation by at least one other person. Single women can use AID, either with a known or anonymous sperm donor. Lesbian couples can also use AID to impregnate one of the partners, or they can both participate in the conception and birth of a child by contributing different reproductive ingredients. One woman can contribute the egg to form an embryo with donor sperm using IVF, while the other woman can gestate the child and give birth. Such was the case in a recent California Supreme Court decision dealing with parental rights of same sex couples. *See* K.M. v. E.G., 117 P.3d 673, 37 Cal. 4th 130, 33 Cal. Rptr. 3d 61 (2005). Same sex male couples can contract with an gestational carrier and an egg donor (who may be one in the same) to gestate an embryo created using sperm from one partner.

¹⁶ *See* National Survey of Family Growth, *supra* note 12, at 7. The survey also reports that rates of infertility have decreased in the past two decades, with 2.3 married couples experiencing infertility in 1988, and 2.4 couples so reporting in 1982. *Id.* Other sources peg the rate of infertility among heterosexual couples at 1 in 6, or roughly 17% of all couples. *See* Dolores King, *What Price Pregnancy?*, THE BOSTON GLOBE, Aug. 4, 1996, at A35. The American Society for Reproductive Medicine indicates that infertility affects about ten percent of the reproductive-age population in the United States (about 6.1 million people). *See* ASRM Frequently Asked Questions About Infertility, at <http://www.asrm.org/Patients/faqs.html>.

¹⁷ *See* 2003 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 3 (December 2005) (hereafter 2003 ART Report), available at <http://www.cdc.gov/ART/ART2003/index.htm>. The number of women who have ever used infertility services in 9.2 million, according to the National Center for Health Statistics. *See* National Survey of Family Growth at 7, *supra* note 12.

third of all AID consumers in the U.S. are unmarried women.¹⁸ Whatever the true incidence of combined functional and structural infertility, the use of ART is burgeoning. It is estimated that today's ART industry garners annual revenues of nearly \$7 billion, a figure that continues to grow as the use of reproductive technologies soars.¹⁹

The incidence of infertility may be interesting as an epidemiological marker of societal health, but its import to the study of accessing ART comes from measuring the percentage of overall use of various reproductive technologies among populations who are unable to conceive on their own. What follows are the latest figures on the use of ART nationwide, coupled with data detailing the techniques' successes, measured according to the number of live births per treatment cycle. While steady, continued success in achieving ART births may help explain its concomitant rise in use, this technical data is only part of the story. In addition to being heartened by greater odds of success, the infertile are beginning to perceive themselves more worthy of procreative assistance than similarly situated would-be parents of generations past. Thus, both the medical and psychological aspects of ART are worthy of exploration.

A. DUAL ACCELERATION IN THE USE AND SUCCESS OF ASSISTED CONCEPTION

1. TRACKING ART USE

There are several ways to measure the use of ARTs in the U.S. and abroad, though each measure lacks statistical precision. Thus, the conclusions advanced herein are largely extrapolations from existing data collected on the number of ART cycles initiated in a given year, compared to the number of infertile individuals located within the studied jurisdiction. This latter figure, according to the National Survey of Family Growth, has remained fairly constant when measured in terms of married couples over the past 20 years,²⁰ thus any increase in the number of ART cycles likely represents greater usage of these techniques by those with functional infertility. An ART cycle, according to the CDC, consists of several steps over an interval of approximately 2 weeks, designed to prepared the woman to produce eggs for fertilization and transfer back into her uterus. Typically, an ART cycle starts when a woman begins drug therapy to stimulate her ovaries to produce multiple eggs.²¹

¹⁸ See Jennifer Egan, *Wanted: A Few Good Sperm*, N.Y. Times, March 19, 2006, Sec. 6, at 46 (reporting that the California Cryobank, the largest sperm bank in the country, owed a third of its business to single women in 2005, shipping them 9,600 vials of sperm, each good for one insemination).

¹⁹ See Lori Andrews, *Brave New Babies*, 9 DEPAUL J. HEALTH CARE L. 1356, 1360 (2006), citing Deborah Hope, *I Forgot to Buy A Baby*, THE AUSTRALIAN, May 4, 2006, available at www.theaustralian.news.com.au/story/0,20867,18338276-28737.00.html.

²⁰ See *supra* note 12.

²¹ See 2003 ART Report, *supra* note 17, at 4.

In the U.S., which houses over 400 fertility clinics,²² there were 122,872 cycles of ART initiated in 2003, nearly double the number of cycles initiated seven years prior in 1996.²³ Table 1 shows the increase in ART cycles over the 7-year period from 1996 to 2003, displaying a 90% increase in the number of cycles initiated during that time period. The CDC, which collects and reports the data on national ART use, does not report on the marital status or sexual orientation of the patients who seek ART, thus it is impossible to discern what percentage of reported treatment is going to those with structural, as opposed to functional, infertility.

²² According to the 2003 ART Report, there were 437 ART clinics in the U.S. at the time the data was collected. *See id.* at 13.

²³ *Id.* at 55, reporting a total of 64,681 cycles in 1996.

Table 1. ART Success Rates Over A Seven Year Period (1996-2003)

| ART Event | 1996 | 2003 | Percentage Change |
|---|-------------|-------------|--------------------------|
| Number of ART Cycles Performed | 64, 681 | 122,872 | +90% |
| Number of Live Babies Born | 20,840 | 48,756 | +134% |
| Live Births Per Transfer Using Fresh Non-Donor Eggs | 28% | 34.7% | +24% |
| Live Births Per Transfer Using Fresh Donor Eggs | 38.9% | 50.8% | +30% |
| Live Births Using Non-Donor Eggs By Age | | | |
| Under 35 | 33.6% | 43.2% | +29% |
| 35-40 | 25.3% | 31.4% | +24% |
| Over 40 | 8.4% | 10.5% | +25% |

Source: 2003 Assisted Reproductive Technology Success Rates, National Summary and Fertility Clinic Reports (Center for Disease Control and Prevention, December 2005).

One possible measurement of the increase in ART use by those with structural infertility – those who desire to become parents other than by heterosexual coupling – is the rise in the number of children conceived using AID. The number of children born via AID rose from approximately 30,000 in 1987 to 60,000 in 1998.²⁴ While AID can be, and is, used by heterosexual couples experiencing infertility, its use by single woman has risen dramatically in recent years. As noted earlier, today single women comprise one third of the clientele of commercial sperm banks.²⁵ Couple this significant percentage use with a 100% increase in the number of AID children born annually over a recent ten year period, and one might reasonably conclude that single woman and lesbian couples are making greater use of assisted conception for family formation.

The increasing use of ART is attributable to at least two factors – growing success rates and a changing demographic of child-ready adult women.²⁶ A 1998 report by the New York State Task Force on Life and the Law noted that in addition to increasing ART success rates, several other social factors contributed to the growing use of assisted conception, including the phenomenon of delayed childbearing among professional women.²⁷ Since a woman's likelihood of becoming pregnant and giving birth decreases with age, particularly after the age of 35, infertility rates rise as procreation is deferred until late in the fourth decade of life.²⁸ But linking increased ART usage with delayed childbirth is logical only so long as methods of assisted conception are able to yield the desired results. Women and their partners, if any, would continue to patronize ART clinics in the numbers that they have only if they were reasonably sure their childbearing goals could be met. A decade's worth of data suggest that parenthood after infertility is a realistic possibility.

²⁴ Compare United States Congress, Office of Technology Assessment (1988) *Artificial Insemination Practice in the United States: Summary of a 1987 Survey-Background Paper* (reporting 30,000 AID births in 1987) with ISLAT Working Group, *ART Into Science: Regulation of Fertility Techniques*, 281 SCIENCE 651 (1998) (reporting 60,000 AID births annually).

²⁵ See *supra* note 18.

²⁶ Importantly, increases in ART use do not seem to signal an increase in rates of infertility, at least among married women. In fact, infertility rates among this population have decreased over the past twenty years. See *supra* note 16.

²⁷ THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, ASSISTED REPRODUCTIVE TECHNOLOGIES: ANALYSIS AND RECOMMENDATIONS FOR PUBLIC POLICY 15-16 (1998) (also citing increasing rates of chlamydia as risk factors for infertility, and difficulties in accessing adoption as reasons for ART growth).

²⁸ For an insightful analysis of delayed childbearing as a reaction to “soft” discrimination in the workplace, see Michele Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 J. GENDER, RACE AND JUSTICE 1 (2005).

2. TRACKING ART SUCCESS

At bottom, the success of any form of assisted conception is measured strictly by its ability to produce live, healthy babies. For over ten years, professional medical societies in the U.S. have been collecting and reporting data on ART success rates, measured according to live birth.²⁹ From a macro perspective, ART in the U.S. is making a perceptible inroad into the total population. In 2003, U.S. ART births accounted for nearly 3% of all births – specifically, 2.7 out of every 100 children born attributed their conception to some form of medical assistance.³⁰ A quarter century ago, birth following assisted conception – particularly in vitro fertilization, the newest ART form – was so novel it commanded newspaper coverage of the early lives of its progeny.³¹ Today, IVF and other forms of ART are far more common, with nary a Gen Xer unfamiliar with at least one friend, relative or colleague who has explored infertility treatment. Worldwide, it is estimated that 3 million infants have been born to women using IVF, as 200,000 such babies are now born each year.³²

²⁹ In the U.S., ART data began to be collected in 1989 by the Society for Assisted Reproductive Technology (SART), which published annual reports of pregnancy success rates for fertility clinics in the state and Canada. In 1992 Congress passed the Fertility Clinics Success Rate and Certification Act, 42 U.S.C. 263a-1, requiring the CDC to publish ART success rates in the U.S. Since 1995, the CDC has worked in consultation with SART and ASRM to issue annual reports. *See* 2003 ART Report, *supra* note 17, at 1. In Europe, the European Society of Human Reproduction and Embryology (ESHRE) has been publishing ART success rates since 2001, covering treatment cycles beginning in 1997. *See* Assisted Reproductive Technology in Europe, 2002: Results Generated from European Registers by ESHRE, 21 HUMAN REPRODUCTION 1680 (2006) (reporting results for 25 European countries).

³⁰ According to the annual CDC report, in 2003 (the most recent year for which figures are available) there were 48,756 children born in the U.S. who were conceived using some form of assisted reproductive technology (ART), as defined by the CDC. In 2003, 99% of all ART cycles measured by the CDC used IVF, with less than 1% using the related techniques of gamete intrafallopian transfer (in which eggs and sperm are transferred into the fallopian tube) and zygote intrafallopian transfer (in which the early embryo is transferred into the fallopian tube). *See* 2003 ART Report, *supra* note 17 at 11. In addition to IVF births, it is estimated that 60,000 children are born annually via AID, bringing the total number of children born through assisted conception to nearly 110,000. *See supra* note 24. The total birth rate for 2003 was slightly over 4 million. *See* http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_02.pdf (reporting 4,089,950 live births in the U.S. in 2003, up about 2% from 2002). Thus, total ART births in the U.S. in 2003 comprised nearly 2.7% of all live births.

³¹ *See, e.g.* Cole Moreton, *Eye Witness: I'm Nothing Special Says World's First Test-Tube Baby As She Turns 25*, INDEPENDENT ON SUNDAY, July 25, 2003, at 5 (describing hype surrounding Louise Brown's birth and early years). In 2006, Louise Brown again made headlines when it was announced that she would become a mother herself, albeit the old-fashioned way. *See First Test Tube Baby is Pregnant*, BIRMINGHAM POST, July 11, 2006, at 8.

³² *See European Society for Human Reproduction and Embryology; Three Million Babies Have Been Born Using Assisted Reproductive Technologies*, WOMEN'S HEALTH LAW WEEKLY, July 16, 2006, at 77 (citing a 2006 report by the International Committee for Monitoring Assisted Reproductive

The epidemiology surrounding ART use and success over the past decade goes a long way toward explaining its growing popularity, but more is needed to fully understand what motivates a person with infertility to seek assisted conception. As a general matter, only half of all individuals who are diagnosed as infertile seek treatment to assist them in reproduction.³³ While a host of demographic factors, discussed fully in Part III, play into whether one is likely to seek fertility treatment, there remains a largely unexplored inhibition that impacts on one's desire to access reproductive technologies – infertility stigma. Social science and medical literature suggests that some individuals will forgo medical treatment for childlessness based on a great aversion to infertility labels.³⁴ Infertility stigma may continue to inhibit some individuals from seeking ART treatment, but there are signs that its impact is dissipating thanks to slight shifts in social and economic behaviors.

B. OVERCOMING INFERTILITY STIGMA

The emotional and psychological devastation wrought by the recognition or diagnosis of infertility cannot be overstated. Numerous studies have reported on the severe toll that the inability to reproduce has on both men and women. Women have been documented as suffering from severe depression, comparable to that seen in patients with terminal diseases such as cancer.³⁵ Men often express feeling of being deeply demoralized, particularly if they are part of a cultural group that considers itself pronatalist, in which children and parenthood are seen as desirable social attributes.³⁶ While such strong emotional reactions can be motivating to some, prompting them to seek immediate and aggressive treatment, it can likewise be paralyzing for others, who feel overwhelmed at the prospect of expending vast emotional and financial energies on an otherwise natural process. To help coax those in the latter group into the treatment-seeking group, one can observe three evolving features of ART that may assist in reducing infertility stigma. Increasing recognition of infertility as a medical illness, increasing numbers of single

Technologies estimating the use of one million ART cycles a year, producing 200,000 babies worldwide).

³³ See A. Cahndra & E. Stephen, *Impaired Fecundity in the United States: 1982-1995*, 30 FAMILY PLANNING PERSPECTIVES 34 (1998).

³⁴ See Lynn White, Julia McQuillan & Arthur L. Greil, *Explaining Disparities in Treatment Seeking: The Case of Infertility*, 85 Fertility & Sterility 853, 856 (2006).

³⁵ In one study, researchers discovered that infertile women's scores on the Beck Depression Inventory, a test used to measure the severity of depression, rivaled those of cancer patients. See Alice D. Domar et al., *The Prevalence and Predictability of Depression in Infertile Women*, 58 FERTILITY & STERILITY 1158, 1161-62 (1992), as cited in Katherine Pratt, *Inconceivable? Deducting The Costs of Fertility Treatment*, 89 Cornell L. Rev. 1121, 1128 (2004).

³⁶ See See Marcia C. Inhorn & Michael Hassan Fakih, *Arab Americans, African Americans, and Infertility: Barriers to Reproduction and Medical Care*, 85 Fertility & Sterility 844 (2006).

and same sex parents accessing ART, and increasing availability of third party collaborators may help ease the transition from infertility to parenthood for those have shown reticence toward seeking treatment.

1. FAILURE TO CONCEIVE AS A MEDICAL ILLNESS

Professional medical societies such as the American Society for Reproductive Medicine and the American College of Obstetricians and Gynecologists have long considered infertility to be a medical illness.³⁷ Infertility patient advocacy groups have likewise stressed the importance of viewing involuntary childlessness as a medical condition for two primary reasons. First, defining infertility as a medical problem is fundamental to securing health insurance coverage for any treatment thereof. If, for example, state legislators can be convinced that infertility is a medical problem with medical solutions then they may be more likely to compel insurers to cover non-experimental treatments for the condition. Second, patient advocates have expressed the view that by deeming infertility a medical condition, some of the blame – usually directed toward women – and stigma associated with infertility will be reduced.³⁸

The perception of infertility as a medical condition is gaining ground in the all-important arena of health insurance, and thus may concomitantly reduce the shame and stigma that chill some from seeking treatment. It appears that most insurance companies do acknowledge that infertility is a medical condition, even if the company takes the position it is unwilling to cover treatment expenses.³⁹ The Second Circuit recently upheld this bifurcated view, agreeing that infertility is a medical condition, but that failure to provide coverage for its treatment does not violate the law. In *Saks v. Franklin Covey*,⁴⁰ the court dismissed a challenge by a female employee whose employer's self insured health plan did not include coverage for several

³⁷ The ASRM definition of infertility as a “disease of the reproductive system” is spelled out in their website at, <http://www.asrm.org/Patients/faqs.html>. The American College of Obstetricians and Gynecologists define “infertility” as the abnormal functioning of the reproductive system. See American College of Obstetricians and Gynecologists, *Infertility: Causes and Treatment* 1 (1992).

³⁸ These views are expressed by RESOLVE, a national support and advocacy organization for the infertile founded in 1974. RESOLVE has argued in a variety of forums, including state legislatures, that infertility is and therefore should be addressed as a medical condition. See www.resolve.org.

³⁹ Compare *Egert v. Connecticut General Life Insurance Company*, 900 F.2d 1032 (7th Cir. 1990) (rejecting insurance company claim that it does not consider infertility to be an illness where internal company memoranda refer expressly to the “illness of infertility”; company ordered to reimburse insured for infertility treatments) with *Kinzie v. Physician's Liability Insurance Company*, 750 P.2d 1140 (Ok. Civ. App. 1987) (while plaintiff's infertility was considered a medical condition, she was still denied insurance coverage for treatment because conceiving a child was not considered medically necessary to her physical health).

⁴⁰ 316 F.3d 337 (2d Cir. 2003).

treatments she had undergone, including IVF. While the patient argued that denial of coverage for infertility treatment is a violation of federal law protecting against sex, disability and pregnancy discrimination, the court upheld the employer's right to exclude certain (expensive) treatments as gender-neutral.⁴¹ Thus, while insurance coverage exclusion may give rise to financial inhibitors to accessing ART, the industry's acknowledgment that infertility is a medical illness helps suppress the notion of involuntary childlessness as a lifestyle choice, or even a choice at all.

2. THE RISE OF SINGLE AND SAME SEX PARENTHOOD

The current demographics surrounding birth in the United States suggest a more welcoming environment than eras past for so-called "nontraditional parents" – single women and same sex couples who may require assistance in conception. Parenthood among unmarried women now represents a sizable portion of overall births, with 36.8% of all births in the U.S. in 2005 documented to single women.⁴² Birthing by older women is also on the rise, with rates up from prior years for women of various age groups between 30 and 49.⁴³ No doubt at least some of the mothers in the "unmarried" and "older" categories required assistance in reproduction. For unmarried women who have no partner, or whose partner is female, resort to artificial insemination or IVF is a necessary first step to parenthood. For many older women, no matter their marital status, reproduction is often difficult without medical assistance, particularly after the age of 40.⁴⁴ Thus, the growing field of nontraditional procreators should create a more

⁴¹ Plaintiff Rochelle Saks sought reimbursement from her employer for infertility treatment expenses, including several cycles of IVF, but was denied coverage on the basis of the health insurance plan which excludes "surgical impregnation procedures." Her lawsuit claimed that the denial of coverage constituted a breach of her contractual rights and violated her civil rights under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, *et seq.*, the Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k), the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.*, and the New York Human Rights Law, N.Y. Exec. Law § 290, *et seq.* 316 F.3d at 340.

⁴² See National Center for Health Statistics, BIRTHS: PRELIMINARY DATA FOR 2005, at <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimbirths05/prelimbirths05.htm> (up from 35.7% in 2004). While I use the word "single women" to describe this category, it is possible, in fact likely, that some of the women giving birth in this category were in marriage-like relationships, either with a male or female partner. The NCHS does not collect statistics on the social circumstances of birthing women other than to inquire as to marital status.

⁴³ *Id.* The NCHS survey reports that from 2003 to 2004, the birth rate for women aged 30–34 years increased slightly (less than 1 percent) while the rate for women aged 35–39 years rose by 4 percent. The birth rate for women 40–44 years increased 3 percent, to 9.0, and the rate for women aged 45–49 years increased in 2004 to 0.6 births per 1,000 women.

⁴⁴ Women over the age of 37 are considered "advanced maternal age" (AMA) and thus more difficult to treat, by most fertility specialists. See Lawrence Werlin, et al., *Preimplantation Genetic Diagnosis As Both A Therapeutic and Diagnostic Tool in Assisted Reproductive Technology*, 80 Fertility

welcoming environment to women whose predecessors were reticent to enter the ART world.

Parenting among same sex couples also appears to be on the rise. Exact estimates of the number of U.S. same sex couples with children vary widely, but virtually all sources agree that the numbers have increased in recent decades.⁴⁵ According to writings attributable to Dr. Benjamin Spock, the legendary pediatrician and child care expert, as many as 10 million children currently live with 3 million gay or lesbian parents in the United States.⁴⁶ Professor Michael Wald, citing the 1998 Census Bureau Report, pegs the number of same sex couples in the U.S. at 1.5 million, with about 200,000 of those couples living with children.⁴⁷ Finally, the 2000 Census Report states that a total of 594,000 households have partners of the same sex; 33 percent of female same sex households had children, while 22 percent of male couples were living with their sons and daughters.⁴⁸

Whatever the actual number of same sex families, there is no dispute that gay and lesbian couples are having children through ART, so that one partner will have a genetic tie to their offspring. Women can use artificial insemination so that one partner can carry the couple's child, or both women could be involved in creating a child – one woman could donate her eggs and the other could gestate the resulting embryos. For men, genetic childbearing depends on a surrogate parenting arrangement, with a traditional surrogate agreeing to be inseminated, or a gestational carrier giving birth to a child conceived with donor eggs and one of the partner's sperm.⁴⁹ Once the child is born, the parental relationship with the nongenetic partner depends largely on state

& Sterility 467 (2003).

⁴⁵ According to the National Adoption Information Clearinghouse, there were an estimated 300,000 to 500,000 gay and lesbian biological parents in 1976. In 1990, an estimated 6 to 14 million children have a gay or lesbian parent. Between 8 and 10 million children are being raised in a gay and lesbian household.

⁴⁶ See Benjamin Spock, *BABY AND CHILD CARE* 685 (1998 ed.).

⁴⁷ Michael S. Wald, *Same-Sex Marriage: A Family Policy Perspective*, 9 VA. J. SOC. POL. & L. 291 (2001) (citing U.S. Census Bureau, Current Population Reports, 71-73 tbl.8, v. tbl.C (March 1998 (update))).

⁴⁸ See U.S. Census Bureau, *Married-Couple and Unmarried Partner Households: 2000*, 1,10 (Feb. 2003) (explaining that the 2000 census cannot be compared to the 1990 census with regard to same-sex households due to changes in the editing procedures).

⁴⁹ A growing number of egg donation and surrogacy agencies specialize in assisting same sex couples. See, e.g., www.growinggenerations.com (Growing Generations, founded in Los Angeles in 1996, describes itself as "the oldest and largest surrogacy and egg donation firm dedicated to serving the gay and lesbian community.").

law, a complicated matter taken up with gusto by courts, lawmakers and commentators alike.⁵⁰

The demographics surrounding single and same sex parenting are a display of the features that might encourage prospective nontraditional parents to seek assistance in reproduction. Growing use, and presumably growing acceptance of nontraditional families should lift prior inhibitions and barriers to single and gay parenting. But a natural desire to produce and parent offspring, coupled with a friendlier social environment for birthing and rearing children of nonmarried individuals, has still failed to yield equal access to ART for all prospective parents. Despite gains in reducing stigma of and discrimination toward nontraditional families, barriers to access remain. These barriers, as explained in Part IV, are often advanced by private actors sheltered from public prohibitions against such conduct, making expanded access difficult to achieve.

3. THIRD PARTY DONORS AS REPRODUCTIVE COLLABORATORS

A final factor that may reduce infertility stigma is the growing use and acceptance of third party collaborators in the reproductive process. Gamete donors – men and women who donate sperm and eggs – and women who serve as gestational carriers, once viewed with suspicion and mistrust, are now an integral part of the ART world.⁵¹ As noted previously, the number of children born via sperm donation has doubled in recent years,⁵² while the use of donor eggs likewise continues to climb. According to the CDC, donor egg use increased threefold in the last seven years, with donor eggs routinely used in nearly one in every eight ART cycles.⁵³

⁵⁰ See, e.g., Deborah L. Forman, *Interstate Recognition of Same-Sex Parents in the Wake of Gay Marriage, Civil Unions and Domestic Partnerships*, 46 B.C.L. Rev.1 (2005).

⁵¹ The introduction of artificial insemination by donor into American life in the 1950s brought with it judicial proclamations that the children of such conception were “not legitimate” and the women who became pregnant by such method were engaging in “mechanical adultery.” See *Strnad v. Strnad*, 190 Misc. 786, 78 N.Y.S.2d 390 (Sup. Ct. N.Y. County 1948) (holding child of AID was not legitimate); *Doornbos v. Doornbos*, No. 54S. 14981 (Superior Ct., Cook Co., Dec. 13, 1954), *aff’d*, 12 Ill. App. 2d 473, 139 N.E.2d 844 (1956) (AID, with or without consent of husband, constitutes adultery by mother; child is not legitimate child of the marriage). One of the first high court to evaluate the legality of a surrogate parenting arrangement found the agreement a violation of state adoption laws and declared the contract void as against public policy. *In the Matter of Baby M*, 109 N.J. 396, 537 A.2d 1227 (1988).

⁵² See *supra* note 24.

⁵³ Compare 2003 ART Report, *supra* note 17, at 50 (reporting 12% of all ART cycles involved donor eggs, for a total of 14,323 cycles) with 1996 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 22 (1998) (reporting donor eggs used in 8% of all ART cycles, for a total of 5,162 cycles). Thus, the total number of cycles using donor eggs nearly tripled in just 7 years. According to the CDC, in 2003, 16.5% of all ART infants born were conceived using donor eggs. See *Assisted Reproductive Technology Surveillance - United States, 2003*, 55 MORBIDITY AND MORTALITY WEEKLY REPORT, SS-4, at 14 (May 26, 2006).

The use of donor eggs is particularly popular among older women, who dramatically increase their likelihood of giving birth by gestating an embryo formed from a younger donor egg.⁵⁴ Finally, the number of ART clinics offering the services of gestational carriers is on the rise. In 1996, 37% of all ART clinics reported offering gestational carrier services, compared to 74% in 2003.⁵⁵

The foregoing data and observations about the use of reproductive collaborators is set forth to underscore the myriad opportunities that reproductive medicine provides for those who wish to procreate but need assistance in so doing. If one chooses to hop the ART train, one can ride the rails from the most basic technique of AID, to the more invasive IVF procedure, to the most high-tech combination of donor gametes and gestational services. But this journey comes at a price, both financial and emotional, that not all infertile individuals can or wish to embrace.

The majority of ART patients are married women age 40 and under,⁵⁶ whose barriers to access are mainly twofold – financial and psychological. If they can afford it, and they are not sidelined by (understandable) fear or stigma, the demographic of functionally infertile has wide access to ART. But this access belies the obstacles that can bar parenthood for a host of subpopulations within the functionally infertile, as well as the entire group of structurally infertile who face continuing discrimination in their reproductive quest. Women who are over 40, along with members of both genders who are disabled,⁵⁷ HIV-infected,⁵⁸ single, or in a same sex relationship often find themselves on the outside looking in to the panoply of reproductive services,⁵⁹ wanting yet being denied access to their only means of procreation.

⁵⁴ In 2003, among women older than age 45, 77% of all ART cycles used donor eggs. No wonder, the use of donor eggs yields a near 51% live birth rate for women of all ages, compared to a 34% rate when a woman's own eggs are used (measured across age groups – women older than age 42 have only a 5.9% live birth rate using their own eggs). See 2003 ART Report, *supra* note 17, at 56, 58.

⁵⁵ See 1996 ART Report, *supra* note 53, at 35; 2003 ART Report, *supra* note 17, at 75.

⁵⁶ In 2003, over 90% of all ART cycles were performed on women 40 years of age or younger. See 2003 ART Report, *supra* note 17, at 75.

⁵⁷ The issue of ART use by disabled individuals is ably discussed in Carl H. Coleman, *Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies*, 50 UCLA L. Rev. 17, 20-21, 65, 67-68 (2002).

⁵⁸ For a discussion of the provision of ART services to individuals who are HIV-positive in the U.S. and England, see Frodsham LCG, Boag F, Barton S, Gilling-Smith C, *HIV and Fertility Care in the UK: Demand and Supply*, 85 FERTILITY AND STERILITY 285 (2006); Eric S. Daar & Judith F. Daar, *HIV and Fertility Care: Embarking on a Path of Knowledge and Access*, 85 FERTILITY & STERILITY 298 (2006).

⁵⁹ See, e.g., Justyn Lezin, *(Mis)conceptions: Unjust Limitations on Legally Unmarried Women's Access to Reproductive Technology and Their Use of Known Donors*, 14 HAST. WOMEN'S L. J. 185

In some ways, ART is a victim of its own success. Increasing the technical ability to produce biologic parenthood for those whose life plans would not previously have dared to include such joys, only makes its unavailability more stinging. For society, via its various spokespersons, to say to certain individuals, “we can assist you in your procreative dreams, but we won’t” strikes at the heart of Justice Douglas’ dream of procreation as a basic civil right. If procreation were truly a modern civil right, its exercise would not yield to judgments by government or private actors that a person is unsuited for parenthood. After all, nature demands no such qualification. Yet the fortuity of technology has given third parties both opportunity and permission to create barriers to ART, the configurations of which we now explore.

III. LIMITATIONS ON ACCESS TO ART SERVICES

The steep trajectory accompanying the growing use and success of ART might at first glance suggest a market in reproductive services that is rational and largely free of restraints. Prospective patients who choose to enter the market, having assessed their ability to do so, can purchase lawful reproductive services from willing providers. Assuming that this loose description of a market system exists for the provision of medical services in general, does it also exist for the provision of highly specialized medical services that involve the conception and birth of a child? The answer is decidedly no. While the general medical market does display at least two barriers to access in the form of cost for services⁶⁰ and provider discretion,⁶¹ these and a host of other barriers are magnified when the treatment involves assisted reproduction.

As a clinical matter, barriers to ART access take on two forms: they can be direct or they can be indirect yet consequential. Direct barriers are generally easy to detect because they bar access to ART on some explicit basis. For example, direct barriers can take the form of enacted laws or published policies which prohibit providers from servicing a targeted population. Laws that limit ART to married couples is an example of such a direct barrier. Additionally, direct barriers to ART are mounted by the high cost of services which prevents many infertiles from

(2003).

⁶⁰ The U.S. health care system requires insurance or private payment for even necessary health care. For the large number of poor and/or uninsured individuals, the requirement to pay for health services is a major barrier, if not total bar, to treatment. In 2002, 43.3 million Americans were uninsured, a total of 19.6% of all adults in our country. See Barry R. Furrow, Thomas L. Greaney, Sandra H. Johnson, Timothy S. Jost & Robert L. Schwartz, *HEALTH LAW* 528 (5th ed. 2004).

⁶¹ “The traditional legal principle governing the physician-patient relationship is that it is a voluntary and personal relationship which the physician may choose to enter or not for a variety of reasons. Legal obligations on the part of providers to furnish care operate as exceptions to the general rule.” *Id.* at 529.

accessing desired treatments. Barriers are direct when they are designed, either intentionally or unintentionally, to limit or reduce the populations who can access ART services.

Indirect barriers are often more difficult to detect, and thus arguably more nefarious because they fail to give notice to the affected population that ART services will not freely flow. Indirect barriers to ART result when reduced access is a consequence, rather than a goal, of a particular action. For example, past acts of discrimination and sexual stereotyping that chill treatment-seeking by minority populations, as discussed below, is an indirect barrier to ART for targeted populations. Importantly, whether a barrier is direct or indirect, its resulting denial of the basic right to reproduce tears equally at the fabric of procreative opportunity.

A. LIMITATIONS BASED ON COST

Certainly the most obvious barrier to ART access is cost. The average cost for a single cycle of IVF hovers around \$10,000, but can go as high as \$25,000 if features such as donor gametes or intracytoplasmic sperm injection (ICSI – in which a single sperm is injected into the egg), are added.⁶² The costs of such treatment are generally paid directly by patients, as the vast majority of health insurance plans do not cover treatment for infertility.⁶³ Both logic and empirical data dictate that a woman's inclination to access infertility treatment is directly related to her ability to access insurance to cover the costs of the expensive therapy. An international comparison of treatment-seeking behaviors among the infertile bears out this cause and effect relationship. In the U.S., where insurance coverage for ART is extremely limited, only half of all women with infertility seek treatment.⁶⁴ Compare this 50% treatment-seeking statistic with that of Finland (67%), The Netherlands (86%) and the United Kingdom (72-95%), all countries with national health care systems that cover at least some forms of infertility treatment.⁶⁵

These disparities in treatment-seeking behavior among those who have access to health insurance and those who do not would seem to suggest its own remedy for equality: increase

⁶² See Inhorn & Fakih, *supra* note 36 (reporting in 2002, the mean cost of IVF in the U.S. was estimated at \$9,547, and the gross national income per capita was only \$33,360).

⁶³ According to the National Conference of State Legislature, currently 14 states have legislation requiring insurance providers to either cover (9 states) or offer to cover (5 states) treatment for fertility diagnosis and treatment. Even when coverage is required, access to reimbursement can be limited by restrictions on the treatments that are covered (some laws specifically exclude coverage for IVF) or the marital status of the patient (some laws limit coverage to married couples). See States Summary of Legislation Related to Infertility Insurance Coverage, at www.ncsl.org/programs/health.

⁶⁴ See A. Cahndra & E. Stephen, *Impaired Fecundity in the United States: 1982-1995*, 30 Family Planning Perspectives 34 (1998 (citing the National Survey of Family Growth statistic that half of all women with infertility impairments do not seek treatment)).

⁶⁵ See White & McQuillan, *supra* note 34, at 855.

access to insurance by mandating that insurers offer coverage for infertility care. This has been a central goal for the U.S. group RESOLVE, a consumer-based national fertility association that often lobbies state and federal legislatures on behalf of its infertile members. For years, RESOLVE has been advocating state lawmakers to require health insurers who offer plans in their state to cover infertility services, and the group has seen modest success.⁶⁶ A little less than a third of the states have some infertility insurance requirement – either that private insurers provide coverage or offer to provide coverage for those covered in the jurisdiction.⁶⁷

Linking mandated insurance coverage with greater utilization of infertility services would seem a natural consequence of reducing costs to individual patients, but in fact studies show that insurance mandates for fertility treatment have little or no overall effect on the use of such treatments in the U.S. Researchers postulate that the reason for the low impact of insurance mandates on treatment utilization has to do with the population of U.S. women who are affected by changes in health insurance coverage. Since insurance mandates only affect individuals who have access to health insurance, this group is more likely to be employed and operating at a higher socioeconomic level than the general population. These are often the same individuals who can access ART with their own resources, thus the marginal benefit from insurance coverage tends not to increase usage among the insured.⁶⁸ In contrast, in countries where health insurance is not linked to wealth or employment, utilization would reflect medical need, not unrelated socioeconomic factors.

Thus, it appears that wealth status, and to a lesser extent employment status, significantly impact one's ability to access ART services in the U.S. For wealthy individuals who can afford to pay directly for these services, access, for the most part, appears to be wide open.⁶⁹ For individuals covered by private health insurance that includes infertility benefits, access would again seem open, with limitations based on the patient's ability to pay co-payments or non-covered services.⁷⁰ But it must be noted that the group of insured individuals generally share another common attribute – the status of being employed. Most Americans under the age of 65 (when the federal benefit of Medicare becomes activated) receive health insurance coverage as an

⁶⁶ In April 2006, RESOLVE reported success in advocating for inclusion of infertility services in the newly enacted comprehensive health care reform package adopted by the Commonwealth of Massachusetts. See April 13, 2006 press release published on the RESOLVE website, www.resolve.org.

⁶⁷ See *supra* note 63.

⁶⁸ See Marianne Bitler & Lucie Schmidt, *Health Disparities and Infertility: Impacts of State-Level Insurance Mandates*, 85 *Fertility & Sterility* 858 (2006).

⁶⁹ But see *infra* text accompanying notes 73-111 discussing barriers based on race, ethnicity and marital status.

⁷⁰ See *infra* notes 195-196, discussing the problem of non-covered fertility services and unaffordable co-payments embedded in private health insurance.

employer benefit - 61% in 2004.⁷¹ So the true secret to improving access to infertility treatment may rest in increasing employment among those most likely to need ART services.⁷²

Tempting as it might be to explain infertility treatment-seeking behavior by examining employment, on the one hand, and wealth and insurance coverage on the other, viewing access to ART as a pure socioeconomic matter ignores other, important demographic factors that play into an individual's decision to seek or forgo therapy. As with access to health care in general, the race and ethnicity of the prospective patient figure prominently into the access/utilization calculus.

B. LIMITATIONS BASED ON RACE AND ETHNICITY

Disparities in the access and quality of health care in the U.S. along racial and ethnic lines are sadly but ably well-documented. In 2003, the Institute of Medicine released a report entitled, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," documenting differences in health status, available treatment and clinical outcomes along racial and ethnic lines.⁷³ The IOM report summarized data from over 100 studies addressing racial differences in

⁷¹ See THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED 2 (Jan. 2006), available at <http://www.kff.org/uninsured/upload/7451.pdf#search=%22percentage%20of%20americans%20health%20insured%20through%20employer%22>.

⁷² Professor Michele Goodwin cogently warns that the link between employment and access to ART creates a double bind for women in the workplace, especially professional women whose superiors place subtle pressure on younger women to defer childbearing to increase their chances of "fair" opportunities at law firms, businesses, or university posts. ART is seen as a technological bail out for women who put off childbearing, thus encouraging continued participation in the workplace. Pregnancy and motherhood discrimination, Professor Goodwin argues, are soft but real discrimination that create "double binds" for women who believe they must choose between career and early motherhood. Michele Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 J. GENDER, RACE AND JUSTICE 1 (2005). The existence of the double bind does not alter the reality that women who require ART, whether because of a voluntary deferral of childbearing or an earlier diagnosis of infertility, are better off in a workplace that provides health insurance, including coverage for ART. Professor Goodwin acknowledges this reality, but insists that if the mere promise of that benefit, should it be necessary, keeps women in the workplace longer, it should be regarded as a mistaken equitable accommodation that ultimately harms women and their families. *Id.* at 2.

⁷³ INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, UNEQUAL TREATMENT - CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 80-214 (2003). After controlling for differences among the races in socioeconomic status, health insurance, access to health care and geographic differences, the evidence still shows that Blacks and Latinos receive fewer and inferior clinical services than whites, irrespective of whether those services are for treatment of cardiovascular disease, cancers, mental illness, pre-natal care or HIV/AIDS. Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DEPAUL J. HEALTH CARE L. 793, 794 (2006).

health care, collectively and definitely concluding that racial and ethnic disparities are consistent and extensive across a range of medical conditions and healthcare services.⁷⁴ These disparities likewise infect access and treatment in ART, but like the field itself are only beginning to be seriously evaluated.

For about the last decade, commentators have highlighted the disparities in the use of and access to ART services for women of color compared to white women.⁷⁵ Recent research confirms disparities in both the incidence of infertility and the utilization of fertility treatments among women of different races. To begin, Hispanic women and non-Hispanic black and other-race women are significantly more likely to be infertile than white women.⁷⁶ Yet despite higher incidence of infertility, women of color are far less likely to seek treatment than white women.⁷⁷ Part of the reason for lower utilization relates to disparities in insurance coverage – 33% of Hispanics and 20% of blacks lack health insurance, compared to 11% of whites. As a result of these insurance disparities, according to several public health researchers, “ART remains a private, fee-for-service form of health care delivery in the United States, accessible largely to white, middle- to upper-class infertile couples.”⁷⁸

This “stratified reproduction” has been described as a “eugenic logic of IVF” because the

⁷⁴ IOM REPORT, *supra* note 73, at 79.

⁷⁵ See, e.g., Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS LAW JOURNAL 935 (1996).

⁷⁶ According to the 1995 National Survey of Family Growth (NSFG), infertility is higher among married couples where the wife is non-white, compared to couples in which the wife is white. The incidence of infertility is highest, 13.6%, among married women categorized as “non-Hispanic other”, a group that includes Asian, Pacific Islander, Alaskan Native, and American Indian women. Infertility among non-Hispanic black women is 10.5 percent, compared to the 7.0 and 6.4 infertility rate among Hispanic and non-Hispanic white women, respectively. See National Survey of Family Growth, *supra* note 12.

The reasons for infertility disparities along racial lines is explained by Drs. Marcia Inhorn and Michael Hassan Fakh in their work comparing fertility rates among whites, on the one hand, and Arab Americans and African Americans on the other hand. They report “both groups are likely at increased risk for infertility problems because of environmental and lifestyle factors. Both groups tend to be concentrated in urban industrial centers, where they are exposed to reproductive toxins, particularly lead, through occupational exposures, ambient air pollution, and toxic waste disposal in their neighborhoods. In addition their infertility problems might be linked to lifestyle factors, including heavy smoking, caffeine consumption, and drug use, as well as nutritional deficiencies and female obesity, which disrupts ovulation.” See Inhorn & Fakh, *supra* note 36, at 845-46.

⁷⁷ See White & McQuillan, *supra* note 34.

⁷⁸ See Inhorn & Fakh, *supra* note 36.

cost barriers to ART services disparately impact low-income women who are disproportionately nonwhite.⁷⁹ The plight of infertile low-income and racial and ethnic minority individuals to access infertility treatment may be further aggravated by social, structural, and ideological barriers to effective medical care. Several recent studies shed light on these factors, as they document the experience of non-whites in navigating the health care system in general and the provision of ART services in particular. In one look at access to reproductive services by Arab and African Americans, researchers note that both communities regard the U.S. health system with some degree of suspicion and distrust, based on past experiences of racism and discrimination. Moreover, caricatures of these two groups produce images of males as hypersexual and women as hyperfertile.⁸⁰ Such stereotyping in these groups can lead “to the convenient denial of their legitimate reproductive health needs.”⁸¹

One source of hope for reducing racial and ethnic disparities in access to ART looks to state insurance mandates, with the aspiration that at least one group of patients – those with insurance – will have equal access, and thus equal utilization of fertility treatments. But hope fades some when studies show that racial and ethnic disparities in utilization remain unchanged even when insurance coverage is mandated. In Massachusetts, for example, a state with a comprehensive mandate to provide infertility services, disparities in access to infertility treatment continue to exist along racial and ethnic lines.⁸² Clearly research is needed to understand the structural and psychological barriers to care that impact disproportionately on minority populations.

Recently, the National Institute of Child Health and Human Development announced that one of its goals is the support of research on the factors leading to infertility among minority men and women and the reasons for lower levels of use of infertility services in minority populations.⁸³ For health science researches, studying the microcosm of infertility could yield insights into racial and ethnic health disparities in general. But for now, what we do know is that

⁷⁹ *Id.* at 845.

⁸⁰ Drs. Inhorn and Fakih expound upon this caricature of Arab American and African American men as hypersexual and hyperfertile. “Arab American men and Muslim men in general are seen as polygamous fathers of children from multiple wives, harkening back to Western Orientalist fantasies of the harem. Similarly, African American men are often portrayed as “informal” polygamists, spawning offspring with multiple, unmarried sexual partners.” *See* Inhorn & Fakih, *supra* note 36, at 846-47.

⁸¹ *Id.* at 847. Dr. Inhorn and Fakih mince no words in describing in plight of infertile Arab and African Americans. “Both of these populations face significant reproductive disruptions but are despised as reproducers in a racist and classist society.” *Id.* at 851.

⁸² Bitler & Schmidt, *supra* note 68, at 864.

⁸³ *See* Rosalind Berkowitz King & Joan Davis, *Introduction: Health Disparities in Infertility*, 85 FERTILITY & STERILITY 842 (2006).

barriers to ART based on the racial and ethnic background of the patient are a reality. While we don't yet understand all the causes of racial and ethnic disparities in accessing ART, we have identified at least some of the internal and external contributing factors.

Outside, or external, factors that impede minority access to ART include lower socioeconomic status as a group compared to nonminority populations, which results in lower levels of health care coverage, including coverage for ART, as well as lower discretionary income to pay for reproductive services.⁸⁴ In addition, research reveals that racial stereotyping among practitioners can cause minorities to refrain from seeking services.⁸⁵ If the nonminority community in general, and the ART providers in particular (the majority of whom are nonminority) perceive minority women as hyperfertile and minority men as hypersexual, the projection of this caricature could be immensely intimidating for minority patients.

Internal factors include a general distrust of the health care system in general, based on a long history of documented racism.⁸⁶ This history, according to researchers, inspires a lack of trust on the part of minority women in their health care providers to deal with their reproductive complaints effectively and without prejudice.⁸⁷ If minority women anticipate a physician will respond to their infertility by either subtly or explicitly suggesting women of certain racial and ethnic backgrounds do not "need" to birth any more children, one can understand why this subset of the infertile would shy away from seeking treatment. In addition, researchers have suggested that cultural barriers impede treatment-seeking by African American women. Professor Dorothy Roberts reports one black woman's reaction to her infertility: "[b]eing African-American, I felt that we're fruitful people and it was shameful to have this problem."⁸⁸ Such a perception of infertility as a fault-based condition could "influence not only the decision to seek treatment, but

⁸⁴ According to Drs. Inhorn and Fakih, the majority of Arab and African Americans are lower-income, with many families existing below the poverty line. *See Inhorn & Fakih, supra* note 36 , at 846-47.

⁸⁵ *See White & McQuillan, supra* note 34, at 855 (reporting research showing physicians are significantly and substantially more likely to have a variety of negative stereotypes about African Americans than other patients).

⁸⁶ Perhaps the most notorious incident of documented racism is the Public Health Service Study of Untreated Syphilis in the Male Negro (1932-72), commonly referred to as the "Tuskegee Study" in which researchers studied the natural history of latent syphilis, while intentionally withholding known and effective treatments. The study and speculation for the reasons of its origins and longevity are discussed in Paul A. Lombardo and Gregory M. Dorr, *Eugenics, Medical Education, and the Public Health Service: Another Perspective on the Tuskegee Syphilis Experiment*, 80 BULL. HIST. MED. 291 (2006).

⁸⁷ *See Inhorn & Fakih, supra* note 36 , at 846-47.

⁸⁸ Dorothy Roberts, *KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY* 259 (1997).

also the assessment of the need for treatment by clinicians.”⁸⁹

The law’s ability to respond to these internal and external factors is decidedly weak. Various federal and state civil rights statutes prohibit discrimination against potential patients on the basis of a host of factors, including race. Title VI of the federal Civil Rights Act of 1964 prohibits physicians and hospitals receiving federal funding from discriminating in the provision of health care on the basis of race, color, religion, or national origin.⁹⁰ States have likewise enacted laws prohibiting racial discrimination in health care.⁹¹ But a review of case law confirms that attempts to address racial discrimination in health care via traditional civil rights litigation under existing statutory schemes have proved frustrating for private individuals who often must show intentional discrimination on the part of the health care provider.⁹² In a recent article, Professor Dayna Matthew describes the history of health care civil rights litigation under Title VI of the 1964 Civil Rights Act as “singularly ineffective in addressing certain well-known forms of persistent health care inequalities.”⁹³

In the ART arena, scholars have largely shunned litigation as a remedy to address racial inequities in the delivery of assisted conception services, recognizing the futility of such an approach. If plaintiffs have largely failed to prevail in cases dealing with the provision of basic medical services, where documented disparities clearly exist, pursuing a case against a provider for refusing to provide what is often viewed as discretionary services seems daunting. Never mind meeting the burden of proving intentional discrimination with anything less than a “smoking gun” admission of racial bias. Instead of litigation, ART watchers suggest that the infertility industry become more patient-friendly to racial and ethnic minorities by, for example, lobbying to increase insurance coverage for ART services, locating fertility clinics in more diverse neighborhoods, and increasing public awareness in minority communities about

⁸⁹ Nanette R. Elster, *ART For The Masses? Racial and Ethnic Inequality in Assisted Reproductive Technologies*, 9 DEPAUL J. HEALTH CARE LAW 719, 729 (2005) (providing an excellent analysis of racial disparities in ART).

⁹⁰ Civil Rights Act of 1964, 42 U.S.C. §2000d et seq.

⁹¹ See, e.g., the California Unruh Civil Rights Act, Cal. Civ. Code §51(b), which guarantees full and equal accommodations and services in business establishments, including health care providers, regardless of race.

⁹² For a discussion of civil rights litigation in health care, see Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. OF HEALTH POL’Y., L. & ETHICS 215 (2003).

⁹³ Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DEPAUL J. HEALTH CARE L. 793, 820 (2006).

infertility and its treatment.⁹⁴ Whether these or other measures will help lower racial and ethnic barriers to ART is an open question, but the seriousness of such reduced access cannot be overstated in a society that values equality and reproductive freedom for all.

C. LIMITATIONS BASED ON MARITAL STATUS

Solid data about the percentage of ART patients who are unmarried is difficult to procure, as the national reporting system for assisted conception does not collect demographic information on ART users other than age.⁹⁵ What we do know is that single women are giving birth in record numbers. According to the National Center for Health Statistics, in 2005 36.8% of all births in the U.S. were to unmarried women.⁹⁶ Statistics about the number of these unmarried women who sought infertility services is largely unavailable, with the exception of informal and anecdotal reports which peg the percentage of single women using one type of assisted conception – artificial insemination by donor (AID) – at approximately one third of all users.⁹⁷

Both AID and IVF offer unmarried individuals – with and without partners – opportunities for parenthood they simply could not achieve on their own. IVF, for example, offers lesbian couples the opportunity to co-create a child. If both women wish to contribute to the reproductive process, one woman can supply the egg (the genetic mother) and the other can gestate the fetus (the birth mother). For male singletons and couples, ART is an absolute necessity to procreation, supplying both the egg and the womb to conceive and gestate the child.

But such technological capabilities will be meaningful only if unmarried individuals have ample access to ART. While access to treatment for unmarried individuals can be hampered by the same cost and racial barriers that plague ART access in general, single women and same sex couples face reduced access from at least two additional sources – provider discrimination against single and gay women and legislative efforts to ban access to unmarried individuals.

Published cases of provider discrimination against single women and lesbian couples are few, but recent research suggests such conduct is widespread. In a study conducted by researchers at the University of Pennsylvania, survey results show that one in five treatment

⁹⁴ See Elster, *supra* note 89, at 731-33.

⁹⁵ The national reporting system refers to the annual ART Report issued by the CDC, discussed *supra*, in note 29.

⁹⁶ See National Center for Health Statistics, BIRTHS: PRELIMINARY DATA FOR 2005, at <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/prelimbirths05/prelimbirths05.htm>.

⁹⁷ See Jennifer Egan, *supra* note 18.

providers refuse treatment to unmarried women.⁹⁸ Whether such refusal is actionable as unlawful discrimination will probably depend upon the law of the state where the treatment was refused. A recent California tale may be representative. In *North Coast Women's Care Medical Group v. Superior Court*,⁹⁹ Guadalupe Benitez sued the defendant medical group and two of its physicians for refusing to provide her artificial insemination because she was a lesbian. She and her partner of 15 years tried to conceive for several years using self-insemination techniques, but when Ms. Benitez required intrauterine inseminations (IUI), a more invasive reproductive technology,¹⁰⁰ the North Coast doctors refused saying it was against their religious beliefs to provide such services to the plaintiff.

The facts are disputed as to whether the doctors claimed the religious objection on the basis of the patient's sexual orientation (the state's antidiscrimination law prohibits discrimination in the provision of medical services on the basis of sexual orientation) or on the basis of the patient's marital status (surprisingly, at the time the lawsuit was filed, California law did permit physicians to refuse treatment on the basis of a patient's marital status). Even though the California Supreme Court ruled in early 2005 that lawsuits could be filed alleging discrimination on the basis of marital status,¹⁰¹ and the legislature enacted a law expressly prohibiting discrimination in the state on the basis of marital status,¹⁰² the Court of Appeal ruled in April 2006 that since both the supreme court case and the statutory change occurred after Ms. Benitez filed her lawsuit, these measures did not apply retroactively. Thus, the case will proceed to trial to determine whether the doctors refused treatment on the basis of marital status or sexual orientation.¹⁰³

⁹⁸ See A. Gurmankin, A. Caplan, & A. Braveman, *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61 (2005).

⁹⁹ 40 Cal. Rptr. 3d 636 (2006), *rev. granted*, 139 P.3d 1, 46 Cal. Rptr. 3d. 605.

¹⁰⁰ Intrauterine insemination (IUI) is a two-step process in which sperm is washed to remove bacteria and other components harmful to the uterus, and then injected into the back of the uterus using a narrow tube threaded through the vagina, cervix and uterus. See Daar, *supra* note 2, at 40.

¹⁰¹ *Koebke v. Bernardo Heights Country Club*, 36 Cal. 4th 824, 31 Cal. Rptr. 565, 115 P.3d 1212 (2005).

¹⁰² Cal. Civ. Code §51 (amended by Assembly Bill 1400, signed by the Governor on Sept. 29, 2005).

¹⁰³ In addition to California law which prohibits discrimination in the provision of healthcare on the basis of a patient's sexual orientation, both the California Medical Association and the American Medical Association have adopted explicit policies to the same effect. See CALIFORNIA PHYSICIAN'S LEGAL HANDBOOK, California Medical Association 1:83 (2003) ("Physicians may not decline to accept patients because of ... sexual orientation"); AMA CODE OF MEDICAL ETHICS, Opinion E-9.12 ("Physicians who offer their services to the public may not decline to accept patients because of ... sexual orientation).

In states in which medical antidiscrimination laws are either silent or ambiguous with respect to marital status or sexual orientation as protected categories, unmarried individuals may face impenetrable barriers to access. Moreover, even if state law does prohibit discrimination on the basis of marital status or sexual orientation, presumably a provider could argue that ART services are not “medical services” as defined by the relevant statutes, and thus not covered services. We earlier noted the consensus among courts that infertility is a “medical illness” but it does not necessarily follow that its treatment will always be considered a medical service.¹⁰⁴ This battle of the medicalization of ART services has been waged in the health insurance arena, with courts varying widely on whether infertility treatment should be considered medical treatment in the litigated context.¹⁰⁵ Perhaps discrimination law will borrow from insurance law should these cases present in this fashion.

In addition to provider discrimination, unmarried individuals may be facing an increasingly hostile statutory environment, as lawmakers in several states attempt to limit ART to married individuals.¹⁰⁶ In late 2005 and early 2006, legislators in Indiana and Virginia, respectively, introduced legislation that would prohibit health care providers from offering or performing any medical procedure on an unmarried woman for the purpose of conception or procreation. The Indiana bill, introduced by State Senator Patricia Miller (R-Indianapolis) in October 2005, would have required that couples who seek assistance to become pregnant, such as through IUI, donor eggs, sperm and embryos, IVF or “other medical means” would have to be married to each other. While the Senator ultimately dropped the bill, its mere introduction caused alarm among those who favor equal access to ART regardless of marital status.¹⁰⁷

¹⁰⁴ See *supra* text accompanying notes 37-41. In addition, state antidiscrimination laws generally apply to full and equal access to accommodations and services in all business establishments of every kind. See, e.g., Cal. Civ. Code §51 (the Unruh Civil Rights Act). Thus, for a provider to argue that ART is not a medical service for unmarries when it is being offered without barrier to married couples is an absurdity that only serves to prove the discriminatory conduct at issue.

¹⁰⁵ See *supra* note 39.

¹⁰⁶ One particular form of ART – gestational services – is already limited to married couples in two states, Florida and Texas. Florida law provides, “A contract for gestational surrogacy shall not be binding and enforceable unless...the commissioning couple are legally married and are both 18 years of age or older.” Fla. Stat. Ann. §742.15(1) (West 2005). Presumably this law, and a similar requirement in Texas, Tex. Code Ann., Family Code §160.754(b) (West 2005), would void any surrogacy contract entered into by a single individual or a same-sex couple. While access to surrogacy by single and same-sex parents is not prohibited, the enforceability of any gestational agreement is seriously called into question by the prevailing laws.

¹⁰⁷ See Mary Beth Schneider, *Assisted Reproduction Bill Dropped*, Indianapolis Star, Oct. 6, 2005 (Sen. Miller is quoted upon dropping the bill, “The issue has become more complex than anticipated.”).

A similar bill was introduced into the Virginia Legislature in January 2006. Virginia House Bill 187 provides in relevant part:

No individual licensed by a health regulatory board shall assist with or perform any intervening medical technology, whether in vivo or in vitro, for or on an unmarried woman that completely or partially replaces sexual intercourse as the means of conception, including, but not limited to, artificial insemination by donor, cryopreservation of gametes and embryos, in vitro fertilization, embryo transfer, gamete intrafallopian tube transfer, and low tubal ovum transfer.

Read literally, this bill could mean that if a single woman develops cancer and seeks to have her eggs or a portion of her ovary cryopreserved, a Virginia doctor would risk loss of a medical license by assisting this patient. Such a doctor would be cryopreserving gametes for an unmarried woman for purposes of [future] conception. True, the patient might be married when she thaws the gametes, but certainly the statute can be read to prohibit cryopreservation for single individuals. Perhaps because of this scenario, or perhaps because of opposition in general, the bill was passed by indefinitely (essentially dropped) by the Committee on Health, Welfare and Institutions two weeks after it was introduced.¹⁰⁸

These proposed generalized marital status restrictions may have dodged enactment for now, but ART barriers based on marital status are in place in several states. In two states, for example, only married couples may enter into valid, enforceable contracts for gestational surrogacy services. In Texas and Florida, contracts for gestational surrogacy are enforceable only if the commissioning couple is legally married.¹⁰⁹ Such a requirement translates into an automatic exclusion of single men and same sex male couples from ART, who must turn to gestational surrogacy to achieve biologic parenthood. Thus, the chief form of family formation for unmarried males is explicitly unavailable in two of our most populous states.

In addition to these specific ART exclusions based on marital (and by extension sexual orientation) status, another recent bill would de facto reduce access to assisted conception for unmarried women. Another Virginia bill introduced in 2006 would require that all unrelated gamete donors be identified in a woman's medical chart.¹¹⁰ Though the proposed bill appears

¹⁰⁸ 2006 Va. H.B. 187. The legality of this bill is seriously challenged by the Virginia Human Rights Act, Va. Code Ann. §2.2-3900, which prohibits discrimination on the basis of marital status in places of public accommodation. If a physician's office is considered a place of public accommodation, the new law would run afoul of existing protections for unmarried women.

¹⁰⁹ See Tex. Code Ann., Family Code §160.754(b) (West 2006); Fla. Stat. Ann. §742.15(1) (West 2006).

¹¹⁰ See Va. H.B. 412 (2006), requiring the identity of all gamete donors be written in a woman patient's chart when used in connection with assisted conception.

facially neutral in terms of the marital status of the woman patient, in fact it would have the most dramatic impact on single and lesbian women. Experience in other countries confirms that mandating donor identity significantly reduces the number of donors willing to provide gametes.¹¹¹ Thus, a non-anonymous donor policy in the U.S. would reduce the availability of donor sperm for unmarried women, the vast majority of whom rely on commercial sperm banks to fulfill their procreative dreams.

In sum, current barriers to ART access can be categorized according to six factors: direct barriers, indirect barriers, formal acts, informal acts, intentional acts and unintentional acts. Cross-cataloguing these factors gives a broad overview of the types of conduct that impair an infertile person's opportunity to reproduce. Table 2 displays examples of the various barriers discussed herein, according to whether the barrier is direct (a bar to service) or indirect (a deterrent to service), and whether the conduct giving rise to the barrier is formal (enacted law), informal (private conduct), intentional or unintentional. What is striking about Table 2 is the range and depth of the panoply of access barriers. Each barrier, whatever its origin, no less grieves the affected populations by depriving them a highly prized and revered right. Harms from lack of ART access are as deep and diverse as the barriers themselves, and it to these harms we now turn.

¹¹¹ Donor tracing schemes exist in Sweden (which resultingly prompt single women to routinely travel to Denmark for AID), Australia and the UK, where shortages of donor sperm has been noted since passage of the tracing laws in 2005. The plummeting supply of donor sperm in the UK has been described as a "crisis." See Kristy Horsey, *Sperm Donor "Crisis" in UK*, available at www.bionews.org.uk (Sept. 18, 2006).

Table 2. A Catalogue of ART Barriers

| | Direct Barrier | Indirect Barrier |
|--------------------------|--|---|
| Formal Act | <p>State laws banning ART to unmarrieds</p> <p>State laws limiting commercial surrogacy to married couples</p> | <p>Laws requiring identification of gamete donors (creating severe shortages of available donor gametes)</p> |
| Informal Act | <p>Physician groups and individual providers who refuse service to unmarrieds</p> | <p>Past discriminatory practices by health care providers chilling treatment-seeking behavior by racial and ethnic minorities</p> |
| Intentional Act | <p>State lawmakers and employers unwilling to offer fertility treatment as covered health care benefit</p> | <p>Locating the majority of ART clinics in mostly urban and coastal areas</p> |
| Unintentional Act | <p>The high cost of ART services</p> | <p>Lower socioeconomic status and levels of employment among racial and ethnic minorities compared to nonminorities</p> |

IV. MEASURING HARMS

Access barriers to ART services affects four main groups – patients, providers, children and society. Depriving an individual the right to procreate, or creating a substantial obstacle to the exercise of that right, is as much an affront to the affected individual as it is to the other cohorts that comprise the ART world. While at first blush it may appear that barriers to ART access are visited only upon those clamoring for assisted conception services, the import and significance of procreation to our collective well-being means that deprivation of reproductive services casts a long shadow across a large swath of our society.

Notably, many of the barriers to assistance in reproduction cluster along demographic lines, impacting would-be parents on the basis of their socioeconomic status, race, ethnicity and marital status. Such stratification of reproductive freedom leaves one to wonder whether current ART barriers are descendants of our eugenics past? In early 20th century American life, a powerful eugenics movement advanced the concept that certain social ills could be cured through selective breeding, thus leading the way for forced sterilization laws to be passed in more than 30 states.¹¹² Clearly ART barriers do not force sterilization, but they may serve as commentary on the social worth of certain prospective parents. Such commentary, and its clinical effects of suppressing ART treatment-seeking, inflict indelible harms on a host of individuals and associated ART-related groups, as explored below.

A. HARM TO ART PATIENTS

As human beings, in the main we have a natural inclination to reproduce and to value the products of our reproductive efforts. Ask virtually any parent about the relative value of his or her life experiences and you will hear, “The most significant and meaningful thing I have done in my life is parent my child(ren).” Because of the central importance of procreation to the human

¹¹² See Lisa Powell, *Eugenics and Equality: Does the Constitution Allow Policies Designed to Discourage Reproduction Among Disfavored Groups?*, 20 YALE LAW & POLICY REV. 481, 483 (2002), citing Harry Laughlin, MODEL EUGENICAL STERILIZATION LAW, IN EUGENICAL STERILIZATION IN THE UNITED STATES, A REPORT OF THE PSYCHOPATHIC LABORATORY OF THE MUNICIPAL COURT OF CHICAGO 445, 447 (1922). Between 1900 and 1963, at least 60,000 Americans were sterilized pursuant to eugenic sterilization laws. In response to a lawsuit, in 1974 the federal government adopted regulations banning sterilization without consent in hospitals that receive federal funds, but reports of violations surface periodically. For a thorough discussion of the eugenics movement and its impact on current ART dialogue, see Michael J. Malinowski, *Choosing the Genetic Makeup of Children: Our Eugenics Past–Present, and Future?*, 36 CONN. L. REV. 125 (2003).

experience, denial of this opportunity, either through refractory infertility or government restrictions on ART, strikes at the core of how one sees oneself and one's place in the world. As phrased by Professor John Robertson, "reproductive experiences...are central to personal conceptions of meaning and identity. To deny procreative choice is to deny or impose a crucial self-defining experience, thus denying persons respect and dignity at the most basic level."¹¹³ The experience of being denied access to lawful means of reproductive assistance is equally devastating, knowing that the means of biologic parenthood are at hand but feeling the wrench of denial of those services based on personal characteristics largely outside of one's control. The harms to prospective ART patients from lack of treatment access impact on human well-being in a variety of ways, ranging from measurable financial burdens to more ethereal but no less haunting dignitary harms. Since prospective patients are on the front line of treatment denials, the harms are felt most acutely by those denied the fundamental right to reproduce.

1. FORCED CHILDLESSNESS

Individuals who confront reduced or restricted access to ART may resign themselves to a life without children, suppressing or managing their feelings of disappointment and worthlessness that often accompany unresolved infertility. The prospect of childlessness from reduced or denied ART treatment can provoke a range of responses from the affected individuals, depending upon the basis for the curtailed access. In some instances, the reaction to treatment denials may be to seek alternative routes to parenthood; in others, infertiles may withdraw entirely from a health care system that has utterly failed to meet their reproductive needs.

Perhaps the most obvious alternative to ART is adoption. Infertiles denied access to ART, particularly those who face barriers based on the high cost of services, may turn to adoption. As described by Professor Ellen Waldman, there are at least two routes to adoption, public agency adoption and private /independent adoption, with cost representing one of the main differences between the two.¹¹⁴ Public agency adoption places children who come into the care of the state, often via parental abandonment or abuse and neglect. Agency adoption can be relatively low cost (compared to the cost of IVF), and thus can offer parenthood to couples who are financially unable to access ART. The drawback, however, is that the demand for healthy infants far exceeds the supply, forcing eligible couples to endure long waits for a much-wanted child. Moreover, state agencies often limit placement of infants to married couples, thus shutting out single and same sex couples from this adoption process.¹¹⁵

¹¹³ Robertson, *supra* note 8, at 4. *See also* Bragdon v. Abbott, 524 U.S. 624, 638 (Supreme Court declaring "[r]eproduction and the sexual dynamics surrounding it are central to the life process itself").

¹¹⁴ *See* Ellen Waldman, *The Parent Trap: Uncovering the Myth of "Coerced Parenthood" In Frozen Embryo Disputes*, 53 AM. U.L. REV. 1021, 1054 (2004).

¹¹⁵ More specifically, state agencies often limit the placement of "desirable" children, i.e., healthy newborns, to married couples. Single individuals, typically women, must be willing to accept special needs children, such as those who have physical or mental handicaps, older or behaviorally hard to handle.

Adoption through a private agency or independently is legal in most states, and involves only a lawyer or physician as an intermediary between the pregnant woman (or parent of an existing child) and the adoptor(s). However, all private agencies have their own requirements regarding age, marital status and income that may exclude, for example, couples of lower socioeconomic status, older single women, or same sex couples. Additionally, private adoptions can be as expensive as IVF, ranging in cost from \$10,000 to \$25,000, a prohibitory expense that may have knocked a prospective parent out of the ART arena in the first place. Finally, laws in several states prohibit same sex couples from adopting children, thus imposing a secondary barrier to parenthood for this select group of infertiles.¹¹⁶

In the end, adoption offers only a limited reprieve from ART denials to a select group of infertiles – mostly married couples whose income is sufficiently high to meet wealth requirements, but not high enough to afford the staggering cost of infertility treatment. Both practice and law reveal that adoption is not widely available to many of the individuals and couples who are shut out of the ART arena for reasons of race, marital status, and sexual orientation. The ineligibility of older single women, same-sex couples, and racial and ethnic minorities of lower socioeconomic status, coupled with the scarcity of adoptable children, is hardly a recipe for combating the devastating harm of forced childlessness engendered by barriers to ART.

2. UNDUE BURDENS ON PROCREATION

The Supreme Court decision in *Skinner v. Oklahoma* remains the only high court precedent to consider the right to procreate as an affirmative, intentional act.¹¹⁷ Every other case

Id.

¹¹⁶ Florida, Mississippi, and Utah bar same sex partners from adopting. See Fla. Stat. Ann. 63.042 (2006) (providing, “[n]o person eligible to adopt under this statute may adopt if that person is a homosexual”); Miss. Code Ann. § 93-17-3(2) (2004) (prohibiting “[a]doption by couples of the same gender”); Utah Code Ann. § 78-30-1(3)(b) (2002) (prohibiting adoption “by a person who is cohabiting in a relationship that is not a legally valid and binding marriage”). See also *Lofton v. Secretary of Department of Children and Family Services*, 358 F.3d 804 (11th Cir. 2004), *cert. denied*, 125 S.Ct. 869 (2005) (upholding constitutionality of Florida prohibition on adoption of children by “practicing” homosexuals).

¹¹⁷ Despite its brief appearance on the high court stage, the fundamental right to procreate established in *Skinner* has been reaffirmed by the Court on numerous occasions, typically as a starting point for discussing conduct of a most personal nature. See, e.g., *Washington v. Glucksberg*, 521 U.S. 702 (1997) (challenge to state assisted suicide laws which deprive terminally ill patients the right to physician aid in dying); *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) (upholding right of competent adults to refuse life-sustaining medical treatment); *Michael H. v. Gerald D.*, 491 U.S. 110 (1989) (discussing right of biological father to establish paternity and right to visitation of child born to married woman living with her husband); *Bowers v. Hardwick*, 478 U.S. 186 (1986) (upholding

to come before the Court in the realm of reproduction has involved the right to avoid procreation, either through the use of contraceptives or abortion.¹¹⁸ Taken as a whole, Professor John Robertson describes this body of case law as giving rise to “procreative liberty,” defined as “a negative right against state interference with choices to procreate or to avoid procreation.”¹¹⁹ Logically, it follows that procreative liberty is not a “positive right to have the state or particular persons provide the means or resources necessary to have or avoid having children” but merely the right to be left alone by the state in pursuit of reproductive choices.¹²⁰ Thus, the meaning and viability of procreative liberty, like any constitutional right, derives from a cadre of cases raising challenges to governmental actions that arguably impact a protected right. In the modern era, comprehensive judicial discussion of the fundamental right to procreative liberty is embedded in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,¹²¹ the Court’s 1992 abortion decision.

In *Casey*, the Court began by confirming that the constitutional protection of a woman’s decision to terminate her pregnancy derives from the Due Process Clause of the Fourteenth Amendment.¹²² The language extolling that no State shall “deprive any person of life, liberty, or property, without due process of law” gives rise to the procreative liberty at stake in the abortion context. This liberty, the Court explained, is not absolute but must be balanced against the State’s legitimate interest in the life of the unborn. Thus, the Court formulated a legal standard for evaluating state regulation of elective abortion, weighing the woman’s liberty interest against the government’s interest in potential life. State abortion regulation, the Court declared, will be invalid if it poses an “undue burden” on the right to decide whether to terminate a pregnancy. An undue burden exists, “if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.”¹²³

constitutionality of Georgia sodomy statute as applied to homosexual conduct, later overturned in *Lawrence v. Texas*, 123 S. Ct. 2472 (2003)).

¹¹⁸ See, e.g., *Griswold v. Connecticut*, 381 U.S. 485 (1965) (striking down state law criminalizing use of contraceptives); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (striking down state law criminalizing distribution of contraceptives to unmarried persons); *Roe v. Wade*, 410 U.S. 113 (striking down state law making it a crime to procure an abortion); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992) (upholding several regulatory provisions and striking down a spousal notification provision of a state abortion law); *Stenberg v. Carhart*, 530 U.S. 914 (2000) (striking down state law banning partial birth abortion).

¹¹⁹ Robertson, *supra* note 8, at 23.

¹²⁰ *Id.*

¹²¹ 505 U.S. 833 (1992).

¹²² 505 U.S. at 846.

¹²³ *Id.* at 877.

The undue burden test remains the centerpiece of the Court' abortion jurisprudence, though the high court has taken precious little opportunity to elucidate on exactly when state action constitutes an undue burden on a woman's reproductive liberty.¹²⁴ But the concept of undue burdens and procreative liberty need not be limited to the abortion context. Arguably, this same procreative liberty that attaches to a decision to choose or refrain from obtaining an abortion, likewise applies to a decision to actively engage in procreation. If this logical inference is sound, then state action that impacts on the decision *to* procreate can likewise be evaluated under the undue burden analysis. Imagine, for example, that the undue burden test was the reigning analysis in 1942 when the Court in *Skinner* evaluated the Oklahoma Habitual Criminal Sterilization Act, which authorized state officials to sexually sterilize certain convicted felons. We can have a great deal of confidence that Justice Douglas would have found the law to pose an undue burden on the right to procreate.

Thankfully the era of state-sponsored sterilization is in the past, so directed measures that prohibit or prevent individual procreation would seem to be of historic interest only. But as discussed in Part III, there remain numerous barriers to one type of procreation - reproduction using assisted conception. The question for constitutional purposes is whether any of these barriers rise to the level of state action and if so whether they pose an undue burden on procreation. As for the question of state action, the barriers arising from wealth status, employment, race and ethnicity seem unrelated to governmental activity in that no laws appear to directly prevent access to ART on any of these bases. But the two proposed laws limiting ART to married individuals clearly rise to the level of state action. Moreover, such laws, by design, pose an undue burden on the rights of unmarrieds to procreate.

Recall that the proposed Virginia law prohibits physicians from performing "any intervening medical technology, whether in vivo or in vitro, for or on an unmarried woman that completely or partially replaces sexual intercourse as the means of conception."¹²⁵ The notion of singling out unmarried individuals for disparate treatment in the realm of reproduction was long-ago shunned by the Supreme Court. In a 1972 case striking down a state law prohibiting, *inter alia*, the distribution of contraceptives to single people, Justice Brennan penned the oft-quoted

¹²⁴ In the years since *Planned Parenthood v. Casey*, the Supreme Court has cited the 1992 case over two dozen times, but only one of these decisions involved the regulation of abortion. See *Stenberg v. Carhart*, 530 U.S. 914 (2000) (declaring unconstitutional Nebraska statute banning "partial birth abortion" as unduly burdening right to chose abortion). Two cases involved the question of access to health care facilities by anti-abortion protesters, *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993) (denying permanent injunction to enjoin anti-abortion organizations from trespassing on premises) and *Hill v. Colorado*, 530 U.S. 703 (2000) (First Amendment challenge to criminal statute prohibiting any person from knowingly approaching within 8 feet of another near health care facility), while most of the other cases cited *Casey* for its discussion of *stare decisis*.

¹²⁵ 2006 Va. H.B. 187.

admonition, “[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child”¹²⁶ A law that prevents an infertile single woman from accessing safe and effective assistance in reproduction is a clear affront to her “right to privacy,” a right which today is framed in terms of the above-described procreative liberty interest. Depriving a single person access to reproductive assistance which is readily available to married individuals seems unlikely to serve any state interest, let alone a compelling state interest needed to justify infringement on the fundamental right to procreate.¹²⁷

State laws that deprive unmarried individuals access to ART seem ripe for invalidation under the Constitution on deprivation of liberty grounds, but what of discriminatory policies that are the product of private conduct? Denial of ART services to unmarried individuals has been documented and reported in the U.S., with a full 20% of fertility clinics refusing to accept single women, and 53% refusing to accept single men, as patients.¹²⁸ A lesbian woman in California, Guadalupe Benitez, became a victim of one such discriminatory policy when she sought AID services at a San Diego fertility clinic. The clinic, North Coast Woman’s Care Medical Group, the only ART provider listed on Ms. Benitez’s health plan, refused to provide her services because she was unmarried.¹²⁹ This refusal policy was adopted by all of the ART providers at North Coast, prompting Ms. Benitez to search for an “off plan” provider, whom she eventually located and proceeded to give birth to a healthy boy.¹³⁰

¹²⁶ Eisenstadt v. Baird, 405 U.S. at 453 (1972).

¹²⁷ In Eisenstadt, Justice Brennan set the constitutional standard that must be met for the government to justify a law restricting access to contraceptives. “Compelling” he wrote, “is of course the key word; where a decision as fundamental as that whether to bear or beget a child is involved, regulations imposing a burden on it may be justified only by compelling state interests, and must be narrowly drawn to express only those interests.” *Id.* at 686. The compelling state interest requirement was extended to reproduction in *Roe v. Wade*, where Justice Blackmun wrote, “[w]here certain ‘fundamental rights’ are involved, the Court has held that regulation limiting these rights may be justified only by a ‘compelling state interest...and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake.” 410 U.S. 113, 155 (1972).

¹²⁸ See Gurmankin & Caplan, *supra* note 98. The study questioned ART clinics about their likelihood to assist or turn away prospective patients on a variety of bases. When asked about aiding a lesbian couple with AID, 17% said they would turn this couple away, compared to 20% who said they would not assist a single woman. When asked about gay male couples, 48% said they would turn this couple down for the provision of surrogacy services.

¹²⁹ The details surrounding the *Benitez* case are set forth in the text surrounding notes 99-103.

¹³⁰ *North Coast Women’s Care Medical Group v. Superior Court*, 40 Cal. Rptr. 3d 636 (2006), *rev. granted*, 139 P.3d 1, 46 Cal. Rptr. 3d 605.

While North Coast is a private health clinic and thus would probably not be considered a state actor for purposes of Fourteenth Amendment jurisprudence, it is important nevertheless to consider whether the clinic's "no singles" policy posed an undue burden on Ms. Benitez and the universe of single individuals who routinely and by necessity seek assistance in reproduction. Put simply, do policies limiting ART services to married individuals pose an undue burden on the rights of unmarried individuals to exercise their fundamental right to procreate? The answer is unequivocally yes. Consider the following three burdens imposed by marital status discrimination in the ART market.

First, single individuals who access ART services via their health insurance plans will be forced to incur additional and out of pocket expenses if the plan providers refuse service on the basis of marital status. Such was the case with Guadalupe Benitez, who eventually sought treatment from an "out of plan" physician, at substantially greater cost than continuing treatment with North Coast would have posed.¹³¹ In addition to denying treatment and forcing Ms. Benitez outside the health plan, North Coast refused to reimburse its patient for the added expense imposed on her by its refusal to provide service. Despite these setbacks, Ms. Benitez was fortunate in at least two ways – she had the resources to fully fund her treatment and she resided in an area with a relatively large number of ART providers.¹³²

The economic burden on "disqualified" patients who rely on their health insurance coverage for all their medical needs, including their reproductive needs, cannot be ignored. It is certainly possible that Ms. Benitez or myriad other unmarried individuals selected their job, or even their domicile, on the basis of the proffered health care plan. A person who selects a job, or a health plan, in reliance on its availability for covered services suffers unduly from being forced to seek and individually bankroll ART treatment. Since policies regarding marital status are generally not formalized by ART clinics, there is simply no notice to single individuals that they are disqualified from receiving service, either when they select a health plan or when they visit a covered clinic for treatment.¹³³ Such lack of notice and hidden selectivity forces single individuals to search out alternate providers, possibly incurring additional expenses for travel or time away from work, adding to their already unanticipated economic burden.

A second burden that befalls unmarried individuals who are denied treatment based on their marital status is the involuntary foray into fertility tourism. If a prospective parent lives in an area in which the only, or all of the ART clinics have adopted a "no singles" policy, the patient will be forced to travel, possibly great distances, to seek out care. The economic burden of this

¹³¹ *Id.* at 641.

¹³² According to the CDC, there are eight ART clinics in the San Diego area. *See* ART Report, *supra* note 17, at Appendix C.

¹³³ *See* Gurmanki & Caplan, *supra* note 98, at 63 (reporting that only 28% of ART clinics have a formal policy describing on what grounds they might turn away a given candidate).

forced travel is obvious, but there are psychological and emotional costs as well. Leaving one's home, one's job, one's partner, one's family, to pursue a quest that itself poses physical and mental challenges disproportionately burdens unmarried individuals compared to their married counterparts. While some commentators have downplayed the burden of rejection, remarking that patients can "simply go elsewhere,"¹³⁴ such callousness wholly discounts the realities of ART treatment. In at least six states, there is only one ART clinic, making distance travel a necessity should the single in-state clinic choose to turn away unmarried individuals.¹³⁵ Moreover, this travel burden may be heaped on top of the economic burden from having to pay for "out of plan" services, since a health plan is unlikely to cover an out-of-state ART clinic.

A final burden that treatment denials impose on patients who are refused treatment based on their marital status is a lasting and negative impact on the long-term health of the targeted population. While this observation could apply generally to any targeted population, it has been studied and documented in the lesbian population. According to a study conducted by a Stanford University researcher, lesbian patients experience widespread sexual orientation bias by health care providers, shutting down critical communication between patient and physician and driving gay women away from the medical system. As a result, this population experiences greater incidence of illness because they reduce "their utilization of standard screening modalities, potentially resulting in higher morbidity and mortality from cancers and heart disease."¹³⁶ A sister researcher at UCLA concurs, finding "research has repeatedly documented that lesbians report frequent negative encounters in health care settings, including inappropriate interventions, hostility from providers, and violation of confidentiality."¹³⁷

Treatment denials for ART on the basis of marital status are uniquely and profoundly damaging to patients. Medically qualified individuals are denied a particular type of treatment

¹³⁴ See Jacob M. Appel, *May Doctors Refuse Infertility Treatments to Gay Patients?*, 36 Hastings Center Report 20 (2006), remarking, "[i]f any physicians opting out of performing certain procedures on certain patients publicize their decision adequately, it appears unlikely that prospective patients will be highly inconvenienced. They will simply go elsewhere." *Id.* at 21. As explained above in text, this assumption is easier made than actualized.

¹³⁵ U.S. residents may find they need to travel outside their state of domicile to access ART services from another state because their state lacks a fertility clinic. Five U.S. states have no ART clinic (Alaska, Idaho, Maine, Montana, Wyoming, according to the 2003 ART Report), while another 6 house only one clinic (New Hampshire, New Mexico, North Dakota, South Dakota, Vermont, West Virginia). The bulk of the 437 U.S. clinics are clustered in the northeast and California. See 2003 ART Report, *supra* note 17, at 13.

¹³⁶ Kate O'Hanlan, *Lesbian Health and Homophobia: Perspectives for the Treating Obstetrician/Gynecologist*, 18 Current Probs. Obs. & Gyn. 93, 136 (1995).

¹³⁷ Susan Cochran, et al., *Cancer-Related Risk Indicators and Preventive Screening Behaviors Among Lesbians and Bisexual Woman*, 91 Am. J. Pub. Health 591, 596 (2001).

strictly because of their social structure. And while doctors do withhold treatment based on the social status of patient, these treatment denials are based on poor medical outcomes, such as rejection of an intravenous drug user for solid organ transplantation. Denying a person the opportunity for parenthood only magnifies the emotional and psychological trauma that is already associated with infertility. Feelings of worthlessness, withdrawal, alienation, and self-doubt can only mount in the face of a direct attack on a person's worthiness to contribute another member of the human race. After such an affront, it is no surprise that members of the targeted population would retreat from the medical system altogether, risking their health and ultimately their lives.

The burdens of ART treatment denials pose short-term economic and long-term physical and psychological injury to individuals whose ability to parent rests largely in the hands of physician providers. The affront to personhood is especially grave when one considers that no similar screening mechanism exists for natural conception. Prospective parents whom society may adjudge "unfit" because of their social interactions are free to procreate without interference by the State or private actors.¹³⁸ They live under the "basic civil rights of man" deemed so essential by Justice Douglas generations ago. Surely the substantial obstacles to choice eschewed when a woman decides whether to terminate a pregnancy should likewise be banished when any individual embarks upon the pathway to parenthood.

3. DIGNITARY HARMS

Embedded in our nation's tradition of protecting individual civil rights is a recognition that denial of equal access to public goods on the basis of immutable characteristics is an affront to personal dignity. Recognition of this sentiment was codified in Title II of the Civil Rights Act of 1964, which provides in relevant part:

All persons shall be entitled to the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation, as defined in this section, without discrimination or segregation on the ground of race, color, religion, or national origin.¹³⁹

¹³⁸ This statement is certainly not to suggest that single and gay parents are unfit in any way because of their social interactions or structures. In fact, numerous studies looking at gay parenting have confirmed that children fair equally well or equally badly with heterosexual and same sex parents. The sexual orientation of the parent has no overall impact on a child's well-being. According to legendary pediatrician Dr. Benjamin Spock, "[t]ests of psychological adjustment show no significant differences between the well-being of children raised by heterosexual parents and those raised by gay or lesbian parents. Like any family, what is most important for children is how loving and nurturing the parents are and whether or not the parents are aware of any special needs they may have." Benjamin Spock, *Gay and Lesbian Parents*, in *BABY AND CHILD CARE* 685-6 (1998 ed.).

¹³⁹ 78 Stat. 243, 42 U.S.C. §2000a .

Almost immediately after passage of the Act, in *Heart of Atlanta v. U.S.*, the Supreme Court affirmed both the wisdom and constitutionality of Title II as a legitimate legislative effort to “vindicate the ‘deprivation of personal dignity that surely accompanies denials of equal access to public establishments.’”¹⁴⁰ The Court observed that laws prohibiting discrimination in public accommodations “eliminate [the] evil” of businesses serving only those “as they see fit,” which demeans both the individual and society as a whole.¹⁴¹

From a litigation strategy perspective, one might want to explore whether ART clinics are “public accommodations” under the Civil Rights Act (they probably are not)¹⁴² or other federal laws (they probably are),¹⁴³ such that treatment denials are actionable civil rights offenses

¹⁴⁰ *Heart of Atlanta, Inc. v. U.S.*, 379 U.S. 241, 250 (quoting from the Senate Commerce Committee’s report on the bill that became the Civil Right Act of 1964); *Accord Roberts v. U.S. Jaycees*, 468 U.S. 609 (1984)(upholding state human rights act as applied to sex discrimination in places of public accommodation).

¹⁴¹ *Id.* at 259. Numerous commentators have documented the depth of dignitary harm that arises when goods and services are withheld from individuals or couples based on personal characteristics. *See, e.g.*, Holning Lau, *Transcending the Individualist Paradigm in Sexual Orientation*, 94 Cal. L. Rev. 1271 (2006) (“[e]xclusion [based on sexual orientation] suggests that the business refuses to recognize the couple’s legitimacy, striking a blow at the couple’s collective dignity and self-respect”). For further discussion of dignitary harm and discrimination, *see* Christopher A. Bracey, *Dignity in Race Jurisprudence*, 7 U. Pa. J. Const. L. 669 (2005) (“[d]ignity remains the core aspirational value in the struggle for racial justice”); Rosa Ehrenreich, *Dignity and Discrimination: Toward a Pluralistic Understanding of Workplace Harassment*, 88 Geo. L. J. 1 (1999) (discussing the dignitary harms associated with workplace sex harassment).

¹⁴² Title II limits places of public accommodation to specific locales, including hotels, restaurants, theaters and places of “exhibition or entertainment.” 42 U.S.C. §2000a(b). A later part of the Civil Rights Act, Title VI, prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. 24 U.S.C. §2000d. Clearly, this section captures hospitals or health care facilities that received federal funding (generally via the Medicare or Medicaid programs), but does not appear to apply when a provider is financed exclusively by private entities, such as patients and private health insurance carriers. Thus, it would appear that Title VI would not reach independent, non-university-based fertility clinics.

¹⁴³ For example, the Americans With Disabilities Act, 42 U.S.C. §12101 et seq., prohibits discrimination on the basis of disability “in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation...” *Id.* at §12182. Further, the term “public accommodation” is defined in the ADA to include the “professional office of a health care provider.” *Id.* at 12181(7)(F). Public funding is not a requisite for action under the ADA, which has been interpreted to apply to the disability of “substantial limitations” on the “major life activity” of reproduction. *See Bragdon v. Abbott*, 524 U.S. 624, 637-38 (1998).

(probably only if the claim arises on the grounds of race, color, religion, or national origin).¹⁴⁴ But from a policy perspective the more salient inquiry is whether intentional withholding of ART services on the basis of personal characteristics works a deprivation of personal dignity. I believe that it does.

The provision of ART services is at its heart a medical activity in which physicians control and patients seek the technical means to procreate. Central to the provision of reproductive medical services is the patient's right to decide whether to accept or reject a proffered treatment, after due consideration of the risks and benefits attendant to a given modality. Both common law and bioethics principles have long acknowledged the preeminence of patient autonomy and respect for persons in the arena of medical decision-making – and nothing suggests these values would not extend to decision-making surrounding assisted conception. Such values, bioethicists argue, also support recognizing the dignitary rights of patients – rights that arise in the health care setting independent of physical injury and even emotional distress.¹⁴⁵ Dignitary rights arise from a patient's common law right of self-determination in medical decision-making, a century-old right first described by Judge Cardozo in *Schloendorff v. Society of New York Hospital*.¹⁴⁶ As explained by Professor Richard Saver, “[t]his common law right safeguards not only patients’ physical health but also arguably advances their intrinsic worth as independent moral agents.”¹⁴⁷

Borrowing from Professor Saver's language, the act of procreating can certainly be described as an activity that advances one's intrinsic worth as an independent moral agent. Deciding whether and when to create another life, a life that takes on one's genetic traits and social history, is deeply tied to one's sense of self and place in the world - i.e., one's intrinsic worth. Those in the fertile community can exercise their positive right to reproduce as independent moral agents, free from interference by state or private actors (other than intimate partners whose parenting prospects may also be at stake). The infertile, on the other hand, are not generally free to make independent procreative decisions, as their choices must be vetted by

¹⁴⁴ *But see* Matthew, *supra* note 93, at 820, explaining the difficulty individual plaintiffs experience in bringing Title VI claims on the basis of racial discrimination in the provision of health care services. Under Supreme Court precedent, private individuals can sue to enforce Title VI's prohibition against intentional discrimination (intent often difficult to prove), but the Court has denied a private right of action to claim an activity has a disparate impact (less difficult to prove) on the basis of race. *Alexander v. Sandoval*, 532 U.S. 275 (2001).

¹⁴⁵ *See, e.g.*, Richard S. Saver, *Medical Research and Intangible Harm*, 74 U. Cin. L. Rev. 941 (2006) (arguing for recognition of dignitary harm in the context of human subject research).

¹⁴⁶ 105 N.E. 92 (N.Y. 1914). Judge Cardozo penned the oft-quoted refrain that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body...” *Id.* at 93.

¹⁴⁷ Saver, *supra* note 145, at 957.

those who hold the means to procreation. The fortuity of infertility creates in the hands of ART providers an awesome power that would otherwise rest solely with the individual. Abuse or misuse of that power works not just a deprivation of parenthood, but a deprivation of the human dignity that is at the root of procreative decision-making.¹⁴⁸

Dignitary harms are particularly acute when treatment denials are based on personal characteristics, rather than personal circumstances. The barriers to ART discussed in Part III fall into these two categories. Race and ethnicity, and marital status, are examples of personal characteristics, while wealth and employment status are better categorized as personal circumstances. Both federal and state civil rights laws recognize the invidious nature of characteristic-based discrimination, prohibiting conduct that is motivated by fear, or hatred, or stereotyping, of individuals who bear the protected qualities.

In many instances, state civil rights laws offer broader protection to individuals than are available under federal law. For example, in the context of housing discrimination, the California fair housing law protects against discrimination on the basis of “race, color, religion, sex, sexual orientation, marital status, national origin, ancestry, familial status, source of income or disability,”¹⁴⁹ whereas the federal Fair Housing Act provides no protection against sexual orientation, marital status, or source of income discrimination.¹⁵⁰ The provision of rental housing, like the provision of ART services, is often at the mercy of third party providers (landlord/physician). Thus, a case about the limitations on denying benefits on the basis of personal characteristics may be instructive.

In *Smith v. Fair Employment and Housing Commission*,¹⁵¹ a California landlord refused to lease property to a cohabitating unmarried couple because she “believes that sex outside of marriage is sinful, and that it is a sin for her to rent her units to people who will engage in nonmarital sex on her property.”¹⁵² She claimed protection under the First Amendment to the United States Constitution which guards against state interference with freedom of religious

¹⁴⁸ The Supreme Court has spoken about the personal dignity attached to procreative decision-making, calling the decision about whether to bear a child one of “the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy.” *Casey*, 505 U.S. at 851.

¹⁴⁹ Cal. Gov. Code §12955(a).

¹⁵⁰ 42 U.S.C. §3604(a).

¹⁵¹ 12 Cal. 4th 1143 (1996).

¹⁵² *Id.* at 1151. Perhaps her true motive was more aspirational, as she also revealed that she “believes that God will judge her if she permits people to engage in sex outside of marriage in her rental units and that if she does so, she will be prevented from meeting her deceased husband in the hereafter.” *Id.*

exercise.¹⁵³ The California Supreme Court rejected the landlord's claim, explaining that the right of free exercise does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability. The California housing law was such a law because it prohibits all discrimination without regard to the actor's motive, and its objective is to prohibit discrimination irrespective of the actor's reason. Even if the actor's reason is religiously based, the law measures the act of discrimination, not the stated reasons for such action.¹⁵⁴

The California court's holding that state antidiscrimination laws trump free exercise objections was based in part on the impact that denial of commercial services has on the rights and interest of third parties. If a person controls access to public accommodations or necessary services, permitting that person to discriminate "would sacrifice the rights of [others] to have equal access to public accommodations and their legal and dignity interests in freedom from discrimination based on personal characteristics."¹⁵⁵ In a free market where commercial services are distributed largely on economic grounds, injecting race or marital status as an eligibility requirement for acquisition significantly suppresses the ability of those in the target population to maintain their status as an equal member of the society. Denial of certain services which are generally available to most can only engender more acts of isolation and deprivation based on these despised characteristics.

The landlord's actions in *Smith* can be likened to an ART physician who objects to assisting an unmarried couple on similar grounds – aiding a couple to have a child outside of marriage goes against her religious beliefs. A physician, like a landlord, is a member of a group that controls access to essential services necessary for human flourishing. These services (shelter, assistance in procreation) can affect the well-being of the individual denied such services, and can also impact the well-being of third parties (friends or relatives of homeless person who may be coerced into providing shelter, partner of prospective parent who is likewise deprived of procreative opportunities, existing children of rejected patient who may question their own self-worth). Thus, a person denied essential services suffers the indignity of such denial, but the concentric circles of harm extend beyond the individual to third parties. This kind of third party harm is exactly the type of harm the California Supreme Court sought to prevent in *Smith* when it elevated antidiscrimination laws over claims of individual religious autonomy.

Even if dignitary harms arising from ART denials gain recognition as legally cognizable claims, questions remain about the appropriate mechanism for redress and the impact on physician autonomy. I believe both of these uncertainties can be resolved by codifying existing

¹⁵³ She also claimed exemption from the California Government Code under the Religious Freedom Restoration Act of 1993, 42 U.S.C. §2000bb et seq., and article 1, section 4, of the California Constitution. She lost on these two counts.

¹⁵⁴ *Id.* at 1161-62.

¹⁵⁵ *Id.* at 1170.

antidiscrimination policy statements by physician organizations within the framework of existing state civil rights laws. For example, the American Medical Association Code of Medical Ethics provides a comprehensive statement of nondiscrimination in the provision of medical services by licensed physicians:

Physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination.¹⁵⁶

With the exception of marital status discrimination, this statement encircles the bases on which ART providers might refuse to provide care to an otherwise “ready, willing and able” patient. Codifying this prohibition and applying it to ART refusals on the basis of the enumerated personal characteristics (including marital status) could go a long way toward remedying the dignitary harms suffered when essential reproductive services are denied. An ART-specific statute could read:

A physician and surgeon or other health care provider delivering fertility treatment shall not decline to accept, or incite others to decline to accept, any patient because of race, color, religion, national origin, sexual orientation, or marital status.¹⁵⁷

Moreover, incorporating a calculus for damages further recognizes and addresses the serious harm to dignity that results when parenting opportunities are arbitrarily withheld. Borrowing from existing state laws, violations of a medical-specific antidiscrimination law could be punishable by monetary damages, such as those described in one state’s law:

Whoever denies, aids or incites a denial, or makes any discrimination or distinction contrary to [the applicable antidiscrimination law] is liable for each and every offense for the actual damages, and any amount that may be determined by a jury, or a court sitting without a jury, up to a maximum of three times the amount of actual damage but in no case less than [\$10,000 - representing the average cost of an ART cycle], and any attorney’s fees that may be determined by the court in addition thereto, suffered by any person denied the rights provided in [the applicable antidiscrimination law].¹⁵⁸

Providing monetary damages that are loosely linked to the cost of the sought-after services seems

¹⁵⁶ AMA CODE OF MEDICAL ETHICS, Opinion E-9.12.

¹⁵⁷ Absent from this proposed statute are denials on the basis on age and disability. In a more general way, I discuss treatment denials based on patient age and disability which cause physicians to question the patient’s child-rearing abilities *infra* in text surrounding notes 173-174. For a discussion of ART and patient disabilities, see Coleman, *supra* note 57.

¹⁵⁸ This language is borrowed from the California Unruh Civil Rights Act, Cal. Civ. Code §52(a).

a fair solution and a fair penalty for unlawful discrimination in the provision of ART services. Other solutions might include imposing a duty on physicians to refer patients to a willing provider, or imposing monetary damages equal to the out-of-pocket losses incurred by patients who are forced to seek procreative health care outside their health insurance network, or outside their domicile. But the imposition of treble “actual damages, and any amount that may be determined by a” trier of fact bests other options by expressing the seriousness of the harm inflicted. Providers who discriminate will incur losses that exceed the cost of “buying off” the patient by sending her to another physician (and paying the differential costs). Moreover, creating a secondary market of nondiscriminating ART providers only serves to emphasize and institutionalize the second-class status of those who experience barriers to ART. Separate but equal is not a value the ART community, or any community, should strive to achieve.

B. HARM TO ART PROVIDERS

The harm visited upon physicians from barriers to ART access are best evaluated in terms of the nature of the barrier imposed. From the perspective of an ART physician, barriers can be external or internal. External barriers are those impediments to ART treatment put in place by third party actors. For example, laws that limit ART treatment to married couples, or health care policies that fail to provide coverage for assisted conception could be considered external barriers to ART based, respectively, on marital and wealth status. Internal barriers are those impediments to ART treatment put in place by providers themselves. Clinic policies that refuse to accept patients based on race, ethnicity, marital status, family background or sexual orientation would be examples of internal barriers. It is my contention that practitioners suffer harm from treatment denials based on both external and internal barriers to ART access.

1. External Barriers: Economic and Reputational Harms

Laws and policy decisions (including those of insurance carriers) that restrict or reduce patient access to ART can have an obvious effect on the economic well-being of ART providers. When physicians are barred from assisting certain patients, as would be the case if a Virginia-type bill prohibiting physicians from assisting unmarried women was in force,¹⁵⁹ they are deprived of the potential market generated by these prospective patients. As noted earlier, the market of single individuals and same sex couples desiring assistance in conception is ample and growing,¹⁶⁰ such that a physician’s inability to tap into that patient population could be financially devastating. Moreover, decisions among health insurance providers to limit or withhold coverage for ART could also have a negative impact on provider economic health. At a minimum, casting fertility services into a “pay to play” mode limits the number and breadth of patients a physician encounters, patients who could act as a rich source of referrals and repeat visits for future health care needs.

¹⁵⁹ See *supra* note 108.

¹⁶⁰ See *supra* text accompanying notes 42-49.

Measuring harms to a provider's bottom line seems straightforward enough, though it depends largely on the ability to identify the lost market and calculate the corresponding lost revenues. Harms to a provider's reputation as a result of external barriers is far more speculative, but nevertheless worthy of exploration. It might seem, at first blush, that a law or policy prohibiting a physician from servicing members of a group would not attract blame to the provider, but rather to the body propounding such a prohibitory mandate. But physician compliance with directives that violate societal norms can engender ill-will toward the willing discriminators. Why, one might wonder, didn't the physicians object to the imposition of this mandate as a sign of support for their patients? Why, one might wonder, would providers allow such restrictions unless they viewed them as permission to act in a desired discriminatory fashion?

Prospective or even current patients who perceive their physicians' willingness to submit to exclusionary policies as a sign of endorsement may find themselves among the growing group of fertility tourists. Outrage, disturbance, or even sister solidarity with their shunned infertile counterparts could prove harmful to a physician's reputation, perhaps even decimating her patient population. Such was the concern among physicians in Sweden who faced a government-mandated change in the administration of ART services. When Swedish lawmakers abolished donor anonymity for sperm donors in 1985, a significant number of fertility specialists expressed their unwillingness to support the new legislation.¹⁶¹ These physicians understood that donors opposed the law, and would be unlikely to participate in open-identity donation. In addition, the Swedish physicians also perceived that their patients would prefer a system of donor anonymity, leaving the decision of disclosure up to each individual parent rather than the state.¹⁶² Thus, instead of working within a system they considered to have serious flaws, these physicians stopped recruiting sperm donors altogether and referred their patients abroad.

While the Swedish physicians may have been motivated by economic factors (a downturn in the AID market), their actions are also fairly viewed as an attempt to shore up their professional integrity among the relevant actors in their ART world. Showing respect for a patient's desire for autonomy in her procreative and parental decision-making by providing her alternatives to existing, restrictive services, can go a ways toward protecting a provider's reputation for independence and compassion.

¹⁶¹ See Eric Blyth, *Sperm Donation: Time to Look Forward, Not Back*, available at <http://bionews.org.uk/commentary.lasso?storyid=3190>, citing K. Daniels & O. Lalos, *The Swedish Insemination Act and the Availability of Donors*, 10 *Human Reproduction* 1871-1874 (1995).

¹⁶² This perception proved accurate, as a follow up study in 2000 revealed that 89% of parents had not disclosed their use of AID to their children. See Claus Gottlieb, Othon Lalos, & Frank Lindblad, *Disclosure of Donor Insemination to the Child: The Impact of Swedish Legislation on Couples' Attitudes*, 15 *Human Reproduction* 2052 (2000).

2. INTERNAL BARRIERS: THE ROLE OF PHYSICIAN AUTONOMY

Physician motivation for refusing to provide medical treatment, including treatment for infertility, to interested parties derives from the principle of physician autonomy. As noted earlier, the concept that a physician is free to determine whether or not to enter a doctor/patient relationship with a prospective patient is embedded in American health law. Professor Furrow and his colleagues who authored a major textbook in health law describe the principle of physician autonomy in the context of the doctor/patient relationship as follows:

The traditional legal principle governing the physician-patient relationship is that it is a voluntary and personal relationship which the physician may choose to enter or not for a variety of reasons. Legal obligations on the part of providers to furnish care operate as exceptions to the general rule.¹⁶³

The exceptions to which Professor Furrow and his colleagues refer are the statutorily enumerated categories of impermissible discrimination contained in federal and state civil rights laws. Under federal law, these categories include race, color, religion, national origin¹⁶⁴ and disability.¹⁶⁵ State laws similarly prohibit discrimination on the bases enumerated in federal law, but some states extend the group of protected classifications to include other categories, including marital status and sexual orientation.¹⁶⁶ Despite these explicit prohibitions against health care discrimination on the basis of personal characteristics, it will likely be the rare physician who makes a “smoking gun” admission to the patient that care is being withheld because of the person’s race, national origin, marital status, sexual orientation, etc.¹⁶⁷ Overwhelmingly,

¹⁶³ See Barry R. Furrow, Thomas L. Greaney, Sandra H. Johnson, Timothy S. Jost & Robert L. Schwartz, *HEALTH LAW* 529 (5th ed. 2004).

¹⁶⁴ Civil Rights Act of 1964, 42 U.S.C. §2000d et seq.

¹⁶⁵ Americans With Disabilities Act, 42 U.S.C. §12101 et seq.

¹⁶⁶ See, e.g., Cal. Civ. Code §51, which provides in relevant part: “All persons within the jurisdiction of this state are free and equal, and no matter what their sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status, or sexual orientation are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.” Laws in Alaska, California, Colorado, Connecticut, Delaware, the District of Columbia, Florida, Hawaii, Illinois, Maine, Maryland, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, Oregon, Vermont, Virginia, and Washington also prohibit discrimination in public accommodations on the basis of marital status. Laws in Connecticut, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Minnesota, Nevada, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and Wisconsin also prohibit discrimination in public accommodations on the basis of sexual orientation.

¹⁶⁷ *But see*, North Coast Women’s Care Medical Group v. Superior Court, 40 Cal. Rptr. 3d 636 (2006), *rev. granted*, 139 P.3d 1, 46 Cal. Rptr. 3d 605 (where physicians admitted to patient that fertility

treatment denials will be justified on the basis of physician autonomy, unrelated to the personal characteristics of the patient which would amount to impermissible discrimination.

Proponents of physician autonomy in the provision of ART services might look to a companion area of the law which permits doctors to refuse to provide certain types of health care services on moral or ethical grounds. In an earlier work on physician autonomy, I described the most striking example of this legislative safe harbor – the performance of abortion. A majority of states permit physicians and other ancillary health care workers to opt out of participating in the procedure on the ground that it offends his or her conscience.¹⁶⁸ I argued that “these abortion refusal statutes demonstrate...that our society is sensitive to the fact that doctors are not mere technicians who, because of their special training, must use their skills whenever asked. Instead, society accords physicians a right to moral autonomy in selected clinical settings.”¹⁶⁹ In my mind, this statement rings as true today as it did over a decade ago. But it must be analyzed in the specific clinical setting at issue herein – the selective provision and denial of ART services.

My first foray into physician autonomy involved cases of medical futility – the provision of care to critically ill patients who were unlikely to receive any medical benefit from the requested treatment. The clash at the bedside pitted family members demanding intensive care for loved ones whose conditions would not be aided by the treatment, against physicians whose medical judgment dictated that treatment should be withheld or withdrawn because it provided no benefit to the patient. In such clashes, forcing physicians to continue to provide medically ineffective care is an assault on their professional integrity and a violation of their professional autonomy.¹⁷⁰ The solution, it seemed to me, was to allow physicians to exercise their autonomy by transferring patients to other willing providers with the assistance of neutral hospital-based committees that could evaluate the merits of each physician’s claim for dismissal from the patient’s care.¹⁷¹ Is this solution of elective transfer also a viable solution for physicians who wish to refuse to provide ART to certain populations? No it is not.

services were being withheld because of her marital status).

¹⁶⁸ See Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician’s Professional Conscience*, 44 HAST. L. J. 1241 (1993).

¹⁶⁹ *Id.* at 1247.

¹⁷⁰ This protection of physician autonomy in the context of medically futile care was incorporated into the Uniform Health Care Decision Act, which provides that “[a] health care provider...may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care...” Uniform Health Care Decisions Act, Sec. 7(f). However, if a health care provider declines to comply with a patient or family’s request for treatment, he or she must inform the patient and “immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision.” *Id.* at Sec. 7(g)(3).

¹⁷¹ Daar, *supra* note 168, at 1285 (describing “treatment evaluation boards” as mechanisms for effectuating patient transfers in cases of claimed medical futility).

Transfer rights in the case of medical futility allow doctors to implement their medical judgment about a patient's clinical condition. Transfer rights in the case of selective ART refusals would allow doctors to express their personal animus toward a patient's personal characteristics. Cases of treatment refusal involving medical futility or abortion share the commonality that what is being refused is based on the nature of the procedure, not the nature of the patient. If doctors were to refuse to provide ventilator support, for example, only to Black patients, or Jewish patients, or Asian patients, while providing such support to other patients with identical medical profiles, this conduct would be wholly impermissible. Likewise, if obstetricians refused to perform abortions only on White patients, but agreed to abort all other races, the race-based discrimination would be obvious and actionable.

ART treatment denials are never wholesale refusals to provide a specific procedure; they are selective refusals to provide treatment to specific individuals. In fact, ART providers are solicited by prospective parents of all stripes because of their skill in performing AID, IVF, IUI and the like. Physicians who routinely provide these services in their practices should not be able to withhold these treatment on the basis of patient personal characteristics, so long as the treatments would be provided to other patients with similar medical profiles. Such a policy does not prevent physicians from exercising their medical judgment. Telling a single woman, or a woman with a lesbian partner, that IUI is not available to her, while providing IUI to a married woman is not an expression of the physician's medical judgment, but rather an expression about the worthiness of single and gay women as parents. Physicians should not use patients as a means to express their views about the social context of parenthood.¹⁷²

To say that ART physician autonomy is not absolute is not to say that doctors have a duty to fulfill all requests for service. Inescapably, ART involves the welfare of more than one person – the parent and the child. Treatment decisions can and should take into account known or significantly suspected characteristics that would render the parent(s) unable to deliver a decent minimum of child-rearing. The American Society for Reproductive Medicine has pondered this question of when, if ever, ART providers should decline to treat patients they believe pose a substantial risk of harm to offspring. In balancing the reproductive rights of infertile individuals against the duty to respect the well-being of offspring, the ASRM Ethics Committee propounded that “fertility programs should be attentive to serious child-rearing deficiencies in their patients, and if they have a substantial, non-arbitrary basis for thinking that parents will provide inadequate child-rearing, they should be free to refuse to provide treatment

¹⁷² In a recent Ethics Committee Report, the American Society for Reproductive Medicine endorsed this view, stating “[a]lthough professional autonomy in deciding whom to treat is also an important value, we believe that there is an ethical obligation to treat all persons equally, regardless of their marital status or sexual orientation.” Ethics Committee of the American Society for Reproductive Medicine, *Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons*, 86 FERTILITY & STERILITY 1333 (2006).

services to such patients.”¹⁷³ According to the ASRM, examples of “substantial, non-arbitrary basis” for concern about parental adequacy include uncontrolled psychiatric illness, a history of child or spousal abuse, or drug abuse.¹⁷⁴

I agree that physician discretion to deny ART is warranted in certain situations, but would support this value on grounds different than those articulated by the ASRM. Basing a physician’s ability to deny ART services on his or her prediction about the child-rearing abilities of a prospective parent is speculative and leaves too much opportunity for masking pure discrimination with concern for offspring. Instead, providers should be able to deny ART services if they believe the patient’s well-being will be negatively affected by the treatment. Just as intensive care physicians should have the right to refuse to provide nonbeneficial care to irreversibly ill patients, ART providers should be able to withhold services they reasonably believe would cause harm to a person. Admittedly, this window of refusal is decidedly narrow, but it is not nonexistent. For example, it may be reasonable for an ART provider to conclude that a woman with uncontrolled psychiatric illness or a history of drug abuse would not fare well during pregnancy. She may be unable to manage the physical and psychological burdens of pregnancy, causing harm to herself or others. Likewise, a woman who is the subject of spousal abuse might be an even greater target of violence, as studies show that abused women report higher levels of violence during pregnancy.¹⁷⁵

Though perhaps at first blush counterintuitive, reducing physician autonomy to deny ART services is beneficial to providers of assisted conception technologies. Put another way, physicians suffer harm when they individually or collectively impose barriers to treatment by private acts of discrimination against individuals who are as medically and socially capable of bearing children as their fertile counterparts. Patient defection and loss of confidence – either among the rejected patients or even among those who support the latter group’s right to reproduce – can be devastating to a physician’s practice.

Without opportunities to deny treatment on the basis of personal characteristics unrelated to patient well-being, physicians can operate in an environment of medical objectivity and administrative certainty. For physicians who remain refractory to providing ART services to certain populations on moral grounds, they cannot reasonably expect to be permitted to use their state-issued medical license for purposes of discrimination. For the vast majority of physicians who recognize the value and import of access to ART for virtually all, the rewards in patient trust and regard substantially outweigh any perceived reduction in autonomy. After all, without

¹⁷³ Ethics Committee of the American Society for Reproductive Medicine, *Child-Rearing Ability and the Provision of Fertility Services*, 82 FERTILITY & STERILITY 564, 565 (2004).

¹⁷⁴ *Id.* at 565.

¹⁷⁵ See J. McFarlane, JC Campbell, P Sharps, K Watson, *Abuse During Pregnancy and Femicide: Urgent Implications for Women’s Health*, 100 OBSTETRICS & GYNECOLOGY 27 (2002).

patient support, physicians would suffer a total deprivation of livelihood.

C. HARMS TO ART CHILDREN

Barriers to ART access profoundly affect family formation, forcing childlessness on those who have never procreated, and limiting the growth of existing families whose progenitors experience secondary infertility after the birth of one or more children. The harms from forced childlessness and constriction of family growth impair the dignitary and procreational autonomy rights of prospective parents, as previously discussed. But do denials of ART services cause harm to offspring? Unlike their actual or prospective parents, ART offspring do not have the capacity to be harmed in their dignitary or procreational rights, as they possess no such rights. Offspring who are never born because their infertile potential parents met insurmountable barriers to ART lack existence, but does this mean they lack the ability to be harmed by treatment denials? And what about harm to existing children who are denied siblings because of ART barriers? Let us now consider whether barriers to ART access cause harm to existent and nonexistent children.

1. THE NEVER BORN

Can a person who was never born experience harm from lack of existence? This question trends toward the philosophical, and its answer may proceed from an assumption about the merits of being born. If human existence, in and of itself, is assumed to be good, then its denial may be said to cause harm. But if human existence is assumed to be less than good, or at least equivocal, then it is less certain that its denial can cause harm. The moral value of procreation as a human activity has garnered at least two schools of thought – one celebrating its absolute goodness and one more cautiously balancing the benefits and harms that are attendant to every human birth.

The position that procreation is an absolute good was recently articulated by the Ethics Committee of the American Society for Reproductive Medicine. Commenting of the “ethical paradox” that arises when harm to ART offspring is avoided by avoiding the birth of offspring altogether, the Committee took the position that “the birth of a child is deemed a good in itself, and helping the parents achieve that goal is a morally worthwhile endeavor.”¹⁷⁶ This attitude that being born is itself a good, even if one’s life is unwanted or miserable, finds support in the law of torts which largely shuns the legal cause of action for wrongful life – a claim by a child for damages sustained as a result of his or her creation.¹⁷⁷ Claiming they are ill-equipped to decide,

¹⁷⁶ ASRM Ethics Committee, *supra* note 173, at 565. The Committee concluded that only “when significant harm to future children is likely” do ART providers have a moral obligation to withhold treatment services. *Id.* at 567.

¹⁷⁷ See Seana Valentine Shiffrin, *Wrongful Life, Procreative Responsibility, and the Significance of Harm*, 5 LEGAL THEORY 117 (1999) (explaining that wrongful life claims are brought on behalf of children and allege that their parents’ doctors were at fault for failing to inform the parents of a likely defect that would have forestalled creation, such as a genetic defect that was likely to cause pain and

as a legal matter, “whether it is better never to have been born at all than to have been born with even gross deficiencies,” courts punt this mystery by denying recovery for claims related to wrongful life.¹⁷⁸

The alternative view that procreation brings both benefits and harms, in every case, is articulated by Professor Seana Shiffrin in an essay discussing the merits of wrongful life as a viable legal claim. She maintains that “procreation is a morally hazardous activity because in all cases it imposes significant risks and burdens upon the children who result.”¹⁷⁹ Being created, Professor Shiffrin argues, “*can* benefit a person in part, or overall, should her life be sufficiently worth living, and that it is also possible that being created *can* harm a person.”¹⁸⁰ On balance, Professor Shiffrin takes a morally equivocal view toward procreation as a routine matter, because of its inevitably beneficial and burdensome nature.

These articulations of the moral value of procreation are generally not abstract, but arise in the context of procreation gone awry. When a child is born disabled, either the result of a physician’s negligent failure to warn parents of a likely congenital defect, or the result of a negligently performed abortion or surgical sterilization, anguished parents seek compensation for the lifelong burden they will bear. With the child presented as “damages,” the legal system is forced to consider the value of the child’s diminished life. The question of whether a suffering child’s life is worth more or less than a nonexistent life must be resolved if culpability is to be allocated in a legal context.

But in the context of ART barriers, the equation comparing the benefits and harms of existence against those of nonexistence is not the same as the calculation made in the wrongful life arena. The numerator – the value of the child’s diminished existence – is zero when ART services are denied because the child never comes into existence. In wrongful life cases, the numerator represents the life of an actual child, thus must be either a positive number (child experiences overall benefit) or a negative number (child experiences overall harm). In either case, the value of an existing child’s actual life can be compared to the harm or benefit of

suffering).

¹⁷⁸ See *Becker v. Schwartz*, 46 N.Y.2d 401, 413 N.Y.S.2d 895, 386 N.E.2d 807 (1978). According to Professor Shiffrin, *supra* note ___, only three states recognize a cause of action for wrongful life – California, New Jersey and Washington.

¹⁷⁹ Shiffrin, *supra* note 177, at 137. She explains that while “procreators may benefit their progeny by creating them, they also impose substantial burdens on them. By being caused to exist as persons, children are forced to assume moral agency, to face various demanding and sometimes wrenching moral questions, and to discharge taking moral duties. They must endure the fairly substantial amount of pain, suffering, difficulty, significant disappointment, distress, and significant loss that occur within the typical life.” *Id.*

¹⁸⁰ *Id.* at 119.

nonexistence. If one assumes that the denominator – the harm to a never born child – is also zero, because nonexistent children cannot undergo harm if they are not created¹⁸¹ – then measuring the harms from wrongful life v. harms from ART denials or barriers will always yield different results. In wrongful life cases, some number, either positive or negative will emerge, to represent the value of the child’s diminished life. But in cases of ART denials, since both the numerator and the denominator are assumed to be zero, one would conclude there is no net harm because no child suffers as a result of human activity.

The problem with this analysis is that it fails to take into account that the vast of majority – if not all – barriers to ART are not based on concerns for the welfare of the child. In cases where prospective parents are poor, or minority, or single, or gay, there is no evidence that these features cause a child to be born into a life of misery and suffering. Probably only in the latter cases of single and same sex parents do ART providers refuse to provide treatment because they have concerns about the patient’s child-rearing abilities. Numerous studies have shown these concerns to be unfounded. On balance, children of single and gay parents fare as well or as poorly as children raised in marital and heterosexual homes.¹⁸² Thus, ART barriers are universally preventing a positive activity – the birth of a healthy child into a nurturing family environment. When one considers the potential benefit to such children, it no longer makes sense to conclude that the never born suffer no harm from ART barriers.

Suppressing or restricting access to safe and effective methods of assisted conception to individuals who, if they reproduced naturally would be as likely as any other parent to produce a healthy child and provide a positive rearing experience, seems a deprivation of liberty for both the prospective parent and would-be child. Never born children can be said to suffer harm when their very creation is thwarted for reasons unrelated to their own well-being. However, recognizing that never born offspring can experience harm does not necessarily mean that legal remedies must be forthcoming that award damages on the basis of a theoretical child’s worth. Instead, other remedies that address physician denials, as set forth in Part IV(A)(3), can be fashioned to encompass harms that arise when offspring are denied an opportunity to exist. Calculating damages according to the loss suffered by a prospective patient would seem to suitably compensate for the loss of a potential human being.

3. THE BORN

Individuals who seek ART are not necessarily childless. They may have conceived naturally one or more times, but later experience infertility.¹⁸³ Or they may have procreated

¹⁸¹ See Shrifin, *supra* note 177, at 120.

¹⁸² See ASRM Ethics Report, *supra* note 172, at 1334, citing several studies evaluating the social and psychological health of children raised by single and same sex parents.

¹⁸³ Secondary infertility – the inability to conceive or carry a pregnancy to term after successfully

using ART, but now face a barrier to accessing assisted conception to expand their extant family. In either case, barriers to ART impact on existing children in ways that can be harmful to their well-being.

For a child or children whose parents are experiencing infertility following natural conception, the pain and frustration of failing to conceive may come to infect the family dynamic. The psychological stress on the family may be even greater if the parents' inability to expand the family is attributable to one or more barriers to ART access. Parents who lack insurance coverage for assisted conception and cannot afford to pay for these medical services out of pocket may stretch the family's resources to fund treatment. If the treatment fails, or even if it is successful, the parents may face tremendous debt that detracts from their ability to properly care for the existing children. In addition to economic barriers, couples with secondary infertility may encounter ART barriers due to their race or ethnicity. An African or Arab American couple, for example, may shun treatment for fear of confronting a provider's stereotypic attitudes toward their reproduction.¹⁸⁴ Inevitably these attitudes, real or perceived, will become known to the existing children, threatening dignitary harm to a second generation.

For children who were conceived using ART whose parent(s) desires another child, subsequent barriers to assisted conception can impact the self-worth and identity of these first born children. For example, a child born via AID may feel the absence of a father in her life, and long for a connection with a sibling who understands the unique circumstances of her birth.¹⁸⁵ In fact, it is becoming increasingly common for donor-conceived children to search each other out, helped along by the internet, so as to make a connection with a genetically related individual.¹⁸⁶ Closing the door to family expansion means that ART children will not enjoy the companionship of siblings who share the distinct nature of their conception. While it is certainly true that only children thrive in this world, single ART children whose parents face insurmountable barriers to family expansion may interpret their singleness as a wrong that is being addressed by repressing further similar births.

Children whose parents face ART barriers may be part of a newly blended family

and naturally conceiving one or more children – is fairly common. According to a 1995 survey by the National Center for Health Statistics, 3.3 million American women were experiencing secondary infertility. This represented an increase from 1988, when 2.7 million women were affected by secondary infertility. See http://www.pregnancy-info.net/infertility_secondary_infertility.html.

¹⁸⁴ See *supra* text accompanying note 80.

¹⁸⁵ See Katrina Clark, *My Father Was A Sperm Donor*, WASH. POST, Dec. 18, 2006, at B1 (personal narrative describing author's anger and confusion over being a donor-conceived child).

¹⁸⁶ See Amy Harmon, *Hello, I'm Your Sister. Our Father Is Donor 150*, N.Y. TIMES, Nov, 20, 2005, at A1, describing a website accessed at www.donorsiblingregistry.com that allows children conceived through donor insemination to register and to search for other children of the same donor.

configuration. For example, a woman who was previously married, or who had a child as a single woman via AID, may now be part of a same sex relationship. If the new couple wishes to expand their family but is unable to do so because they encounter marital status or sexual orientation discrimination, their existing children may view this treatment denial as an expression of society's negative view toward their nontraditional family. The child comes to symbolize the unworthiness of the family unit. Conversely, bringing much wanted children into a newly blended family may be a sign of strength in the developing relationships, a sign that could reassure existing children about the stability of their own place in the family unit and the world around them.

Whether children are in traditional or nontraditional settings, one cannot discount the impact that functional or structural infertility could have on their lives. A parent's frustration over the inability to further reproduce, whether attributable to medical or social causes, can easily bleed into the parent/child relationship, igniting a host of feelings within the child ranging from empathy, to helplessness, to fear, to self-doubt. While infertility may be a medical condition that is resistant to all forms of treatment, it should not be an opportunity for social engineering. Parents who require assistance in reproduction are no more or less worthy of the opportunity for parenthood than their fertile counterparts. Treatment denials based on subjective perceptions of parental worth can morph into societal expressions about the worth of selected ART children and their parents. It is to this expressivist argument that we now turn.

D. HARMS TO SOCIETY

At the outset of this article, we noted the prevalence of ART-conceived children in today's society, at last count approaching 3% of the total U.S. population.¹⁸⁷ Though growing, the number of individuals and couples who look to ART for family formation is still low on an absolute scale, prompting one to question whether barriers for these few prospective parents have any impact on society as a whole. Is denial of assistance in reproduction to a single individual worthy of redress by comprehensive measures that reach beyond the life of the individual? I argue such redress is both appropriate and necessary because of the import of the societal interests at stake.

Constructing or refusing to dismantle barriers to human reproduction causes harm to society in at least two ways. First, policies or formal laws that reduce access to ART on the basis of personal characteristics that are unrelated to child-rearing capacity express attitudes that unfairly stigmatize the population to which these barriers apply. Formal expressions of stigma are harmful to both the individuals being stigmatized as well as the society from which they hail. Second, imposition of reproductive regimes that deny procreative rights to certain members of a society are dangerously reminiscent of our eugenics past. While the eugenicists of a century ago

¹⁸⁷ See *supra* note 30.

coerced the “feeble minded” into surrendering their reproductive capacity through forced surgeries,¹⁸⁸ today’s practices act to deprive the disempowered of their capacity to reproduce by withholding the means necessary to produce a child. Whether by coercion or deprivation, removing reproductive decision-making from the individual has broad, negative consequences for society as a whole.

1. THE EXPRESSIVIST ARGUMENT

All conduct, according to some legal theorists, expresses values and attitudes on the part of the actor. Whether the actor is an individual, a group, or the State, the expression of negative or inappropriate attitudes toward a person causes harm to that individual. This “expressive harm” is addressed by the expressive theory – a theory which strives to direct actors to act in ways that express appropriate attitudes toward various substantive values.¹⁸⁹ As applied to law, expressive theorist measure actions by governments according to the message that state-backed actions convey.¹⁹⁰ One legal scholar explains that expressive theories of law “converge on the idea that wrongful governmental expressive acts matter because of the stigma they involve; the theories argue that government should neither make nor enforce laws that express attitudes that unfairly stigmatize people.”¹⁹¹ Expressive theory works to decipher the message that government-back action sends by studying the reaction it generates in individuals, groups and the State.¹⁹²

As applied to access to assisted conception, attitudes toward those who face functional or structural infertility¹⁹³ are expressed in at least two ways - by enacted law and by physician

¹⁸⁸ See *Buck v. Bell*, 274 U.S. 200 (1927) (Justice Holmes, writing for the Court, upholds a Virginia law allowing forced sterilization of “mental defectives,” including the plaintiff Carrie Buck, described as “a feeble-minded white woman”).

¹⁸⁹ See Elizabeth S. Patterson & Richard H. Pildes, *Expressive Theories of Law: A General Restatement*, 148 U. PA. L. REV. 1503 (2000) (explaining that expressivism is a method of evaluating action, “an internal account of existing normative practices, but one with sufficient critical capacity to exert leverage over those practices and to indicate where they ought to be reformed.”).

¹⁹⁰ See Mary B. Mahowald, *Aren't We All Eugenacists?: Commentary on Paul Lombardo's "Taking Eugenics Seriously"*, 30 FLA. ST. U. L. REV. 219 (2003) (explaining how the expressivist argument, as applied to prenatal testing, sends the message to people with disabilities that their lives are not worth living).

¹⁹¹ Alan Strudler, *The Expressive Dimension of Government Action: Philosophical and Legal Perspectives*, 60 MD. L. REV. 492 (2001).

¹⁹² See Patterson & Pildes, *supra* note 189, at 1504, arguing that “most of the purposes, beliefs, attitudes, intentions, and other mental states that individuals can have on their own can also be properly attributed to groups, including the State.”

¹⁹³ See *supra* text accompanying notes 12-15 for a description of functional and structural infertility.

conduct. Enacted law on the subject of ART access is sparse, but what we can glean from the few existing laws may be instructive. Legal expressions of ART access generally take the form of reducing access to certain individuals, mainly those who are poor and those who are unmarried. The infertile poor do not fare well under our current system of fee-for-service reproductive care for the simple reason that they lack the resources to access infertility treatment. The majority of U.S. states do not require insurance carriers to provide coverage for infertility treatment,¹⁹⁴ and in the handful of states that do mandate coverage, evidence suggests that employer-based insurance providers often exempt key forms of treatment¹⁹⁵ or impose insurmountable co-payment requirements that dissuade utilization.¹⁹⁶ Thus, arguably both enacted and neglected laws on insurance coverage for ART express a negative attitude toward its utilization by those who cannot afford to pay for these expensive services out of pocket.

A second group of enacted laws on ART access limits certain treatments and services to married couples. For example, one particular form of ART – gestational services – is limited to married couples in two states, Florida and Texas. Florida law provides, “A contract for gestational surrogacy shall not be binding and enforceable unless...the commissioning couple are legally married and are both 18 years of age or older.”¹⁹⁷ Presumably this law, and a similar requirement in Texas,¹⁹⁸ would void any surrogacy contract entered into by a single individual or a same sex couple. While access to surrogacy by single and same sex parents is not prohibited, the dubious enforceability of any gestational agreement is a serious deterrent to family formation in this manner by unmarried individuals. In addition to these enacted laws, at least two states have entertained bills that would prohibit physicians from providing assisted conception services to all unmarried individuals.¹⁹⁹

¹⁹⁴ See *supra* note 63.

¹⁹⁵ See, e.g., *Saks v. Franklin Covey*, 117 F. Supp. 2d 318 (S.D.N.Y. 2000), *aff'd*, 316 F.3d 337 (2d Cir. 2003) (employer-based plan that excludes coverage for artificial insemination and IVF upheld as lawful under federal law). In addition to private plans that exclude certain fertility services, some state laws that mandate coverage for infertility do not require coverage for IVF. New York is one such state. See N.Y. Ins. Law §3221 (McKinney 2006).

¹⁹⁶ As for insurmountable co-pays, consider the law in Rhode Island. While insurance providers who offer coverage for pregnancy are required to provide coverage for “medically necessary expenses related to diagnosis and treatment of infertility,” the law further provides “that a subscriber co-payment not to exceed twenty percent (20%) may be required for those programs and/or procedures the sole purpose of which is the treatment of infertility.” R.I. Gen. Law §27-18-30 (West 2006). When a single cycle of IVF can cost up to \$25,000, a co-pay of \$5,000 may be out of reach for many couples.

¹⁹⁷ Fla. Stat. Ann. §742.15(1) (West 2005).

¹⁹⁸ Tex. Code Ann., Family Code §160.754(b) (West 2005).

¹⁹⁹ See *supra* text accompanying notes 107-108 for a discussion of the Indiana and Virginia bills.

Physician conduct expressing negative views toward certain patients may be less apparent in the public sphere, but these stigmatizing attitudes are discernable upon careful inspection. In at least one reported case that is currently pending before the California Supreme Court, a physician group was sued by a former patient for refusing to provide ART on the basis of her sexual orientation.²⁰⁰ This case may be the proverbial “tip of the iceberg” as data suggests discrimination against unmarried and same sex individuals is fairly widespread. In survey data, results show that ART providers are disinclined to provide services to certain individuals on the basis of marital status and sexual orientation. In one recent survey, one in five providers said they were “very or extremely likely to turn away” a single woman, 48% said they would turn away a gay male couple who wanted to use surrogacy, and 53% said they would refuse to assist a single male.²⁰¹ As to racial status, studies reveal that doctors are significantly and substantially more likely to have a variety of negative stereotypes about African American than other patients.²⁰² If these racial views infect the ART field, as there is no reason to believe they don’t, they express negative and stigmatizing attitudes toward minority patients.

Enacted law and physician conduct that limit or reduce access to ART cause expressive harm to prospective patients, to others who share the despised characteristics of the shunned patients, and to the children of both of these groups of adults. Expressive harm is measured by the unwarranted stigma it causes its victim.²⁰³ Stigma, according to Professor Alan Strudler, “is harm, even if not tangible or monetary harm, and harm, particularly wrongful harm, should not be taken lightly.”²⁰⁴ Patients who seek but are denied ART services suffer stigma by being cast out of the core group of human beings that exercise their natural inclination to reproduce. As discussed previously, infertility itself is a stigma²⁰⁵ – one that is surely exacerbated when patients are turned away from treatment. Denying treatment expresses a view that the patient is herself unworthy of parenthood, and therefore unworthy of membership in the human race. If one believes that one’s individual worth can only be validated by the production of offspring – whose mere existence confirm that their progenitor has value – then denying the right to biologic parenthood imposes an irrecoverable stigma.

²⁰⁰ See *North Coast Women’s Care Medical Group v. Superior Court*, 40 Cal. Rptr. 3d 636 (2006), *rev. granted*, 139 P.3d 1, 46 Cal. Rptr. 3d. 605, discussed *supra* in text accompanying notes 99-103.

²⁰¹ See Gurmankin & Caplan, *supra* note 98, at 65.

²⁰² See White & McQuillan, *supra* note 34, at 855.

²⁰³ As Professor Strudler explains, not all stigma is unwarranted. Stigmatizing people who commit crimes, for example, serves a legitimate law enforcement goal. Stigmatizing tortfeasors expresses society’s empathy for victims of wrongdoing. See Strudler, *supra* note 191, at 494-95.

²⁰⁴ *Id.* at 495.

²⁰⁵ See *supra* text accompanying notes 35-36.

Even people who themselves are not denied access to ART can be stigmatized by the expressive harms suffered by rejected patients. For example, a lesbian couple with no desire to procreate may learn of the disappointment suffered by other gay couples in their quest to have a child. Even though the voluntarily childless couple will suffer no measurable consequence from the treatment denial, they may be profoundly affected by the attitude expressed toward their peers. Inevitably, as is human nature, the lesbian couple may internalize their friends' experience as a message about their own worth as human beings. The couple may wonder – if providers are willing to withhold ART services because of their negative attitudes toward gay parents, why would they also not have negative attitudes toward gay people in general? The couple may worry – if gay people are denied access to parenthood, the most basic of human activities, then what is to stop society from denying them all manner of human rights? Living with this worry can be both stigmatizing and stultifying. If the negative attitudes of providers are seen as representative of societal attitudes in general, such worrying is both justified and necessary.

The idea that a person can feel stigmatized from the presence of a single trait or characteristic has been described in the literature expounding the disability rights critique. As explained by Professor Adrienne Asch, a disability rights scholar, when a child has a disability, “a single trait stands in for the whole, the trait obliterates the whole” with “no need to find out about the rest.”²⁰⁶ In the context of disabilities and prenatal testing, detection of a genetic disability often leads to selective abortion because the parents view the fetus only in terms of the disability, paying no regard to the myriad other qualities of the potential child. The parent sees the prospective child only as the disability, and this single trait enables the parents to justify their action. The abortion is ridding society of the disability – not of a child who, despite or possibly because of the disability, could lead a productive and happy life.

This sequence of events – prenatal diagnosis followed by selective abortion – sends a message, i.e., “expresses”, that disability itself, not societal discrimination against people with disabilities, is the problem to be solved.²⁰⁷ Why is disability itself a problem? The disability rights critique argues that disability is seen as a problem not to the disabled person (whose main problem is the attitudes of others toward disability), but rather as a diminishment to the parental experience. Having a disabled child, prospective parents worry, will rob them of their anticipated rearing experience. Thus, aborting a disabled child is a way of preserving and upholding parental notions about the role that reproduction will play in their lives.²⁰⁸

²⁰⁶ See Erik Parens and Adrienne Asch, *PRENATAL TESTING AND DISABILITY RIGHTS* 13 (2000).

²⁰⁷ *Id.*

²⁰⁸ *Id.* Professors Asch and Parens lament this parental view as “unfortunate, often misinformed” because they overestimate the negative aspects and underestimate the value and satisfaction of parenting a disabled child.

With very little modification, the disability rights critique of prenatal diagnosis can be applied to selection against nontraditional patients seeking assistance in reproduction. The notion that a single trait obliterates the whole is certainly the case when ART treatment denials are based on the marital status or sexual orientation of the patient. Instead of being seen as a person who can provide a loving and nurturing environment for a child, as is the case in innumerable gay and single households, the prospective patient is viewed as “unmarried” or “gay,” and this characteristic obliterates any evidence of parental fitness. Instead of trying to address societal discrimination against single or same sex parents, permissive ART treatment denials reinforce such attitudes by expressing approval for suppression of nontraditional parenthood.

The expressivist argument that treatment denials harm all who share the despised trait seems weighty and valid in the context of assisted conception: denying procreation to single and same sex individuals signals that nontraditional parenthood is a problem to be solved, not understood and accommodated, because of the threat it poses to society as a whole. Just as a child's disability is viewed as a diminishment to the parental experience, the offspring of nontraditional parents are viewed as a diminishment of a certain persistent myth in contemporary society – the myth that only married couples can bring joy into the life of a child. Purposefully withholding the means to reproduce sends a message to would-be parents, to existing children of nontraditional parents and to society at large that unmarried individuals, and by extension their offspring, lack value in today's world.

Allowing such antiquated and outright inaccurate expressions of parental fitness seems to serve no current legitimate societal purpose. As birth by single women and same sex couples continues to climb, discrimination against nontraditional parenthood will only serve to highlight the negative attitudes of those who wield control over assisted conception. Whether these individuals are ART providers who are privileged by the State to practice reproductive medicine, lawmakers who are privileged by the people to represent their best interests, or judges who are privileged by the judicial system to evaluate the merits of alleged public and private wrongdoing, neither the government nor society as a whole should tolerate negative expressive acts because of the stigma they involve. Permitting one group to be stigmatized only invites tolerance for future stigma against others. Besides, as history proves, what is seen as a legitimate basis for stigma at one moment in time, reveals itself to be totally unfounded a brief moment later. The current debate over access to ART would be well-served by looking to a prior era when procreation suppression was seen as a boon to the betterment of society. That boon – the eugenics movement – was founded on some of the same ideals that motivate current treatment denials, and thus may be useful in shaping our current thinking on who should and who should not have access to assisted conception.

2. REVISITING OUR EUGENICS PAST

The regulation of reproduction in this country is often haunted by the specter of the American eugenics movement, a groundswell for improvements in human nature through selective

breeding that gained support during the dawn of the 20th century. Coined in the 1880s by Francis Galton, a Victorian aristocrat and nephew of Charles Darwin, the term “eugenics” originates from the Greek word “eugenes,” meaning good in birth. Galton and his colleagues harnessed the growing enthusiasm over the infant, yet burgeoning field of genetics to advance the concept of controlled human reproduction. Eugenacists believed that most social problems were caused by hereditary faults of those afflicted by the problem, and they sought to eventually eliminate these problems from society through selective breeding.

One of the chosen methods for “improving” the human future was a series of compulsory sterilization laws, eventually enacted in more than 30 U.S. states.²⁰⁹ The laws were broadly drawn, applying to a host of human characteristics, including insanity, criminality, chronic illness, blindness, deafness, physical disability, feeble-mindedness, and homelessness.²¹⁰ No doubt the strongest sign of judicial support for state-sponsored selective breeding came in the 1927 Supreme Court decision, *Buck v. Bell*.²¹¹ Writing for the majority, Justice Oliver Wendell Holmes Jr. upheld a Virginia law permitting sterilization of “mental defectives” in order to promote “the welfare of society.”²¹² In language that what would (hopefully) strike the modern ear as extraordinarily offensive and wrong, Justice Holmes condones, even celebrates the law, saying “[i]t is better for all the world, if...society can prevent those who are manifestly unfit from continuing their kind.”²¹³

At issue in the case was an order to sterilize eighteen year-old Carrie Buck, described as “a feeble-minded white woman.”²¹⁴ Carrie and her mother were committed to the State Colony for Epileptics and Feeble Minded, the former because she was “the mother of an illegitimate

²⁰⁹ See Lisa Powell, *Eugenics and Equality: Does the Constitution Allow Policies Designed to Discourage Reproduction Among Disfavored Groups?*, 20 YALE LAW & POLICY REV. 481, 483 (2002), citing Harry Laughlin, *Model Eugenical Sterilization Law*, in EUGENICAL STERILIZATION IN THE UNITED STATES, A REPORT OF THE PSYCHOPATHIC LABORATORY OF THE MUNICIPAL COURT OF CHICAGO 445, 447 (1922). Though no such laws remain in force today, during their reign tens of thousands of Americans were involuntarily sterilized by state mandate. Between 1900 and 1963, at least 60,000 Americans were sterilized pursuant to eugenic sterilization laws. In response to a lawsuit, in 1974 the federal government adopted regulations banning sterilization without consent in hospitals that receive federal funds, but reports of violations surface periodically.

²¹⁰ *Id.* This list of forced sterilization candidates also included drug addicts, orphans, ne'er do wells, tramps and paupers.

²¹¹ 274 U.S. 200 (1927).

²¹² *Id.* at 207.

²¹³ *Id.*

²¹⁴ *Id.* at 205.

feeble-minded child.”²¹⁵ For this, Justice Holmes validated the sterilization order, decreeing “[t]hree generations of imbeciles are enough.”²¹⁶ As it turns out, neither Carrie Buck nor her daughter, Vivian, were “feeble-minded.” Carrier’s sole transgression was being the victim of a rape that left her pregnant by a relative of her foster parents, and records show Vivian was an honor roll student in her school years.²¹⁷

The Court’s assurance that ending the Buck line was in the best interest of society was as misguided and unfounded then as denying single and same sex parenthood is today. Permitting those with the power to prevent procreation to do so in a way that elevates their personal animus to a level of officialdom is dangerously reminiscent of the forsaken eugenics practice of a bygone era. We were wrong then to allow certain human conduct to justify forced sterilization, and we are wrong today to connect a certain social status with harm to offspring and society.

This legacy of state control over procreation has perhaps forever cloaked the term “eugenics” in negative, even loathsome, connotations. Though its literal definition – well born – does evoke a positive, the term’s association with coercive, highly intrusive, life-altering measures casts doubt that contemporary use of the word eugenics can signify anything good.²¹⁸ In fact, the word has crept into the modern critique of ART, in the context of emerging technologies that enable parents to control the health of their offspring through prenatal testing and embryo selection. Recent commentators have resurrected the negative view of eugenics to caution against widespread and unfettered availability of ART, particular techniques that reveal the genetic health of the early embryo or growing fetus. As Professor Michael Malinowski warns:

Contemporary genetic medicine promises to add scientific substance and practicality to what eugenicists set out to accomplish at the outset of the 20th century – improve the human condition through genetic selection. Given the now dominant ethos of autonomy and self-determination in medicine, which is underscored by the libertarian elements of United States culture, there is meaningful assurance that eugenics will not be imposed by a government body in the United States. However, we must at least recognize the danger that through ART, the genetics revolution, and *carte blanche* procreative liberty we could do unto ourselves via the collective impact of individual decision-making what

²¹⁵ *Id.*

²¹⁶ *Id.* at 207.

²¹⁷ See Paul Lombardo, *Facing Carrier Buck*, 33 HASTINGS CENTER REP. 14 (2003) (displaying photographs of all three generations of buck women).

²¹⁸ *But see* Mahowald, *supra* note 190, explaining that eugenics can connote a positive, such as when women take positive steps to ensure the health of their offspring by, for example, eating well during pregnancy and adhering to doctor’s orders regarding exercise and vitamin intake. Taking steps to ensure the health of offspring – to improve the human race – is engaging in good eugenics.

governments have imposed in the past in the name of bettering the human condition.²¹⁹

Professor Malinowski points out that today's eugenics arise as a matter of private choice, rather than the public regulation that sanctioned controlled reproduction a century ago. Nevertheless, he and other commentators maintain that the evils of eugenics arise not out of the source espousing a desire for human improvement (public law v. private choice), but out of coercion. What makes eugenics morally objectionable is its association with coercion.²²⁰ Whether the coercion is instituted by state actors who handcuff and dissect the ill-bred so they cannot reproduce, or, as some argue, the ethos of society that overvalues perfection and subtly encourages women to avoid and abort a differently-abled child,²²¹ the lack of free will is at the core of negative eugenics. When a person lacks the free will to decide whether or not to reproduce, a great harm is done to the individual and to society.

Are the barriers to ART access discussed herein – cost, race, ethnicity, marital status, domicile-specific restrictions – a form of modern day eugenics? True enough, none of these barriers coerce individuals to surrender their reproductive capacity or refrain from reproducing should the ability to do so arise. But isn't the deprivation of reproductive opportunity just as coercive as any formal, explicit directive to forgo offspring? While "coercion implies the presence of formal, legal barriers to choice; to others, practical impediments such as economic costs and social pressures function coercively."²²² The coercive eugenic nature of ART barriers come into sharp focus upon inspection of the individuals whose access to assisted conception is most suppressed – poor, minority, unmarried individuals who historically lack political and economic power. These are the very individuals, who like their early 20th century counterparts, are not terribly welcome in a society that measures human improvement by its ability to coalesce around a set of homogeneous characteristics. Introducing difference into the mix is viewed as interfering with the steady march toward human betterment.

A system need not literally castrate or ligate in order to be deemed eugenic. While ART has evoked concerns of eugenics because it empowers parents to select against what they perceive as a defective child, too little attention has been paid to the more worrisome practices

²¹⁹ Michael J. Malinowski, *Choosing the Genetic Makeup of Children: Our Eugenics Past–Present, and Future?*, 36 Conn. L. Rev. 125, 204 (2003).

²²⁰ "[W]hat people object to in eugenics is not the goal, such as improving the health of the population, but the means employed to achieve it." Mahowald, *supra* note 190, at 223-24, quoting Diane B. Paul, *Eugenics, Anxieties, Social Realities, and Political Choices*, in ARE GENES US? THE SOCIAL CONSEQUENCES OF THE NEW GENETICS 142, 143045 (Carl. F. Cranor ed., 1994).

²²¹ See, e.g., Barbara Rothschild, *THE DREAM OF THE PERFECT CHILD* (2005) (arguing rapid advances in prenatal testing has engendered a culture of discrimination against those with disabilities and pressured women to abort pregnancies when any defect is detected).

²²² Mahowald, *supra* note 190, at 224.

that deny reproductive opportunities to the most vulnerable among us.²²³ Unlike the eugenic laws at issue before the Supreme Court in *Skinner v. Oklahoma* or *Buck v. Bell*, today's version of reproductive deprivation is a patchwork of mostly informal policies quietly practiced by insurance companies, ART providers and select lawmakers whose activities threaten to institutionalize discrimination against nontraditional parents. So long as ART remains an exclusively private good that is largely inaccessible to the least well-off among us, a good capable of being withheld without legal consequence, birth by assisted conception will take on a eugenic quality that rivals the goals of the early movement – repression of breeding by those deemed unworthy of dynastic participation in the human race.

V. CONCLUSION

The constitutional jurisprudence surrounding assisted conception is only beginning to take shape, guided by little more than a generalized notion that the state's interest in preventing or forcing procreation pales in comparison to the individual's fundamental right to decide whether to bear or beget a child. When conception occurs naturally, both positive and negative rights surrounding procreation are fairly clear, but grow murky as the reproductive process invites third parties to assist. As methods of assisted conception show increasing technical promise for those whose bodies or social structures require they look to ART for family formation, worrying trends suggest that public and private actors are quietly mounting status-based barriers to fertility treatment. Barriers to ART are taking shape on the basis of patient characteristics including wealth status, race, ethnicity, and marital status, all under the guise of preventing harm to offspring and society at large. But judgments by ART providers and public lawmakers that certain individuals will be unfit parents veers dangerously close to the coercive eugenics practices of early 20th century America, an era whose only positive legacy is the extreme caution with which we now approach state-sponsored limitations on reproduction.

Like a pentimento, ART barriers are only beginning to come into view from the experiences of an increasingly diverse and nontraditional reproductive medicine patient population. As each barrier emerges – whether it be a provider refusing treatment to a single or same sex prospective parent, or a lawmaker attempting to limit the availability of a reproductive technology for reasons unrelated to human health – it is essential to evaluate these actions by the same standards we would evaluate barriers to natural conception. Ameliorative measures, including broader health insurance coverage for fertility treatment and antidiscrimination statutes tailor-made to address ART denials based on personal characteristics, offer the prospect of

²²³ This statement is in no way intended to dismiss or downplay the very real concerns that arise from preconception and prenatal diagnosis, especially as those techniques are applied to gender selection and deselection of embryos with genetic abnormalities. For a recent critique, see Kimberly Kristin Downing, *A Feminist Is A Person Who Answers "Yes" to the Question, "Are Women Human?": An Argument Against the Use of Preimplantation Genetic Diagnosis for Gender Selection*, 8 DEPAUL J. HEALTH CARE L. 431 (2005).

increased access and reduced discrimination in the provision of ART services. State-sponsored or state-approved limitations on any individual's right to procreate simply cannot stand in a society that acknowledges the preeminence of reproductive freedom. Justice Douglas' self-evident observation that reproduction is a basic human right is as durable and universal as the human race – it simply must be nurtured in order to continue to thrive.