

If I Say “Yes” to Regulation Today, Will You Still Respect Me in the Morning?

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Marsha Garrison¹ and Michele Goodwin² have each written clever, edgy, and insightful articles on the oversight of new reproductive technologies. Both of them frame the issues around the regulation of *reproduction*, not *assisted reproduction*. “Assisted reproduction” might mean doctors, clinics, or patients. “Reproduction” clearly means mothers. Both are correct in this recognition: the regulation of assisted reproduction necessarily implicates our approach to motherhood.

Garrison starts with the intrinsic conflicts of interest between mothers and children in medical decisionmaking and argues for “the equivalence of future and current children.”³ She observes that parental decisions may be particularly suspect in the context of the treatments elected in pursuit of a much sought-after pregnancy.⁴ The infertile may ignore risks to “future children,” if the alternative is no children at all.⁵ Garrison accordingly answers with a resounding “yes” to oversight that would restrict reproductive choice, believing it would reduce the number of children who burden the community with avoidable birth defects.⁶

Goodwin is more ambivalent. She starts her article not in the pristine surroundings of a fertility lab, but with the first woman to be prosecuted and convicted for giving birth to a stillborn baby.⁷ She queries whether a “communitarian” approach that regulates reproduction in the name of collective well-being will inevitably sacrifice the interests of poor, African American women to majoritarian

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1 Marsha Garrison, *Regulating Reproduction*, 76 GEO. WASH. L. REV. 1623 (2008).

2 Michele Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657 (2008).

3 Garrison, *supra* note 1, at 1642.

4 *See id.*

5 *See id.*

6 *See id.* at 1647–51 (proposing a quasi-public regulatory system similar to that currently utilized for organ donation be used to regulate reproductive choices).

7 Goodwin, *supra* note 2, at 1657–58 (discussing the “homicide by child abuse” conviction of Regina McKnight in South Carolina in 2003).

norms.⁸ She tellingly juxtaposes the prosecution of drug-addicted pregnant women for harm to their fetuses, whose conceptions may not have been planned or entirely voluntary, with the very deliberate (and uncriminalized) choices of middle-class women to ingest fertility enhancing chemicals, implant multiple embryos, undergo prenatal testing, and otherwise engage in elective medical practices known to increase the likelihood of birth defects.⁹ She seems to doubt that any system of regulation can be applied with equal respect for all women, and therefore doubts whether she can respect any system at all.¹⁰

This Article suggests that the intersection of Garrison and Goodwin's articles raises profound issues about the purpose and practicality of regulating reproduction. Historically, reproduction has been highly regulated, whether through official sanctions, e.g., laws channeling reproduction into marriage by criminalizing fornication and adultery,¹¹ or through less formal norms. These regulations, both formal and informal, established expectations about the circumstances in which highly dependent new mothers could expect support in caring for their children.

Naomi Cahn and I have argued elsewhere that the terms of acceptable reproduction are changing, and that they are doing so along class, race, and regional lines.¹² What we have termed "the new middle class morality"¹³ privileges childbearing after the acquisition of emotional maturity and financial independence. For college educated women and their children, this has further enhanced the resources, financial and emotional, available for childrearing. It has also meant, however, beginning efforts to conceive at a time in life when fertility may already have begun to decline. For these women, access to assisted reproduction that will guarantee biological offspring may seem to be a matter of entitlement in the psychological sense, if not the legal sense.

⁸ See *id.* at 1669–70.

⁹ See *id.* at 1710–14.

¹⁰ Goodwin states: "The Article argues that the communitarian approach to regulating reproduction leads to inconsistent outcomes, unintended consequences, distributional unevenness, decreased utility, and economic inefficiencies." *Id.* at 1663.

¹¹ For a more thorough discussion of such laws, see RICHARD A. POSNER & KATHARINE B. SILBAUGH, *A GUIDE TO AMERICA'S SEX LAWS* 98 (1996); Jeremy D. Weinstein, Note, *Adultery, Law, and the State: A History*, 38 HASTINGS L.J. 195 (1996) (recounting and analyzing remedies for adultery throughout history).

¹² See generally Naomi Cahn & June Carbone, *Deep Purple: Religious Shades of Family Law*, 110 W. VA. L. REV. 459 (2007) (arguing, in part, that variations in approaches to abstinence education and teen pregnancy break along religious, racial, and regional lines).

¹³ See, e.g., *id.* at 479.

The new middle-class norms do not offer much support to those women who experience pregnancies outside these new parameters. The accidental conception, in an era before contraception and abortion, might have triggered a shotgun wedding and the marshalling of resources to address the birth. Today, women may more readily choose to raise a child on their own, but they cannot always rely on support from the father or the surrounding culture. As a result, family structure and resources have become markers of inequality, with young, nonmarital childbearing contributing to a growing disparity in the resources, both financial and emotional, available for children.

This Article examines the prospect for regulation "we can still respect in the morning" in the context of these class-, race-, and regional-based differences that exist in reproduction experiences. First, the Article describes Garrison and Goodwin's respective approaches to the role of regulation. The rise of the administrative state—and pervasive regulation of private life—came with the expectation that expertise could be separated from politics. Today, with that illusion in tatters, the issue becomes the role of regulation in setting appropriate norms that are accepted by the public rather than imposed from above.

Second, the Article discusses the prospects for agreed upon norms in the context of diverging expectations about reproduction. It demonstrates that age is an increasing marker of different understandings about family formation. For the middle-class women who have taken advantage of the greater opportunities made possible by the information economy, the average age of marriage and childbearing has moved from the early-twenties to the late-twenties, and with the shift has increasingly come intact, two-income families with considerably more resources than other parts of society.

Third, the Article explores the relationship between regulatory perspectives and race- and class-based differences in fertility. Statistics show, for example, that African Americans have higher fertility rates at every age until twenty-five, and have lower fertility rates at every age thereafter.¹⁴ In addition, almost half of African American pregnancies end in abortion, and two-thirds are unplanned.¹⁵ Moreo-

¹⁴ See Paul D. Sutton & T.J. Mathews, Nat'l Ctr. for Health Stats., *Trends in Characteristics of Births by State: United States, 1990, 1995, and 2000–2002*, NAT'L VITAL STATS. REPS., May 10, 2004, at 1, 31 tbl.4 (Vol. 52, No. 19), available at http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_19acc.pdf.

¹⁵ Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSP. ON SEXUAL & REPROD. HEALTH 90, 93 tbl.1 (2006), available at <http://www.guttmacher.org/pubs/psrh/full/3809006.pdf>; see also Rebekah J.

ver, while the profile of involuntary infertility has not been clearly mapped, preliminary studies indicate that African Americans suffer from greater infertility at younger ages, at least in part because of lesser access to medical care and higher rates of untreated sexually transmitted diseases.¹⁶

The Article finishes with a discussion of whether regulation of any kind is possible in this context. In doing so, it distinguishes between externally imposed sanctions such as the criminal law, and norm-shifting measures such as voluntary professional guidelines. A combination of autonomy and subsidy ultimately may prompt greater acceptance of responsible practices than prohibitions. The shared goal should be principles that enjoy consensus and respect in the light of day.

I. Garrison's "Interpretative Approach": ART as Site of Values Conflict?

In deciding who the legal parents of children conceived through assisted reproduction are, Garrison has advocated previously what she calls an "interpretative approach."¹⁷ She maintains that the values that inform family oversight more generally should be applied to the families produced through emerging reproductive technologies;¹⁸ those families do not require or benefit from a *sui generis* approach. If improvident conception is not a good idea in the bedroom, it is no better an idea in a test tube.¹⁹ Moreover, if the law in a given state favors two parents over one, on the basis of functional rather than biological roles *or vice versa*, Garrison would apply the same principles to the child who emerges from a petri dish.²⁰

Smith, *Family Caps in Welfare Reform: Their Coercive Effects and Damaging Consequences*, 29 HARV. J.L. & GENDER 151, 231–32 (2006) (reporting that 18% of white conceptions ended in abortion in comparison with 43% of African American conceptions and 25% for Hispanics).

¹⁶ See *infra* note 111 and accompanying text.

¹⁷ See Marsha Garrison, *Law Making for Baby Making: An Interpretive Approach to the Determination of Legal Parentage*, 113 HARV. L. REV. 837, 872–76 (2000). For a critique of this approach, see Naomi Cahn, *Perfect Substitutes or the Real Thing?*, 52 DUKE L.J. 1077, 1086 (2003).

¹⁸ See *supra* note 3 and accompanying text.

¹⁹ As Garrison puts it, "[t]he law has never cared whether sperm and ovum met in a fallopian tube or in the uterus; there is no obvious reason why it should care if sperm and ovum meet in a petri dish." Garrison, *supra* note 17, at 880.

²⁰ Compare, e.g., *In re Jesusa V.*, 85 P.3d 2, 15 (Cal. 2004) (applying the marital presumption in finding a biological mother's husband the presumed father when that status was challenged by the biological father), with *Callender v. Skiles*, 591 N.W.2d 182, 192 (Iowa 1999) (granting unmarried biological fathers a constitutional right to establish a relationship with their offspring, even if the child is born within an intact marriage to someone else), and *Witso v.*

Garrison's interpretative approach is controversial for at least two reasons. First, it takes the values that inform traditional family law as a given. Many scholars, in contrast, question those values as patriarchal or outmoded, and would like to see the legal principles emerging from assisted reproduction used to encourage the development of what they view as more appropriate values.²¹ Second, even putting aside the wisdom of traditional family law principles, the needs and aspirations of families created in the context of assisted reproduction may be different.²²

For example, women seeking to conceive a child through the use of artificial insemination by a donor often do not want or expect the donor to play an active role in rearing the child.²³ If a state that strongly favors two-parent families insists therefore on conferring the legal status, rights, and responsibilities of "father" on the donor, the effect may be to encourage use of anonymous sperm, or to alter the bargaining power of mother and donor in ways neither the state nor the parties may have foreseen. Nonetheless, Garrison has a strong argument that at least at the broader policy levels underlying the recognition of parenthood, the law applied to the children of assisted reproduction should be reconciled with more general family law principles.²⁴

In her article, Garrison extends her interpretative approach from the family law context in which she originally developed it to the medical decisions involved in assisted reproduction.²⁵ In doing so, however, she rejects a focus on the doctor-patient relationship, which she concedes is governed in other contexts by the principle of informed consent and patient autonomy.²⁶ Instead, she bases her "interpretative" critique on the laws governing abuse and neglect that protect

Overby, 627 N.W.2d 63, 69 (Minn. 2001) (concluding that an alleged biological father has standing to compel blood or genetic testing in order to establish he is the child's presumed father).

²¹ See, e.g., Cahn, *supra* note 17, at 1086 (emphasizing the importance of avoiding principles that have "bad beginnings").

²² See *id.* at 1084 (using the example of adoption to suggest that analogies drawn in the context of different functional families may not be appropriate).

²³ See, e.g., NANCY D. POLIKOFF, *BEYOND (STRAIGHT AND GAY) MARRIAGE: VALUING ALL FAMILIES UNDER THE LAW* 52 (2008) (noting use of artificial insemination by lesbian couples).

²⁴ For a detailed critique of the California Supreme Court's effort to do so, see June Carbone, *From Partners to Parents Revisited: How Will Ideas of Partnership Influence the Emerging Definition of California Parenthood?*, 7 WHITTIER J. CHILD & FAM. ADVOC. 3 (2007).

²⁵ Garrison, *supra* note 1, at 1628–31.

²⁶ *Id.* at 1634 (noting that "exclusive reliance on the decisionmaking of individual patients and physicians as a means of screening out inappropriate treatments is problematic . . . in the field of reproductive medicine").

children from their parents' ill-considered decisions.²⁷ She bases a critical part of her argument on the equivalence of existing children and future children, observing that:

Once a preembryo or fetus has been selected for birth, the state has an interest, grounded in both the public good and the principle of equality, in providing this future child with protections against health risks that are comparable to those that the state offers to current children.²⁸

In doing so, she emphasizes that existing law limits parental discretion in the treatment of their children, and cites as an example the Child Abuse Prevention and Treatment Amendments of 1984 ("CAPTA").²⁹ CAPTA provides that (virtually all) federally funded hospitals may not withhold "medically indicated treatment" to a neonate except in severely constrained circumstances.³⁰ Garrison then reasons that the "skewed parental risk-calculation possibilities inherent in infertility treatment bear more than a passing resemblance" to parental decisions to withdraw nutrition from seriously handicapped infants.³¹ Accordingly, if regulation is appropriate in the one context, it is appropriate in the other.

Putting aside the wisdom of the "interpretative approach" in the context in which it was developed, its extension to the regulation of medical decision raises a series of issues. First, why is this treated as a "parental risk calculation" rather than a medical decision reached through doctor-patient consultation and guidance? At least part of the reason seems to be Garrison's rejection of the medical model,

²⁷ See *id.* at 1642 (arguing for the "equivalence of future and current children" in the protection afforded to them by government regulations). See generally Sanford N. Katz et al., *Child Neglect Laws in America*, 9 FAM. L.Q. 1 (1975) (providing a survey of the child neglect laws for all fifty states and the District of Columbia); Elizabeth J. Sher, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157 (1983) (discussing the problems that beset courts in attempting to settle disputes regarding parental decisionmaking in the non-life-or-death medical context).

²⁸ Garrison, *supra* note 1, at 1640.

²⁹ 42 U.S.C. § 5106g (2000); see Garrison, *supra* note 1, at 1641–42.

³⁰ Under CAPTA, the "withholding of medically indicated treatment" is defined as "the failure to respond to the infant's life threatening conditions by providing treatment . . . which . . . will be most likely to be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment . . . to an infant when . . . (A) the infant is chronically and irreversibly comatose; (B) the provision of such treatment would—(i) merely prolong dying; (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or (iii) otherwise be futile in terms of the survival of the infant; or (C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane." 42 U.S.C. § 5106(g).

³¹ Garrison, *supra* note 1, at 1642.

which would concede decisionmaking autonomy to the patient, in favor of a family law model that would give more weight to children's interests.³²

Even then, this analysis raises the additional issue of why only the "parental" risk calculation is "skewed" and not also the doctors'? Doctors normally exercise considerable influence over a patient's decision about how many embryos to implant and what drugs to take. Doctors obviously can refuse to implant more embryos than the number they deem consistent with the children's and the mother's health. Moreover, to the extent that the existing system skews the incentives in favor of implanting more embryos than the ideal number required to protect the children's health, it skews the incentives even more for the doctors than for the patients.

Existing regulations mandate disclosure of fertility clinics' "success" rates.³³ "Success" is defined in terms of live births, not healthy infants.³⁴ Accordingly, a clinic, which competes with other clinics in demonstrating success in producing births, benefits from high birth rates. The clinics, however, do not bear the costs of the complications associated with multiple births;³⁵ the families of the resulting children do. While the drive to produce a biological child may cloud a parent's judgment, the parents will have to live with the resulting child. They, and not the doctors nor the hospital, bear the responsibility for the child. Moreover, to the extent that the parents' judgment is unsound, it is likely to be influenced by advice, one way or the other, from the doctors.³⁶ So why should concern over the number of embryos implanted focus on the wisdom of parental judgment, rather than the clinical setting for fertility treatments?

³² See *supra* notes 26 and 28 and accompanying text.

³³ Jennifer L. Rosato, *The Children of ART (Assisted Reproductive Technology): Should the Law Protect Them from Harm?*, 2004 UTAH L. REV. 57, 63 ("Under the 1992 Fertility Success Rate and Certification Act . . . fertility centers are required to provide information regarding their success rates, which are measured by the numbers [sic] of pregnancies and live births.").

³⁴ See 42 U.S.C. § 263a-1(b)(2).

³⁵ It has been reported, however, that "ART success rates are measured six ways: by pregnancy per cycle rate, live births per cycle rate, live births per egg retrieval rate, live births per transfer rate, singleton live birth per cycle rates, and singleton live birth per transfer rates. . . . CDC began reporting singleton rates for the first time in 2003, because 'everybody agreed that was the ideal'" Rosato, *supra* note 33, at 63 n.40 (quoting Silvia Pagán Westphal, *The BEST Way to Judge the Success of IVF Clinics*, NEW SCIENTIST, Jan. 17, 2004, at 7).

³⁶ Some doctors do maintain, however, that parents engaging in assisted reproduction often prefer twins because of a desire to avoid future reproduction costs and/or to complete their families with a single pregnancy. See Laurie Tarkan, *Lowering Odds of Multiple Births*, N.Y. TIMES, Feb. 19, 2008, at F1.

These questions underscore the potential arbitrariness of an “interpretative” approach. Consider Garrison’s selection of the decision to withhold “medically indicated treatment” for a handicapped newborn as the point of comparison.³⁷ It could be argued that the more relevant comparison is with a decision weighing the advantages of aggressive cancer therapy in stopping the spread of a life-threatening melanoma against the risks that the treatment will have serious, life-long side effects on the child’s well-being. Such a decision is agonizing because, as with fertility treatments, the same medical intervention can both make the child’s existence more likely and cause the child harm. Moreover, in both cases, it is impossible to know in advance what the effect will be.³⁸

So why isn’t the balance between the possibility of life and the risk of harm left to the same doctor-parent deliberation that takes place in the context of cancer treatments? Garrison skews her analysis by taking off the table the parents’ concern that without aggressive fertility treatments they may not have children at all. She refers to John Robertson’s observation—that a child born with a handicapping condition caused by infertility treatment could “not have been wronged or harmed because there was no other way that they could have been born”³⁹—and dismisses it.⁴⁰

Indeed, Garrison says of voluntary guidelines that, although they are “consistent with the self-determination ideal that underlies the U.S. healthcare system,” they are “inconsistent with the tradition of limiting parental choice when there is clear risk to a child’s health or safety.”⁴¹ By insisting on the equality of present and future children,⁴² she treats the children produced by assisted reproduction as though their existence is never a matter of doubt. Her analysis thus becomes the equivalent of saying that parents considering the potential harm of a course of treatment to a cancer patient should not balance that harm

³⁷ See *supra* note 31 and accompanying text.

³⁸ In the withholding of medical treatment for a handicapped newborn, by contrast, the outcome—death—is certain and intended; it is the prognosis with treatment and the value of the handicapped child’s life that is subject to debate.

³⁹ John A. Robertson, *Procreative Liberty and Harm to Offspring in Assisted Reproduction*, 30 AM. J.L. & MED. 7, 25 (2004).

⁴⁰ Garrison, *supra* note 1, at 1643.

⁴¹ Garrison, *supra* note 1, at 1648. She further emphasizes that “autonomous” preembryo-implantation decisionmaking may be biased by “economic pressures and insurance circumstances, or by limited patient knowledge about risk factors.” *Id.* (quoting Norbert Gleicher & David Barad, *The Relative Myth of Elective Single Embryo Transfer*, 21 HUM. REPROD. 1337, 1338 (2006)).

⁴² See *supra* note 28 and accompanying text.

against the possibility that their child will die without the treatment. While Garrison is right that the balance society might strike between the risk of continued infertility and potential harm to newborns may be different from the balance patients undergoing infertility strike,⁴³ she never really explains how either society or parents should weigh the competing risks. Transferring such a difficult—and intrinsically value-laden—decision to a regulatory agency is an invitation to mischief.

Garrison's "interpretative" approach makes it that much more so. To the extent she provides guidance to the new agency as to the content of its decisions, she emphasizes that the agency must seek to harmonize the law that governs assisted reproduction with the objectives and values that govern related areas.⁴⁴ That makes the choice of the reference areas critical to the analysis. Garrison's selection of the laws restricting parental decisionmaking about handicapped newborns is instructive.⁴⁵ The law in that area does not address technical decisions that require expertise,⁴⁶ nor does it involve claims that doctors, influenced by their own bottom lines, are misleading parents or inappropriately skewing the analysis.⁴⁷ Instead, the legislation reflects the imposition of particular, religiously driven values, on parents who may disagree with them.⁴⁸ Is an irreconcilable debate over values the inev-

⁴³ A classic utilitarian calculus might weigh the sum of the harms caused by avoidable birth defects against the sum of the losses caused by fewer children. In a society like the U.S., however, where overall fertility is not an issue, fewer children, even fewer middle-class children, is not much of a concern. The public and private costs of a larger number of birth defects, however, are huge. For a chronicle of these costs, see Garrison, *supra* note 1, at 1645–46. Once the analysis shifts to the individual losses suffered from the inability to have children, though, the emotional and practical loss can be incalculable.

⁴⁴ See *id.* at 1656 ("Regulatory policy for ART should thus rely on policies that underlie related areas of law.").

⁴⁵ See *supra* note 25 and accompanying text.

⁴⁶ See generally 42 U.S.C. § 5106g (2000).

⁴⁷ *Id.*

⁴⁸ See, e.g., Dionne Koller Fine, *Government as God: An Update on Federal Intervention in the Treatment of Critically Ill Newborns*, 34 NEW ENG. L. REV. 343, 349–51 (2000) (summarizing the different religious and philosophical views underlying the policy embodied by CAPTA); Sylvia Law, *Families and Federalism*, 4 WASH. U. J.L. & POL'Y 175, 213–14 (2000) (concluding that the "federal standards are simultaneously rigid, imprecise[,] and porous Some doctors now assert that the federal law and the threat of prosecution leads them to provide care that they believe is futile and that the parents do not want, while others recognize that they are not legally compelled to do this and that there is no realistic threat of prosecution."); John-Anderson L. Meyer, *"Tis a Consummation Devoutly to Be Wished": Towards Consistency in End-of-Life Treatment Decisions for Comatose Adults and Imperiled Newborns*, 10 MICH. ST. J. MED. & L. 321, 330–32 (2006) (summarizing the enactment of CAPTA following extensive lobbying during the Reagan Administration and concluding that "CAPTA dealt a severe blow to the decision-making rights of both parents and caregivers").

itable context for the regulation of assisted reproduction? If so, what does a new agency add to the process?

*II. Goodwin's Communitarian Critique: ART as a Site
of Racial and Class Division?*

Garrison provides a brief for regulation; Goodwin expresses a profound skepticism that regulation in the name of the greater good delivers anything more than partial—and biased—results. She argues that “the communitarian approach to regulating reproduction leads to inconsistent outcomes, unintended consequences, distributional unevenness, decreased utility, and economic inefficiencies.”⁴⁹

Like Garrison, Goodwin insists on parity between the regulation of reproduction and assisted reproduction.⁵⁰ Like Garrison, Goodwin calls attention to the harm reproductive medicine often inflicts on the resulting children.⁵¹ Like Garrison, she explores what parity in treatment might mean if the law called parents to account for the risks of reproductive techniques on the same terms that it polices parental decisions that affect existing children.⁵² Goodwin, however, unlike Garrison, emerges from the exercise profoundly wary that the shared values necessary to regulate on a consensus basis can be forged.⁵³

Goodwin's account starts with the first homicide conviction under the fetal drug laws for a stillborn child by a drug-using mother.⁵⁴ Although the expert testimony did not clearly establish that Regina McKnight's use of cocaine during her pregnancy caused the stillbirth, the court imposed a twenty-year sentence (later reduced to twelve).⁵⁵ Goodwin tellingly juxtaposes McKnight's fate with that of Brianna Morrison.⁵⁶ Morrison took fertility drugs, including Follistim, to stimulate her ovaries, and conceived sextuplets, almost certainly as a re-

⁴⁹ Goodwin, *supra* note 2, at 1663.

⁵⁰ *See id.* at 1710 (“FDLs [Fetal Drug Laws], tell us little about harms to fetuses as the laws exempt from prosecution a breadth of behaviors that negatively impact pregnancies and miscarriages.”).

⁵¹ *Id.* at 1737 n.416 (recounting the numerous health risks to fetuses that assisted reproduction poses, including “premature births, fetal cognitive delays, cesarean surgeries, cerebral palsy, blindness, and deafness”).

⁵² *See id.* at 1738–43 (discussing the normative implications of policing reproduction differently compared to assisted reproduction).

⁵³ *See supra* note 10 and accompanying text.

⁵⁴ Goodwin, *supra* note 2, at 1657–58; *see also* State v. McKnight, 576 S.E.2d 168 (S.C. 2003) (affirming trial court conviction of Regina McKnight for the deliberate indifference to her fetus), *cert. denied*, McKnight v. South Carolina, 540 U.S. 819 (2003).

⁵⁵ *See* Goodwin, *supra* note 2, at 1657–59.

⁵⁶ *See id.* at 1658–59.

sult.⁵⁷ Doctors recommended that Morrison selectively reduce the number of fetuses to better the chances that some would survive, but she refused.⁵⁸ Within six weeks of their birth, all but one of the sextuplets had died.⁵⁹ No one, however, suggested that Morrison be subject to criminal sanctions for her decisions to use fertility drugs and to forgo the doctor-recommended reduction, both of which increased the likelihood that five of her six infants would die. Goodwin finds it particularly telling that South Carolina, the state that prosecuted Regina McKnight, rated among the highest in the nation in multiple births, with over seventy percent of the births to women over thirty-five resulting in multiples.⁶⁰

Goodwin thus raises fundamental questions about the objectives and fairness of regulations that intrude upon women's reproductive decisions. She argues that such reproductive regulation is "consistent with a communitarian approach."⁶¹ Drawing from Amitai Etzioni, she observes that "a communitarian approach to rulemaking promotes community (government)⁶² as serving a central role in negotiating a set of ethics and developing policies that legislate predetermined values."⁶³ Indeed, Garrison's call for regulation of assisted reproduction fits into this framework. It assumes the existence of "predetermined values," drawn primarily from the regulation of parents' actions toward their children, that quasi-public agencies will apply to reproductive decisions.⁶⁴ It thus makes the content of the values critical to the result.

⁵⁷ With fertility drugs, unlike IVF, there is no way to control the number of embryos that implant. For that reason, some doctors now recommend greater oversight of fertility drugs and greater use of IVF. See, e.g., Lars Noah, *Assisted Reproductive Technologies and the Pitfalls of Unregulated Biomedical Innovation*, 55 FLA. L. REV. 603, 652–59 (2003).

⁵⁸ Goodwin, *supra* note 2, at 1659.

⁵⁹ *Id.*

⁶⁰ See *id.* at 1660 (citing L.A. Schieve et al., Ctrs. for Disease Control, *Use of Assisted Reproductive Technology—United States, 1996 and 1998*, MMWR WEEKLY, Feb. 8, 2002, at 2, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5105a2.htm>).

⁶¹ Goodwin, *supra* note 2, at 1664.

⁶² I have argued elsewhere that "community" and "government" need not be identical, and, indeed, that market mechanisms can help create communities based on shared values. See June Carbone & Paige Gottheim, *Markets, Subsidies, Regulation, and Trust: Building Ethical Understandings into the Market for Fertility Services*, 9 J. GENDER RACE & JUST. 509, 513, 517–18 (2006).

⁶³ Goodwin, *supra* note 2, at 1667 (citing AMITAI ETZIONI, *THE SPIRIT OF COMMUNITY: RIGHTS, RESPONSIBILITIES AND THE COMMUNITARIAN AGENDA* (1993)).

⁶⁴ See Garrison, *supra* note 1, at 1656.

The regulation of women's reproductive decisions, as Goodwin underscores, has always been a value-laden enterprise.⁶⁵ Community norms about the acceptability of reproduction establish the terms on which a woman may seek support for the family she is creating.⁶⁶ Moreover, reproductive norms may not only affect members of different classes and racial groups differently, they may also *define* class standing and racial membership.⁶⁷ In many eras, for example, a nonmarital birth served to disqualify a mother and child from middle-class standing or support.⁶⁸ In addition, lineage rules defined racial identity in accordance with such notorious principles as the "one-drop rule" or the attribution of the child's status to the slave status of the mother.⁶⁹

⁶⁵ Goodwin, *supra* note 2, at 1704 (noting that reproduction policing in the form of eugenics "came to be positively associated with social responsibility, community values, religious virtue, social responsibility, economic efficiency, moral leadership[,] and a paternalist sense of duty toward the 'socially unfit'").

⁶⁶ See, e.g., JUNE CARBONE, *FROM PARTNERS TO PARENTS: THE SECOND REVOLUTION IN FAMILY LAW 199–200* (2000) (observing that during the Progressive era the solution to nonmarital pregnancies was to make children wards of the state).

⁶⁷ See Goodwin, *supra* note 2, at 1677 (providing an account of events at the Medical University of South Carolina in which twenty-eight black women were turned over to the police for using illegal drugs during a pregnancy, with the only other woman who was turned over, a white woman, being singled out because she "live[d] with her boyfriend who [wa]s a Negro").

⁶⁸ CARBONE, *supra* note 66, at 35 (noting tradition of *filius nullius*, which under English law treated the nonmarital child as the "child of no one," and therefore not entitled to inherit from either father or mother).

⁶⁹ See, e.g., Daniel J. Sharfstein, *Crossing the Color Line: Racial Migration and the One-Drop Rule, 1600–1860*, 91 MINN. L. REV. 592, 593, 604 (2007) (defining the "one-drop rule" as "the idea that anyone with any African 'blood' is legally black" and noting that "[b]efore the one-drop rule's widespread codification in the 1910s and 1920s . . . slave status was ultimately a question of maternal descent"). See generally PAUL FINKLEMAN, *CRIMES OF LOVE, MISDEMEANORS OF PASSION: THE REGULATION OF RACE AND SEX IN THE COLONIAL SOUTH* 124–35 (Catherine Clinton & Michelle Gillespie eds., Oxford Univ. Press 1997) (describing interracial romantic relationships in Colonial Virginia); Cheryl I. Harris, *Finding Sojourner's Truth: Race, Gender and the Institution of Property*, 18 CARDOZO L. REV. 309 (1996) [hereinafter Harris, *Sojourner's Truth*] (examining race and gender in terms of property); Cheryl I. Harris, *Whiteness As Property*, 106 HARV. L. REV. 1707 (1993) (discussing the evolution of whiteness from a racial identity to a form of property); Christine B. Hickman, *The Devil and the One Drop Rule: Racial Categories, African Americans, and the U.S. Census*, 95 MICH. L. REV. 1161 (1997) (analyzing how the black race has been defined by the one-drop rule); Trina Jones, *Shades of Brown: The Law of Skin Color*, 49 DUKE L.J. 1487 (2000) (discussing colorism, the discrimination of people based on skin color within races); Peter Wallenstein, *Law and the Boundaries of Place and Race in Interracial Marriage: Interstate Comity, Racial Identity, and Miscegenation Laws in North Carolina, South Carolina, and Virginia, 1860s–1960s*, 32 AKRON L. REV. 557 (1999) (describing the historical dynamics of romantic interracial relationships in North Carolina, South Carolina, and Virginia).

As the abortion debate further underscores, a pregnant mother's well-being, for better or ill, is intrinsically linked to the fate of her offspring.⁷⁰ So community provisions for the social standing, resources, and well-being of the next generation necessarily circumscribe the current generation's reproductive options. The fact that today these decisions take place within a relatively wealthier and freer environment than in times past does not change the fact that community norms continue to affect the outcomes.

Goodwin is acutely aware of this history. Indeed, she identifies reproductive norms with the communitarian tradition of regulation and observes that "communitarianism assumes one set of values and inevitably forces one group's preferences on another, usually less-powerful group."⁷¹ Thus, she believes that the enforcement of the fetal drug laws provides a cautionary tale.⁷²

First, the drug laws arise in the context of differential access to medical care. Wealthier women enjoy medical insurance and private health care. Poorer women are dependent on government-funded access. The government then insists on what Goodwin describes as a *quid pro quo* that provides prenatal care in government-subsidized hospitals in exchange for invasive medical information sharing.⁷³ As a result, virtually all of the women prosecuted under the fetal drug laws come to the attention of authorities because the clinics from which they sought prenatal care reported them.⁷⁴ Private clinics, in contrast, do not disclose their patients' drug habits to the police.⁷⁵

Market mechanisms, in this case private health care, provide safer spaces, more likely to be governed by principles of confidentiality and trust.⁷⁶ To the extent a pregnant mother's drug use is a concern in the

⁷⁰ Indeed, Goodwin links the fetal drug laws to the resurgence of the antiabortion movement. See Goodwin, *supra* note 2, at 1672–73.

⁷¹ *Id.* at 1671.

⁷² See *id.* at 1661.

⁷³ See *id.* at 1676–77.

⁷⁴ For an account of the South Carolina prosecutions, in particular, see Dorothy E. Roberts, *Unshackling Black Motherhood*, 95 MICH. L. REV. 938, 941–44 (1997) (describing the prosecutions as the result of collaboration between the prosecutor's office and public health officials); see also Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug [sic] or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202 (1990) (documenting differences in reporting).

⁷⁵ See Goodwin, *supra* note 2, at 1672–73 (reporting that in 1990, white women in Florida were more likely to abuse alcohol and drugs but African American women were ten times more likely to be reported to health authorities).

⁷⁶ Goodwin observes: "[P]hysician authority and judgment is often deferred to by hospital administrators, but increasingly judges, district attorneys, and police play an active role in expanding 'physician power,' while leaving open the question about duties and obligations to the

⁸⁰ Goodwin, *supra* note 2, at 1684 (citing Nutrition Data, 211 Foods Highest in Caffeine, <http://www.nutritiondata.com/foods-00013100000000000000.html> (last visited Aug. 13, 2008)).

Garrison refers, regulating treatment of handicapped children, survives because it is infrequently and inconsistently enforced.⁸¹

Third, Goodwin questions whether a consensus basis can ever exist for the regulation of reproduction. She observes that: "Reproduction follows social and economic constructions of citizenship, privilege, and caste."⁸² The regulation of reproduction involves the creation and recreation of the norms that connect one generation to the next; it also reinforces the hierarchies that underlie these relationships. Goodwin suspects that it was relatively easy to prosecute drug-addicted African Americans because they are not "[b]irthing the right way."⁸³ Regina McKnight, for example, like other women prosecuted under fetal drug laws, was a rape victim and a drug addict.⁸⁴ She has an IQ of 72, and she had become homeless after her mother's death from an automobile accident several years earlier.⁸⁵ She almost certainly lacked the funds to support herself or the child,⁸⁶ and she is unlikely to have been married. While her circumstances should have generated more sympathy,⁸⁷ they are unlikely to have inspired confidence in her capacity as a mother or the wisdom of her decisions to proceed with the conception and birth.⁸⁸

Goodwin accordingly fears that the regulation of assisted reproduction, and, indeed, the regulation of the parent-child relationship, can easily become the regulation of acceptable reproduction, with enormous practical and symbolic significance.⁸⁹ Moreover, as the fetal

⁸¹ See Law, *supra* note 48, at 213–15.

⁸² Goodwin, *supra* note 2, at 1697.

⁸³ *Id.* at 1661 (suggesting this as the reason for choosing to prosecute Regina McKnight and choosing not to prosecute ART couples).

⁸⁴ *Id.* at 1590–91 (citing NATIONAL ADVOCATES FOR PREGNANT WOMEN, SOUTH CAROLINA: FIRST IN THE NATION FOR ARRESTING AFRICAN-AMERICAN PREGNANT WOMEN—LAST IN THE NATION FOR FUNDING DRUG AND ALCOHOL TREATMENT (2003), <http://advocatesforpregnantwomen.org/issues/briefingpaper.htm>).

⁸⁵ Tiffany Scott, Note, *Repercussions of the "Crack Baby" Epidemic: Why a Message of Care Rather than Punishment Is Needed for Pregnant Drug-Users*, 19 NAT'L BLACK L.J. 203, 211–12 (2005–06).

⁸⁶ Linda C. Fentiman, *The New "Fetal Protection": The Wrong Answer to the Crisis of Inadequate Health Care for Women and Children*, 84 DENV. U. L. REV. 537, 554 (2006) (noting that "Ms. McKnight . . . was a vulnerable woman with few resources").

⁸⁷ McKnight sought drug treatment repeatedly but was told it was unavailable. Scott, *supra* note 85, at 212.

⁸⁸ Neither decision may have been entirely voluntary, however, given that McKnight's mental functioning was described as below that expected of someone with an IQ of 72, along with her lack of resources and support. See *id.* at 211.

⁸⁹ See Goodwin, *supra* note 2, at 1695–97 (noting that an unintended consequence of selectively policing reproduction will be that certain more obvious behaviors will be penalized, although those behaviors may not pose the greatest risk of harm to fetuses. On the other hand,

drug abuse cases suggest, separating issues of safety from contested norms about race, class, and family creation may not be easy matters. While Goodwin's primary concern is the poor African American women who have historically been on the losing end of the imposition of such norms,⁹⁰ the controversies are unlikely to be so limited.

III. Age, Class, and Fertility: The New Battleground for Acceptable Reproduction?

Naomi Cahn and I have argued elsewhere that the terms of acceptable reproduction are being redefined. What we have termed "the new middle class morality" makes financial independence and emotional maturity the new hallmarks of readiness for childbearing.⁹¹ In a comprehensive report, Sara McLanahan finds, for example, that the upper quarter of the population, defined by the mother's educational achievement, is enjoying traditional family life with dramatically greater resources than did their peers of thirty years ago.⁹² For these women and their families, divorce rates peaked in the '70s, and have now fallen back to the divorce levels in the mid-'60s, an era that preceded adoption of no fault divorce.⁹³ In addition, the nonmarital birth rate for the best educated women is below ten percent,⁹⁴ mothers' workforce participation in these families has tripled,⁹⁵ and family income has increased substantially.⁹⁶

other behaviors and technologies that are largely celebrated and used by wealthier couples will continue outside the shadow of the law.).

⁹⁰ See *id.* at 1741–43 (discussing the normative implications of current reproduction policing on race).

⁹¹ See generally, e.g., June Carbone, *Is Fertility the Unspoken Issue in the Debate Between Liberal and Conservative Family Values?*, 32 LAW & SOC. INQUIRY 809 (2007) (reviewing LINDA C. MCCLAIN, *THE PLACE OF FAMILIES: FOSTERING CAPACITY, EQUALITY, AND RESPONSIBILITY* (2006) & JAMES Q. WILSON, *THE MARRIAGE PROBLEM: HOW OUR CULTURE HAS WEAKENED FAMILIES* (2002)) (arguing that delayed childbearing holds the key to "the new middle-class morality").

⁹² See Sara McLanahan, *Diverging Destinies: How Children Are Faring Under the Second Demographic Transformation*, 41 DEMOGRAPHY 607, 608 (2004) ("Children who were born to mothers from the most-advantaged backgrounds are making substantial gains in resources. Relative to their counterparts 40 years ago, their mothers are more mature and more likely to be working at well-paying jobs.").

⁹³ *Id.* at 613 fig.4. California adopted the first "true" no-fault statute in 1969; New York adopted a form of mutual consent divorce, requiring a waiting period, in 1965. For the history of these laws, see HERBERT JACOB, *SILENT REVOLUTION: THE TRANSFORMATION OF DIVORCE LAW IN THE UNITED STATES* 42 (1988).

⁹⁴ McLanahan, *supra* note 92, at 612 fig.3.

⁹⁵ *Id.* at 610–11 fig.2.

⁹⁶ *Id.* at 614 fig.6.

The prospects for the rest of the population are not so promising. For the less educated three-quarters of the population, divorce rates have leveled off near their historic highs.⁹⁷ Nonmarital birth rates have continued to rise, and now constitute more than a third of all births, two-thirds of African American births, and close to fifty percent of the births for the bottom quarter of the population, defined by women's education.⁹⁸ The majority of poor mothers remain out of the labor force, and the incomes of the bottom quartile have stagnated, while the income of the top quartile nearly doubled.⁹⁹

What explains the disparities? At least part of the explanation is age. McLanahan observes that between 1970 and 2000, the average age of a mother with children under five in the top quartile rose from twenty-six to thirty-two.¹⁰⁰ In the bottom quartile, it stayed about the same, while rising by about two years for the middle half.¹⁰¹ The age differences become more dramatic when race is factored in. African American women have higher birth rates than whites at every age until twenty-five, and lower birth rates at every age over twenty-five, with twenty-five the new average age of first births for the nation as a whole.¹⁰²

These new and longer "pathways to adulthood," which champion autonomy and self-sufficiency as a prerequisite for family life, have obvious implications for fertility. No precise measure of infertility, that is, of the inability of women who want children to conceive, yet exists. Goodwin reports that about fifteen percent of women of reproductive age have made an appointment with a fertility specialist and that researchers expect infertility rates to increase as more women delay childbearing until the years when reproductive fertility declines.¹⁰³ Scientists have yet to determine the optimal age for

⁹⁷ *Id.* at 613 fig.4.

⁹⁸ *Id.* at 612 fig.3; Child Trends DataBank, Percentage of Births to Unmarried Women fig.1, http://www.childtrendsdatabank.org/pdf/75_PDF.pdf (last visited Aug. 13, 2008). The percentage of nonmarital births for the bottom quarter declined in the '90s, however, though overall totals have remained high. McLanahan, *supra* note 92, at 612 fig.3.

⁹⁹ McLanahan, *supra* note 92, at 611 fig.2, 614–15 fig.6.

¹⁰⁰ *Id.* at 609.

¹⁰¹ *See id.* at 609–10 fig.1.

¹⁰² *See* T.J. Mathews & Brady E. Hamilton, Nat'l Ctr. for Health Stats., *Mean Age of Mother, 1970–2000*, NAT'L VITAL STATS. REPS., Dec. 11, 2002, at 1, 2 & fig.2 (Vol. 51, No. 1), available at http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_01.pdf; *supra* note 14 and accompanying text.

¹⁰³ *See* Goodwin, *supra* note 2, at 1716–17.

childbearing, but overall fertility begins to decline by the late-twenties, and birth defects increase markedly by the mid-thirties.¹⁰⁴

While precise records do not exist, all indications are that fertility issues are greater for African Americans, who disproportionately suffer from the factors linked to reproductive difficulties. Goodwin reports that, aside from greater maternal age,¹⁰⁵ it is the environment,¹⁰⁶ a history of sexually transmitted diseases,¹⁰⁷ and poor health that af-

¹⁰⁴ See *id.* at 1717–18. Goodwin reports that:

Researchers confirm that female fertility peaks in the twenties. Conversely, their slightly older counterparts, women right out of graduate school or barely in their thirties, are, according to scientists, reproductively old. Scientists report that fertility decline begins for women in their thirties, with a dramatic decrease in fertility at and over the age of thirty-five. . . . Along with the decrease in fertility, there is a heightened probability for birth defects in children conceived by “reproductively” older women—even without in vitro fertilization and other forms of ART. Chromosomal abnormalities, for example, occur in forty to fifty percent of pregnancies in women ages thirty to thirty-five. As one commentator observes, “the share of embryos that women produce that are chromosomally abnormal rises . . . to about 70% in women 40 and over.” Consequently, the likelihood of pregnancy is incredibly low even with the use of in vitro technologies

Id. (citations omitted).

¹⁰⁵ See, e.g., Dawn P. Misra & Cande V. Ananth, *Infant Mortality Among Singletons and Twins in the United States During 2 Decades: Effects of Maternal Age*, 110 PEDIATRICS 1163, 1163 (2002) (concluding from a study that “[m]aternal age had a U-shaped association with mortality among singletons [single babies], with the highest rates seen at extremes of age”); Suzanne C. Tough et al., *Delayed Childbearing and Its Impact on Population Rate Changes in Lower Birth Weight, Multiple Birth, and Preterm Delivery*, 109 PEDIATRICS 399, 399 (2002) (finding that “the recent increase in LBW [low birth weight] and preterm delivery is partly related to the population phenomenon of delayed childbearing”).

¹⁰⁶ Harmful environmental agents have been linked to sterility, infertility, cancer, and many other chronic illnesses. See, e.g., Robert Brent, *Environmental Causes of Human Congenital Malformations: The Pediatrician’s Role in Dealing with These Complex Clinical Problems Caused by a Multiplicity of Environmental and Genetic Factors*, 113 PEDIATRICS 957, 957 (2004) (discussing the environmental hazards “that have been documented to produce congenital malformations and reproductive effects”); Robert Brent et al., *A Pediatric Perspective on the Unique Vulnerability and Resilience of the Embryo and the Child to Environmental Toxicants: The Importance of Rigorous Research Concerning Age and Agent*, 113 PEDIATRICS 935, 935 (2004) (expressing concern about “the increased susceptibility of the embryo, infant, and child to environmental toxicants”); Robert W. Miller, *How Environmental Hazards in Childhood Have Been Discovered: Carcinogens, Teratogens, Neurotoxicants, and Others*, 113 PEDIATRICS 945, 945 (2004) (concluding that “environmental hazards cause adverse health effects that include sterility, infertility, embryotoxicity, low birth weight, skin lesions, neurodevelopmental defects, immunological disorders, cancer, and fear of late effects”).

¹⁰⁷ Sexually transmitted diseases result in infertility, increased risk of hysterectomy, subfertility, ectopic pregnancies, and chronic pelvic pain. See, e.g., Robert L. Brent & Michael Weitzman, *The Pediatrician’s Role and Responsibility in Educating Parents About Environmental Risks*, 113 PEDIATRICS 1167 (2004) (“Sexually transmitted disease can be life-threatening, cause infertility or sterility, and increase the risk of cervical cancer.”); Nadereh Pourat et al., *Medicaid Managed Care and STDs: Missed Opportunities to Control the Epidemic*, 21 HEALTH AFF. 228

fect female fertility.¹⁰⁸ Male sperm counts have been falling also, with causal factors being obesity, drug and alcohol use, smoking, and exposure to laptops, pesticides, chemicals, and radioactive material.¹⁰⁹ African Americans in poor communities likely suffer disproportionately from all of these hazards except exposure to laptops.

The changing patterns of reproduction explain changing reproductive norms. For the middle class, reproduction at later ages will increasingly be seen as a mark of maturity and fitness.¹¹⁰ For those who wait—and accumulate greater wealth, power, and income in the interim—the ability to conceive may then be seen as a matter of right, with the new reproductive technologies providing well-deserved comfort.

For the poor, and particularly for poor African Americans, waiting may instead mean permanent childlessness. African American women are disproportionately likely to suffer fertility problems, to do so at younger ages, and to lack access to medical care sufficient to address even easily treated issues.¹¹¹ The cost of the new reproductive technologies places them out of the reach of poorer women.¹¹² Moreover, to the extent that African Americans are more dependent on collateral relatives such as grandparents,¹¹³ they may need to bear children at younger ages to be able to rely on assistance from these relatives. Yet, for the entire population, childbearing at younger ages,

(2002) (finding "[t]he burden of illness from STDs is exacerbated by infertility, pregnancy complications, cancer, and a greater susceptibility to HIV infection"). See generally Brian M. Willis & Barry S. Levy, *Child Prostitution: Global Health Burden, Research Needs, and Interventions*, 359 THE LANCET 1417 (2002) (discussing the pregnancy complications experienced by prostitutes).

¹⁰⁸ Goodwin, *supra* note 2, at 1718–19.

¹⁰⁹ *Id.* at 1718 & n.290.

¹¹⁰ See generally ELIZABETH GREGORY, READY: WHY WOMEN ARE EMBRACING THE NEW LATE LATER MOTHERHOOD (2007) (discussing the reasons for women waiting to have children at an older age).

¹¹¹ For an in-depth review of these racial disparities, see NAOMI CAHN, TEST TUBE FAMILIES: WHY THE FERTILITY MARKET NEEDS LEGAL REGULATION (forthcoming 2009) (manuscript at ch. 7, on file with author).

¹¹² See Garrison, *supra* note 1, at 1653 (noting that, like organ sales, reproductive services "can command extremely high, coercive prices").

¹¹³ See, e.g., Sarah E. Oberlander, Maureen M. Black & Raymond H. Starr, Jr., *African American Adolescent Mothers and Grandmothers: A Multigenerational Approach to Parenting*, 39 AM. J. COMMUNITY PSYCHOL. 37 (2007) (noting that in a study of 148 African American adolescent mothers, 66% of the mothers shared caregiving with the grandmother); Dorothy S. Ruiz, *Intergenerational Households Maintained by African American Grandmothers: New Roles and Challenges for the 21st Century*, 6 AFR. AM. RES. PERSP. 57, 58 (Spring/Summer 2000), available at <http://www.rcgd.isr.umich.edu/prba/perspectives/springsummer2000/druiz22.pdf> (documenting greater percentage of grandmother-headed families among African Americans).

while likely to produce more children, is also more likely to take place in poorer, more fragile families, with less access to society's resources.¹¹⁴

These factors suggest that the reproductive norms of the poor and the middle class may be on a collision course. Naomi Cahn and I have argued elsewhere that the age of reproduction is a critical divide not only for race and class, but for region and religion.¹¹⁵ More rural, evangelical, and traditional parts of the country are also likely to reproduce at younger ages.¹¹⁶ Assisted reproduction, although hardly limited to college-educated women, is an increasingly critical part of middle-class reproduction, while it is more of an exotic luxury for everyone else. The challenge of creating assisted reproduction norms, much less norms for reproduction, that resonate with the country as a whole is therefore a daunting one.

Conclusion: Toward Inclusive Reproductive Norms?

Garrison and Goodwin have done a superb job of articulating the concerns in the debate over regulation, focusing not on technology but on motherhood. They have set out the poles of the debate over the regulation of reproduction. Garrison articulates the most sympathetic case for regulation—the existence of safety risks that other countries have addressed more systematically than the free market system in the United States is likely to do.¹¹⁷ Goodwin identifies the most dramatic downside to increased regulation—heavy-handed intervention

¹¹⁴ For a comprehensive account of the role that age of reproduction plays in determining class status, see June Carbone, *Age Matters: Class, Family Formation, and Inequality*, SANTA CLARA L. REV. (forthcoming).

¹¹⁵ See Cahn & Carbone, *supra* note 12, at 463–64 (observing that approaches to teen parenting differ based on religion and region).

¹¹⁶ Three of the five states with the highest level of church attendance, for example, were also among the top five with the youngest average age of first birth (Oklahoma, Louisiana, and Arkansas). *Id.* at 481–82. The region with the lowest level of church attendance (the Northeast) also had the highest average age of first birth, although only two states (Massachusetts and New Hampshire) were in the top five in both categories. *Id.* The regions with greater church attendance and lower average ages of first birth were also more likely to vote Republican in 2004 and to embrace the moral values agenda, with the exception of Nevada, a state with low church attendance that voted Republican, albeit by a narrow margin. See *id.* Areas with greater population density were more likely to vote Democratic than rural areas, except in the Northeast where the rural/urban split was less critical than other factors. See LAWRENCE HAMILTON, CARSEY INST., RURAL VOTING IN THE 2004 ELECTION, FACT SHEET NO. 2, at 6 (2006), http://www.carseyinstitute.unh.edu/publications/FS_ruralvote_06.pdf.

¹¹⁷ See Garrison, *supra* note 1, at 1646 (noting that, due to the clear health hazards of multiple implantation, the United Kingdom and Belgium have placed limits on multiple-embryo transfers).

that sends poor women to prison for decades for events over which they have less than full control.¹¹⁸ At the center of the debate, however, lie very basic questions about the purpose of regulation.

Goodwin identifies communitarian approaches with the development of tenets enforced through mechanisms that instill loyalty and punish outliers.¹¹⁹ She describes the "is he Black enough" question underlying African American ambivalence about Barack Obama as an example of the intrinsic tension between cohesion and diversity.¹²⁰ In the process, she does not emphasize the source of Obama's appeal as a presidential candidate: that he transcends the limitations of different groups, and that he counters the threat of assimilation (and thus the potential loss of distinctive identity) with the hope of inclusion, and support for a better life.

In these articles, both Garrison and Goodwin focus on prohibitions and criminal sanctions.¹²¹ They do not explore how greater consensus on appropriate reproduction practices might provide a foundation for greater support in realizing the ideals. To do so, however, would require a broader perspective than focusing exclusively on *assisted* reproduction is likely to provide.

First, the means to realize the middle-class ideal of autonomy, responsibility, and independence is beyond the reach of a good part of the population, but at least with respect to reproductive autonomy, that result is not inevitable. If consensus genuinely existed on the importance of managing reproduction, the tools for that management should be available to everyone. These tools would start with comprehensive sex education, ready access to contraception, support for abortion, and greater protection from coercive sexual practices. The Guttmacher Institute, for example, reports that: "[U]nintended pregnancy is becoming increasingly concentrated among poor women. Between 1994–2001, the unintended pregnancy rate rose 29% among women living below the poverty level . . . but fell 20% among more affluent women."¹²² Moreover, while overall rates of contraception

¹¹⁸ See Goodwin, *supra* note 2, at 1664 (noting that the communitarian-based policing of reproduction over the past twenty years has disfavored poor women, while allowing wealthier couples using reproductive technologies to escape unscathed).

¹¹⁹ See *id.* at 1674–75.

¹²⁰ *Id.* at 1675.

¹²¹ See generally Garrison, *supra* note 1; Goodwin, *supra* note 2.

¹²² HEATHER D. BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES 28 (2008), available at <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf>. Racial disparities track the class differences, with African Americans and Hispanics less likely to use contraception than whites. See Nat'l Ctr. for Health Stats., *Fertility, Family Planning and Reproductive Health*

use increased in the 1990s, use rates had declined by 2002 due mainly to rising nonuse among low-income women of color.¹²³ In 2006, teen pregnancies rose for the first time since 1991, and the racial group with the largest increase was black women aged fifteen to nineteen.¹²⁴

Second, increased access to health care might provide more effective use of contraception, more preventive measures aimed at causes of infertility such as untreated sexually transmitted diseases, earlier and better prenatal care, and greater attention to substance abuse. Regina McKnight, for example, sought treatment for her cocaine addiction, but was told no such treatment was available.¹²⁵

Third, the limited and prohibitively expensive access to fertility services also limits greater protection for the resulting children. Patients may feel greater pressure to implant multiple embryos because of the expense of multiple treatments.¹²⁶ Doctors try experimental procedures on patients, without first testing them on animals, because neither the patients nor the government provide funds for the testing.¹²⁷ European systems that effectively provide greater oversight do so in the context of health care systems that provide greater public coverage. Where, like the Italians, they combine more conservative restrictions with less subsidization, they spur the development of fertility tourism to friendlier—and less expensive—locales.¹²⁸

of U.S. Women: Data from the 2002 National Survey of Family Growth, VITAL & HEALTH STAT., Dec. 2005, at 1, 101 tbl.62 (Series 25, No. 23), available at http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf (reporting in a study that 29.9% of Hispanics and 26.6% of African Americans questioned used no contraceptive method when engaging in sexual intercourse, compared to 12.9% of whites who were questioned); Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000–2001*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 294, 297–98 tbl.2 (2002), available at <http://www.guttmacher.org/pubs/journals/3429402.pdf> (noting that white women were “more likely than all other women to have used the pill . . . , more likely than black and Hispanic women to have used condoms . . . , and more likely than black women to have used other methods”).

¹²³ BOONSTRA, *supra* note 122, at 25–26 figs.5.1 & 5.2.

¹²⁴ Brady E. Hamilton et al., Nat'l Ctr. for Health Stats., *Births: Preliminary Data for 2006*, NAT'L VITAL STATS. REPS., Dec. 5, 2007, at 1, 2 (Vol. 56, No. 7) (revealing that the pregnancy rate among adolescents fell 34% between 1991 and 2005 before it reversed in 2006, rising by 3% among females aged 15–19, with the largest single-year increase by race being reported by black teenagers).

¹²⁵ See Scott, *supra* note 85, at 212.

¹²⁶ See, e.g., RICKI LEWIS, HUMAN GENETICS: CONCEPTS AND APPLICATIONS 432 (5th ed. 2003) (estimating that in vitro fertilization costs from \$8000 to \$15,000 per cycle).

¹²⁷ See Rosato, *supra* note 33, at 73 (noting that “federally funded experimentation on embryos is not permitted”).

¹²⁸ See Carbone & Gottheim, *supra* note 62, at 525 (“While many may agree with the effort to curb the ‘wild west’ atmosphere of Italian fertility services before the law, the net effect may

Fourth, the limited effectiveness of assisted reproduction should focus renewed attention on the forces producing the delays in childbearing. Both middle-class women who defer childbearing, and poorer women who struggle to support the child they bear in less than opportune circumstances, are reacting to the difficulty of combining employment and motherhood. Family friendly policies, such as flex-time, family leave, or universal, state-supported preschools, may be more effective in the long run in balancing the needs of society and families than better access to assisted reproduction.

While realizing existing reproductive norms—reducing, for example, unintended pregnancies—should command consensus support, divisions over the means (contraception or abstinence, abortion or adoption?) limit the capacity for legislative action and the prospects for more effective regulatory oversight. Consider, for example, the case of the New Jersey clinic that experimented with a technique that produced children genetically related to three adults.¹²⁹ The clinic took a donor egg and added the cytoplasm from that egg, including the donor's mitochondrial DNA, to a fertilized egg from the intended parents.¹³⁰ The donor cytoplasm made it possible for the intended parents to conceive a genetically related child in spite of the poor quality of the intended mother's own eggs.¹³¹ When the births became public, however, the FDA asserted jurisdiction and ended the experiments.¹³²

Consensus support should exist for further testing to guarantee the safety of the procedure. The clinic used the experimental process without prior testing,¹³³ and at least two of the children had medical difficulties that scientists believe may have been caused by the incom-

be to encourage international comparison shopping for efficacy and price as well as relaxed ethics.”).

¹²⁹ See Rebecca Skloot, *Sally Has 2 Mommies + 1 Daddy, and Other Side Effects of Experimentation on Unborn Children in the Underregulated World of High-Tech Fertility Treatments*, *POPULAR SCI.*, March 2003, at 72, 77.

¹³⁰ See *id.* Technically, the procedure involves “ooplasm transfer,” or the transfer of ooplasm (the extranuclear material) from a healthy donor egg into the egg of a woman experiencing infertility, which ostensibly increases fertilization of the recipient egg. An embryo resulting from ooplasm transfer has three “genetic” parents since it contains mitochondrial DNA from the donor egg. See J. Barritt et al., *Mitochondria in Human Offspring Derived from Ooplasmic Transplantation*, 16 *HUM. REPROD.* 513, 513 (2001) (describing how the transfer of ooplasm results in children genetically related to three adults).

¹³¹ See Skloot, *supra* note 129, at 77.

¹³² See *id.*; Rosato, *supra* note 33, at 74 & n.120.

¹³³ See Rosato, *supra* note 33, at 73 (observing a lack of clinical testing for new reproductive methods because of the ban on federal funding of embryo research).

patibility of the two different sources of mitochondrial DNA.¹³⁴ Moreover, news reports indicate that the prospective parents discounted the risk of birth defects in exactly the way Garrison suggests may be typical of fertility patients.¹³⁵

Yet, proponents of greater regulatory oversight objected to the procedure on the basis of a host of other reasons that might give Goodwin pause. Many would ban the procedure irrespective of its safety because they oppose all use of “germline genetic engineering” that would pass the results (DNA from three sources) to the resulting child’s offspring.¹³⁶ Others reject any use of in vitro fertilization, especially if the techniques result in the destruction or significant alteration of a fertilized egg.¹³⁷ Still others would object to the use of a donor egg under any circumstances,¹³⁸ while many more would insist on a level of testing that would make the procedure prohibitively expensive.¹³⁹ The FDA’s assertion of jurisdiction, given the prohibition

¹³⁴ See Robert M. L. Winston & Kate Hardy, *Are We Ignoring Potential Dangers of In Vitro Fertilization and Related Treatments?*, NATURE CELL BIOLOGY & NATURE MEDICINE FERTILITY SUPP., at s17 (2002), available at <http://www.nature.com/fertility/content/pdf/ncb-nm-fertilitys14.pdf>.

¹³⁵ Compare Skloot, *supra* note 129, at 103 (quoting one father as saying: “Is there a possibility of long-term effects? Yeah, there is. And that worries us. But even if we’d found the kids would be at higher risk, we would have still done it all.”), with *supra* notes 4–5 and accompanying text.

¹³⁶ See, e.g., THE PRESIDENT’S COUNCIL ON BIOETHICS, REPRODUCTION AND RESPONSIBILITY: THE REGULATION OF NEW BIOTECHNOLOGIES 45 (2004), available at http://www.bioethics.gov/reports/reproductionandresponsibility/_pcbe_final_reproduction_and_responsibility.pdf (expressing concern that “because mitochondrial DNA is maternally inherited, if the resulting child is female, she will pass on to her own offspring the genetic contribution of both her mother and the female ooplasm donor”).

¹³⁷ This particular technique did not, but the new generation of experiments, designed to deal with the problem of the mitochondrial DNA incompatibility, use a fertilized donor egg and cloning techniques to destroy the nucleus of that egg in order to replace it with the nuclear DNA from the intended parents. For a discussion of the role of abortion in preventing regulation of use of nuclear transfer techniques, see Rosato, *supra* note 33, at 74–76. For an example of positions objecting to in vitro fertilization entirely, see Congregation for the Doctrine of the Faith, Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation—Replies to Certain Questions of the Day (Feb. 22, 1987), available at http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19870222_respect-for-human-life_en.html (summarizing the Catholic Church’s position condemning in vitro fertilization in its entirety); Leon Kass, *Making Babies—The New Biology and the “Old” Morality*, 26 PUB. INT. 18, 48–50 (1972) (“[T]he laboratory production of human beings is no longer human procreation.”).

¹³⁸ See, e.g., THE PRESIDENT’S COUNCIL ON BIOETHICS, *supra* note 136, at 199 (maintaining that respect for children requires legislation be passed ensuring that all children have “a natural connection to two human genetic parents”).

¹³⁹ For discussion of the lack of funding for embryo research, see ROBIN MARANTZ HENIG, PANDORA’S BABY 90 (2004). The lack of federal funding means that fertility clinics, unlike drug companies, do no test procedures on animals before trying them on humans. Where the FDA

of federal funding for reproductive research, therefore had the effect of stopping the use of the procedure without a complete ban or full consideration of its potential merits.¹⁴⁰ Subsequent work along these lines, which has particular promise in addressing the difficulties caused by aging eggs, now takes place quietly overseas—if it takes place at all.¹⁴¹

Seeking consensus on the reduction of teen pregnancy, family friendly work policies, and safer reproductive techniques should be easy in comparison. Garrison and Goodwin have done an enormous service to the debate by emphasizing that the regulation of assisted reproduction can only take place in the context of norms associated with all reproduction. Crafting such norms, and insuring that all parts of the population enjoy the means to realize them, may do more to shape reproductive practices in the long run than prohibitions or compulsion ever could.

has required "clinical investigation" before use of a new product or procedure, as it did with the use of donor cytoplasm or nuclear transfer techniques, the clinics have simply stopped using the procedures.

¹⁴⁰ One scholar notes: "Although the FDA did not completely ban the transfer of genetic material, it concluded that the method was a 'clinical investigation' requiring, among other things, submission of an Investigative New Drug (IND) application. Instead of proceeding with INDs, practitioners 'halted the procedure altogether.'" Rosato, *supra* note 33, at 74 n.120.

¹⁴¹ See Antonio Regalado & Karby Leggett, *Fertility Breakthrough Raises Questions About Link to Cloning*, WALL ST. J., Oct. 13, 2003, at 1A (reporting that a team of Chinese and American doctors were expected to announce that they had created the first human pregnancy using technology "similar to that which created Dolly the sheep" in an experiment that had to be conducted in China after the U.S. banned it in 1998); see also Sarah Boseley & Jonathan Watts, *Chinese Connection Beats Ban on Cloning-Style Fertility Technique*, THE GUARDIAN, Oct. 14, 2003, <http://www.guardian.co.uk/world/2003/oct/14/science.china> (reporting that the Chinese succeeded in creating pregnancy using nuclear cell transfer just before the Chinese government banned the procedure).