WELCOME TO THE WILD WEST: PROTECTING ACCESS TO CROSS BORDER FERTILITY CARE IN THE UNITED STATES

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As has been the case with other types of medical tourism, the phenomenon of cross border fertility care ("CBFC") has sparked concern about the lack of global or even national harmonization in the regulation of the fertility industry. The diversity of laws around the globe leads would-be parents to forum shop for a welcoming place to make babies. Focusing specifically on the phenomenon of travel to the United States, this Article takes up the question of whether there should be any legal barriers to those who come to the United States seeking CBFC. In part, CBFC suffers from the same general concerns raised about the use of fertility treatment in general, but it is possible to imagine a subset of arguments that would lead to forbidding or at least discouraging people from coming to the United States for CBFC, either as a matter of law or policy. This paper stands in opposition to any such effort and contemplates the moral and ethical concerns about CBFC and how, and if, those concerns warrant expression in law.

Part I describes the conditions that lead some couples and individuals to leave their home countries to access fertility treatments abroad and details why the United States, with its comparatively liberal regulation of ART, has become a popular CBFC destination for travelers from around the world. Part II offers and refutes arguments supporting greater domestic control over those who seek to satisfy their desires for CBFC in the United States by reasserting the importance of the right of procreation while also noting appropriate concerns about justice and equality in the market for babies. Part III continues the exploration of justice by investigating the question of international cooperation in legislating against perceived wrongs. This Part concludes that consistent

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legislation across borders is appropriate where there is consensus about the wrong of an act, but it is unnecessary and inappropriate where there remain cultural conflicts about certain practices—in this case assisted reproduction.

INTRODUCTION

What do the son of a Hong Kong-based billionaire[1] and a British couple desperate to save their child's life have in common?[2] While it sounds like the start of a very odd joke, the link between these people is

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[1] Peter Lee, the 47-year-old unmarried son of a Hong Kong billionaire, garnered press attention when he announced the arrival of triplets reportedly born to a surrogate mother in California. Cathy Yan, *Maternal Mystery: Babies Bring Joy, and Questions, in Hong Kong*, WALL ST. J. (Dec. 14, 2010), *available at* http://online.wsj.com/article/SB10001424052748703471904576002913040745224.html. Hong Kong made surrogacy illegal in 2000 when it passed the Human Reproductive Technology Ordinance. *Id.*

[2] *See Charlie Whitaker Cured by 'Saviour Sibling'*, BIONEWS (Aug. 22, 2005), http://www.bionews.org.uk/page_12478.asp [hereinafter *Whitaker*]. In 2004, in the United Kingdom, Charlie Whitaker's family sought permission from the Human Fertilization and Embryology Association (HFEA), the British authority that regulates the use of assisted reproductive technology (ART), to use pre-implantation genetic diagnosis (PGD) to create a savior sibling. *See id.* At the time of their request, Charlie was in desperate need of a bone marrow transplant, but no living donor could be found for him. *See id.* His parents wanted to screen embryos for donor compatibility with Charlie so that they could use their new child's umbilical cord blood stem cells to save Charlie's life. *See id.* The HFEA turned down their request and the family travelled to the United States for treatment where they successfully used PGD to give birth to a child who was a perfect donor for Charlie. *See id.*; *see also How is PTT Regulated in the United Kingdom?*, HUM. FERTILISATION & EMBRYOLOGY AUTH., http://www.hfea.gov.uk/5932.html (last visited Oct. 21, 2011) [hereinafter *PTT Regulated*] (discussing the United Kingdom's decision to allow preimplantation tissue typing as of 2008).

that they successfully sought cross-border fertility care (CBFC).[3] CBFC refers to individuals who travel from their home countries to access assisted reproductive technology (ART) to facilitate the process of creating a pregnancy where coital reproduction has failed or is otherwise not an option.[4] Such travel has become more popular and more possible in a world of increasing infertility and ever-advancing techniques that allow the infertile to have biologically or genetically related children.[5]

Along with creating babies for people who want them, ART brings substantial ethical anxieties that spark deep and wide-ranging discussion about appropriate regulation and use of such technology. Coupled with the disquiet attendant to globalization, the fact that some people, given the means, will leave their home countries to take advantage of such technologies—especially when they do so in order to make use of technology in a way that is forbidden by the laws of the home country—ignites debate about procreation, exploitation, commodification, and even the relationships between and among nations.

In light of concerns that some have raised about the lack of global or even national harmonization in ART regulation that leads to forum shopping for a welcoming place to make babies, this Article takes up the question of whether there should be any legal barriers to those who come to the United States seeking CBFC. This Article refers to this group as reproductive travelers to distinguish them from individuals who are native users of the technology.[6] While the phenomenon of CBFC cannot resist being swallowed by general debates about ART, especially in the United States where the lack of strong or consistent regulation of the

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3 This Article borrows this term from individuals working outside the legal arena. *See, e.g.*, Karl Nygren et al., *Cross-Border Fertility Care—International Committee Monitoring Assisted Reproductive Technologies Global Survey: 2006 Data and Estimates*, 94 FERTILITY & STERILITY e4, e4 (June 2010). Many commentators use the term reproductive tourism to refer to such travel. As Dr. Guido Pennings explains, however, "[t]ourism mainly refers to travelling for recreational reasons. Indirectly, this connotation devalues the desire motivating the journey; it implies that the fertility tourist goes abroad to look for something exotic and strange." Guido Pennings, *Reproductive Tourism as Moral Pluralism in Motion*, 28 J. MED. ETHICS 337, 337 (2002) [hereinafter Pennings, *Reproductive Tourism*]. I think it inappropriate to perpetuate the use of a term that may belittle those to whom it is applied, even if that is not the intent of the individual employing the phrase. Therefore, I embrace the term cross border fertility care as used by other scholars. *See id.*

4 *See* Nygren et al., *supra* note 3, at e4.

5 Silvia Spring, *The Trade in Fertility*, THE DAILY BEAST (Apr. 11, 2006, 8:00 PM), http://www.thedailybeast.com/newsweek/2006/04/11/the-trade-in-fertility.html (noting a "burgeoning fertility tourism trade" to developing nations fueled by "[c]heaper prices, high-quality health care and the availability of donor eggs and surrogates.").

6 For ease of discussion, this Article distinguishes reproductive travelers from native users. The term native user is only a way to indicate a category of users who are already in the United States as contrasted with people who travel to the United States to use reproductive technology. I do not use these designations as a way of delineating the worth of any particular user or to signal a preference for one group over another.

fertility industry leads to much consternation,[7] it is possible to imagine a subset of arguments that would lead to forbidding or at least discouraging people from coming to the United States for CBFC, either as a matter of law or policy. This Article opposes any such effort and contemplates various moral and ethical concerns about CBFC and how, and if, those concerns warrant expression in law.

Part I describes the conditions that lead some couples and individuals to leave their home countries to access fertility treatments abroad and details why the United States, with its comparatively liberal set of ART regulations, has become a popular CBFC destination for travelers from around the world. Part II offers and refutes arguments supporting greater domestic control over those who seek to satisfy their desires for CBFC in the United States by reasserting the importance of the right of procreation while also noting appropriate concerns about justice and equality in the market for babies. Part III continues the exploration of justice by investigating the question of international cooperation in legislating against perceived wrongs. This Part concludes that consistent legislation across borders is appropriate where there is consensus about the wrong of an act, but it is unnecessary and inappropriate where there remain cultural conflicts about certain practices—in this case, assisted reproduction.

I. WHY DO PEOPLE TRAVEL? MAKING BABIES IN THE U.S.A.

"The ethics of [reproductive] exile suggest that both justice and compassion are necessary to assure individual autonomy and respect in the maintenance of reproductive rights."[8]

While it is clear that many people travel for CBFC,[9] why people make these pilgrimages is a separate question from whether any government or society should support or discourage citizens who make these

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[7] *See, e.g.*, NAOMI R. CAHN, TEST TUBE FAMILIES: WHY THE FERTILITY MARKET NEEDS LEGAL REGULATION 2–3 (2009) (discussing the need to use an ethical approach to create laws regulating assisted reproduction that respect human dignity and suggesting various ways in which the fertility industry should be regulated to respond to concerns about possible harms, especially to children); Michele Bratcher Goodwin, *Baby Markets*, *in* BABY MARKETS: MONEY AND THE NEW POLITICS OF CREATING FAMILIES 2, 2 (Michele Bratcher Goodwin ed., 2010) (anthology of essays in which authors discuss the complicated nature of economic transactions that result in the creation of children and families); June Carbone, *Who Decides What Number of Children Is "Right"?*, 104 Nw. U. L. REV. 109, 109 (2009) (raising issues about whether it is appropriate to legally regulate the number of embryos used in an IVF cycle).

[8] Marcia C. Inhorn & Pasquale Patrizio, *Rethinking Reproductive "Tourism" as Reproductive "Exile,"* 92 FERTILITY & STERILITY 904, 906 (2009).

[9] *See, e.g.*, Nygren et al., *supra* note 3, at e5 ("As in the past, at present people who believe that they do not have access to the kind of treatment they need, or rather a proportion of such people (with a different proportion in different settings), cross borders to search for it. It is expected that all countries will experience some level of CBFC."); *see also*, Guido Pennings et al., *ESHRE Task Force on Ethics and Law 15: Cross-border Reproductive Care*, 23

trips. This Part addresses the easier of the two questions—the "why" question.

People use ART because they desire to have children but either cannot or opt not to do so through coital reproduction.[10] They travel for ART often because the intricacies of local regulation and local custom make travel necessary or desirable even when ART is available in the home country.[11] The vastness of the fertility industry reflects the substantial number of people around the globe who experience difficulty in their attempts to become pregnant through coital reproduction.[12] Medical infertility[13] is a global phenomenon with a worldwide estimate of 9% prevalence for current infertility and 16% prevalence for lifetime infertility in couples in fertile age groups.[14] Millions of people qualify as infertile under the medical definition of that term.[15] Infertility, however, need not be confined to its medical definition. Some individuals use ART not

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HUM. REPROD. 2182, 2182 (2008) [hereinafter Pennings et al., *ESHRE*] ("Cross-border medical care is a growing phenomenon.").

10 *See, e.g.*, MARGARET MARSH AND WANDA RONNER, THE EMPTY CRADLE: INFERTILITY IN AMERICA FROM COLONIAL TIMES TO THE PRESENT 2 (1996) (describing the increasing turn to fertility treatment as a response to the inability to reproduce); Karen Sermon et al., *Review: Preimplantation Genetic Diagnosis*, 363 LANCET 1633, 1633 (2004) (describing the use of IVF and preimplantation genetic diagnosis to avoid genetic disease in future children).

11 See I. Glenn Cohen, *Circumvention Tourism*, 97 CORNELL L. REV. 1309, 1323 (2012) (describing the vast array of limitations on the uses of assisted reproduction, including surrogacy, around the globe). It is the case that "[m]odern diagnostic and treatment services are available in most countries." Nygren et al., *supra* note 3, at e5. For instance, India has created a booming business in surrogacy by providing access to a service that can be prohibitively costly in other parts of the world or banned altogether. *See, e.g.*, Rina Chandran, *Poverty Makes Surrogates of Indian Women in Gujarat*, REUTERS (Apr. 8, 2009, 12:47 PM), http://www.reuters.com/article/2009/04/08/us-india-surrogate-idUSBOM15745200904 08.

12 *See* Abdallah S. Daar & Zara Merali, *Infertility and Social Suffering: The Case of ART in Developing Countries*, *in* CURRENT PRACTICES AND CONTROVERSIES IN ASSISTED REPRODUCTION: REPORT OF A MEETING ON "MEDICAL, ETHICAL AND SOCIAL ASPECTS OF ASSISTED REPRODUCTION" HELD AT WHO HEADQUARTERS IN GENEVA, SWITZERLAND 17-21 SEPTEMBER 2001, at 15 (Effy Vayena et al. eds., 2002). Historically, infertility was viewed "as sent by the Gods, possibly as punishment, or representing a personal fate, or just bad luck . . . . Infertility is today regarded as a global public health issue." Nygren et al., *supra* note 3, at e4. As such, there is increasing attention paid to the fertility gap, meaning the disproportionate impact of infertility in some communities along with increased concern about the steps that people will take to circumvent their own fertility challenges. Daar & Merali, *supra*, at 15–16.

13 Medical infertility generally refers to a failure to achieve pregnancy after a year of unprotected heterosexual intercourse. *Infertility FAQs*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/reproductivehealth/Infertility/index.htm (last visited Apr. 10, 2011). A person over the age of 35 will be labeled infertile if pregnancy is not achieved after six months of unprotected sexual intercourse. *Id.* Being able to get pregnant without being able to carry that pregnancy to term is also a form of infertility. *Id.* This Article uses the term medical infertility to distinguish from other circumstances in which a person or couple might want or need to access ART for reasons other than inability to achieve pregnancy without medical assistance.

14 Nygren et al., *supra* note 3, at e5.

15 *See* Jacky Boivin, et al., *International Estimates of Infertility Prevalence and Treatment-Seeking: Potential Need and Demand for Infertility Medical Care*, 22 HUM. REPROD.

because they are physically incapable of either becoming pregnant or creating a pregnancy through coital reproduction, but because of social or other factors that stand as obstacles to procreating.[16] People who fall into this category of social or situational infertility are in same-sex relationships, single, or harbor genes for disease or disability that they do not wish to pass on to their children.[17] While the socially or situationally infertile may not comprise the largest segment of those who use ART in general,[18] they are an important segment of reproductive travelers.

1506, 1510 (2007). One study found that on a global scale 72.4 million people are currently infertile and that approximately 40.5 million are seeking infertility treatment. *Id.*

16 There are many ways that people have articulated infertility as a non-medical phenomenon. One term for this category of people is "social factor infertility." Connie Shapiro, *No Heterosexual Partner? It's* Called "Social Factor Infertility," PSYCHOL. TODAY (Mar. 4, 2010), http://www.psychologytoday.com/blog/when-youre-not-expecting/201003/no-heterosexual-partner-its-called-social-factor-infertility. Others use the term to describe individuals who are medically fertile, but who may still find cause to use ART in order to become pregnant. *See, e.g.*, LAURA MAMO, QUEERING REPRODUCTION: ACHIEVING PREGNANCY IN THE AGE OF TECHNOSCIENCE 2 (2007) (describing a lesbian using ART to become pregnant as having a "social" rather than medical problem). Lisa Ikemoto uses the term dysfertile to describe the dysfunction that the discourse on infertility attributes to gay men and lesbians who use ART to procreate. Lisa C. Ikemoto, *The In/Fertile, the Too Fertile, and the Dysfertile*, 47 HASTINGS L.J. 1007, 1009 (1996).

17 Adrienne Asch & Rebecca Marmor, *Assisted Reproduction*, *in* FROM BIRTH TO DEATH AND BENCH TO CLINIC: THE HASTINGS CENTER BIOETHICS BRIEFING BOOK FOR JOURNALISTS, POLICYMAKERS, AND CAMPAIGNS 5, 7 (Mary Crowley ed., 2008) (noting that "ARTs are increasingly sought by those who cannot reproduce using only their own genetic and biological capacities. Heterosexual and same-sex couples and single women and men who seek to have biologically connected children frequently turn to clinics and agencies for 'donors' who provide sperm, eggs, or gestational services, usually for a fee."). *See also*, LIZA MUNDY, EVERYTHING CONCEIVABLE: HOW ASSISTED REPRODUCTION IS CHANGING OUR WORLD 11 (2007) [hereinafter MUNDY, EVERYTHING CONCEIVABLE] ("Single mothers, lesbians, and gay men are among the fastest-growing groups of assisted reproductive technology patients."). Mundy also notes that another group of ART patients are those who "suffer from, or carry a gene for, a genetic disease such as cystic fibrosis, Huntington's disease, hemophilia, Tay-Sachs disease, or even a propensity for certain adult-onset cancers, and who want to use IVF, combined with genetic testing, to create children who are unafflicted." *Id.*

18 Making claims about who does and does not use assisted reproduction can be difficult because robust data on the demographics of the market is not always widely available. It is certainly the case that there are fertility brokers who not only serve large numbers of gay and lesbian clients, but who also cater to that market, as evidenced by the existence of Rainbow Flag Health Services which actively recruits gay and bisexual men as donors and which caters to the lesbian and gay community as fertility clients. *See* RAINBOW FLAG HEALTH SERVICES, http://gayspermbank.com/ (last visited Oct. 21, 2012); *see also*, MUNDY, EVERYTHING CONCEIVABLE *supra* note 17, at 129 (noting that in Los Angeles there are fertility practices that cater to gay men). Similarly, advances in male infertility treatment have increased the percentage of women who use sperm-banks, especially lesbians, making the market for sperm largely dependent on women. *Id.* at 115 (noting that women had become 60% of sperm bank users). Even so, the fertility industry is largely geared towards those who are medically infertile, and the National Survey of Family Growth (NSFG), estimated in 2002 that "7.3 million American women aged 15–44 years had impaired fecundity (i.e., experienced difficulties conceiving or bringing a pregnancy to term during their lifetime)" and that "[t]wo million couples in the United States were infertile (i.e., had not conceived during the previous 12 months despite trying)." *A Public Health Focus on Infertility Prevention, Detection, and Management*,

As an offshoot of the more widely reported phenomenon of medical travel or tourism,[19] CBFC shares with that broader phenomenon a lack of good data about who travels, where they travel, and what services they receive, among other useful information.[20] This dearth of information exists for a variety of reasons including reluctance on the part of those engaging in such travel to share information about their quest.[21] Solid numbers notwithstanding, "most of the experts who analyse [sic] the phenomenon . . . agree that cross-border reproductive care will continue to increase in the coming years."[22]

The reasons for reproductive travel can vary, but those reasons tend to coalesce around some common themes illustrated by the following hypothetical scenarios:

CENTER FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/reproductivehealth/Infertility/Whitepaper-PG2.htm (last visited October 19, 2012).

19 *See* Diane York, *Medical Tourism: The Trend Toward Outsourcing Medical Procedures to Foreign Countries*, 28 J. CONTINUING EDUC. HEALTH PROFS. 99, 99 (2008) (describing the phenomenon of medical travel); Michael D. Horowitz et al., *Medical Tourism: Globalization of the Healthcare Marketplace*, 9 MEDSCAPE GENERAL MED. 33, 33–34 (2007).

20 *See* L. Culley, *et al.*, *Crossing Borders for Fertility Treatment: Motivations, Destinations and Outcomes of UK Fertility Travelers*, 26 HUM. REPROD. 2373, 2373 (2011) (citations omitted). As the study notes in reference to fertility travel, "there has been little systematic study of this apparently growing phenomenon. Therefore, while there is evidence of cross-border fertility treatment occurring in many countries across the globe, there are few robust data on incidence." *Id.* Popular media sometimes refers to this phenomenon as fertility tourism. These terms for the phenomenon of traveling to receive fertility treatment have been criticized as trivializing the phenomenon and its origins given that many patients who travel for fertility care make "considerable sacrifices of resources and emotion in the hope to become parents." Bernard M. Dickens, *Legal Developments in Assisted Reproduction*, 101 INT'L J. GYNECOLOGY & OBSTETRICS 211, 214 (2008). Dickens continues, "commitment to this goal [of becoming parents] warrants . . . respect due to other patients seeking to overcome disability, without discrimination in health service professional access or attitude." *Id.* This Article eschews that term because the notion of tourism suggests something flippant or fanciful, which is inappropriate in the context of seeking serious medical care. As Dr. Guido Pennings explains, "[t]ourism mainly refers to travelling for recreational reasons. Indirectly, this connotation devalues the desire motivating the journey: it implies that the fertility tourist goes abroad to look for something exotic and strange." Pennings, *Reproductive Tourism*, *supra* note 3, at 337. Others have suggested the use of the term reproductive exile, rather than reproductive tourism, as exile more accurately describes the sense that those seeking CBFC may feel "'forced' to leave their home countries to access safe, effective, affordable, and legal infertility care." Inhorn & Patrizio, *supra* note 8, at 905. Some criticize the use of the word exile because it connotes punishment, which may sometimes be an accurate description of the forces that drive people from their home countries, but not always. *See* Guido Pennings, Letters to the Editor, *Reply: Reproductive Exile Versus Reproductive Tourism*, 20 HUM. REPROD. 3571, 3571 (2005). I sympathize with these concerns and think it inappropriate to perpetuate the use of a term that has the potential to belittle those to whom it is applied, even if that is not the intent of the individual employing the phrase.

21 *See* Anna Pia Ferraretti et al., *Cross-border Reproductive Care: A Phenomenon Expressing the Controversial Aspects of Reproductive Technologies*, 20 REPROD. BIOMEDICINE ONLINE 261, 263 (2010).

22 *Id.* at 265.

Scenario 1: A 62-year-old post-menopausal British woman comes to the United States with the goal of being inseminated with the sperm of her now deceased brother who, for reasons only the two of them understand, left the frozen sperm to her in his will with the request that she use it to become pregnant and bear a child.[23]

Scenario 2: A legally married lesbian couple from Canada comes to the United States to purchase and use sperm from a United States-based cryobank because they want access to sperm from a seller who will remain anonymous.

Scenario 3: A single man from France comes to the United States to purchase an egg that he will fertilize with his sperm and then implant in a gestational carrier in California, to whom he will pay a fee of $15,000 in exchange for her reproductive labor.

Scenario 4: A married Italian couple, both of whom are otherwise fertile, travels to the United States for in vitro fertilization (IVF)[24] coupled with pre-implantation genetic diagnosis (PGD),[25] which will allow them to transfer only female embryos and avoid the risk of passing on a sex-linked disease.[26]

Scenario 5: A couple from India travels to the United States to use PGD in conjunction with IVF to screen for male embryos in order to effectuate a cultural and personal preference for sons.

All of the individuals described in the preceding scenarios might be compelled or obliged to travel abroad to achieve their desires because they cannot be pursued legally in their countries of origin. The laws on ART on a global scale are varied and range from the very restrictive to slightly restrictive, though there are few countries with an active ART industry that could accurately be called highly permissive whereby all

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[23] It is possibly apocryphal, but one scholar references a story about a 62-year-old French woman who came to the United States seeking a fertility specialist who would inseminate her with her brother's sperm. Pennings, *Reproductive Tourism*, *supra* note 3, at 337. Of course, given that a 62-year-old woman is almost certainly post-menopausal, a true attempt to get pregnant would require the use of eggs from a much younger woman coupled with in vitro fertilization.

[24] In vitro fertilization (IVF) is a technique that involves fertilizing ova outside of the body and then transferring the fertilized ova to the uterus of a woman who is a willing carrier. *See* AM. SOC'Y FOR REPROD. MED., ASSISTED REPRODUCTIVE TECHNOLOGY: A GUIDE FOR PATIENTS 4 (2011), *available at* http://www.sart.org/uploadedFiles/ASRM_Content/Resources/Patient_Resources/Fact_Sheets_and_Info_Booklets/ART.pdf. That woman might intend to parent the child to whom she will give birth, but she might also be a surrogate.

[25] *See* Sermon et al., *supra* note 10, at 1633.

[26] "X-linked diseases are single gene disorders that reflect the presence of defective genes on the X chromosome." *See* Richard Twyman, *X-linked Diseases: Single Gene Disorders Caused by Defective Gene on the X Chromosome*, WELLCOME TRUST (Apr. 16, 2003), http://genome.wellcome.ac.uk/doc_wtd020851.html.

reproductive desires can be satisfied.[27] On the list of the most banned procedures on a global scale are "surrogacy, social sex selection, gamete donation, preimplantation genetic diagnosis (PGD) and screening (PGS)."[28] Thus, as described in more detail below, one reason for travel is that a specific service has been banned in a traveler's home country.

Legality of specific uses of technology aside, a broad systemic driver of CBFC is discrimination. Some individuals or couples travel to the United States to access fertility care that is available in their country of origin, but to which local laws deny them access as a form of invidious discrimination. For instance, in some countries where ART is otherwise available, perhaps even widely available, access to the technology is denied to same sex couples, single gay people, or couples who are casually cohabitating.[29] Often these restrictions are based on perceptions about what is in the best interest of a child and go hand-in-hand with systems that treat the use of ART as akin to adoption.[30] In these regimes, any interest or right a person has to procreate is secondary to the state's interest in requiring that babies created through ART be born into family structures the state believes are most likely to afford a foundation for a good life. In many parts of the world, homes that do not include a mar-

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[27] Even in the more permissive United States, human cloning for purposes of reproduction is explicitly illegal in many states. *See Human Cloning Laws*, NAT'L CONFERENCE OF STATE LEGISLATORS, http://www.ncsl.org/issues-research/health/human-cloning-laws.aspx (last updated Jan. 2008). It is also the case that sperm cannot be used for purposes of artificial insemination without certain laboratory testing protocols. *See* U.S. Dep't of Health & Hum. Services, *What You Should Know - Reproductive Tissue Donation*, FDA (Nov. 5, 2010), http://www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/TissueSafety/ucm232876.htm (describing regulations governing the "donation" of sperm and eggs) [hereinafter FDA].

[28] Ferraretti et al., *supra* note 21, at 262.

[29] *See* Connie Cho, *Defining Parenthood: Assisted Reproduction in France*, 7 YALE J. MED. & L. 19, 19 (Spring 2011). France restricts access to "only heterosexual, young, medically infertile couples that have been married or have cohabitated for at least two years." *Id.* These restrictions in French law are based on the concept of *projet parental* ("responsible parenthood"), which is premised on the idea that a child's right to good parenting trumps a potential parent's right to have a child. *See id.* Italy's law also limits use of ART to people who are legally married or in committed heterosexual relationships. V. Fineschi et al., *The New Italian Law on Assisted Reproduction Technology (Law 40/2004)*, 31 J. MED. ETHICS 536, 537 (2005).

[30] *See* I. Glenn Cohen, *Regulating Reproduction: The Problem with Best Interests*, 96 MINN. L. REV. 423, 456 (2011)(rejecting the use of the best interests of the child rationale to justify regulation of reproduction). This author argues elsewhere that ART and adoption are substantially different and that ART, therefore, is best treated as akin to coital reproduction rather than as a form of adoption. *See* Kimberly Mutcherson, *Procreative Pluralism: Defending the Right to Reproduce without Sex* (unpublished article) (on file with author). *See also*, Melanie B. Jacobs, *Procreation Through ART Why the Adoption Process Should Not Apply*, 35 CAP. U. L. REV. 399, 399 (2006). Another way of critiquing comparisons between ART and actions taken for existing children is through a rejection of the idea of acting in the best interest of children not yet conceived. *See, e.g.*, Cohen, *supra*, at 426 (arguing that the best interest of the child trope is wholly misplaced in the context of considering regulating reproduction to the extent that the regulation actually results in a child not being conceived.).

ried, heterosexual couple are not seen as fit places to raise a child or are deemed homes in which there is no right to create a child of the relationship.[31] Ironically, access rules may drive some individuals away from health systems that might otherwise provide much cheaper or even free access to ART.[32]

This legal backdrop explains why in Scenario 1 a woman from the United Kingdom travels to the United States for artificial insemination. The patient's age, desire to procreate with a person who is dead, status as single, and efforts to use sperm from her brother, would all disqualify her from proceeding with her plan in her home country.[33] The Human Fertilisation and Embryology Act of 1990 established the legislative framework that governs ART in the United Kingdom. The Act also created the Human Fertilisation and Embryology Authority (HFEA), which has ongoing responsibility for overseeing the use of ART in the United Kingdom.[34] The HFEA licenses clinics that work with ART clients, and the web of regulations on that work is dense. As part of their work, licensed clinics are required to take account "of the welfare of any child who may be born as a result of the treatment [to be provided] (including the need of that child for supportive parenting), and of any other child who may be affected by the birth."[35] One can only get a sense of the specificity

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[31] For many years, researchers have worked to rebut the myths about parenting by lesbians and gay men that have led to negative outcomes in courts and in public policy making. *See* CHARLOTTE J. PATTERSON, LESBIAN AND GAY PARENTS AND THEIR CHILDREN: SUMMARY OF RESEARCH FINDINGS 5, 5 (Am. Psychological Ass'n ed., 2005), *available at* http://www.apa.org/pi/lgbt/resources/parenting-full.pdf. Three concerns have historically been associated with judicial decision making in custody litigation and public policies governing foster care and adoption: the belief that lesbians and gay men are mentally ill, that lesbians are less maternal than heterosexual women, and that lesbians' and gay men's relationships with sexual partners leave little time for ongoing parent–child interactions. *Id.* at 7.

[32] Some number of those who travel to the United States for CBFC pay more for fertility care than they would have paid had they remained in their origin countries where the cost of ART is a standard part of subsidized healthcare. Assuming that a patient meets the criteria, the National Health Service in the United Kingdom will cover the cost of fertility treatment for eligible patients. *See NHS Fertility Treatment*, HUM. FERTILISATION & EMBRYOLOGY AUTH., http://www.hfea.gov.uk/fertility-treatment-cost-nhs.html (last updated May 9, 2012). In other countries, like Israel, the government pays for fertility care as a way of encouraging birth among its citizens. *See* Frida Simonstein, *IVF Policies with Emphasis on Israeli Practices*, 97 HEALTH POL'Y 202, 203 (2010). *See also* Joseph G. Schenker, *Assisted Reproductive Technology in Israel*, 33 J. OBSTETRICS & GYNAECOLOGY RES., S51, S51 (2007 Supp. 1). The exchange rate for public financing is often significant limits on who may use government financed fertility services.

[33] *See* The Human Fertilisation and Embryology Act, 1990, c. 37, § 4 (U.K.).

[34] *See id.* at § 8.

[35] *Id.* at §13(5). On the question of supportive parenting, guidance issued by HFEA states:

> When considering a child's need for supportive parenting, centres [sic] should consider the following definition: 'Supportive parenting is a commitment to the health, well being and development of the child. It is presumed that all prospective parents will be supportive parents, in the absence of any reasonable cause for concern that

with which the HFEA expects this pre-parenting fitness screening to be conducted by reading the factors that clinics should take into account. They are:

> (a) past or current circumstances that may lead to any child . . . experiencing serious physical or psychological harm or neglect, for example:
>
> (i) previous convictions relating to harming children
>
> (ii) child protection measures taken regarding existing children, or
>
> (iii) violence or serious discord in the family environment
>
> (b) past or current circumstances that are likely to lead to an inability to care throughout childhood for any child who may be born, or that are already seriously impairing the care of any existing child of the family, for example:
>
> (i) mental or physical conditions
>
> (ii) drug or alcohol abuse
>
> (iii) medical history, where the medical history indicates that any child who may be born is likely to suffer from a serious medical condition, or
>
> (iv) circumstances that the centre [sic] considers likely to cause serious harm to any child mentioned above.[36]

These requirements are a small slice of a lengthy guidance document with sections dealing with surrogacy,[37] pre-implantation genetic diagnosis,[38] counseling requirements,[39] and compensation for gamete donors, among other topics.[40] Faced with these stringent requirements, high-tech incest, consensual posthumous reproduction, or post-menopausal pregnancy for a single woman will never pass muster.

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any child who may be born, or any other child, may be at risk of significant harm or neglect. Where centres [sic] have concern as to whether this commitment exists, they may wish to take account of wider family and social networks within which the child will be raised.'

Hum. Fertilisation & Embryology Auth. Code of Practice, *Guidance Notes* § 8.11 (8th ed., 2009), *available at* http://www.hfea.gov.uk/docs/8th_Code_of_Practice.pdf [hereinafter *HFEA Guidance*].

36 *HFEA Guidance*, *supra* note 35, at § 8.10.

37 *See id.* at § 14.

38 *See id.* at § 10.

39 *See id.* at § 3.

40 *See id.* at § 13.

In scenario 2, the couple could not make a child with an anonymous sperm seller because Canada made it illegal to sell sperm in 2004;[41] therefore, they would be obliged to travel in order to access this service. Some countries allow the use of purchased or donated sperm[42] for in vitro fertilization (IVF),[43] but Canada does not stand alone in its prohibitions on the sale of sperm and anonymity. For instance, Austria, Germany, Italy, Tunisia and Turkey do not allow the sale of sperm;[44] sperm donors or sellers can be anonymous in France and Greece, but they must be identified or identifiable in the Netherlands, Norway, and Sweden.[45] Similar prohibitions exist for the use of eggs in Germany, Italy, Norway, Switzerland, Tunisia, Turkey, China, Croatia, Egypt, Japan, Morocco, and the Philippines, while the use of such eggs is permitted in at least 21 other countries.[46]

In scenario 3, the person seeking CBFC would need to leave France to engage in a commercial surrogacy arrangement because France made commercial surrogacy a criminal offense in 1991[47] and because the country's tight control over ART includes refusing to provide this care to people who are single.[48] Prohibitions on commercial surrogacy are globally widespread; the United Kingdom and Canada make commercial surrogacy illegal.[49]

In scenario 4, travel is necessary because Italy has some of the strictest laws on ART in the world and those laws forbid couples from refusing to transfer embryos in an IVF cycle even if PGD reveals anomalies in the embryos or for any other reason.[50] Finally, the couple in sce-

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41 *See* Assisted Hum. Reprod. Act, S.C. 2004, c. 2, § 7 (Can.). *See also*, Alison Motluk, *Canadian Court Bans Anonymous Sperm and Egg Donation*, NATURE (May 27, 2011), http://www.nature.com/news/2011/110527/full/news.2011.329.html (describing a Canadian High Court Ruling eliminating complete anonymity in the sale of sperm or ova).

42 In the interest of accuracy, this Article refrains from the convention of using the term donor to describe the men and women who sell sperm and ova in a thriving gamete market. Donor is a factually inaccurate term given that the gametes are sold, not donated. I also reject the language of donation for fear that it attempts to mask the commerce inherent in the baby-making industry. One need not reject the language of commerce in order to properly respect the ethical and legal intricacies of a market that creates people.

43 *See Donation*, 87 FERTILITY & STERILITY S28, S28 (2007) [hereinafter *Donation*]. Countries such as Argentina, Australia, Brazil, Chile, China, India, Lithuania, Mexico, Singapore, South Africa, Thailand, and the United States allow for the use of donor sperm in IVF. *Id.*

44 *Id. See also* Ferraretti et al., *supra* note 21, at 262.

45 *Donation*, *supra* note 43, at S28.

46 *Id.* at S31.

47 *See* Mina Chang, *Womb for Rent: India's Commercial Surrogacy*, HARV. INT'L REV., 11, 12 (2009).

48 *See* Cho, *supra* note 29, at 19.

49 Many countries that have legislated on the issue have banned commercial surrogacy. *See* Chang, *supra* note 47, at 12; Assisted Hum. Reprod. Act, S.C. 2004, c. 2, § 6(1) (Can.).

50 *See* Fineschi et al., *supra* note 29, at 537.

nario 5 would leave India because that country has legislated against sex selection,[51] a practice that has led to skewed sex ratios in the country and claims of millions of "missing" girls because parents exercise son preference through abortions after prenatal ultrasounds.[52] Thirty-six countries around the globe, including Canada, China, Germany, Russia, Singapore, and the United Kingdom, have laws or policies that prevent sex selection.[53]

On a range of issues and in many countries, a citizen might find his procreative desires thwarted by the laws that bind him while on his home soil. By contrast, it is less clear that any of the possible scenarios are illegal in the United States, which has a well-documented if not completely deserved reputation as the Wild West of fertility treatment because of its comparative lack of strong regulation of the multi-billion dollar fertility industry.[54] No state or federal laws ban anonymous sperm sales and the market for sperm in the United States is brisk, in part because the ban of such sales in other countries has spurred an international market.[55] The sale of ova is also a big business in the United States and

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[51] *See* The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act, 2002, No. 14, Acts of Parliament, 2003 (India). The Act also limits the use of prenatal diagnosis to a list of selected congenital conditions and prohibits using these techniques for sex determination of the fetus. *See* The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, No. 57, Acts of Parliament, 1994 (India).

[52] Mohit Sahni et al., *Missing Girls in India: Infanticide, Feticide and Made-to-Order Pregnancies? Insights from Hospital-Based Sex-Ratio-at-Birth over the Last Century*, 3 PLOS ONE 1,1 (May 21, 2008), http://www.plosone.org/article/info:doi/10.1371/journal.pone.0002224.

[53] MARCY DARNOVSKY, COUNTRIES WITH LAWS OR POLICES ON SEX SELECTION 1–2 (2009), *available at* http://www.geneticsandsociety.org/downloads/200904_sex_selection_memo.pdf.

[54] *See* Francine Coeytaux et al., Editorial, *Assisted Reproduction and Choice in the Biotech Age: Recommendations for a Way Forward*, 83 CONTRACEPTION 1, 2 (2011) ("The United States, often called the 'Wild West' of assisted reproduction . . . ."); Rebecca Dresser, *Regulating Assisted Reproduction*, 30 HASTINGS CENTER. REP. 26, 26 (2000) ("As the twentieth century comes to a close, this country's laissez-faire approach to assisted reproduction is under attack. References to the 'Wild West' of infertility treatment are common."); Suzanne Leigh, *Reproductive 'Tourism,'* USA TODAY, May 3, 2006, at 7D ("But in the USA—dubbed the Wild West of reproductive technology by bioethicist Arthur Caplan . . . ."); Carole C. Wegner, *Who's the Sherriff in the Wild West of ART?*, FERTILITY LAB INSIDER (May 25, 2010), http://fertilitylabinsider.com/2010/05/wild-wild-west-of-art/. Those who practice medicine in the fertility industry think that this moniker is inaccurate. The American Society for Reproductive Medicine argues that ART is "one of [the] most highly regulated of all medical practices in the United States." AM. SOC'Y FOR REPROD. MED., OVERSIGHT OF ASSISTED REPRODUCTIVE TECHNOLOGY 3 (2010), *available at* http://www.asrm.org/uploadedFiles/Content/About_Us/Media_and_Public_Affairs/OversiteOfART%20%282%29.pdf [hereinafter *Oversight of ART*].

[55] *See* Assisted Hum. Reprod. Act, S.C. 2004, c. 2, § 7(1) (Can.); G. Pascal Zachary, *A Most Unlikely Industry Finds it Can't Resist Globalization's CallExp orting Human Sperm is a Fast-Growth Business, Banks in Denmark, U.S. Find*, WALL ST. J., Jan. 7, 2000, at B1 (noting the decrease in the sale of British sperm and the increase in the sale of sperm in

is legal.[56] Some states ban commercial surrogacy,[57] but others, California[58] being a prominent example and Illinois becoming more well-known for its surrogacy industry,[59] welcome and support the surrogacy business. No state or federal law specifically prevents single or gay people from using ART; in fact, a person discriminated against in such a manner may be able to sue a healthcare provider for unlawful discrimination, at least in California.[60] No state or federal law bans the practice of PGD.[61] While Pennsylvania legislates against sex-selective abortion,[62] there are no similar statutes that would make a person civilly or criminally liable for choosing not to transfer embryos of a specific sex, especially when it is done for the purpose of avoiding disease.

For different reasons, the actors in scenario 5, the Indian couple coming to the United States to engage in sex-selection for the purpose of expressing a son preference, might raise red flags for many fertility providers in the United States who find acceding to such preferences ethically troubling.[63] Other clinics, however, advertise their sex selection services to foreign travelers determined to avoid laws at home, aimed at eliminating sex selection practices based on preference rather than concerns for sex-linked disease or disability, so this couple would likely find someone to help them get their boy.[64] The actors in the other scenarios, however, would find satisfaction somewhere in the United States, thus establishing that legal impediments are a significant reason for CBFC.

Denmark in part because of "tighter government regulations" in the former country and "liberal regulations" in the latter).

56 *See* DEBORA SPAR, THE BABY BUSINESS: HOW MONEY, SCIENCE, AND POLITICS DRIVE THE COMMERCE OF CONCEPTION 46 (2006).

57 *See, e.g.*, MICH. COMP. LAWS §722.859 (2009).

58 *See, e.g.*, CAL. FAM. CODE § 7600 et seq. (West 2004).

59 See Nara Schoenberg, *Born in the USA*, CHI. TRIBUNE (Apr. 13, 2011), http://articles.chicagotribune.com/2011-04-13/health/ct-news-surrogate-mom-20110413_1_surrogacy-center-for-surrogate-parenting-international-parents (describing the growing international surrogacy business in Illinois).

60 *See* N. Coast Women's Care Med. Grp., Inc. v. Superior Court, 189 P.3d 959, 965 (Cal. 2008) (holding that a medical practice that refused to perform artificial insemination for a lesbian based on religious objections violated California's anti-discrimination law).

61 There is some argument to be made that PGD might be classified as research on embryos, which is banned in some states. However, given the frequency with which the technique is being used, and the time frame, it is unlikely that it can fairly be classified as an experimental technique.

62 *See* 18 PA. CONS. STAT. ANN. § 3204(c) (West 2000) ("No abortion which is sought solely because of the sex of the unborn child shall be deemed a necessary abortion.").

63 *See* Ethics Comm. of the Am. Soc'y for Reprod. Med., *Preconception Gender Selection for Nonmedical Reasons*, 75 FERTILITY & STERILITY 861, 861–62 (2001).

64 *See id.* By contrast, the Fertility Institutes, with offices in Los Angeles, New York, and Mexico, prominently advertises the availability of sex selection through PGD to couples from all over the world. *See Sex Selection and Family Balancing*, FERTILITY INST., http://www.fertility-docs.com/fertilitygender.phtml (last visited Apr. 10, 2011).

Wild West label notwithstanding, this Article would be remiss if it failed to note that the formal legality of the desired act in each scenario does not guarantee that each of these would-be-travelers will find a way to satisfy their procreative desires in the United States. This is especially true for scenario 1, in which the woman seeking CBFC desires to engage in a procreative act that raises serious ethical and medical concerns even if there is no relevant law banning the desired act. That scenario—which involves a post-menopausal would-be mother, an attempt to create a child in the context of what would be an incestuous relationship if it involved coital reproduction, and a desire for posthumous reproduction (albeit with the consent and blessing of the dead party)—would almost certainly ask more of a potential pregnancy facilitator than she would be willing to give. The lack of legal impediments means that fertility providers, frequently with some measure of guidance from professional agencies, must decide what to do when faced with a would-be patient whose choices are troubling in some way.[65] Thus, even in the absence of legal rules, it is doubtful that the woman in scenario 1 would leave the United States having fulfilled her desires.

Though significant, illegality is just one motive for fertility travel. Other motives include money or the search for cheaper care,[66] lack of technology in the home country,[67] and long waiting lists in the home country.[68] For the reasons described in the preceding paragraphs, from

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[65] The American Society for Reproductive Medicine (ASRM) provides several ethics opinions to guide practice among its members. *See, e.g.*, Ethics Comm. of the Am. Soc'y for Reprod. Med., *Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons*, 92 FERTILITY & STERILITY 1190, 1190 (2009); Ethics Comm. of the Am. Soc'y for Reprod. Med., *Child-rearing Ability and the Provision of Fertility Services*, 92 FERTILITY &STERILITY 864, 864 (2009); Ethics Comm. of the Am. Soc'y for Reprod, Med., *Posthumous Reproduction*, 82 FERTILITY & STERILITY S260, S262 (2004).

[66] For instance, surrogacy in the United States might cost as much as $40,000–$120,000. Lorraine Ali & Raina Kelley, *The Curious Lives of Surrogates*, NEWSWEEK, Apr. 7, 2008, at 44. The cost of such an arrangement in India, however, might be as low as $12,000. Abigail Haworth, *Surrogate Mothers: Womb for Rent*, MARIE CLAIRE (July 29, 2007), http://www.marieclaire.com/world-reports/news/surrogate-mothers-india. By contrast, in the United Kingdom, commercial surrogacy is banned. *See* Surrogacy Arrangements Act 1985, c. 49, § 2 (U.K.).

[67] ART is not widely available in countries without relatively advanced health care systems. According to the World Health Organization, "[m]ost of those who suffer from infertility live in developing countries where infertility services in general, and ART in particular, are not available." *Forward*, *in* CURRENT PRACTICES AND CONTROVERSIES IN ASSISTED REPRODUCTION: REPORT OF A MEETING ON "MEDICAL, ETHICAL AND SOCIAL ASPECTS OF ASSISTED REPRODUCTION" HELD AT WHO HEADQUARTERS IN GENEVA, SWITZERLAND 17-21 SEPTEMBER 2001, at xv, xv (Effy Vayena et al. eds., 2002); *see also* Robert D. Nachtigall, *International Disparities in Access to Infertility Services*, 85 FERTILITY & STERILITY 871, 873 (2006) ("Of the 191 member states of the WHO, only 48 have medical facilities that offer IVF.")

[68] Where the pool of gamete providers or surrogates is small, sometimes as a direct consequence of specific types of restrictive regulation, a person seeking pregnancy might need to leave her home country in order to get access to the tools that she needs to procreate. *See*

waiting lists to discrimination to missing technology, people seek CBFC. The reputation that the United States has earned as a nation with wide accessibility to high-quality fertility care, for those who can afford the equally high price tag that accompanies such care, has made it a popular travel destination for those in search of such care. This phenomenon raises questions about whether movement of this type is good for those who travel, for the countries from which they leave and to which they will return, or for the country that welcomes their business, in this case the United States.

II. SHOULD PEOPLE TRAVEL TO MAKE BABIES? THE LEGAL AND ETHICAL DILEMMAS OF CBFC

"Cross-border reproductive care represents an urgent and challenging issue to tackle from medical, legal, psychologic [sic], and ethical perspectives."[69]

The previous section considered why people travel for ART. This section considers the more ethereal notion of whether they should travel for such care and the relationships between such travel and the state. The discussion in this part deals with the reality that subsumed under the rubric of the second question are a number of complicated inquiries. Do people have a right to have children with the use of technology and, if so, what is the nature of that right? Do nations have any obligation to facilitate, or at least not hinder, the procreative desires of their citizens or

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Leigh, *supra* note 54. In the United Kingdom, where eggs cannot be sold anonymously and where those sellers can only be reimbursed for their services and not paid a fee, the wait to purchase eggs can be as long as one to two years. *Anonymity*, 87 FERTILITY & STERILITY S33, S33 (2007). Many older women, whose chances of pregnancy with their own eggs are greatly diminished, feel a strong push to leave the United Kingdom in order to purchase eggs. Sarah Boseley, *NHS Restrictions Prompt Fertility Tourism Boom*, GUARDIAN (June 30, 2009), http://www.guardian.co.uk/society/2009/jun/29/women-over-40-fertility-tourism ("Hundreds of women over the age of 40 are travelling to fertility clinics in Europe to try to get pregnant because NHS clinics in the UK will not take them, the first-ever Europe-wide study of fertility tourism shows."). Similarly, Canada made it illegal to pay men for their sperm or women for ova in a 2004 law called the Assisted Human Reproduction Act. *See* Assisted Hum. Reprod. Act, S.C. 2004, c. 2, § 7(1) (Can.) ("No person shall purchase, offer to purchase or advertise for the purchase of sperm or ova from a donor or a person acting on behalf of a donor."). As such, the number of men in the country willing to sell their sperm dropped precipitously. In short order, all of the agencies that formerly sold sperm closed their doors save for one. *See Anonymous Sperm Donation Needed Fertility Experts*, CANADIAN PRESS (Oct. 27, 2010), http://www.ctv.ca/CTVNews/Health/20101027/sperm-donation-caanda-101027/. One 2010 newspaper article reported that there were only forty sperm sellers available in all of Canada. *Id.* Gaia Bernstein provides a more comprehensive review of the link between loss of anonymity in sperm donation and shortages in men willing to sell sperm. *See* Gaia Bernstein, Essay, *Regulating Reproductive Technologies: Timing, Uncertainty, and Donor Anonymity*, 90 B.U. L. REV. 1189, 1206 (2010).

69 Petra Thorn & Sandra Dill, *The Role of Patients' Organizations in Cross-Border Reproductive Care*, 94 FERTILITY & STERILITY e23, e24 (2010).

those who are not their citizens? Does the status of a nation, developing or developed, matter in evaluating the question of control over procreative practices? Are there some procreative practices or potential parents that the state should sanction and others that it should shun? If so, on what basis would such decisions be made? This part discusses all of these questions and concludes that a right to procreate with ART does exist as a United States constitutional matter and as a matter of human rights. From there, it concludes, as a matter of law and ethics, that nations should avoid impeding procreative desires in most circumstances, and that justice demands a careful accounting in circumstance in which authorities make the call to block access to such care.

A. *What is Not at Stake*

Many of the concerns raised about how people seeking CBFC will use ART are general concerns about ART as a practice and are not specific to those who travel to use ART. There is a strong movement in the United States for greater regulation of the fertility industry based on a number of general concerns about ART use and practice.[70] For instance, objections to the commodification of children[71] or the degradation of women's bodies or women's labor as part of ART[72] are in no way confined to CBFC.[73]

When Professor Lisa Ikemoto asserts in an article about CBFC that ART is a "gendered technology" that "allocates most of the health risks to women," this is a claim that is endemic to ART and not one that is rooted in who, in terms of citizenship, is using ART or the geographic location of its use.[74] When it comes to objections to the disproportionate

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[70] *See, e.g.*, CAHN, *supra* note 7, at 190–93 (Cahn argues for greater regulation due to concerns about the market that are rooted in issues of the commodification of gametes, the complications of familial relationships created through ART, and issues of identity for children born with the assistance of technology); Carbone, *supra* note 7, at 109.

[71] *See, e.g.*, GENA COREA, THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL WOMBS 93 (1985) ("And I wonder this: when babies are turned into consumer products, who oversees quality control?").

[72] *See, e.g.*, DEBRA SATZ, WHY SOME THINGS SHOULD NOT BE FOR SALE: THE MORAL LIMITS OF MARKETS 128 (2010) (arguing that in our society contracts for pregnancy "will turn women's labor into something that is used and controlled by others and will reinforce gender stereotypes that have been used to justify the unequal status of women.").

[73] *See* Lisa C. Ikemoto, *Reproductive Tourism: Equality Concerns in the Global Market for Fertility Services*, 27 L. & INEQ. 277, 303–04 (2009).

[74] *Id.* at 303. Ikemoto refers specifically to egg donation and surrogacy, each of which has risks for women, some of which can be dire, including infertility or death for the gamete provider or surrogate. *See id.* While I agree in part with Ikemoto's characterization, I am not convinced that it is completely accurate across the total range of ART uses. First, I reject that notion that technology has a gender; so, to the extent that this is her claim, I do not find that claim to be accurate or useful. While technologies may be used on one sex versus another, I would not ascribe gender, the social construction, to technologies that have meaning only in the context of how they are wielded by and understood by human beings. In this sense, tech-

physical impact of many technologies of reproduction—which necessarily require the presence of a uterus—a surrogate in India feels those impacts just as a surrogate in California feels them. When commentators flag concerns about ART being a technology reserved largely for those with economic privilege,[75] this truth cuts across a variety of geographic contexts. Therefore, there is nothing more pernicious about having a baby through ART in the United States who will be raised elsewhere, than there is about having a baby through ART who will remain in the United States. In fact, these concerns have been a consistent and constant part of the academic and popular conversation about ART for decades.[76]

This is not the say that broader concerns about how ART is used and by whom are illegitimate or should play no part in shaping future conversations about ART regulation in the United States. Rather, the point is that these concerns are not new or unique in the context of CBFC. If one pursued the idea of treating people seeking CBFC in a different manner than native users, there would need to be some plausible claim that there is something different about people seeking CBFC that warrants more stringent control or even prohibition as contrasted with how native users access or utilize the technology. Some possibili-

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nology itself is neutral and the problem is with us and not with it. This Article makes this point only to be clear that the root of our concerns about ART is not a dispute with inanimate objects. Rather, it is a dispute with people and the ways in which our society gives meaning to technology. Second, I worry a bit about her characterization that "[r]egardless of the cause of infertility, it is the woman who is seen as infertile." *Id.* at 294. This assertion seems to flow from an ART narrative that focuses on heterosexual couples to the exclusion of considering that same-sex couples, male or female, frequently enter this market without the weight of medical infertility existing as part of the narrative of resort to technology. In these cases, I do not think it is accurate to proclaim that the narrative of the female body as the primary site of infertility is paramount.

75 *See* Liza Mundy, *A Special Kind of Poverty; The Poor Get Used to Going Without. But Going Without a Baby is Hard to Get Used to*, WASH. POST, Apr. 20, 2003, at W08 (describing economic barriers to accessing ART); M.M. Peterson, *Assisted Reproductive Technologies and Equity of Access Issues*, 31 J. MED. ETHICS 280, 280 (2005) (describing the problem of unequal access to ART in Australia).

76 As explained by Jennifer Parks, some radical feminists "have argued that reproductive technologies serve to oppress and subordinate women, that they are the final frontier for the patriarchal usurpation of women's reproductive role, and that these technologies have turned women's bodies into sites for dangerous experimentation and research." Jennifer Parks, *Rethinking Radical Politics in the Context of Assisted Reproductive Technology*, 23 BIOETHICS 20, 20 (2009). *See e.g.*, THE BABY MACHINE (Jocelynne A. Scutt ed., 1988) (offering a series of essays in which authors give voice to the claim that reproductive technology does not free women from oppression, but rather enhances and reinforces it while moving women further away from equality); COREA, *supra* note 71 (arguing that the fertility industry is rooted in patriarchy and that it reproduces and reinforces systems that oppress and exploit all women, especially poor women).

ties for differences that might serve as the basis for disparate treatment appear in a later part of this discussion.[77]

A starting pointing for thinking about CBFC in the United States is analyzing how it differs from medical travel in general or from travel for CBFC in other countries. In this vein, an interesting element of general medical travel, and the academic writing about such tourism, is that it often focuses on people who travel from developed nations to developing nations for the purpose of accessing healthcare that is comparable in quality, but substantially cheaper in price than the care provided in the traveler's country of origin.[78] The concerns raised about this kind of travel generally focus on issues such as whether the quality of care is in fact comparable,[79] what legal remedies an individual might have if a practitioner in a foreign country commits medical malpractice,[80] and whether the resource allocation to support medical travel has unacceptable consequences for the overall quality of medical care in a developing nation.[81]

Specifically in the context of people traveling for fertility care, Richard Storrow adds another worry, which is that:

> [L]ocal laws that purport to outlaw socially irresponsible forms of procreation have extraterritorial effects that violate the spirit of those same laws. By importing oppression in the form of infertile individuals who travel abroad to exercise what they perceive to be their reproductive rights in the destination country in ways that oppress women there, these laws turn public oppression in one country into private oppression in another.[82]

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77 *See* discussion *infra* Part III.

78 *See* John Connell, *Medical Tourism: Sea, Sun, Sand and . . . Surgery*, 27 TOURISM MGMT. 1093, 1094 (2006); Leigh Turner, *'First World Health Care at Third World Prices': Globalization, Bioethics and Medical Tourism*, 2 BIOSOCIETIES 303, 312–13 (2007); Diane York, *Medical Tourism: The Trend Toward Outsourcing Medical Procedures to Foreign Countries*, 28 J. CONTINUING EDUC. IN THE HEALTH PROFS 99, 100 (2008).

79 This concern has been raised specifically in the context of CBFC. *See* Trish Davies, *Cross-border Reproductive Care: Quality and Safety Challenges for the Regulator*, 94 FERTILITY & STERILITY e20, e20 (2010) ("The lack of international standards allows practices restricted in one country to be carried out in another, where quality and safety may not be equivalent.").

80 *See* Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, 10 YALE J. HEALTH POL'Y L. & ETHICS 1, 3–4 (2010).

81 *See* Priya Shetty, *Medical Tourism Booms in India, but at What Cost?*, 376 LANCET 671, 672 (2010) ("Increasingly, Indian doctors are worried about how gearing the health care system towards rich foreign patients will affect the care of India's millions of impoverished people.").

82 Richard F. Storrow, *Quests for Conception: Fertility Tourists, Globalization and Feminist Legal Theory*, 57 HASTINGS L.J. 295, 329 (2005).

Storrow elaborates on this point by using the example of purchasing eggs for use in IVF.[83] When a developed nation limits the available market in anonymous egg purchases, buyers will make those purchases in countries with more favorable laws. These same countries may also have large populations of impoverished or economically fragile women with few opportunities for economic stability for whom the sale of eggs, a process that entails some physical risks for the seller,[84] is far more attractive than it might otherwise be.[85] Storrow points specifically to economically fragile women from Eastern European countries like Romania who sell their eggs to clients from wealthier and economically stable countries.[86] However, Storrow's concern about the exploitation of women who live in precarious economic positions, echoed by others,[87] does not consider how, if at all, one should evaluate travel from one wealthy economy to another wealthy economy, or from a less developed economy to a more developed economy.[88]

Arguably, the depth of concern about substandard healthcare, misplaced public health expenditures, and the exploitation of native populations are either irrelevant or substantially less relevant in the context of people traveling to the United States for ART. First, the United States is a world leader in providing ART, and there are significant practices in

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[83] *See id.* at 327.

[84] *See* Helen Pearson, *Health Effects of Egg Donation May Take Decades to Emerge*, 442 NATURE 607, 607 (2006) (describing the unknown risks of ovarian stimulation with fertility drugs that are used for harvesting ova).

[85] As an example, restrictions on ART in some European countries have spurred "European reproductive travel on a massive scale, either to less restrictive Western European countries such as Spain . . . or to the 'white' post-Soviet bloc of Eastern Europe (e.g., countries such as Russia, Czech Republic, and Romania)." Inhorn & Patrizio, *supra* note 8, at 905. In these countries, young women "may comprise a vulnerable population of egg donors, who are compelled out of economic necessity to sell their ova in the local reproductive marketplace." *Id.*

[86] *See* Storrow, *supra* note 82, at 327.

[87] See, e.g., B.C. Heng, *The Advent of International* 'Mail-Order' Egg Donation, 113 BJOG 1225, 1225–26 (2006).

[88] Storrow considers the parallels between those who seek CBFC and sex tourists, a link that draws the mind to something nefarious in a way that he likely does not intend, but other scholars agree that this link between sex tourism and CBFC is valid. *See* Storrow, *supra* note 82, at 317; Inhorn & Patrizio, *supra* note 8, at 905 ("Given the newly recognized category of the 'traveling foreign egg donor' who seeks economic mobility through the sale of her body parts . . . unregulated fertility tourism has been compared with sex tourism, as young women in the economically deteriorated post-socialist societies discover that prostitution and egg donation offer economic rewards."). Storrow also compares fertility travelers to those who travel abroad to adopt a child, perhaps a more apt analogy in that it involves a quest for parenthood, but one that also does not entirely fit with the reality of CBFC. *See* Storrow, *supra* note 82, at 320–22. As just one mark of difference, the available descriptions of systematic abuse of the rights of birth mothers in some developing nations, *see, e.g.*, David M. Smolin, *The Two Faces of Intercountry Adoption: The Significance of the Indian Adoption Scandals*, 35 SETON HALL L. REV. 403, 404 (2005), are substantially more documented than harms to those who are participants in the gamete market in the United States. *See* Storrow, *supra* note 82, at 320–21.

place to evaluate and elevate the quality of fertility care being provided to patients in this country.[89] While there are many aspects of the industry that are not closely regulated—such as the price of gametes that are sold, the characteristics of people who can act as surrogates, or the parental abilities of those who seek to create children—the actual providing of medical care is regulated by the same system that regulates all medical care in this country.[90] This means that physicians who work in this field are licensed to practice medicine and are in good standing with the relevant licensing and professional societies.[91] Where an injury happens, there is a robust medical malpractice system in place to respond to failures to adhere to an appropriate standard of care.[92] There is some amount of medical screening of those who sell gametes, especially sperm.[93] There is a system of professional self-regulation that, while neither perfect nor binding, provides standards for how physicians and laboratories should provide care.[94] Furthermore, the laboratories used to store gametes and provide a range of services, including fertilizing eggs outside of the body, must be licensed and inspected to ensure a minimum level of competence among personnel and to adequately maintain the facilities.[95] It is hard to make an argument that the quality of care might be lacking in the United States. Therefore, this general medical travel concern is no reason to discourage people from traveling to the United States.

Furthermore, the availability of the tort system to redress wrongs where there is an injury caused by a provider's negligence, also makes the concern about redress of injuries irrelevant in the context of people

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89 *Oversight of Art*, *supra* note 54, at 4 (describing the web of state, federal, and professional regulation of the fertility industry).

90 As noted in an admittedly self-serving, but still accurate, report from the American Society of Reproductive Medicine:

> As with all medical practice in the United States, safety in reproductive medicine is assured by a combination of state and federal government regulation and professional self-regulation that includes facility accreditation and practitioner certification. On the state level, there is a strict physician licensure system. On the federal level, several agencies enforce standards and practices designed to protect public health and safety. Several national groups accredit laboratories as well. In the realm of professional self-regulation, an on-going system of quality assurance includes specialty training and certification of physicians, accreditation of clinics and ethical and practice guidelines developed by professional organizations through consensus and evidence.

Id. at 4.

91 *See id.*

92 *See id.* at 5.

93 *See* FDA, *supra* note 27.

94 *See Oversight of ART*, *supra* note 54, at 4.

95 *See* FDA, *supra* note 93.

traveling to the United States for treatment.[96] Moreover, to the extent that there is any relevance to the concern about access to legal redress, that relevance emanates from a broader critique of the United States' medical malpractice system and is not related specifically to the use of ART in general or the use of ART by those seeking CBFC. Although there may be barriers to accessing the legal system, such as a need to return to one's home country or a lack of financial resources, the structure for seeking a legal response exists.

Finally, while there are many reasons to think that the United States' healthcare system is deeply flawed, including the dearth of medical students who choose to enter the field of primary care,[97] the problems of the system are not caused or deepened by a glut of people seeking to practice specialized fertility treatment to the detriment of other necessary areas of medical care.

The final concern, that of exploitation of people in developing nations by citizens of developed nations, will be explored in-depth in other parts of this Article.[98] Nevertheless, if it is the case that most of the standard concerns about medical travel are wholly irrelevant, or at least less relevant in the context of CBFC provided in the United States, there are other reasons why some would object to the idea of people traveling to the United States for CBFC. Those potential objections are manifold and may be aimed at very different populations of ART users.

B. Procreation as a Right and as a Component of Justice

The arguments in the sections that follow rest upon the notion that procreation is a right as a matter of United States constitutional law,[99] and as a matter of human rights[100] and ethics. That right, it has been argued, extends to a right to use assisted reproduction.[101] This Article

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96 One place where this may not be completely true is in the context of wrongful life claims, which are seldom allowed in the United States, but might be available in other countries. *See, e.g.* Smith v. Cote, 513 A.2d 341, 347–48, 355 (N.H. 1986) (holding that parents of a child born with various disabling conditions could sue for wrongful birth, but that the child had no cause of action for wrongful life).

97 See Editorial, *Bolster Primary Care: Avert a Physician Shortage,* AM. MED. NEWS (Jan. 5, 2009), http://www.ama-assn.org/amednews/2009/01/05/edsa0105.htm.

98 *See* discussion *infra* Part II.D.

99 *See* Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535, 541 (1942).

100 *See, e.g.*, INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS 112, *available at* http://www.dfa.ie/uploads/documents/Political%20Division/iccprfinalpdf.pdf, which provides, "[n]o one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence . . . ." The Covenant also holds that "[t]he family is the natural and fundamental group unit of society and is entitled to protection by society and the State . . . . The right of men and women of marriageable age to marry and to found a family shall be recognized." *Id.* at 132.

101 See, e.g., T. Tännsjö, *Our Right to In Vitro Fertilisation—Its Scope and Limits*, 34 J. MED. ETHICS 802, 802 (2008) (arguing that the right to procreate encompasses a right to use

will not engage in a defense of the right to procreate with ART, but will assume the existence of such a right for the purposes of the analysis of CBFC. The notion of rights espoused here is one rooted in the idea of reproductive justice, which means that the procreative right is not simply about choice and autonomy, though reproductive autonomy is crucial and the choice it allows is significant.[102] Rather, it is a right tempered by concerns about equality, community, and intersectionality.[103] Therefore, though a person has a right to procreate,[104] and may access technology in order to bring that right to fruition, the discussion that follows does not see that right as a complete trump to notions of responsibility to future children, to the society in which those children will live, or to the individuals who participate in the market for the building blocks of babies.[105]

A balanced discussion of ART as practiced across borders must acknowledge "there are political ramifications of citizens crossing borders to receive treatments deemed illegal or restricted in their homeland. Respect for individual autonomy as well as respect for political and social value systems should be considered."[106] The tangible and intangible ramifications of these decisions may be felt in the individual's country of origin as well as in her destination country. Consequently, there is no doubt that countries can and will come to their own conclusions about how to deal with citizens who access CBFC and then return to their native countries to give birth to and raise those children. Some countries have already identified CBFC as a problem that they wish to solve.[107] Turkey, for instance, has taken drastic measures to stem the flow of its citizens seeking CBFC.[108] The country has long made surrogacy and

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IVF and various embryo screening technologies); JOHN A. ROBERTSON, THE FUTURE OF THE CONSTITUTION: REPRODUCTIVE RIGHTS AND REPRODUCTIVE TECHNOLOGY IN 2030, at 5 (Jan. 21, 2011), available at http://www.brookings.edu/~/media/research/files/papers/2011/1/21%20reproductive%20technology%20robertson/0121e_reproductive_technology_robertson.pdf (arguing that the United States Constitution protects a broad and fundamental right to access reproductive technologies).

102 As one author notes, "[b]eing able to decide whether or how to reproduce based on one's own values is crucial to people's well-being. In other words, having reproductive autonomy is crucial." Carolyn McLeod, Editorial, *Rich Discussion About Reproductive Autonomy*, 23 BIOETHICS ii, ii (2009).

103 The concept of intersectionality refers to the ways in which intersecting and overlapping identities frequently result in the erasure of the experiences of marginalized communities, especially, but not limited to, women of color. *See, e.g.*, Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV 1241, 1244 (1991).

104 *See, e.g.*, *Skinner*, 316 U.S. at 541 (1942).

105 For a fuller account of the relationship between reproductive justice and a right to procreate, *see* Kimberly M. Mutcherson, *Transformative Reproduction* 16 J. GENDER RACE & JUST. (forthcoming Winter 2013).

106 Nygren et al., *supra* note 3, at e5.

107 *See* Peter Shanks, *Struggling to Control Fertility Tourism*, BIOPOLITICAL TIMES (Apr. 17, 2010), http://www.biopoliticaltimes.org/article.php?id=5156.

108 *See id.*

egg selling illegal but, even so, an estimated 2,000 to 3,000 women travel abroad each year to circumvent these rules.[109] The government responded by passing a regulation under which people who went in search of CBFC could face prison terms of up to three years if caught upon their return home.[110] Additionally, Turkish clinics found to have encouraged such travel or to have informed individuals of the possibility of CBFC could face suspension or closure.[111]

Other countries penalize physicians who publicize information about where banned services can be accessed abroad,[112] and still other countries may delay or deny citizenship to the children born in banned or legally specious arrangements.[113] Responses of this kind, meant to curb travel for fertility purposes, have potentially devastating consequences for the practice of medicine, relationships between providers and patients, and the stability of familial units.[114] The concern of this Article, however, is with how the United States should react to those who travel here. What nations do to discourage or prevent such travel by their own citizens is a discussion for another article and should not control decisions made by United States policymakers about how this nation should think about CBFC.[115]

Focusing then on arguments to be made about the United States as a destination for CBFC, this Article assumes that no one would seriously argue strictly in economic terms about protecting access to market transactions that lead to the creation of human beings. Praising the efficiency of markets without reference to the unique context of making children fails to capture what makes this slice of medical travel particularly wor-

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109 *See id.*

110 *See id.*

111 *Id.*

112 *See* Fineschi et al., *supra* note 29, at 537.

113 *See, e.g.,* Denis Campbell, *Couples Who Pay Surrogate Mothers Could Lose Right to Raise the Child*, GUARDIAN (Apr. 5, 2010, 2:40 PM), http://www.guardian.co.uk/uk/2010/apr/05/surrogacy-parents-ivf.

114 For instance, in the well-publicized Baby Manji case, a child born to an Indian gestational surrogate, pursuant to a contract with Japanese intended parents, was left in legal limbo after her intended parents divorced prior to her birth. *See* KARI POINTS, TEACHING NOTES: COMMERCIAL SURROGACY AND FERTILITY TOURISM IN INDIA: THE CASE OF BABY MANJI 5 (2009), *available at* http://kenan.ethics.duke.edu/wp-content/uploads/2012/07/Case-Study-Surrogacy-notes.pdf. Japanese law recognizes only a birth mother as a legal mother; therefore Baby Manji's father could not secure a Japanese passport for her. *Id.* He also could not secure a legal tie to her through Indian law because that body of law did not recognize him as a legal father despite his being the genetic father, and he could not adopt the child because the law forbids adoptions of baby girls by single men. *Id.*

115 I. Glenn Cohen has extensively explored the question of how home nations should respond to what he calls "circumvention tourism," meaning travel to avoid prohibitions on certain health procedures in a home country. *See* Cohen; *supra* note 11, at 1312. His conclusions about how home countries should respond are not necessarily relevant to how a destination country should respond to such acts. *See id.* at 1336.

thy of study.[116] Traveling to see impressive landmarks or even traveling for a beauty enhancing cosmetic procedure is different in kind and character from traveling for serious medical care, especially care that, if successful, will result in the birth of a child. This is not to say that the fertility industry is not a business through which billions of dollars flow per year, because it most certainly is.[117] However, it is also a business that requires a careful understanding of the basic building blocks of family, kinship, and intimate obligation.

A second argument that this Article does not pursue with vigor is the claim that the actual implementation of a rule that distinguishes between native ART users and people seeking CBFC would be so unwieldy to enforce so as to essentially be unenforceable and therefore not worth attempting to implement. This may be true on some important levels. For example, would fertility providers be required to ask for identity papers from all clients, or only those who speak with foreign accents? Would people be held at the border if they indicate that they are entering the United States for an appointment with a fertility provider? Would it matter whether the goal in coming to the United States was to have an actual procedure done versus seeking consultation? What if one member of a couple was a United States citizen? It is possible that issues of this nature would be so vexing that lawmaking would seem ineffective. Even so, the larger question of whether we should stop or discourage these individuals from coming allows us to engage in an analysis, as a matter of law and ethics, of the core issues inherent in a discussion about potentially controlling or limiting access to the tools for creating babies.

Given that many of the big concerns about medical travel generally do not apply to the United States, those who object to such travel need to

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116 With some notable exceptions, *see, e.g.*, Hon. Richard A. Posner, *The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood*, 5 J. CONTEMP. HEALTH L. & POL'Y 21, 21–22 (1989) (arguing for the enforcement of surrogacy contracts based, in part, on an economic model of the benefits of contract enforcement), most of those who write about legal and ethical issues surrounding reproductive technology are careful to avoid the perception that market principles are the only, or even the primary, principles that should govern law and policy in this arena. In fact, many scholars, especially, but not exclusively feminist scholars, find the injection of market principles into this discussion about the creation of new life to be one of the most objectionable consequences of the business of making babies. *See, e.g.*, Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1935–36 (1987); Elizabeth S. Anderson, *Is Women's Labor a Commodity?*, 19 PHIL. & PUB. AFF. 71, 80–81 (1990). As one scholar wrote,

> The rules and rhetoric of commerce seem to fail all things reproductive. The events and choices made along the reproductive continuum resist marketplace classification. Their meaning spills over, leaving a residue that is not easily wiped away. Marketplace terms ("informed parties," "uncoerced choices," "thorough contracts," "services," "products") ring anemic here. They do not seem to capture everything that goes into whether people desire a child or not.

Erika Blacksher, *On Ova Commerce*, 30 HASTINGS CENTER REP. 29, 30 (2000).

117 *See* SPAR, *supra* note 56, at 3.

find other reasons for their opposition. In responding to these objections, it is necessary to review two types of arguments. The first type of argument is rooted in law and legal theory. Unfortunately, like resort to market talk, a narrow focus on the law does not capture the full range of what is important on an individual and societal level in this discussion of CBFC. This is because law talk, in the arena of reproduction, tends to focus quite heavily on autonomy and choice.[118] This is not surprising given that our legal system fetishizes the notion of radically autonomous individuals,[119] but static notions of autonomy are a slippery foundation upon which to rest conversations about making new human beings.[120]

This is not to say that autonomy is irrelevant in this context, but the notion of autonomy sought to be protected in this arena needs to take account of the shared interests of individuals, future individuals,[121] and the state in a way that is not always as stark in other conversations about autonomous decision making.[122] To take proper account of the range of vital interests involved in this discussion, this Article draws from the work of legal scholars, philosophers, and ethicists. Expanding the range of scholarly discussion provides greater opportunities for thinking about how decisions about law and legal regimes impact important societal institutions, such as the family, and how they implicate the worth of individuals and the importance of human freedom. This Article discusses arguments from law and ethics, sometimes separately, sometimes together, and argues that neither set of arguments is persuasive enough to

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118 *See, e.g.*, JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 22–25 (1994) (as made clear in Robertson's title, the concept of choice is central to his arguments about reproduction and the right to use ART).

119 *See, e.g.*, Martha Minow, *"Forming Underneath Everything That Grows:" Toward a History of Family Law*, 1985 WIS. L. REV. 819, 877 (1985) (complicating the relationship among rights, autonomy, and community in the history of families and family law).

120 *See, e.g.*, JANICE G. RAYMOND, WOMEN AS WOMBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN'S FREEDOM 76–107 (1993) (critiquing and refuting liberal arguments about the positive nature of procreative liberty as it pertains to the use of assisted reproduction); Sarah S. Boone, *Slavery and Contract Motherhood: A "Racialized" Objection to the Autonomy Arguments*, *in* ISSUES IN REPRODUCTIVE TECHNOLOGY: AN ANTHOLOGY 349, 357–64 (Helen Bequaert Holmes ed., 1992) (comparing the market for surrogates to the institution of slavery and, in particular, the exploitation of the reproductive capacities of enslaved African-American women); JANET L. DOLGIN, DEFINING THE FAMILY: LAW, TECHNOLOGY, AND REPRODUCTION IN AN UNEASY AGE 213 (1997).

121 The idea that conversations about reproductive technology should include references to the interests of future people is not without its critics. *See, e.g.*, Cohen, *supra* note 30, at 426–27. *But see* Kimberly M. Mutcherson, Response, *In Defense of Future Children: A Response to Cohen's* Beyond Best Interests, 96 MINN. L. REV. 46, 49–50 (2012).

122 *See, e.g.*, Anne Donchin, *Autonomy and Interdependence: Quandaries in Genetic Decision Making*, *in* RELATIONAL AUTONOMY: FEMINIST PERSPECTIVES ON AUTONOMY, AGENCY, AND THE SOCIAL SELF 236, 237–40 (Catriona Mackenzie & Natalie Stoljar eds, 2000) (describing a notion of strong relational autonomy which is marked by an understanding of the balance between interdependence and independence, especially in how people are tied together in familial units).

actually warrant serious effort to make it more difficult or less attractive to seek CBFC in the United States.

C. *Justice Concerns: Who Has the Right to Procreate?*

A broad argument against CFBC is that the United States should not be a literal breeding ground for people whose home countries have determined that it is inappropriate for them to use ART, either because of who they are or because of what they would like to do with the technology. Part of that argument rests on the idea that travelers have a moral obligation to obey the law of their home countries no matter where they are. We can reject this idea with relative ease in some cases, but it may be harder to reject in others. As Professor Guido Pennings notes, while there may be a "prima facie obligation of citizens to obey national law" there "is a wealth of precedence in reproductive healthcare, i.e. termination of pregnancy, sterilization and contraception" in which individuals, especially women, flee their home countries to obtain care.[123] Women from a long list of countries, from Spain to Ireland, have fled their homes to access various reproductive healthcare denied to them on their own soil.[124]

A woman who left Ireland to have an early second trimester abortion in New Jersey would not be denied access to that heavily contested, but still legal, medical procedure in the United States. In fact, many would defend and praise the United States' willingness to allow a woman access to abortion, birth control, or sterilization services that are banned or criminalized in her home country, thereby affirming both women's rights to make decisions about their bodies and a broader right to determine their destinies by controlling their reproductive decisions. As a his-

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[123] *See* Pennings et al., *ESHRE supra* note 9, at 2182. For instance, in 2009, just under 4,500 women traveled to the United Kingdom from Ireland to have abortions—a drop from 6,500 women in 2001. *See* Marie O'Halloran, *Abortion Travel Numbers to UK Fall*, IRISHTIMES.COM (July 7, 2010), http://www.irishtimes.com/newspaper/breaking/2010/0722/breaking55.html.

[124] As one commentator explained, "[i]n Spain, we have a lot of experience with such reproductive exile: when oral contraceptives were banned, Spanish women acquired them in France; when termination of pregnancy was illegal, they went to England." Roberto Matorras, Letters to the Editor, *Reproductive Exile Versus Reproductive Tourism*, 20 HUM. REPROD. 3571, 3571 (2005). According to a 2010 report issued by Human Rights Watch on abortion access in Ireland:

> Abortion is legally restricted in almost all circumstances, except where the pregnant woman's life is in danger. Even in those rare circumstances where an abortion can be legally performed, it appears that it almost never happens. Despite interviewing a number of prominent obstetricians and physicians, Human Rights Watch was unable to document a single case where an abortion had been legally performed in Ireland. As a result, all women living on Irish soil are forced to travel to access a medical procedure.

A State of Isolation: Access to Abortion for Women in Ireland, HUM. RIGHTS WATCH (Jan. 28, 2010), http://www.hrw.org/en/reports/2010/01/28/state-isolation.

torical matter, differing rules on abortion are credited as "the first cause of migration in the field of reproduction."[125]

In circumstances where the care sought outside of the home jurisdiction is of the type thought to be well within the parameters of acceptable healthcare in many parts of the world, condemning people to follow the precepts of their home nations while abroad would perpetuate an already dismal set of circumstances for the affected individuals. Circumventing such rules can be praised as an important act of defiance or even civil disobedience to the extent that an individual refuses to be bound by a legal code that would deny her the opportunity to express the full extent of her human freedom. It may be easier to see this link in the context of terminating an unwanted pregnancy or getting access to contraception that will aid in preventing pregnancy, but similar arguments can be made in the context of pregnancy creation.[126]

Where a country denies access to tools of procreation and family expansion on the basis of invidious discrimination, such as sexual orientation, the United States should proudly open its borders to those who would circumvent such rules. Allowing CBFC is akin to providing a platform for people to play out political objections to the restrictive and discriminatory rules in their home countries. Certainly most people who travel to access ART will not think of themselves as making a political statement; they will instead be focused on building their families. But when they do build those families and go back home to live, their very presence facilitates the process of breaking down the restrictions that drove them from their home in the first place. To the extent that our open fertility borders play a role in helping to dismantle unfairly discriminatory structures in other countries, a decision not to restrict access to fertility care is an important policy choice. Of course, it is possible that those who leave their home country will only be the elite whose departure actually saps political will for a change. This is a risk, no doubt, but the possibilities of transformation by virtue of acknowledged resort to CBFC are not insignificant.

Similarly, one might also argue in this context that the United States has an interest in acting to protect procreation and family building across a wide spectrum as a human right. The difficulty of this argument is similar to the difficulty that comes in the domestic context when one tries to make sense of whether ART is a constitutional right that emanates from the fundamental right to procreate.[127] A person skeptical of ART

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125 *See* Ferraretti et al., *supra* note 21, at 262.

126 *See, e.g.*, Zakiya Luna, *From Rights to Justice: Women of Color Changing the Face of US Reproductive Rights Organizing*, 4 SOCIETIES WITHOUT BORDERS 343, 361 (2009).

127 For decades, John Robertson has advocated for a constitutional right to procreate broad enough to encompass the use of ART by married and single people. *See, e.g.*, John A.

as a form of human procreation might question whether access to ART is a human right that warrants sufficient respect, and whether it should be made available to people who cross borders for the specific purpose of using ART. Unlike traveling across borders to get life-saving care, traveling for ART is about access to a type of care that can be conceptualized quite differently. ART does not cure disease or disability necessarily. Rather, it finds a way around that disease or disability. For people who are using ART because they have no partner or because their partner is of the same sex, ART may not have any connection to an infirmity of the body that needs to be fixed, so a rationale of alleviating disease or disability is inapposite. Instead, one has to root the importance of ART in a belief that access to family formation and procreation are significant enough that those who seek these things through technology should be welcomed.

Under this belief, open fertility borders speak to a larger desire to expand rather than restrict the definition of family, a process that for some is proceeding at a slower pace than they would like, while for others it is proceeding too rapidly—nonetheless the process is moving forward. As states slowly grind their way to greater openness and inclusivity for diverse family structures as well as broader understandings of how children's best interests can be served, shutting our borders to individuals similarly inclined to embrace this kind of expansion is a regressive move. Open fertility borders express a belief in expanding rather than constricting the available options for those who would include children in their plans for family. So, the United States might want to be a safe haven for the married lesbian couple or the single gay man as a way of putting into practice a belief in both familial and procreative pluralism.

Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405, 428–33 (1983) [hereinafter Robertson, *Procreative Liberty*]; John A. Robertson, *Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction*, 59 S. CAL. L. REV. 939, 958–67 (1986) [hereinafter Robertson, *The Legal Structure of the New Reproduction*]. Other scholars, legal and otherwise, however, have been substantially less inclined to extend the same broad right to procreate using ART. See, e.g., Jennifer L Rosato, *The Children of ART (Assisted Reproductive Technology): Should the Law Protect Them from Harm?*, 2004 UTAH L. REV. 57, 59–62 (2004) (recommending both state and federal regulation of assisted reproduction in the interest of avoiding harm to children born of such technologies); Maura A. Ryan, *The Argument for Unlimited Procreative Liberty: A Feminist Critique*, 20 HASTINGS CENTER. REP. 6, 7 (July 1990) (arguing that "[t]he view of offspring presupposed in such a position is unacceptable from a feminist perspective; further, treating the act of reproducing in such a way has serious implications for efforts to bring about a society free of oppression.").

D. Justice Concerns: Surrogacy

Surrogacy arrangements have been happening in the United States for decades, and causing controversy,[128] but the outsourcing of this specific type of reproductive labor to developing nations, like India, has exacerbated concerns about the practice and its potential for harm.[129] For some, surrogacy marks the height of what is wrong with ART and its potential to transform society in negative ways.[130] Especially in its traditional form, in which the surrogate mother provides the egg used to create a child, surrogacy raises the specter of baby selling and women as wombs in a manner that is more visible than the selling of gametes.[131] Where subjugation and exploitation of women are concerns, especially for women of color and low-income women, surrogacy is near the forefront of the discussion. This level of concern, coupled with the growth of surrogacy in developing nations, makes this a ripe arena for discussion as to why and how travel to developed nations differs from, and should be analyzed separately from, travel to developing nations.

Surrogacy as practiced in the United States is not well documented. There have been no large-scale, multi-year studies about the experiences of surrogates nor has there been substantial data collection about who uses surrogates, how they are paid, or what the contracts between surrogate mothers and the individuals who hire them typically look like.[132] As a result, much of the information about United States-based surrogacy centers comes from anecdotes or court cases that take place when there is

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128 *See, e.g.*, Elizabeth S. Scott, *Surrogacy and the Politics of Commodification*, 72 LAW & CONTEMP. PROBS. 109, 112–20 (2009) (describing the legal history of surrogacy in the United States and the impact of the *Baby M.* case on legislation regulating the practice). *See also In re* Baby M., 537 A.2d 1227, 1240 (N.J. 1988) (holding that commercial surrogacy contracts are against public policy in New Jersey).

129 *See* Sarmishta Subramanian, *Wombs for Rent*, MACLEAN'S, July 2, 2007, at 40, 41 (describing the commercial surrogacy market in India). Although India has been the subject of media attention on a national scale, there are serious concerns about surrogacy practices in other nations with a high population of economically vulnerable women. For instance, police in Thailand rescued fourteen Vietnamese women, seven of whom were impregnated by an illegal "surrogate breeding ring." *See Thai Police Free Women From Surrogate Baby Ring*, AFP (Feb.24, 2011), http://www.google.com/hostednews/afp/article/ALeqM5gXBt7gEuqdnil4KYH2zcvjZvsFpQ?docId=CNG.e4206a773b164839c18a6b3802794fe5.6d1. To the extent that there are concerns about human trafficking for fertility purposes, protecting surrogates is likely more possible in a country in which there are opportunities to legally make these arrangements and establish judicial oversight.

130 See Feminist Perspectives on Reproduction and the Family, STAN. ENCYCLOPEDIA OF PHIL., http://plato.stanford.edu/entries/feminism-family/#3.2 (last updated Jan. 5, 2010).

131 *See* Katha Pollitt, *The Strange Case of Baby M.*, NATION, May 23, 1987, *available at* http://www.thenation.com/article/strange-case-baby-m#.

132 The first ethnography of the experiences of gestational surrogates was published in 2010, but that book focuses on Jewish Israelis. *See* ELLY TEMAN, BIRTHING A MOTHER: THE SURROGATE BODY AND THE PREGNANT SELF 2–4 (2010). One imagines that the experience of gestational surrogacy is different in a very pro-natalist nation that strongly supports and highly regulates the practice.

a breakdown between the parties.[133] Even so, it is possible to make some claims about the surrogate population in the United States.

For instance, women acting as surrogates in the United States, at least within the brokered element of the market,[134] are generally not in a wholly precarious economic position or completely reliant on using their reproductive capacity to find economic stability. Instead, because of the desire of the ART consumer to hire a woman in possession of certain qualities, including good overall health, decent health insurance, and a deep altruistic streak,[135] surrogates in the United States are typically married, have children of their own, and are economically stable, though certainly not wealthy.[136] Depending on the agency, the fee paid to a surrogate in the United States can start at as little as $24,000 and go up to $37,000, depending upon a variety of factors, including the number of fetuses the surrogate will carry and her prior successful surrogacy experiences.[137] Of course, the surrogacy fee is one small slice of the total expense of a surrogacy arrangement—fees for lawyers, counseling, med-

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133 *See, e.g.*, Johnson v. Calvert, 851 P.2d 776, 778 (Cal. 1993) (in which intended parents triumphed over gestational surrogate who sought custody of the child to whom she gave birth); *In re* Baby M., 537 A.2d 1227 (N.J. 1988) (in which traditional surrogate was found to be the legal mother of a child to whom she gave birth, but lost custody to the biological father).

134 There are numerous agencies in the United States acting as brokers between intended parents and surrogates. *See* SPAR, *supra* note 56, at 3; Stephanie Saul, *Building a Baby, with Few Ground Rules*, N.Y. TIMES, Dec 13, 2009, at A1 [hereinafter Saul, *Building a Baby*]. Outside of these agencies, which are not subject to licensing or other regulation by state or federal governments, potential surrogates and potential parents can find each other on websites like Surrogate Mothers Online (http://www.surromomsonline.com/) which post classified ads for intended parents and potential surrogates. Brokered deals are no guarantee of a successful arrangement as evidenced by the disastrous implosion of a baby-selling ring spearheaded by a well-known reproductive lawyer. *See Prominent Surrogacy Attorney Sentenced to Prison for Her Role in Baby-Selling Case,* FBI (Feb. 24, 2012), http://www.fbi.gov/sandiego/press-releases/2012/prominent-surrogacy-attorney-sentenced-to-prison-for-her-role-in-baby-selling-case. California was also the site of a scandal when the owners of a surrogacy agency called SurroGenesis abruptly shut the agency's doors and disappeared with approximately two million dollars paid by clients and owed to surrogates, some of whom were mid-pregnancy. *See* Stephanie Saul, *Would-Be Parents Find Surrogate Agency Closed*, N.Y. TIMES, Mar. 21, 2009, at A14 [hereinafter Saul, *Would-Be Parents Find Surrogate Agency Closed*] Even so, do-it-yourself deals may have a greater likelihood of ending in disaster for all of the parties involved. *See* Mark Hansen, *As Surrogacy Becomes More Popular, Legal Problems Proliferate*, ABA J., March 2011, at 53, 55–56.

135 See Melanie Thernstrom, *Meet the Twiblings*, N.Y. TIMES MAG., Jan. 2, 2010, at 30 (describing the process of hiring two gestational surrogates to carry children for an infertile couple); Alex Kuczynski, *Her Body, My Baby*, N.Y. TIMES (Nov. 28, 2008), http://www.nytimes.com/2008/11/30/magazine/30Surrogate-t.html?pagewanted=all&_r=0 (describing the profiles of gestational surrogates).

136 *See* Kuczynski, *supra* note 135.

137 *See, e.g.*, *Agency Fees & Surrogate Mother Costs*, THE SURROGACY SOURCE, http://www.thesurrogacysource.com/ip_fees.htm?type=Intended%20Parent (last visited Oct. 26, 2012) (noting that fees for surrogates begin at $24,000, but that experienced surrogates can earn $32,000-$37,000).

ical care, travel, housing, and a range of other costs can make the final price tag of a surrogacy arrangement soar as high as six-figures.[138]

By contrast, in India, surrogacy arrangements take place within a context of very lopsided power dynamics and access to resources.[139] While the standard of hiring women who are married and who have already given birth to children exists overseas as it exists in the United States,[140] the lives of Indian surrogates are substantially less economically stable than those of surrogates hired in the United States.[141] The "globalization of reproduction" as practiced in India involves hiring women who often come from harsh economic circumstances.[142] Dr. Nayana Patel runs a successful fertility clinic in Anand, India where, at any given time, there might be six or seven pregnant women living in her facility while waiting to give birth to children for paying customers.[143] Patel's surrogates are paid anywhere from $3,900 to $6,500 for their reproductive labor; Patel sets the fee for each surrogate based on her own criteria.[144]

Even the high end of this pay scale is low by U.S. standards, though the payments made to these Indian surrogates is enough to substantially change their life circumstances.[145] For instance, one woman who worked for Patel as a surrogate used her $3,900 fee (150,000 rupees) to purchase a two-bedroom apartment for her family.[146] Other women use their surrogacy fees to buy much needed medical care for sick children or pay school fees for children who would otherwise need to leave school in order to help support their struggling families.[147] For Patel's surrogates,

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138 *See* Ali & Kelley, *supra* note 66 (noting that a surrogacy arrangement can cost between $40,000 and $120,000).

139 *See* Subramanian, *supra* note 129, at 40.

140 *See id.* at 44. In one small study of Indian surrogates, all of the women interviewed were married with children and ranged in age from 20–45 years old. Amrita Pande, *"At Least I Am Not Sleeping with Anyone": Resisting the Stigma of Commercial Surrogacy in India*, 36 FEMINIST STUDIES 292, 297 (2010).

141 Subramanian, *supra* note 129, at 44

142 *Id.* at 41–42.

143 *Id.* at 41, 44.

144 *Id.* at 47.

145 *See id.* (discussing that $2,500 is enough to change the lives of a middle-class Indian family). In some ways, the comparison to the pay scale in the United States is perhaps inapt. A woman in India whose surrogacy fee matches or exceeds what she earns with years of paid work, and that allows her to substantially lift the material circumstances of her family, is left much better off economically than a woman in the United States whose fee, often hovering around $20,000, might, in some cases, represent a year or less of salary. Ali & Kelley, *supra* note 66 (noting that surrogacy arrangement in the United States generally involve fees between $20,000-$25,000 for the surrogate). In this sense, the ultimate meaning of the pay might be significantly more consequential in India even if it is leaps and bounds less than what is offered in the United States. *See* Subramanian, *supra*, note 129, at 46.

146 Subramanian, *supra* note 129, at 40.

147 *See id.* at 44–45.

their fees exceed what they would earn from many years of conventional forms of paid work.[148] It should be noted, though, that not every person running a fertility clinic in India is necessarily as generous as Patel, who reports that she also provides ongoing primary healthcare to her surrogates even after they have completed their work for her.[149] Given the lack of extensive regulation in India, it is certain that there are unscrupulous actors who take serious advantage of the women engaging in this labor.[150]

Regarding the fear of exploitation, a surrogate working in the United States may have greater power in her relationship with the intended parents than a surrogate in India. For one, she may be able to communicate with the intended parents in a common language, giving her an opportunity to talk to them without the potential for important details getting lost in translation. The pool of available surrogates may be smaller in the United States, and the work and costs of finding someone to play this role is likely greater, also giving the surrogate more bargaining power. Ironically, the fact that the law on surrogacy in the United States is unformed and sometimes hostile to commercial arrangements may also put the surrogate in better standing if, at the end of a pregnancy, she desires to keep the child.[151] This is because in the absence of statutes or case law that dictate otherwise, the law will consider a woman who gives birth to a child to be that child's legal mother, even if she has no genetic tie to the child.[152]

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148 *See, e.g.*, *id.* at 40 (stating that one woman was paid "a sum that would take her years to earn in her job as a clerk at an incense store or with her occasional work as a government security guard."). A fee of $3,000 can be the equivalent of four to five years of family income for an Indian surrogate. Pande, *supra* note 140, at 297.

149 *See* Subramanian, *supra* note 129, at 47.

150 Margot Cohen, *A Search for a Surrogate Leads to India*, WALL ST. J., Oct. 8, 2009, at D1.

151 See Saul, *Building a Baby*, *supra* note 134. As a normative matter, laws that create ambiguity about children born to gestational surrogates do not serve the interests of intended parents, children, or gestational surrogates. *See id.* Arguably, a state that has no specific law in place and that defaults to gestation also creates an ambiguity of sorts by failing to respond to the reality of post-coital reproduction. But at least in those states courts can default to rules formed in a world in which coital reproduction was the only way to create babies. Others have argued persuasively that markets in reproduction would function better with clearer standards for parentage, and beyond. As one author wrote,

> In an effort to bring order to the current chaos, some experts have called for a uniform federal law governing surrogacy. Such a standard would prevent forum shopping for states with more favorable surrogacy laws—which reduces the bargaining power of individual surrogates; draws prospective parents from all over the country with the promise of easy, risk-free transactions; and allows agencies to get around the most restrictive state laws.

Hansen, *supra* note 134, at 57.

152 *See, e.g.*, *In re* Parentage of a Child by T.J.S. and A.L.S., 16 A.3d 386, 389 (N.J. 2011) (determining that despite a pre-birth order, the New Jersey Parentage Act does not confer parentage on the wife in a couple that commissioned a gestational surrogacy).

None of this is to say that there are no serious questions about the practice of surrogacy in the United States. There have been scandals related to surrogacy arrangements, including financial scandals involving agencies that misled surrogates and intended parents,[153] and tragic court cases involving surrogates who did not want to relinquish a child, or intended parents who did not want a child whose existence is owed to third-party reproduction.[154] These problems are almost inevitable in such a personal and volatile set of transactions. Nevertheless, setting these concerns aside, the distinctions this Article has drawn between surrogacy as practiced in the United States and surrogacy as practiced in India indicate that United States-based surrogacy practices engender less concern about the powerlessness of surrogates and the extent of their deprivation and exploitation than it does in developing nations. But it is worthwhile to test that initial instinct with a more stringent analysis of ethics.

The language of ethics is useful for thinking about what distinctions, if any, may be drawn between surrogacy in the United States and surrogacy in India, serving the larger purpose of this article—to contemplate why the interests of ART consumers and sellers are served when people travel to the United States to take advantage of ART. The ethics of a particular practice can potentially be evaluated differently across time, space, and geography.[155] The surrogacy example proves this point when viewed through Michael Sandel's rubric of coercion and corruption.[156] Sandel argues that some markets corrupt and some markets coerce. He urges rejecting unjust markets that "arise when people buy and sell things under conditions of severe inequality or dire economic neces-

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153 In 2009, a California based surrogacy broker, SurroGenesis, found itself the subject of several media reports and, ultimately, a federal investigation after money meant to pay surrogacy fees and medical expenses disappeared. *See* Kimi Yoshino, *Fears Over Surrogacy Funds: Firm's Alleged Halt in Payments to Surrogates Raises Prospective Parents' Concerns*, L.A. TIMES, Mar. 21, 2009, at A3.

154 *See, e.g.*, Johnson v. Calvert, 851 P.2d 776, 778 (Cal. 1993) (intended parents triumphed over gestational surrogate who sought custody of the child to whom she gave birth); Buzzanca v. Buzzanca, 72 Cal. Rptr. 2d 280 (Cal. Ct. App. 1998) (involving intended parents who paid a surrogate to carry their child, and later the biological parents sought a court order to be named the legal parents of the child); *In re* Baby M., 537 A.2d 1227 (N.J. 1988) (traditional surrogate was found to be the legal mother of a child to whom she gave birth, but lost custody to the biological father).

155 As the anthropologist Lynn M. Morgan notes: "Bioethicists have joined the quest to become more culturally sensitive, acknowledging that philosophy is too often rooted in culture-bound assumptions phrased in the language of universal truths." Lynn M. Morgan, "*Life Begins When They Steal Your Bicycle*": *Cross-Cultural Practices of Personhood at the Beginnings and Ends of Life*, 34 J.L. MED. & ETHICS 8, 10 (2006). In other words, our ethical understandings are rooted in culture and therefore are subject to the critique that they speak not to universal understanding, but to the understanding of a particular time and place.

156 *See* MICHAEL J. SANDEL, WHAT MONEY CAN'T BUY: THE MORAL LIMITS OF MARKETS 43–47 (2012) (describing different ways in which markets can corrupt or coerce).

sity."[157] In these circumstances, "market exchanges are not necessarily as voluntary as market enthusiasts suggest."[158] By this measure, people who bring their fertility quest to India in order to hire surrogates at cheaper rates and/or avoid bans on commercial surrogacy in their home countries are, in fact, participating in a markedly coercive exchange because it is an exchange in which the background conditions of the exchange are substantially unfair.[159] Women in India acting as surrogates do not necessarily do so in an environment in which they have access to a multiplicity of choices and find that surrogacy best suits their skills and interests.[160] Instead, within the constraints of culture and economics, they may acquiesce to an act that would hold little or no appeal to them in a world that offered substantially more diverse choices for survival and flourishing.[161]

Arguably, in the United States, the background conditions between typical commissioning intended parents and a typical surrogate mother are less troubling, in part because of the desires of the intended parents for healthy and well-insured surrogates as described earlier. The less gaping divide between buyer and seller in the American surrogacy market allows for the conclusion that this element of objection to the exchange is less salient in United States-based CBFC. This is not to say that the claim is completely without merit in the United States, but it does not resonate in the same way. While one can certainly still make the claim that the market in surrogate bodies is coercive, whether in the United States or abroad, the extent of that coercion seems to be lessened when the people involved are not from countries with drastically opposing overall economic structures.

A separate issue is whether the market in surrogacy corrupts, which Sandel describes as "the degrading effect of market valuation and exchange on certain goods and practice."[162] This critique goes to "the moral importance of the goods at stake, the ones said to be degraded by market valuation and exchange."[163] It should be clear that the corruption argument is "intrinsic" and therefore "cannot be met by fixing the background conditions within which market exchanges take place."[164] By

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157 Michael J. Sandel, Professor of Government, Harvard University, The Tanner Lectures on Human Values: What Money Can't Buy: The Moral Limits of Markets, delivered at Brasenose College, Oxford, (May 11–12, 1998), at 89, 94 [hereinafter Sandel Lecture] *available at* http://tannerlectures.utah.edu/lectures/documents/sandel00.pdf.

158 *Id.*

159 *Id.* at 94–95.

160 *See* Arlie Hochschild, *Childbirth at the Global Crossroads*, AM. PROSPECT (Sept. 19, 2009), http://prospect.org/article/childbirth-global-crossroads-0.

161 *Id.*

162 Sandel, *supra* note 157, at 94.

163 *Id.* at 95.

164 *Id.*

this measure, whether consent is coerced or voluntary is irrelevant to the question of whether placing a value on babies or on a woman's womb degrades these "products" to such an extent that the market must be condemned. Here, the objection carries just as strongly through the Indian market in surrogates as it does through the United States. In either case, one can believe that the societal consequence of creating commercial transactions that result in the birth of a child and the transfer of rights from a gestational carrier to intended parents in exchange for money is at least troubling, if not deeply concerning. If the market corrupts, one can vociferously argue that it should be shut down, and if it is not shut down, its reach should at least be confined as much as possible. If this is a fair argument, then we should not only condemn the market as an unethical practice, legality notwithstanding, but we should also discourage people from participating in it, no matter whether they are native users or people seeking CBFC.

While it may be tempting to use people seeking CBFC as pawns in an attempt to create a more generally stringent regulation of surrogacy, we should be hesitant to go down the road of using travel status to mark some desires for genetic parenthood as unworthy of satisfaction. If it became United States' policy to exclude people from engaging in surrogacy on United States soil based on a corruption rationale, it would seem ludicrous to limit this ban only to CBFC. If the surrogacy market corrupts, then it corrupts for all, not just the few who seek CBFC, and it should therefore be inaccessible to all.

Even if the surrogacy consumers will leave the country once their wanted children are born, the impact of such a trade on our society will remain. In other words, the country in which the deed is done will experience some taint from CBFC even if the most pernicious impact will come mostly from native users, assuming that most of them will raise their surrogate conceived children on United States' soil. It is these native families that remain in our midst who will ostensibly slowly rend the fabric of family as we know it. If, as a nation, we are insufficiently motivated to end this trade as practiced by the people who are native users of the technology, it is difficult, if not impossible, to offer solid reasoning for making the technology inaccessible to others.

Importantly, the conversation here is not about providing insurance coverage for people seeking CBFC, or loosening any existing restrictions that may exist, or even facilitating such arrangements. The focus here is simply on the question of complicating or banning access to surrogacy for a specific population of people based only on where they are from. That this nation, unlike others, has not seen fit to completely ban commercial surrogacy, either because we do not completely believe that it corrupts or because we are more concerned with other things, is a con-

vincing indicator that the practice's perceived or possible impact on the larger society is insufficient to spur reaction. Until we create consensus on whether the market should be open for anyone, the market should remain open to all those who would use it as long as they do not violate existing laws in doing so and can find a willing practitioner to provide the requested care.

III. MORE JUSTICE CONCERNS: DISCARDED EMBRYOS, LIVES UNLIVED, AND CBFC

"Cross border reproductive care is an under recognised [sic] and unregulated phenomenon that is likely to increase as ART technology becomes ever more and possibly more attractive . . . ."[165]

A more vexing set of concerns raised in the proffered scenarios is how to react to foreign rules and laws focused not on a desire to deprive individuals of access to genetic parenthood, but on a governmental obligation to act in the interest of its citizens. This includes diminishing practices like sex-selection that unfairly and disproportionately target girls,[166] or more broadly, a perceived obligation to protect the category of procreation and human reproduction, i.e., by refusing to allow market principles to overtake the process of creating and giving birth to new human beings. In these circumstances, the balance between protecting an individual interest in family and procreation against a potentially more far-reaching societal interest is perhaps harder to do. A native country or its government might say that it is because the traveler will return with a child and integrate her expanded family into the community that the United States needs to be more restrained in its provisions for fertility services. The societal consequences of choices made by people accessing CBFC may be partially born by the country that hosts the traveler, but they will also weigh heavily upon, and perhaps most heavily upon, the countries to which those travelers return. In other words, the political and social ramifications may be substantial enough to warrant being taken seriously by the country that will not experience the brunt of those ramifications.

If India wants to reduce the number of *missing* girls, it will not be pleased if those with the wherewithal to do so travel abroad to avoid strictures against sex selection. If Italy wants to show respect for *natu-*

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165 A. McKelvey et al., *The Impact of Cross-Border Reproductive Care or 'Fertility Tourism' on NHS Maternity Services*, 116 BJOG 1520, 1523 (2009).

166 *See* Sabu M. George, *Millions of Missing Girls: From Fetal Sexing to High Technology: Sex Selection in India*, 26 PRENATAL DIAGNOSIS 604, 604–605 (2006); Ted Plafker, *Sex Selection in China Sees 117 Boys Born for Every 100 Girls*, 324 BRITISH MED. J. 1233, 1233 (2002).

ral[167] procreation and the human variation that it brings, including disease or disability, by requiring the transfer of all embryos made outside of the body, it too may find fault with a country that turns a blind eye to its concerns. Similarly, if the United Kingdom thinks that all children have a right to know their genetic origins, the society suffers when children whose parents use ART in the United States do so with gametes sold anonymously. In these cases, open borders, unlike discrimination against single people or families created by gays and lesbians, facilitate and support an arguably discriminatory act, rather than rejecting that act. Perhaps CBFC may be devastating enough to a country's character such that not only should travelers feel bound by the laws of home, but the destination country should also seek to effectuate the moral precepts that undergird those laws when foreign citizens are on their soil.

One response to this claim is that if there is such an obligation to respect the rules of one's home, it is the obligation and right of the home country to enforce these rules, rather than an obligation of the destination country. As described in parts earlier, countries that wish to assert power beyond their borders to restrict the actions of their citizens can take steps to make the option of CBFC less attractive.[168] Some nations create sanctions for physicians or others who promote CBFC.[169] In other countries, laws complicate the process of creating a legally recognized relationship with a child born through ART on foreign soil.[170] This serves the purpose of creating a serious impediment to fertility travel if one plans to return home afterwards.

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167 The distinction being drawn here between natural and unnatural procreation is meant only to highlight this element of the critique of assisted reproduction and not to embrace any categorization of ART as unnatural.

168 *See* discussion *supra* Part I.A.

169 *See* Ferraretti et al., *supra* note 21, at 262.

170 New Zealand warns its citizens who engage in international surrogacy arrangements that:

> 1. being named as a parent on a foreign birth certificate for a child born as a result of a surrogacy arrangement, does not mean that the birth certificate will meet New Zealand immigration or citizenship requirements, and
> 2. any adoption or guardianship orders issued by an overseas court for a child born overseas as a result of a surrogacy arrangement will not necessarily meet New Zealand immigration or citizenship requirements, and,
> 3. that the issuing of a foreign passport does not necessarily entitle the child to New Zealand citizenship.

International Surrogacy, CHILD YOUTH & FAMILY OF N.Z., http://www.cyf.govt.nz/documents/adoption/international-surrogacy-information-sheet.pdf (last visited Apr. 9, 2011). Further, a surrogate mother is the legal mother of a child under New Zealand law and "as the egg and sperm donor will usually have no legal parental relationship with a child born as a result of a surrogacy arrangement, the child is not entitled to be issued with New Zealand citizenship by descent, and travel documents will not be issued for the child." *Id.* All of this means that parents, even genetic parents, who have a child via surrogate in a foreign country will need to do an adoption once they return to New Zealand in order to become legal parents of their child. *Id.*

The adoption laws of a destination country may create impediments to family formation, as one Japanese man discovered when his wife left him during the pendency of a surrogate pregnancy in India, and he found that India would not let him adopt as a single father.[171] Similarly, some countries make it difficult to establish citizenship in the home country for a child who is born outside of that country's borders to a gestational carrier who is a United States citizen. In April 2011, a French court ruled against the Mennessons, a husband and wife raising ten-year-old twin girls in France who were born to a gestational surrogate in California.[172] The family was attempting to establish French citizenship for the girls who are American citizens due to the circumstances of their birth.[173]

Still other travelers will find that the adoption laws of their country will not let them create the legally recognized families that they seek even if they are able to bring a child into a relationship by accessing services in the United States. For instance, a same-sex couple not allowed to legally marry in a home country may be similarly barred from being the adoptive parents of a child who is born through an arrangement facilitated in the United States that would not have been sanctioned in the home country.[174] Arguably, where the laws of a home country will thwart the family building goals of reproductive travelers, the travel should not be undertaken. But for many people for whom having a child is paramount, and particularly having a child with whom they share a genetic connection, the risks inherent in engaging in CBFC will be worth

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171 The complicated entanglement of laws relating not just to ART, but to adoption, can create unforeseen complications for those accessing CBFC. One Japanese man discovered this truth when he and his wife hired a surrogate in India to bear a child for them. The couple divorced during the process and the ex-wife was no longer interested in parenting the child born to the surrogate, though her husband remained eager to be the child's legal father. Unfortunately, Indian law does not allow single men to adopt. Consequently, the man spent many months wrangling with Indian authorities before he was able to leave the country with his child. Marcy Darnovsky, *Complications of Surrogacy: The Case of Baby Manji*, BIOPOLITICAL TIMES, Sept. 18, 2009, http://www.biopoliticaltimes.org/article.php?id=4923.

172 *See France Rules Against Children of Surrogate Mothers*, SIFY NEWS, http://www.sify.com/news/france-rules-against-children-of-surrogate-mothers-news-others-lejrOnbhdee.html (last updated Apr. 9, 2011).

173 See id.

174 According to the Human Rights Campaign:

> At this point, it is very difficult to pursue an international adoption as an openly same-sex couple, or as an openly single LGBT person. Many of the countries that have children for adoption are extremely prejudiced against LGBT people, and either have explicit laws or policies or implicit cultural or societal "codes" that are against LGBT adoption. Presently, even the most welcoming agencies are exercising extreme caution about representing any LGBT people for international adoption because the process in general is becoming more challenging and even non-LGB couples are likely to face increased barriers.

Adoption Options Overview, HUMAN RIGHTS CAMPAIGN, http://www.hrc.org/resources/entry/adoption-options-overview (last visited October 5, 2012).

it. The fact that there are risks to CBFC suggests some obligation on the part of any agency that brokers such deals or attorneys who participate in these deals to make sure that clients are well informed of the pitfalls of their choice to travel for access to ART, but this does not require or suggest that a ban on such procedures would be appropriate or necessary. Further, as noted, the fact that home countries can, and do, act to protect their own interests diminishes the need for the United States to pursue policies that arguably violate its own commitment to pluralism.

All of this discussion, though, begs the question of whether there is value or valor in providing access to ART tools that will be used in ways that potentially denigrate whole communities of people. As a starting point, one can reject the inquiry based on the idea that if there is a concern about sex-selection as a means of reinforcing sexism, the problem that needs to be dealt with is sexism, not sex-selection. Barring people from engaging in sex-selection is not a way of changing the underlying foundation of a society in which pressure for boys is so significant that people will use a variety of technological means to have sons rather than daughters.[175] One could make a similar claim about concerns that PGD undermines the worth of people who are living with disabilities.[176] Again, if the goal is to change how the society perceives disabilities, the use of PGD is a symptom, not a cause, of that perception. This is also a situation in which it is clear that the impetus for change must come from within the society and that choices made in other nations will have negligible impact on domestic norms to the extent that those choices are unknown or unknowable by the home country.

There are certainly instances in which world-wide cooperation to stamp out a universally condemned practice is appropriate and nations seek and expect cooperation when it comes to citizens who cross borders to engage in these behaviors. For instance, as part of an international effort to protect minors from sex trafficking, the United States punishes its citizens who travel to foreign countries to engage in sexual conduct that is illegal in those countries and in the United States, such as sexual contact with minors.[177] It is a violation of federal law for a citizen or a permanent resident of the United States to travel in order to engage in

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175 *See, e.g.*, Julian Savulescu & Edgar Dahl, *Sex Selection and Preimplantation Diagnosis: A Response to the Ethics Committee of American Society of Reproductive Medicine,* 15 HUM. REPROD. 1879, 1880 (2000) (rejecting the idea that sex selection is a sexist act, at least as it is practiced in the West, or that it reinforces gender bias in the larger society).

176 *See, e.g.*, Amy Harmon, *In New Tests for Fetal Defects, Agonizing Choices for Parents*, N.Y. TIMES, June 20, 2004, at N1 (describing arguments by advocates for those living with disabilities about the relationship between genetic testing and eugenics).

177 The relevant statutory sections reads as follows:

> (b) Travel with intent to engage in illicit sexual conduct—A person who travels in interstate commerce or travels into the United States, or a United States citizen or an alien admitted for permanent residence in the United States who travels in foreign

sex tourism.[178] The relevant statute proscribes "travel with intent to engage in illicit sexual conduct" or "engaging in illicit sexual conduct in foreign places."[179] There are international instruments (conventions) on child prostitution, sale of children, and inter-country adoption, which speak to the global consensus on the issue of crimes against children.[180]

In light of a relatively world-wide consensus that crimes against minors, sexual and otherwise, deserve to be severely punished and deterred through the use of the substantial weight of the criminal law, it makes complete sense that the United States and other nations cooperate across national borders in stopping this behavior. CBFC, however, is not sex tourism. While it involves the creation of children, it certainly does not involve the systematic sexual abuse and exploitation of children. While some may argue that commodification of reproduction is not good for a society, in that it undermines important values about family and relationships between parents and children,[181] it is difficult to argue that bringing

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commerce, for the purpose of engaging in any illicit sexual conduct with another person shall be fined under this title or imprisoned not more than 30 years, or both.

(c) Engaging in illicit sexual conduct in foreign places.—Any United States citizen or alien admitted for permanent residence who travels in foreign commerce, and engages in any illicit sexual conduct with another person shall be fined under this title or imprisoned not more than 30 years, or both.

(f) Definition.—As used in this section, the term "illicit sexual conduct" means (1) a sexual act (as defined in section 2246) with a person under 18 years of age that would be in violation of chapter 109A if the sexual act occurred in the special maritime and territorial jurisdiction of the United States; or (2) any commercial sex act (as defined in section 1591) with a person under 18 years of age.

Transportation of Minors, 18 U.S.C. § 2423 (2006).

178 *See id. See, e.g.*, Heather Montgomery, *Buying Innocence: Child-Sex Tourists in Thailand*, 29 THIRD WORLD Q. 903, 903 (2008) (describing and analyzing sex tourism with adult women and children in Thailand); Joan Phillips, *Female Sex Tourism in Barbados: A Postcolonial Perspective*, 14 BROWN J. WORLD AFF. 201, 201 (2008); Patrick Vrancken & Kasturi Chetty, *International Child Sex Tourism: A South African Perspective*, 53 J. AFRICAN L. 111, 112 (2009) (describing sex tourism in South Africa).

179 18 U.S.C. § 2423.

180 *See Hague Conference on Private International Law: Final Act of the 17th Session, Including the Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption*, May 29, 1993, 32 I.L.M. 1134 (1993); Optional Protocols to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict and on the Sale of Children, Child Prostitution and Child Pornography, G.A. Res. 54/263, U.N. Doc. A/54/263 (May 25, 2000).

181 *See, e.g.*, Anderson, *supra* note 116, at 90 ("To recognize the legality of commercial surrogate contracts would undermine the integrity of families by giving public sanction to a practice which expresses contempt for the moral and emotional ties which bind a mother to her children, legitimates the view that these ties are merely the product of arbitrary will, properly loosened by the offering of a monetary incentive, and fails to respect the claims of genetic and gestational ties to children which provide children with a more secure place in the world than commerce can supply."); Sandel, *supra* note 157, at 103 ("The marketing of Ivy League sperm commodifies the male reproductive capacity in much the way commercial surrogacy commodifies pregnancy. Both treat procreation as a product for profit rather than a human capacity to be exercised according to norms of love, intimacy, and responsibility.").

wanted children into the world who will be cared for by loving parents is akin to abuse. The dissimilarities continue, but the end point is that the diversity of regulation of ART speaks to the lack of an international consensus on what is and is not acceptable reproductive behavior. Where such a consensus does not exist, there is no convincing rationale for requesting extra-territorial cooperation to enforce culturally specific laws.[182]

A. *CFBC as a Safety Valve*

Rather than undermining the lawmaking of other countries, it is possible to imagine that the role played by the United States in the global market for ART is actually a critical one. It might be the case that other countries feel freedom to restrict choices within their borders because they are well aware that access to such care can be found elsewhere. Richard Storrow suggests that prohibitions created in the United Kingdom, including the commercial surrogacy ban, were created with full knowledge that citizens who desired such treatment could access it by leaving home.[183] He writes, "[i]t is in precisely this way that fertility tourism acts as a moral safety valve permitting national parliaments to express local sentiments while simultaneously acknowledging the moral autonomy of those who do not agree with those sentiments."[184] Others describe the lack of harmonization of ART laws, which facilitate migration, as "reduc[ing] moral conflicts and contribut[ing] to the peaceful coexistence of different ethical and religious views."[185] If these scholars are correct, then a refusal to enforce the rules of an origin nation on United States soil is, in fact, in keeping with that nation's delicate attempt to create a particular type of society on its own soil; a society that recognizes that its diverse citizens might want things that the governments deems not in the interest of the society as a whole. Nations with some semblance of freedom of movement are well aware that their citizens are not trapped within their borders. When those citizens use their passports to exercise a desire for a freedom not available to them at home, that is an exercise of their rights as citizens.

One might argue in this circumstance that the United States should be wary of embracing a role as a place that is insufficiently cognizant and incapable of being legislatively responsive to practices that raise serious red flags about harms to societies and children. On the other hand, the country could be playing a vital role within our flat world where it is

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182 *But see* Cohen, *supra* note 11, at 1373–86 (arguing that jurisdictions may in fact have good reasons to seek extra-territorial enforcement of their laws related to procreation).

183 Storrow, *supra* note 82, at 305.

184 *Id.*

185 Ferraretti et al., *supra* note 21, at 262.

necessary and right to support pluralistic choices about procreation and family. If it is right that countries feel less constrained to liberalize their laws because they know that their citizens can access care elsewhere, in keeping with the earlier discussion about accessing CBFC as an act of resistance, the United States can think of its open borders as a safe haven for those who would be denied fairness and equality in their countries of origin. This is in keeping with a vision of the United States as a pluralist nation with an ethos of equality in access to human goods, including freedom to procreate.

Of course in many nations, only those with class privilege will be able to express their disagreement with their nation's laws by leaving. This does not, however, mean that people who remain within the country will see no benefit from the availability of CBFC. Over time, the outward flow of citizens may force countries to reconsider the strictness of their own rules and perhaps even change those rules to respond to the needs of their citizens. The United Kingdom reconsidered its policy on pre-implantation diagnosis after a widely publicized case of citizens leaving to access a variation of this service abroad.[186] If reconsiderations of this type occur, the United States should feel that its role in leading nations toward more inclusive policies is justified and productive.

B. Protecting the Public's Health

Finally, a nation may seek to diminish access to CBFC not only because of the psychic consequences to the society, but also because of potential costs to the local public health system. As Debora Spar suggests, "[a] cross-border market for reproduction also means that societies that oppose assisted reproduction may nevertheless pay its costs. For who can prove that premature quintuplets born in Bremen were conceived in Istanbul?"[187] One small-scale study of the British National Health Service Maternity Services found that a significant number of multi-fetal pregnancies had their genesis in patients receiving fertility care outside of the United Kingdom.[188] Obviously, because of the unique nature of the care being provided, the consequences of seeking CBFC influence "not just the health and well-being of one individual but also that of the child or children born of the process, as well as potential

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[186] *See Whitaker*, *supra* note 2. In 2008, after Parliament determined that pre-implantation tissue typing (PTT) was an acceptable use of technology, the HFEA reconsidered its stance on so-called savior siblings and decided that it would grant permission for this specific use of reproductive technology in certain cases. *See id.*; *PTT Regulated*, *supra* note 2.

[187] Debora Spar, *Reproductive Tourism and the Regulatory Map*, 352 NEW ENG. J. MED 531, 533 (2005).

[188] *See* McKelvey et al., *supra* note 164, at 1523 ("Fertility treatment outside the UK was responsible for over a quarter of fertility-treated high order multiple pregnancies seen in a UK specialist multiple pregnancy clinic.").

future generations."[189] This concern is more difficult to confront because it ostensibly has less to do with who is seeking to procreate and make a family and much more to do with the public health consequences of such choices for society, families, and children.

Here, though, it appears that there are attempts to harmonize medical practice across borders to serve the interests of people who are accessing fertility care.[190] An example of this phenomenon is found in practices related to the number of embryos transferred during an IVF cycle. Even without the kind of extensive control exercised over fertility practices in other countries, reproductive physicians in the United States, through the professional associations that govern them, are becoming much stricter about promulgating standards for embryo transfer in IVF calculated to lead to substantial reductions in the number of multiple pregnancies created as a result of ART use.[191] This puts United States' practice closer in line with practices in other parts of the world.[192] This shows that harmonization is absolutely possible when the need is clear and the resolution supported by medical science.

CONCLUSION

For some, the United States has earned its reputation as a wild frontier where anything goes when it comes to ART. While the Wild West[193] metaphor has dramatic appeal, it is not accurate, and it denigrates both those who work in the industry with care and conscience and those who travel to the United States, not because they will do anything to fulfill a desire for parenthood, but because they will do many things to fulfill this desire.

In a world in which national borders have lost much of their rigidity, CBFC is just one of many services that consumers will seek in forums that are friendlier because of cost, availability of service, or less stringent laws. In such a world, denying medical services simply on the

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189 Lynn Mainland & Elinor Wilson, *Principles of Establishment of the First International Forum on Cross-Border Reproductive Care*, 94 FERTILITY & STERILITY e1, e2 (2010).

190 Complete harmonization is unlikely, for as one set of authors explains, an international consensus on regulation of fertility care and practice, "could not be reached because of a diversity of traditions, political situations, and medical practices. An international 'consensus' appears to be a utopia, and we can imagine that if it existed, it would reflect the lowest common denominator." *Conclusion,* 87 FERTILITY & STERILITY S67, S67 (Supp. 1 2007).

191 *See* Practice Comm. of the Am. Soc'y for Reprod. Med. and the Practice Comm. of the Soc'y for Assisted Reprod. Tech., *Guidelines on Number of Embryos Transferred*, 92 FERTILITY & STERILITY 1518, 1518 (2009).

192 *See, e.g.*, *HFEA Guidance Note on Multiple Births*, HUM. FERTILISATION EMBRYOLOGY AUTH. (Oct. 7, 2011), http://www.hfea.gov.uk/docs/2011_OCT_7_multiple_births.pdf. (discussing practice guidelines for minimizing the number of multiple births in licensed fertility clinics in the United Kingdom).

193 *See* Coeytaux et al., *supra* note 54, at 2.

basis of travel status may in fact thwart the will of other nations, which can use the United States as a safety valve for their own citizens, and detract from attempts to position the United States as a nation that embraces variations in family structure. At some points, a respect for plural families may seem to conflict with other values related to public health or commodification, and where countries feel strongly about these issues, they have law and policymaking tools at their own disposal to use against their own citizens. Whether these uses are appropriate is a question for a different discussion. Here it suffices to say that the United States' position that sees wide access to procreative tools as furthering other important societal goals warrants respect and should be sustained.