The Right to Procreate: When Rights Claims Have Gone Wrong

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Debates regarding the development of new reproductive technologies (NRTs), funding for infertility treatments, and non-medical criteria for access to infertility treatments frequently invoke "rights to reproduce" or "procreative rights". The claim of this right — literally the right to have children — is not the same thing as many other "reproductive rights" that are invoked in contraception, abortion, and pregnancy management discussions.

The author argues that the claim of a right to bear or beget children, which may in turn support research into NRTs and then funding and access claims, is not justified. Framing procreative decisions in terms of rights claims is a problematic ethical project, which in turn creates difficulties for the establishment of legal procreative rights. There are two critical problems: first, the distinction between positive (entitlement) and negative (liberty) rights claims leaves those requiring reproductive assistance in need of a different justification for their claims than those who need no help; second, a procreative right is generally claimed to be limited by the rights or interests of the future children, but a right of non-conception is an internally contradictory concept.

The author then discusses variations of procreative rights claims, including claims of rights to enter reproductive contracts or to seek assistance, and other conceptual foundations for reproductive decisions. Thus, while reproductive rights are often helpful in protecting individuals and families from undue governmental intrusion, rights are shown to be a problematic, inadequate, and inappropriate framework to describe both the legal and moral status of claims for assisted procreation.

Les débats entourant le développement des nouvelles techniques de reproduction («NTR»), l'accroissement des fonds consacrés aux traitements pour vaincre l'infertilité ainsi que l'émergence de critères non médicaux quant à l'accès aux traitements de l'infertilité font souvent appel au concepts de «droit de reproduction» et «droit procréatif». Ce droit — essentiellement celui d'avoir des enfants — se distingue de plusieurs autres «droits de reproduction» qui sont au cœur de discussions portant sur la contraception, l'avortement, et la gestion de la grossesse.

Selon l'auteure, la revendication du droit de porter un enfant ou de procréer est injustifiée et ce, quoiqu'une telle revendication puisse en retour favoriser la recherche sur les NTR et, conséquemment, le financement ainsi que les demandes pour y avoir accès. Aborder la décision de procréer sous l'angle de l'exercice d'un droit soulève des problèmes éthiques, ce qui rend plus difficile l'établissement d'un droit légal de procréer. Nous faisons face à deux problèmes critiques. Premièrement, la distinction entre une revendication de droits positive (auxquels on a droit) et une revendication de droits négative (liberté) oblige les personnes nécessitant une assistance à la reproduction à faire appel à des justifications différentes de celles invoquées par les personnes ne requérant aucune aide. Deuxièmement, on prétend généralement que les droits de l'enfant à naître limitent le droit de procréer ; or le droit de non-conception constitue un concept contradictoire en lui-même.

Par la suite, l'auteure s'intéresse aux différentes revendications liées au droit de procréer, incluant l'obtention d'aide à la procréation ou le droit de conclure un contrat de gestation. Ainsi, tandis que les droits de reproduction peuvent souvent aider à protéger les individus et les familles contre une intrusion exagérée du gouvernement, ils constituent également un cadre problématique, inapproprié, et inadéquat quand vient le temps de décrire le statut tant juridique que moral des demandes de procréation assistée.

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Synopsis

Introdnction

Who ought to have access to new reproductive technologies (NRTs) and other infertility treatments, and on what moral grounds should access be provided or denied? There are three key types of access problems: whether the development of NRTs ought to be a research priority; whether insurance or public health programmes ought to finance NRT treatments; and whether infertility treatments ought to be available to everyone. The debate also calls into question some contentious social issues. Limited resources and recessionary economies favour restriction rather than expansion of research and medical coverage for expensive infertility procedures such as *in vitro* fertilization (IVF). In addition, when the patient is a recipient of social assistance, financial considerations extend beyond the costs of treatment to the welfare costs of supporting another child. Prospective parents who display criminal, abusive, incompetent, or dysfunctional behaviour raise special concerns for the well-being of their possible children.[1] Social norms regarding families and the well-being of children are also called into question by "non-traditional" families, such as those in which the parents are single, of the same sex, or substantially younger or older than is typical. Many of these categories are clearly value-laden, however, and for people who perceive themselves as discriminated against in reproductive matters, the most effective mechanism to counter this bias and to achieve procreative assistance is to assert a claim of right to this assistance.

Much of the ethical, legal, and political discussion regarding these problems, therefore, centres on an appeal to a basic right to reproduce. As Suzanne Uniacke has observed, groundbreaking fertility specialists have often justified their work by appeal to the right to found a family as identified in international human rights documents.[2] Once research, development, and use of NRTs have been defended by an appeal to reproductive rights, a principle of justice is often added to justify equality of access to the available treatments for low income patients. Single women and lesbians have also appealed to a basic human right to procreate,[3] even though the hindrance to their reproductive potential usually rests with the absence of a male sexual partner rather than with infertility *per se*.

The rights claims that are asserted take several forms, however, and are often unclear. There is rampant confusion between legal rights and moral rights, perhaps partly because the law in Canada and most other countries is silent or uncertain regarding procreative assistance. The freedoms and entitlements established by law are not necessarily moral rights, however, nor are all moral rights captured by legal

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[1] Tragedies focus our attention on the problem: in Philadelphia, James Austin was charged on January 18, 1995 with beating his five-week-old son to death. Austin, a 26 year-old single father, paid $30,000 for Phyllis Huddleston to serve as a surrogate mother and bear his child following artificial insemination ("Death Spotlights Surrogate Parenting" *The [Toronto] Globe and Mail* (19 January 1995) A12 [hereinafter "Death Spotlights Surrogate Parenting"]).

[2] S. Uniacke, "*In Vitro* Fertilization and the Right to Reproduce" (1987) 1 Bioethics 241 at 245.

[3] See generally G. Hanscombe, "The Right to Lesbian Parenthood" (1983) 9 J. Medical Ethics 133.

documents. Further, distinctions between negative (liberty) and positive (entitlement) rights are often muddled. Thus, claims that fall under a heading of "reproductive rights" may encompass a gamut of topics including abortion, contraception, freedom from sterilization, freedom from coercion in pregnancy management, and a right of access to infertility treatment.

I will reserve the phrase "procreative rights" to refer more specifically to initiating a pregnancy and bringing children into the world. Procreative rights are thus literally rights to have children *at all*, as distinguished from reproductive rights that concern the *timing* and *manner* in which one reproduces. The area of procreative rights is itself in need of greater conceptual clarity, as it has been asserted to include a right to make procreative decisions without governmental restriction or force; a right to procreate without discrimination by doctors or others; an equal right of infertile people to procreate when fertile people can do so; a right to be assisted in procreating; a right to engage in reproductive contracts or multiple-party interventions; and a right to have procreative assistance funded.

In this paper, I will argue that the claim of a right to bear or beget children, which may in turn support research into new reproductive technologies and then funding for infertility treatment, is not a justified rights claim. It is generally accepted that reproduction is a deeply meaningful and important human experience, and one that we often take for granted. The inability to bear children can therefore be devastating emotionally and socially,[4] and many infertile people genuinely need assistance and relief. I will argue, however, that framing procreative decisions in terms of rights claims is a problematic ethical project, which in turn creates difficulties for the articulation and establishment of legal procreative rights. I will focus on two critical problems. First, the distinction between positive and negative rights claims leaves those requiring reproductive assistance in need of a different justification for their claims than those who need no help. Second, a procreative right is generally claimed to be limited by the rights of future children; I will argue, however, that a right of non-conception is internally contradictory and leaves an asserted procreative right essentially unchallenged and unlimited until after procreation has occurred. I will then discuss problems raised by variations of procreative rights claims, including claims of rights to enter reproductive agreements or contracts and rights to seek assistance. Thus, while reproductive rights are helpful in a political or legal context to protect individuals and families from governmental intrusion, the rights model will be shown to be problematic, inadequate, and inappropriate to describe both the legal and moral status of claims for assisted procreation.

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[4] For descriptions of the psychosocial turmoil that frequently accompanies infertility, see L. Shanner, "Bioethics Through the Back Door: Phenomenology, Narratives, and Insights into Infertility" in W. Sumner, ed., *Philosophical Perspectives on Bioethics* (Toronto: University of Toronto Press, forthcoming); A.P. Zoldbrod, *Men, Women and Infertility: Intervention and Treatment Strategies* (New York: Lexington Books, 1993). Books aimed at infertile couples often provide sensitive descriptions and advice. Two excellent examples are B.E. Menning, *Infertility: A Guide for Childless Couples* (Englewood Cliffs, N.J.: Prentice-Hall, 1977) and D. Houghton & P. Houghton, *Coping with Childlessness* (London: George Allen & Unwin, 1984).

I will not argue against *all* rights claims in reproductive matters, including abortion, contraception, and pregnancy management, because reproductive rights claims are both legally and morally justifiable in many of these contexts. Nor will I discuss the moral or legal status of human embryos or fetuses, except insofar as this status is invoked relative to procreative rights asserted by adults.[5] I will argue that the claim of a right to procreate, while echoing important rights claims and striking an emotionally resonant chord, is nevertheless an invalid claim and is conceptually problematic.

I. Current Access Policies

Current policies regarding access to infertility treatments vary widely across Canada, throughout the United States, and in other countries. In its 1993 *Final Report*, Canada's Royal Commission on New Reproductive Technologies recommended that "access to IVF treatment should be determined on the basis of legitimate medical criteria, without discrimination on the basis of factors such as marital status, sexual orientation or economic status."[6] A 1992 survey of Canadian infertility clinics revealed, however, that of the twelve responding institutions, eight considered single women ineligible for treatment while two had no policy; and seven considered homosexual women ineligible while four had no policy on this issue.[7]

Donor insemination (DI) is more often sought by single and lesbian women than are IVF and related NRTs because these women simply require a sperm sample; they do not need to overcome infertility. The Commission therefore concluded that sperm for donor insemination, like for IVF, should be provided without regard

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[5] Canada's Royal Commission on New Reproductive Technologies (R.C.N.R.T.) summarized the legal status of embryos and fetuses as follows:

> [T]he fetus is not a legal person under Quebec civil law, the Anglo-Canadian common law, or the Quebec *Charter of Human Rights and Freedoms*. . . . [T]he fetus is not protected under section 7 of the Charter and so does not enjoy a constitutional right to "life, liberty and security of the person." The U.S. Supreme Court came to a similar decision under the U.S. *Bill of Rights*. Legal recognition of the fetus has also been rejected in Britain and Australia and under the *European Convention* (Canada, Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of The Royal Commission on New Reproductive Technologies* (Ottawa: Minister of Government Services Canada, 1993) at 956 [hereinafter *Report*]).

For a summary of relevant American rulings, see D.B. Langley, "In Vitro Fertilization: Eliminating the Current State of Limbo Between Pre-Embryonic Rights and the Fundamental Right to Procreate" (1991) 26 Wake Forest L. Rev. 1217.

[6] Recommendation 145, *Report*, *ibid.* at 569. Commissioner Suzanne Scorsome dissented on this recommendation on the grounds that the best interests of children should be paramount, and that individuals and groups providing infertility treatment ought to be allowed to set access policies according to their pluralistic value systems (*ibid.* at 1056-58).

[7] S. Ikonomidis & F. Lowy, "Access to in vitro Fertilization in Canada" (1994) 16 J. SOGC 50-54.

for non-medical criteria.[8] Since the R.C.N.R.T. found no reliable evidence that the environment in families of single or lesbian parents is better or worse than in families of heterosexual couples, there was no reason to conclude that the best interests of the child would require restricting access to infertility treatments and donor insemination to married or heterosexual couples.[9]

Very recent Canadian court rulings leave the question of gay and lesbian parenting rights muddled. On May 11, 1995, Judge James Paul Nevins of the Ontario Court, Provincial Division, ruled in favour of four lesbian couples who had severally entered seven petitions to legally adopt the biological child of one of the partners.[10] In an ironic turn, the government argued that its own legislation, the *Child and Family Services Act* (C.F.S.A.),[11] was unconstitutional because it only permitted joint applications for adoption by spouses, but defined "spouses" in subsection 136(1) as persons of the opposite sex. Judge Nevins noted, however, that "the issue in these cases is not whether homosexual persons in general may apply to adopt children," as there is no prohibition in the C.F.S.A. or other legislation against individuals applying for or obtaining an adoption order if it is in the best interests of the child; the problem hinged on the definition of "spouse" for the purposes of joint adoption.

Conversely, the Supreme Court of Canada shortly thereafter rejected expansion of the definition of "spouse" to same-sex couples in *Egan* v. *Canada* on May 25, 1995.[12] The issue in *Egan* was access to spousal benefits under the *Old Age Security Act* (O.A.S.A.)[13] for same-sex partners in a forty-seven-year-long relationship. While the Court ruled unanimously that the *Canadian Charter of Rights and Freedoms*[14] prohibits discrimination on the grounds of sexual orientation, the majority ruled, by a five to four vote, that the O.A.S.A. definition of "spouse" as a person of the opposite sex was constitutionally valid. Justice LaForest wrote for the majority that, while people may choose to live together in a variety of relationships,

> [marriage is] firmly anchored in the biological and social realities that heterosexual couples have the unique ability to procreate, that most children are the product of these relationships, and that they are generally cared for and nurtured by those who live in that relationship. In this sense, marriage is by nature heterosexual. ... Many [heterosexual couples who are not legally married] live together indefinitely, bring forth children and care for them ... These couples

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[8] *Report, supra* note 5 at 455-56; see also *ibid.* at 506; Recommendation 94(f), *ibid.* at 480.

[9] See also Note, "Reproductive Technologies and the Procreation Rights of the Unmarried" (1985) 98 Harv. L. Rev. 669 [hereinafter Note].

[10] *Re K.* (24 May 1995), Toronto A1924/94A3, A1925/94A3, A1927/94A3, A1928/94A3, A1926/94A3, A1929/94A3, A1932/94A3 (Ont. Ct. (Prov. Div.)).

[11] R.S.O. 1990, c. C.11.

[12] (25 May 1995), Ottawa 23636 (S.C.C.) [hereinafter *Egan*].

[13] R.S.C. 1985, c. O-0, ss. 2, 19(1).

[14] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

> have need for support just as legally married couples do in performing this critical task, which is of benefit to all society ... [While homosexual] couples undoubtedly provide mutual support for one another, ... [and may] ... occasionally adopt or bring up children, ... this is exceptional and in no way affects the general picture. ... Homosexual couples ... differ from other excluded couples in that their relationships include a sexual aspect. But this sexual aspect has nothing to do with the social objectives for which Parliament affords a measure of support to married couples.[15]

The implications of *Egan* for access to infertility treatments in Canada are quite unclear. Clinics that treat only married and common law couples might adopt the definition of "spouse" supported by the Supreme Court to exclude homosexual partners, while those clinics accepting only legally married couples may be pressured to accept common law spouses. On the other hand, access by lesbians to infertility clinics could undermine the majority's conclusion by overcoming the biological barriers to parenthood upon which Justice LaForest based his reasoning. Gestational or surrogacy arrangements, as well as the possible but unlikely attempt to transfer an embryo to a male gestator, would also extend the options for gay men to become biological parents of children without being in a heterosexual relationship.

In 1984, the Australian state of Victoria became the first jurisdiction in the world to pass legislation specifically tailored to IVF and related techniques.[16] This legislation stipulates that IVF procedures, with or without donor gametes, "shall not be carried out unless (a) the woman to whom the procedure is carried out is a married woman" and "(b) the woman and her husband each consents in writing to the carrying out of the procedure."[17] The *Infertility Act*'s definition of "marriage" includes common law marriages: "a reference to a married woman includes a reference to a woman (i) who, at the commencement of this section, is living with a man as his wife on a *bona fide* domestic basis although not married to him."[18] There are no similar restrictions in the *Infertility Act* which would limit access to artificial insemination to married or common law couples, although section 18 requires that "a person shall not carry out a procedure of artificial insemination unless the woman in relation to whom the procedure is carried out and her husband have received counselling."

Meanwhile, in 1990 in Sydney, New South Wales — a state that rejected legislation on infertility treatment — married couples were routinely admitted to the IVF program, but *de facto* couples were admitted only after an initial interview by a

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[15] *Egan*, *supra* note 12 at 13-14, 15-16 (integral judgment).

[16] *Infertility (Medical Procedures) Act*, No. 10163 (1984) (Victoria) [hereinafter *Infertility Act*].

[17] *Ibid.*, ss. 10(3), 11(3), 12(3), 13(3).

[18] The definitions continue: "(b) a reference to the husband of a woman includes, in relation to a woman to whom paragraph (a) applies, a reference to the man with whom the woman is, at the commencement of this section, living as his wife on a *bona fide* domestic basis but does not include a reference to the man (if any) to whom the woman is, at that time, actually married" (*ibid.*, s. 3(2)).

social worker. A case synopsis and recommendation were then presented to the hospital Ethics Committee for approval.[19] With the divorce rate hovering near fifty per cent, a marriage licence is certainly no indication of a couple's marital stability or capacity to raise a family; nevertheless, it is generally a ticket for automatic acceptance into the program in the absence of medical contraindications. Also, in 1990, the Lingard Fertility Centre in Newcastle, New South Wales, voted to relax its "two-child rule" that stated that the clinic "would not treat couples on the DI or IVF programmes if they have two or more living children to that relationship." The policy, which had been in effect since the clinic opened, was intended to reduce waiting lists and to allow couples with fewer children priority access to treatment.[20]

Policies regarding upper age limits for women applicants vary among clinics but are most often set between the ages of forty and forty-five. An Italian clinic, however, has garnered international attention by establishing late postmenopausal pregnancies: Rossana Dalla Corte, age sixty-two, gave birth in June, 1994, while "Jennifer F", a fifty-nine-year-old London woman, gave birth to twins on Christmas day, 1993.[21] Health officials in France, Great Britain, and Italy have initiated inquiries into this practice, and the R.C.N.R.T. recommended that "IVF treatment should not be offered to women who have experienced menopause at the usual age."[22] While most clinics do not appear to have a minimum age limit, we can assume that most would reject applications from teenagers, even though teens are often provided contraceptives and even abortions without parental consent.

Many clinical decisions regarding the offering or denying of treatment are particularly *ad hoc* in nature. For example, one California woman whose husband was incarcerated attempted to enrol in an IVF program. After lengthy discussion of the appropriateness of including incarcerated individuals in the IVF protocol, the clinical staff finally decided that the couple should be admitted to the program on the grounds that California allows conjugal visits in prison. If not for physical infertility, this couple could have initiated a pregnancy at any time during the husband's incarceration. After this principled debate on parental fitness, however, treatment for this couple ended shortly thereafter when it was discovered that they were unable to pay for it.[23]

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[19] Site visit at Royal North Shore Hospital (2-19 May 1990) Sydney, Australia; site visit at Royal North Shore Hospital, Ethics Committee meeting (15 May 1990) Sydney, Australia.

[20] Site visit at Lingard Fertility Centre (21-26 May 1990) Newcastle, Australia; Memo of Henry Wellsmore to team members and Ethies Committee of Lingard Fertility Centre (4 April 1990) Newcastle, Australia.

[21] M.A. Roberts, "A Way of Looking at the Dalla Corte Case" (1994) 22 J. Law, Medicine & Ethics 339; see also A. Lippman, "'Never Too Late': Biotechnology, Women and Reproduction" (1995) 40 McGill L.J. 875.

[22] *Report, supra* note 5 at 569.

[23] Site visit at The Howard and Georgeanna Jones Institute of Reproductive Medicine (August 1988) Norfolk, Virginia; Interview with Charlotte Shrader (August 1988) The Howard and Georgeanna Jones Institute of Reproductive Medicine, Norfolk, Virginia.

IVF and other NRTs are covered by only some health insurance plans in the United States. In the Oregon prioritization plan, IVF was ranked 696th out of 709 medical procedures, which placed it far below the cut-off point for Medicaid coverage.[24] In 1994, twelve states offered drug treatment and/or reversal of tubal ligations and vasectomies under their Medicaid programs for low-income residents.[25] In Massachusetts in 1993, Medicaid spent $46,000 for Clomid and Serophene, drugs that are prescribed only to treat infertility. Of the 260 Medicaid patients who received the drugs that year, fifty-eight per cent were receiving Aid to Families with Dependent Children (A.F.D.C.), which covers mainly single mothers, and sixty-three per cent already had children; two of the women already had eight children each.[26] These policies confound attempts to reduce births among welfare recipients, but *Moe* v. *Secretary of Administration and Finance*,[27] a 1981 Massachusetts ruling concerning medical coverage of abortions, may complicate attempts to eliminate fertility coverage under Medicare.

> [T]he Legislature need not subsidize any of the costs associated with child bearing, or with health care generally. However, once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weight the options open to the pregnant woman by its allocation of public funds [to cover prenatal care and delivery but not abortion] . . . By thus injecting coercive financial incentives favoring childbirth into a decision that is constitutionally guaranteed to be free from governmental intrusion, [this restriction] deprives the indigent woman of her freedom to choose abortion over maternity, thereby impinging on the due process liberty right recognized in *Roe* v. *Wade*.[28]

It is unclear whether *Moe* could be applied to extend "genuine indifference" to indigent women who choose maternity, through the use of infertility treatments, over non-maternity.

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[24] The R.C.N.R.T. argues that this low ranking is misleading because the Oregon plan involved public evaluations of the importance of the services. Since it may be assumed that most respondents already had the children they wanted (since elderly respondents are beyond childbearing, and most younger adults are not infertile), most people would perceive themselves as not needing infertility services in the same way that they might need treatment for heart disease, kidney failure, or other more common diseases. A more accurate estimate of the need for infertility services would have come from the responses only of people who had not yet had children (*Report*, *supra* note 5 at 504-505). In response, it might also be argued that because only a limited population would be interested in infertility services, the services are indeed of a lower social priority than are treatments for conditions that affect a larger population.

[25] M. Beck, P. Wingert & M. Hagger, "The Infertility Trap" *Newsweek* (April 4 1994) 30. States offering drug treatment only are Iowa, Louisiana, Maine, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, and Wisconsin. Hawaii offers drug treatment and artificial insemination. Maryland, New Jersey, and New Mexico fund reversal of vasectomy and tubal ligation. Maine, Massachusetts, and Wisconsin all introduced bills to cancel assistance in 1994.

[26] Beck, Wingert & Hagger, *ibid.*

[27] 417 N.E. 2d 387, 382 Mass. 629 (1981) [hereinafter *Moe* cited to N.E.].

[28] *Ibid.* at 402; *Roe* v. *Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973).

The *Ontario Health Insurance Plan* (O.H.I.P.) as governed by the *Canada Health Act*[29] is the only provincial health plan to include IVF among its covered services. IVF was covered by O.H.I.P. for all diagnostic groups until mid-1994, when a utility review panel established to delist expendable procedures followed an R.C.N.R.T. recommendation to restrict coverage to cases involving only bilateral fallopian tube blockage. This recommendation was based on the fact that IVF had not been proven effective for any other diagnostic group.[30] In 1990, the Australian Health Service became the first in the world to cover the costs of IVF; its coverage extends across all diagnostic groups of infertility. The Australian Ministry of Health, however, is currently reviewing IVF and other infertility treatments for possible delisting on the grounds of expense and inadequately demonstrated efficacy.

II. Legal Grounding for a Right to Reproduce

A. Canadian Law

The Ontario Law Reform Commission (O.L.R.C.)[31] could not reach a definitive conclusion on whether the *Canadian Charter of Rights and Freedoms* guarantees a right to procreate. It is clear that the *Charter* makes no specific mention of such a right, but section 7[32] may provide a basis for it. If interpreted broadly, section 7 could possibly provide a right of privacy similar to that articulated in the United States in *Griswold* v. *Connecticut*.[33] Parker J. discussed this possibility *inter alia* in *R.* v. *Morgentaler*:

> [Section 7 may be seen as] providing broad protections for the individual against government interference, protections which permit substantive review of a wide variety of laws that purport to infringe or breach the privacy of the individual. Under this model, the word "liberty" would include reproductive liberty. ...
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> This analysis would support the proposition that certain elements of the right to privacy may be protected by s. 7 of the *Charter*. The decision to marry and to have children might be granted constitutional protection because they are considered deeply rooted in our traditions, and fundamental to our way of life.[34]

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[29] R.S.C. 1985, c. C-6.

[30] *Report*, *supra* note 5 at 517-22, 564. The companion recommendation, that all provinces should fund IVF for bilateral fallopian tube blockage, has not yet been adopted.

[31] Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of the Attorney General, 1985) at 39-51 [hereinafter O.L.R.C.].

[32] The section reads: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice".

[33] 381 U.S. 479, 85 S. Ct. 1678 (1965).

[34] *R.* v. *Morgentaler* (1984), 47 O.R. (2d) 353 at 394-95, 407, 12 D.L.R. (4th) 502 (H.C.J.) [hereinafter *Morgentaler* cited to O.R.], appeal quashed on procedural grounds (1984), 48 O.R. (2d) 519, 14 D.L.R. (4th) 184 (C.A.). The Ontario Law Reform Commission notes that Parker J. did not

We should note in the above comment the reference to a *single* decision "to marry and to have children", but a plural pronoun reference that "*they* are considered deeply rooted." It is unclear, therefore, whether Parker J. would consider any procreative rights to be limited within the parameters of *marital* privacy, similar to *Griswold*'s protection of the rights of married persons to use contraception. The recent decision in *Egan* appears to reaffirm the link between marriage and children. Conversely, the Court's comments in *Morgentaler* might indicate that procreating is a decision and a right independent of marital status and analogous to the extension of contraceptive rights as a matter of *individual liberty*:

> It is true that in *Griswold* the right of privacy ... inhered in the marital relationship. Yet the marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional makeup. If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.[35]

The Ontario Law Reform Commission also notes that even if section 7 were interpreted as grounding a right to procreate, this might involve a mere guarantee of procedural, but not substantive, due process. There may therefore be no grounds for a right of access to infertility treatments even if other reproductive rights were respected.

If a right to procreate were supported and if infertility were defined as a physical disability, section 15's prohibition of discrimination on the basis of disability could possibly apply with respect to infertility treatments. There is no mention, however, of marital status, sexual orientation, or economic status in subsection 15(1). Further, the Ontario Law Reform Commission notes that a complete ban on reproductive interventions would not contravene section 15, since access would be denied everyone regardless of fertility, thus substantially limiting the reproductive options of people who want to use NRTs to prevent the transmission of a genetic disease.[36]

In short, while it is possible to construct arguments defending a right of procreation and related rights of access to infertility treatment under the *Charter*, such

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elaborate on the point, however, so procreative rights are not clearly defended (O.L.R.C., *supra* note 31 at 43).

[35] *Eisenstadt* v. *Baird*, 405 U.S. 438 at 453, 92 S. Ct. 1029 (1972) [hereinafter *Eisenstadt* cited to U.S.]. The Note in the 1985 *Harvard Law Review*, *supra* note 9 at 676, points out that although *Eisenstadt* was a plurality opinion, its specific language referring to *individual* freedom from governmental intrusion to procreative choices was quoted with approval by the majority in *Carey* v. *Population Services International*, 431 U.S. 678 at 685, 97 S. Ct. 210 (1977). See also *ibid.* at 687: "Read in light of its progeny, the teaching of *Griswold* is that the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State."

[36] O.L.R.C., *supra* note 31 at 44.

interpretations are highly debatable. Support for access to infertility treatment on the grounds of non-discrimination under the *Ontario Human Rights Code*[37] is similarly unpersuasive. The O.L.R.C. notes the provincial legislatures' ability to override the *Charter* and provincial human rights code guarantees

> [w]hen in the case of the Charter, the action in question is reasonable and justifiable in a free and democratic society, and that, in the case, for example, of section 10 of the Code, the action is reasonable and *bona fide* in the circumstances.[38]

The O.L.R.C. further observed that one of the strongest justifications to limit access to NRTs, despite equality protections, is the "best interests of the child" argument.[39]

B. International Codes of Human Rights

Defenders of new reproductive technologies often point to parenting rights expressed in international human rights conventions such as the *European Convention for the Protection of Human Rights and Fundamental Freedoms*[40] or the United Nations' *Universal Declaration of Human Rights*.[41] References to these conventions were especially influential in securing research funding and approval in the late 1970s and early 1980s, when IVF was harshly challenged on moral grounds by the Vatican, feminist critics, and people concerned about possible damage to the offspring.

For example, British physician Robert Edwards, who, together with Patrick Steptoe, achieved the fertilization *in vitro* of the world's first IVF baby, responded to the increasing ethical concerns about reproductive technologies in the early 1970s as follows:

> I had no doubts about the morals and ethics of our work. I accepted the right of our patients to found their family, to have their own children . . . The Declaration of Human Rights made by the United Nations includes the right to establish a family.[42]

Similarly, Australian pioneer Carl Wood justified "interfering in the natural system of conception" by noting that

> [s]ince the time of Hippocrates codes of medical ethics have stressed the doctor's duty to relieve suffering, a variety of which is exemplified by the situation

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[37] R.S.O. 1990, c. H.19.

[38] O.L.R.C., *supra* note 31 at 51; see also *R.* v. *Oakes*, [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200.

[39] O.L.R.C., *ibid.*

[40] 4 November 1950, 213 U.N.T.S. 221 [hereinafter *European Human Rights Convention*].

[41] 1948, G.A. Res. 217, U.N. Doc. A/810 at 71 [hereinafter *Universal Declaration*].

[42] R. Edwards & P. Steptoe, *A Matter of Life: The Story of a Medical Breakthrough* (New York: William Morrow and Company, 1980) at 101-102.

> of infertility. And the United Nations Declaration of Human Rights (Geneva, 1948) affirmed the right of every individual to have a family.[43]

The relevant passage of the *Universal Declaration* states:

> Article 16: (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family ...
> 3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

This article, however, is prone to the same problems of interpretation as is the *Charter.*

Rebecca Cook[44] summarizes similarly worded rights to marry and found families in article 23 of the United Nations' *International Covenant on Civil and Political Rights*[45] and article 10 of the *International Covenant on Economic, Social and Cultural Rights.*[46] Citing Maja K. Eriksson, she notes that "the recognition of a right to marry and to found a family is a reaction against Nazi racial and reproductive policies that culminated in genocide."[47] The *Universal Declaration* contains no positive entitlement to have a family, though, as states are not directed to provide spouses or children to those wishing to have them.

Cook suggests, however, that the right to found a family, as specified in the international declarations, "implicates rights at opposing ends of the fertility scale, concerning untimely fertility and infertility."[48] Paragraph 16(1)(e) of the *Convention on the Elimination of All Forms of Discrimination Against Women*[49] requires states to ensure that women enjoy "rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."[50] While this statement implies a right of information and access to assistance for both preventing and initiating pregnancy, Cook's interpretation of these documents offers much more support for protection from untimely fertility.

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[43] C. Wood & A. Westmore, *Test Tube Conception* (Melboume: Hill of Content, 1983) at 102.

[44] R.J. Cook, "International Human Rights and Women's Reproductive Health" (1993) 24 Studies in Family Planning 73 [hereinafter "International Human Rights"]; R.J. Cook, "International Protection of Women's Reproductive Rights" (1992) 24 N.Y.U. J. Int'l L. & Pol. 644 [hereinafter "International Protection"].

[45] 1966, G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16 at 52, U.N. Doc. A/6316.

[46] 1966, G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16 at 49, U.N. Doc. A/6316.

[47] "International Protection", *supra* note 44 at 700, citing M.K. Eriksson, *The Right to Marry and to Found a Family: A World-Wide Human Right* (Upsala, Sweden: Justus Förlag AB, 1990).

[48] "Intemational Protection", *ibid.*

[49] 1979, G.A. Res. 34/180, U.N. GAPR, 34th Sess., Supp. No. 46 at 193, U.N. Doc A/34/46 (entered into force 3 September 1981).

[50] *Ibid.*, art. 16(1).

> The right to found a family incorporates the right to maximize the survival prospects of a conceived or existing child, through birth spacing by contraception or abortion. This right complements the right of a woman herself to survive pregnancy, for instance by delaying a first pregnancy. ...
>
> Socio-economic and cultural influences accordingly lead women to early marriage and child bearing, recognizing no function or worth for women except as wives and mothers. Women need legal protection against being conditioned to serve prematurely in the founding of families.[51]

More straightforward support for fertility protection is offered in the context of governmental liability for inaction in halting pandemic reproductive tract infections.[52] This liability does not, however, imply a right to procreate, let alone a right to reproductive assistance. State duties to protect and to promote the health of citizens by preventing disease whenever feasible would apply to reproductive tract infections as much as to the prevention and relief of any other threats to health. Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," and article 12(2) provides for reducing perinatal and infant mortality, promoting child health, and assuring medical attention in the event of sickness.[53] Neither offers more specific references to fertility enhancement. Infertility may raise special concerns, but mainly "because of the differential impact infertility has on the lives of women."[54]

The World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[55] has been challenged as overly idealistic and expansive.[56] However, even this broad definition would not necessarily guarantee the right of an individual to bear or father children, nor would it guarantee a right of access to treatments such as IVF that circumvent, but do not cure, the physical causes of infertility.

The most plausible right of access to reproductive technologies may come from the sections of international documents that address scientific progress. Cook identifies the right of everyone "to enjoy the benefits of scientific progress and its applications" in paragraph 15(1)(b) of the *International Covenant on Economic, Social and Cultural Rights*, and the states' duties to "undertake to respect the freedom indispensable for scientific research" in article 15(3). She interprets these passages

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[51] "International Protection", *supra* note 44 at 701-703.

[52] "International Human Rights", *supra* note 44 at 80.

[53] "International Protection", *supra* note 44 at 719-20.

[54] "International Human Rights", *supra* note 44 at 80, referring to International Women's Health Coalition, *Reproductive Tract Infections in Women in the Third World* (New York: International Women's Health Coalition, 1991) at 3-6.

[55] *Constitution of the World Health Organization* (July 1946) 2 Official Records of the World Health Organization 100, preamble.

[56] D. Callahan, "The WHO Definition of Health" (1973) 1:3 Hastings Center Studies 77.

to require "states parties to tolerate and accommodate research on new techniques of fertility control and enhancement," and notes that "many of the modern techniques of fertility control and promotion, and of assisted reproduction, are the results of recent scientific research."[57] The remainder of her discussion, however, focuses on "[w]omen's freedom from unwanted pregnancy by means of safe, effective, and convenient contraceptives", the availability and safety of surgical and nonsurgical abortion techniques, patenting policies, and RU-486.[58]

Even if we interpret Cook's discussion more broadly to include greater attention to new reproductive technologies, it is certainly not plausible to suggest that everyone has the right to benefit from *every* new invention or discovery. The simple limitations of resource allocation may limit access to reproductive technologies just as they limit access to lifesaving technologies. Similarly, while the *Canada Health Act* extends access to beneficial medical technology to all residents of Canada,[59] thus satisfying the requirement to allow the enjoyment of the benefits of research, each province is responsible for management of its own health care budget and for ensuring the quality of health care. The federal government therefore simultaneously encourages the use of beneficial research and substantially limits access to particular benefits.

Clearly, a general right to benefit from the results of research does not imply any specific right of access to particular benefits. When the results of research are deemed inconclusive (as the R.C.N.R.T. deemed all uses of NRTs except for IVF in cases of bilateral fallopian tube blockage), or the protocol too expensive relative to the benefits, the government and/or medical organizations could justifiably decline to offer it. Thus, residents of Ontario now have a statutory right to the subsidized use of IVF for tubal blockage but not for other diagnoses of infertility. Other provinces offer no right of access to subsidized NRTs, although the techniques are not legally banned for those who can afford them. Further, the benefits of some technologies may be overshadowed by negative consequences for other parties or for society, and it is fully appropriate for a government to restrict access to them on the grounds of careful moral evaluation and justification; this reasoning, for example, supports the current Canadian restrictions on gun ownership.

In addition, neither a right to the benefits of research nor the right of freedom of inquiry for researchers implies a right to promote or fund a particular *kind* of research, such as infertility treatment. The limits of scientific inquiry, like the limits of access to the benefits of research, are also curtailed by legitimate ethical concerns related to the impact of a technology on a society. Regulations, guidelines,

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[57] "International Human Rights", *supra* note 44 at 82.

[58] *Ibid.* at 82-83. RU-486 is a "morning after" drug which interferes with implantation and provides a non-surgical abortion. It was developed in France and is readily available in Europe; however, it remains highly controversial in North America and is only available for research purposes.

[59] In March 1994, O.H.I.P. redefined "resident" to exclude foreign temporary residents such as university students and short-term workers; the implications of this manoeuver under both Canadian law and international codes remain unclear.

and international codes[60] concerning ethical conduct within research pertain to such matters as the humane treatment of non-human animals, informed consent requirements, and the inclusion or exclusion of women as research subjects.[61] These provisions impose a check on unlimited experimentation and legitimately constrain the practical liberty of researchers to follow their interests. Governments often enact moratoria or bans on ethically problematic research topics even if the research promises some identifiable benefits; restrictions on animal vivisection, embryo research, fetal tissue use, and genetic manipulation are common in nations generally recognized as promoters of scientific freedom.

In summary, international declarations emphasize freedom from racist interference in marriage or procreation; freedom from coercive sterilization or abortion; women's sexual freedom; socio-economic security independent of a woman's marital status; contraception and abortion; general rights to health and health care; and general rights to the benefits of scientific research. Collectively, and perhaps individually, these declarations support efforts to protect fertility, to protect individuals from discriminatory government policies, and to affirm the value of families. The protections in these international human rights documents do not necessarily ground rights to procreate, to have reproductive assistance, or to have infertility treatment funded.

III. Two Fundamental Problems

Although domestic and international law have failed to establish and defend a right to reproduce, legislators could still enact such a right. In this section, I will ar-

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[60] See *Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10* (Washington: U.S. Government Printing Office, 1949), vol. 2; "Declaration of Helsinki: Recommendations Guiding Physicians in Biomedical Research Involving Human Subjects" in World Medical Association, ed., *The World Medical Association Handbook of Declarations* (Ferney-Voltaire, France: World Medical Association, 1985) 9; Council for International Organizations of Medical Sciences (IOMS), *International Guiding Principles for Biomedical Research Involving Animals* (Geneva: CIOMS, 1985) at 17-19.

[61] The exclusion of women from medical research and drug trials raises special safety concerns for female infertility patients given large doses of drugs which may only have been tested in men. The effects of fetal exposure to reproductive hormones are also undocumented. The United States' National Institutes of Health (N.I.H.) appropriations bill, signed by President Clinton in June 1993, codified as statute several policies supporting the participation of women in research protocols as both subjects and researchers (*National Institutes of Health Revitalization Act of 1993*, Pub. L. No. 103-43, 107 Stat. 122). The United States' Food and Drug Administration (F.D.A.) has also proposed new regulations to include women in drug trials (Department of Health and Human Services, Food and Drug Administration, *Guideline for the Study and Evaluation of Gender Differences in the Clinical Evaluation of Drugs*, 58 Fed. Reg. 39406 (July 22, 1993)). Canada currently has no legislation or guidelines regarding the inclusion of women as research subjects, but the matter is being considered by the Tri-Council Working Group to develop revised guidelines for human subjects research for the Medical Research Council (M.R.C.), Social Sciences and Humanities Research Council (S.S.H.R.C.), and the Natural Sciences and Engineering Research Council (N.S.E.R.C.).

gue against such a course of action on two grounds: first, the most frequent justification for procreative rights involves a derivation without sufficient justification from other forms of reproductive rights; and, second, typical restrictions on procreative rights that involve "the best interests of the child" raise difficult conceptual problems.

A. Positive and Negative Rights

The judicial, legislative, and human rights protections of reproductive liberty have emphasized the right to use contraception, to have access to abortions, and to be free from coerced sterilization or abortion. It is therefore often inferred that these reproductive rights support a right to procreate. Indeed, the ruling in *Skinner* v. *Oklahoma*[62] rejects the sterilization of convicted felons by appeal to "one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race."[63] It follows that people with reduced fertility retain their liberty and privacy in reproduction, and therefore have the same right to reproduce as do fertile people. If it is unacceptable for governments to restrict reproduction among some individuals by sterilizing them for social purposes or even for the best interests of their possible children, it would be equally unacceptable to restrict the reproductive liberties of those with limited fertility. John Robertson adopts this line of reasoning to conclude that the biological difference between "coital" and "noncoital" reproduction is irrelevant in policies regarding access to NRTs. He emphasizes instead the rights of individuals or couples to choose their life plans and to pursue their goals.[64] His analysis of the interests in reproducing and parenting shared by fertile and infertile people is compelling; less convincing is his attempt to minimize the distinction between coital and noncoital reproductive methods, and the implications of this convergence on legal intervention.

One extremely useful way of understanding this debate is to distinguish negative (liberty) rights from positive (entitlement or benefit) rights. A negative right is essentially a right of forbearance, entailing an obligation upon others to leave the claimant alone. Negative rights thus include the right to bodily integrity, the right not to be killed, the right not to be touched in any manner without permission, and the right to choose one's own beliefs. In addition, the notion is commonly, but more controversially, extended to include freedom to pursue freely chosen goals without interference by governments or others, as long as the exercise of one's liberty does not infringe upon the liberty of others.

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[62] 316 U.S. 535, 62 S. Ct. 1110 (1942) [hereinafter *Skinner* cited to U.S.].

[63] *Ibid.* at 541.

[64] J. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth" (1983) 69 Virginia L. Rev. 405 [hereinafter "Control of Conception"]; J. Robertson, "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction" (1988) 16 Law, Medicine & Health Care 18 [hereinafter "State's Burden"]; J. Robertson, "Life, Liberty and the Pursuit of Offspring" (1991) 21:4 Hastings Center Report 38 [hereinafter "Life, Liberty"].

In contrast, a positive right is a claim to some form of assistance or positive support, which entails an obligation on someone else to provide the goods or services required for a person to exercise the right. For example, a right to life is a negative right when it prevents someone from killing another without strong justification, but access to lifesaving medical resources is a positive rights claim. Robertson employs a second usage of "positive" rights claims that is distinguished from entitlement to services or resources; this is "a person's liberty to engage in certain conduct — in this case, to bring a child into the world."[65] The characterization as a positive or negative right of the liberty to follow one's life plan or to engage in certain conduct is significant in matters of assisted reproduction. Simply by stipulating that positive rights are those of liberty rather than those of entitlement, Robertson nearly draws his intended conclusions. It is unclear, however, what role he believes entitlement rights, or rights of access to the resources required to act upon one's liberties, might play in reproductive medicine or in a conception of positive and negative rights more generally.

I will therefore reserve the phrase "positive rights" to refer to rights of assistance, resources, or (in certain conditions) entitlement. The rights claims involved in medically assisted reproduction are quite complicated because most reproductive issues have both positive (resource requirement) and negative rights aspects, from the perspectives of both the pregnant woman and the fetus or future child.[66] Medical procedures also involve positive rights, since by their nature they involve a claim to beneficent attention by the caregiver.

The family rights embodied in article 16(1) of the *Universal Declaration* are clearly negative rather than positive rights: governments are restricted from interfering with marital or family choices on ethnic or similar grounds. Similarly, the reasoning in *Skinner* emphasizes the discriminatory element of legislation that requires sterilization for those who commit only some types of crimes; Skinner also grounds the right to reproduce in the importance of reproduction for the continuance of the species, not necessarily for the individual (although the individual is harmed by being deprived of the ability to reproduce).

Rights to marry and found a family free of interference or coercion are clearly liberties rather than entitlements; neither governments nor individuals are obliged to assist persons to find suitable marriage partners. However, even marital liberties are routinely curtailed. The same cultures that developed NRTs restrict marriage between close blood relatives. Similarly, minimum age requirements for marriage

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[65] "Control of Conception", *ibid.* at note 4, p. 406.

[66] I use phrases such as "from the perspective of the fetus" and "fetal rights" guardedly, because I am unconvinced that fetuses have any perspective until very late in development. *If* a fetus has interests or rights, we can talk about them by metaphorically adopting the fetus' perspective. The rights or interests of "future children" are not current interests, but involve the sequelae of our current actions. This topic will be discussed at greater length below (see text accompanying note 78, below).

are routinely instituted to prevent unhealthy early pregnancies for girls[67] and to protect minors from sexual abuse by adults. Still debated, of course, are rights to marriage and family formation for same sex partners. Article 16(3) of the *Universal Declaration* does not offer any insight into rights to procreate, but merely asserts that a family should be protected once it has been formed.

Most reproductive rights concerning abortion, sterilization, and contraception are negative rights justified by an appeal to more general negative rights of freedom from physical assault or coercion, especially by the state. Forcing a woman to become pregnant, either through rape or medical intervention, is a case of physical assault that happens to include a reproductive element. Similarly, forced sterilization, contraception, or abortions violate the most basic notions of bodily integrity and individual autonomy. We need not appeal to any specific *reproductive* rights to challenge such interventions; we need merely point to basic rights to be free from bodily invasion by governments or doctors.

The strongest negative claim of infertile people would thus seem to be the right to remain childless, without forced medical treatment or even pressure to seek treatment in the form of social isolation, guilt, or ridicule.[68] If the natural process of mate selection and continued sexual activity does not result in pregnancy, however, any further rights claim regarding assisted reproduction necessarily becomes positive in nature. The infertile couple have been left alone, and have not achieved their goal; they now require assistance if they are to realize their claimed right to procreate. This need for third party assistance is a claim of entitlement to aid and to resources, and is thus a positive claim in the stronger form that I have stipulated.

This positive character of NRTs will become clearer if we consider the mixture of positive and negative claims present in pregnancy and abortion. Abortion is commonly defended in terms of a woman's right to control her reproductive capacity; this is often framed as a right to make one's own decisions about one's health and future life prospects, but it also raises the element of bodily integrity. The fetus (and perhaps the father, state, church, or others with an interest in the offspring) must literally use the woman's body for the purpose of achieving a live birth, and if a woman does not agree to share her body for this purpose, it may be a substantial bodily violation.[69] With available technology, however, (including RU-486) a woman cannot safely perform an abortion upon herself without assistance. The claimed right to an abortion therefore involves both the negative claim of rights to bodily integrity and to choose one's own life plan, and the positive claim to assistance from the medical community.

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[67] See "International Protection", *supra* note 44 at 701-703, 719-20; "International Human Rights", *supra* note 44 at 80.

[68] The social pressures to bear offspring are pervasive and extremely strong, and are often perceived as overwhelming by patients who seek treatment for their infertility (see *supra* note 4).

[69] Judith Jarvis Thomson's famous violinist example was an early expression of this relationship in pregnancy (see J.J. Thomson, "A Defense of Abortion" (1971) 1 Philosophy & Public Affairs 47).

The United States Supreme Court, in *Harris* v. *McRae*, highlighted the positive rights element of abortion by noting that the right to a first trimester abortion does not afford

> a constitutional entitlement to the financial resources to avail [themselves] of the full range of protected choices. The reason why was explained in [*Maher* v. *Roe*[70]]: although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category.[71]

Pregnancy itself takes on the complicated nature of a dual, positive/negative rights claim. Traditional anti-abortion arguments are based on the assertion of the fetus' right to life; abortions are wrong, according to this view, because the fetus' negative right to be left alone to develop is violated. It should be (but often is not) obvious, however, that the fetus is neither a passive nor free standing agent in the pregnancy. Continuing fetal life is therefore not in any meaningful sense equivalent to leaving the fetus alone. Gestation involves development from a single cell to several pounds of flesh, bone, and blood, the materials for which come from the pregnant woman's diet and even from her own body tissues. Fetuses require enormous expenditures of maternal energy and some risk in order to be born. One cannot claim, therefore, that a fetus merely has a negative right to exist undisturbed. The very nature of the fetus involves a positive claim on its mother's body to ensure its survival and growth.

As is the case with women seeking abortions, the persons or couples seeking infertility treatment are asking medical and social institutions to help them achieve what they cannot accomplish on their own. Unlike the abortion case, however, there is no concomitant negative claim akin to that of the pregnant woman's desire to restore her bodily integrity by choosing not to share her body with a fetus. The goal is actually the opposite: to initiate the sharing of a woman's body with the fetus. The patients in the infertility clinic are thus clearly not asking for forbearance; they are asking for help.

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[70] 432 U.S. 464, 97 S. Ct. 2376 (1977).

[71] 448 U.S. 297 at 316, 100 S. Ct. 2671 (1980) [hereinafter *Harris* cited to U.S.]. This tradition is continued in affirmations of the Reagan administration policy of denying the use of federal funds to pay for abortion services (*Williams* v. *Zbaraz*, 448 U.S. 358, 100 S. Ct. 2694, (1980)), or even for a discussion of the option of abortion (*Rust* v. *Sullivan*, 500 U.S. 173, 111 S. Ct. 1759 (1991)). While abortions themselves were still legally protected under *Roe* v. *Wade*, women had no positive right to financial assistance from the state or federal government in order to procure one. Abortion rights activists typically collapse the negative and positive rights distinctions into a single practical consideration: if the government refuses to fund provision of the service (or even counselling about the service), poor women are *ipso facto* denied the ability to exercise their right to have it. While this is true in a practical context, the concepts should be distinguished and clarified: the right of non-interference is conceptually different from a right of beneficent assistance.

Robertson's characterization of infertility treatment — that people have the right to be left alone to make their own decisions and to engage in childbearing activities without governmental interference — is essentially a negative rights claim despite his preference for labelling it as a positive right. Asserting the right of non-interference fails to describe the reality of NRTs, which by necessity require assistance and resources in the pursuit of the claimant's reproductive goals. As with other claims for medical care, there is little about the request for infertility treatment that involves mere liberties. Robertson agrees that the negative liberty to seek assistance, and the positive entitlement to it through funding, are distinct.[72] Nevertheless, by emphasizing liberties to seek assistance without interference, he seems to ignore that assisted reproduction, by its very nature, is a positive rights claim because it necessarily requires assistance.

By equating coital and noncoital reproduction as personal choices that ought not to be limited or regulated, Robertson fails to recognize the radically different forms that interference would take. Preventing individuals from engaging in sexual intercourse would require gross violations of privacy, forcible restraint, quarantine, and/or relocation of one or both partners. Limiting reproductive options by forced sterilization, contraceptive insertion, or abortion all require bodily invasion with drugs or surgery. Refusing to fund the development or provision of NRTs, regulating reproductive services, or even declining to provide infertility treatments to a specific patient, however, would violate no such negative rights of privacy or bodily integrity. These limits would involve the mere refusal to provide a requested form of assistance, and this assistance is not even related to restoring or protecting the claimant's bodily integrity.

While there does seem to exist a right to attempt to procreate without undue political interference, further argument is required to justify a claimed right to access to NRTs. The inappropriateness of limiting reproductive decisions in invasive or biased ways does not justify a right of individuals to reproduce under all circumstances, let alone to have assistance in the undertaking. An appeal to justice regarding access to certain forms of assistance is unpersuasive when a right to that type of assistance has not yet been established. As I will argue below, a right merely to seek assistance is empty without some claim either to receive assistance or to contract for it. When the attempt to procreate under normal conditions has not been successful and NRTs are sought, an appeal to rights to found families free of governmental interference seems irrelevant rather than helpful.

B. The Right of Non-conception

Robertson acknowledges that procreative liberty is not an absolute or unrestricted liberty; it may rightfully be curtailed when the birth of a child would cause excessive harm to the community or to the child himself or herself.[73] The

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[72] "Life, Liberty", *supra* note 64 at 39.

[73] See "State's Burden", *supra* note 64.

R.C.N.R.T. agrees with the O.L.R.C. that the best interests of the child may present a possible justification under section 1 of the *Charter* for the restriction of access to new reproductive teehnologies.[74]

The notion of harm to the unconceived child is, however, problematic within the framework of rights claims. Generally, rights claims are balanced against competing rights claims: one's right to act may be limited when the act threatens others who have the negative right not to be harmed. Harm to non-rights holders, such as plants, is generally not enough to override the claims of the holders of rights. Accordingly, a right of procreation would have to be matched by an equally compelling right of the future child not to be harmed. When the issue at stake is conception through NRTs, a nonexistent future child would have to assert a valid right not to be conceived. This right of non-conception is therefore a eontradictory and impossible concept, leaving the adults' right of procreation virtually unlimited.[75]

The problem I am raising is not based on a lack of concern for future children or on a denial of a future child's interests or rights claims; it is in fact motivated by the opposite goal, which is to include the offspring as an essential party in our moral discourse on reproductive decisions. The problem concerns the ontological status of the claimant of a right of non-conception. What form of existence does an unconceived child have? To understand this problem, and the rights that this type of entity might justifiably claim, it is helpful to consider the ontological status and moral claims of fetuses, future ehildren, and future generations.

Embryos and fetuses exist as actual entities; the challenge is to decide whether they possess valid moral or legal claims against the rest of us or, instead, are more like plants with less morally compelling interests. If we were to assert that fetuses have full moral standing and thus rights claims, both the ontological and moral standing problems would be resolved. The only remaining problems would be those that apply to all acknowledged moral entities: balancing the rights of embryos and fetuses against the competing rights claims of others, and defending specifie elaims.

If we assert that fetuses are not yet persons in the full sense, we face a different challenge, although we may still find metaphysical support. Our notions of fetal interests primarily involve the conditions to be faced in the future by the child that the fetus will or may become. Most of our *own* interests, we should note, also have a forward looking orientation. In fact, very few of our ethical choices and interests rest solely in the present, revolving around momentary physical or emotional pleasures and pains. Instead, our most important interests tend to be those we project

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[74] *Report*, *supra* note 5 at 456-57; see also O.L.R.C., *supra* note 31 at 51.

[75] If the birth of a child would cause harm to *other* rights-bearers, for exainple, by overtaxing a community's scarce resources, limitations on a right to procreate would be justified through a standard appeal to a harm principle not involving the offspring.

into our futures, such as our relationships, our careers, and our economic security.[76] Even physical or emotional pleasures and pains become more important to us when we project them into longer lasting, future conditions. Thus even if fetuses have no rights claims *qua* fetuses, they may nevertheless have future but not yet actual interests that we are obligated to protect. For this reason, it makes sense to speak of a moral obligation upon pregnant women to avoid smoking, drinking, or otherwise badly managing a pregnancy that is expected to go to term and could result in an injured child.[77]

Unconceived future children, on the other hand, either as specific intended children or as future generations, have no current ontological status and thus no current interests or rights. We can, however, mentally project their presence into the future.[78] While we cannot know what a child will be like before he or she is conceived, and we cannot know who will be living on the planet several generations hence, we may assume that *someone* will exist in the future. Children who will actually exist in the future will have interests *then* and we can foresee that our current choices and actions could cause harm which would be felt at that time. It is therefore morally appropriate, for example, that both sexes avoid exposure to radiation or to toxins that could cause birth defects in our future, currently unconceived children and that the current generation avoid creating toxic waste dumps that will poison the environment for future residents. A nonexistent, future person can therefore reasonably be said to have a claim not to be harmed; we merely need to project the existence of an actual (as yet unidentified) victim of actual harm, who will exist in the future.

A future person's claim to avoid harm by never being conceived, however, raises an irresolvable metaphysical puzzle. If an unconceived child has a claim not to be harmed in its future life, the claim rests upon the supposition of the child actually having a future life. What is being asserted in a right of non-conception, though, is precisely that the child should have no future life or existence. In other words, nothing is claiming the right to remain nothingness. When the question is framed in terms of competing rights claims, it seems ludicrous to assert that nothingness can compete with, let alone override, the claims of existing persons.

Robertson, the Royal Commission on New Reproductive Technologies, the Ontario Law Reform Commission, and others are correct in asserting that procreation should be undertaken in ways that protect the interests of the future child. We face a contradiction, however, when we discuss such limitations in the framework of competing rights claims. The future child exerts the claim that limits the rights of

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[76] Past events are also deeply important to us, but they do not function as interests in a moral sense; there is no way for someone to change the past or to harm someone retroactively.

[77] "Wrongful life" lawsuits thus do not rest on a claim to non-conception, but rather on a fetal claim to have been aborted.

[78] This section was inspired by J. Feinberg, "The Rights of Animals and Unborn Generations" in W.T. Blackstone, ed., *Philosophy and Environmental Crisis* (Athens, Ga.: University of Georgia Press, 1974) 43.

the potential parents; the right being limited, however, is exactly the one which, if exercised, would allow the child to exist. If the unconceived child were to succeed in exerting the right of non-conception, no child, fetus, or embryo would ever exist. These entities, not nothingness, are the only plausible bearers of rights.

At this point, we reach the irresolvable paradox: once conception has occurred, asserting the future child's right of non-conception is moot. If conception has not yet occurred, there is nothing to exert such a claim. Further, if a claim of non-conception is asserted by this nothingness, the current non-entity making such a claim would eliminate the only source of its standing: its future existence and interests. We must be clear that the right being asserted is the right not to exist, ever, by someone who does not yet exist, even in embryonic form. Who, then, holds the claim which legitimately restricts the rights of prospective parents, who are actual moral agents? It is generally agreed that unconceived children cannot make a claim to be conceived and brought into the world, precisely because nobody exists to hold such a right; in exactly the same way, they have no right to remain unconceived. Initiating conception, therefore, cannot be an obligation adults owe to the unconceived child. Similarly, an asserted right to conceive offspring cannot be limited or constrained by the interests of the future child, because there *is* no child to constrain the exercise of the right until after the right has been exercised.

Barring limitations imposed by scarce resources and the competing demands of currently existing persons, therefore, one's right to conceive seems unlimited. It makes no sense to assert that one's right to reproduce is limited by the interests of potential children who have a right to remain unconceived and thus protected from harm. At best, we could say that a newly initiated pregnancy ought to be terminated, based upon the future claims and interests of the child that the current embryo or fetus would become. The practical result would be the absurd policy of allowing people to initiate pregnancies through NRTs even under clearly disastrous circumstances, and then counselling the expectant parents to terminate the pregnancy because their offspring would suffer in the future.

The gross absurdities of intentionally initiating pregnancies only to terminate them would result in unnecessary fetal deaths and harm to women; therefore, we speak metaphorically of the rights or interests of the unconceived offspring as limiting the procreative rights of adults. Such an assertion is a fiction, however, and belies the attempt to couch procreation in terms of rights. It is imperative that we consider the interests of future children, and that we exercise responsibility and restraint in our reproductive behaviours when the resulting children would be at risk of harm; however, there is no avenue for incorporating those interests within the framework of the rights of adults to conceive.

IV. Rights to Enter Reprodnctive Contracts

Many defenders of assisted conception assert a rights claim of freedom to contract. This claim is distinct from the right to have a child and is likely motivated by the simple observation that the physical causes of infertility might not be overcome, thereby making a right of procreation impossible to grant. In infertility treatment, the right of autonomous agreement is not a positive claim to resources such as medical technologies; it is a negative claim to be allowed the liberty to establish life plans and for parties to exchange payments, donor gametes, or other resources or services in the attempt to achieve parenthood.[79]

While people may ask for assistance in achieving their life plans, there is no speeific obligation on the part of others to provide such assistance. A general duty of beneficence requires us to help others whenever we can reasonably do so. The needs to be met in the world usually outstrip our resources, though, so we are not merely allowed, but required, to exercise discretion regarding whom to help, in what ways, and for what purposes. Accordingly, medical assistance for infertile persons is either a matter of charity or, more likely, a matter of contract between prospective parents and those who are able to offer help.

A practical implication of this approach is that rich people have the right of access to whatever infertility services they can buy, while poorer people must rely on charity or forego having children. Justice might require equal access to the means to procreate if procreation is a right; if the only valid claim is a right to make autonomous exchanges, though, other members of society would retain the right to refuse to financially support reproductive agreements. Proponents of public funding for NRTs would therefore have to ground a claim to such access in a procreative right rather than in a right of freedom to contract.

The right of frcedom to establish reproductive exchanges may be grounded in several theoretical constructions, and may employ the language of contracts, marketplaces, autonomy, or libertarian theories. All of these theoretical variations are grounded in assumptions of the equal autonomy of moral agents to act, to barter, or to make agreements to achieve their individual goals or preferences. However, frameworks involving contracts, markets, and free exchanges are especially problematic in procreative contexts.

A. Intuitive Limits

Supporters of an exchange model of reproductive assistance envision cases in which autonomous adults agree to cooperate in pursuit of the mutual goal of founding a family. Imagine the following hypothetical scenario: Mr. and Mrs.

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[79] As noted, Robertson's defence of noncoital reproductive liberty takes this approach, although he considers liberty in one's behaviour a positive rather than negative right.

Smith have tried to initiate a pregnancy for three years without success. Agreeing that raising a loving family together is part of their shared life plan, they seek assistance from trained clinicians to achieve this goal. The clinicians freely chose to practise reproductive medicine to satisfy their own scientific interests, to help other people, and/or to obtain a profit. After the prospective parents and clinicians agree on the contractual terms, which include financial compensation in return for medical services, they embark on the NRT protocol. The outcome of this contract cannot be guaranteed, of course, since most attempts at IVF do not result in pregnancy.

Any thoughtful decision to bear children would seem to involve agreements of some sort, as couples may agree to marry in order to establish a nuclear family together, and may decide jointly to stop using contraceptives, or to time intercourse in order to initiate a pregnancy. If making agreements between the two usual reproductive partners is acceptable in the intentional initiation of a family, it seems to follow that contracts with other collaborators or facilitators should be equally acceptable for achieving the same goal in the face of infertility.

On the other hand, we can also imagine cases in which the contracts to create a child established between or among autonomous persons are greatly troubling. Consider, for example, a futuristic "infant supermarket". Mr. and Mrs. Huxley specify the sex, physical features, talents, I.Q., and assorted personality traits they desire their child to have. They then select sperm and ova from the computerized registry at the donor bank. Preimplantation genetic analysis enables the clinicians to dispose of embryos with the wrong sex or with serious genetic flaws, and specific characteristics are inserted with gene replacement techniques. A healthy gestator is selected, and the pregnancy is monitored with several prenatal tests. The contract stipulates that if the infant is born with physical or mental disabilities and falls short of the Huxleys' expectations, they may return the infant to the clinic and demand a refund or replacement.

An "infant supermarket" or "genetic showroom" in which children are custom ordered seems intuitively distressing, but distinctions between acceptable and objectionable reproductive contracts require stronger grounding than intuition. The key difference between these scenarios is that the latter seems to treat the child as an object or product that can be custom designed and returned for a full refund if unsatisfactory, rather than as a developing person in relationships with his or her parents and others.[80]

The critical flaw in contract-based approaches to reproduction is that the contractual model itself does not provide an opportunity to ask whether some matters are by nature unsuitable objects of a contract. The liberty and contractual models fail to explain why we are more bothered by the Huxleys' contract than the Smiths' when both couples and their respective co-contracting parties all acted as fair and

[80] See the discussion at Part **V.B**, below, regarding the range of images and attitudes about offspring that are at play in the claims of procreative rights.

equal negotiators. We must consider, therefore, whether our discretion in bargaining over some matters is legitimate only to a certain extent.

In assisted reproduction, the contractual model — taken by itself and unmodified by other moral considerations — creates a slippery slope between the ideal cases of loving, conscientious prospective parents such as the Smiths, and the seemingly acquisitive, emotionally distanced infant consumers represented by the Huxleys. In between lie several types of cases in current and foreseeable medical practice, and the contractual model allows no clear distinctions between the acceptable and troubling variations. If it is appropriate for a couple to retain the services of physicians in the attempt to initiate pregnancies and to conduct prenatal tests to detect abnormalities, arranging for the further services of embryo genetic analysis, sex selection, and gene therapy or enhancement should also be acceptable within the same contractual model. If parents can procure diagnostic services to avoid serious diseases in their offspring, why could they not also procure services to ensure the gender or other traits of their children, for whatever reason? It would be acceptable to use donated sperm, ova, or embryos, and to accept the altruistically motivated service of gestation without payment, if the donations were made freely and without manipulation; it should be equally acceptable for gamete or embryo providers to bargain for payment and fair compensation for their time, risk, and genetic interest and for gestational mothers to charge for the risks and lengthy personal involvement in pregnancy. However, a case of contracted gestation in which the contracting couple agree to pay the gestational mother $10,000 upon the delivery of a healthy child, but will pay nothing in the event of a birth defect or a decision by the gestational mother to keep the baby, seems to be another intuitively objectionable example of treating the child as a commodity. There must be some identifiable difference between the acceptable cases of a couple's agreement to enlarge their family and the impermissible cases of an agreement to buy a child produced according to specifications. Concerns other than the freedom to contract must be at play in defining these notions.

B. The Myth of the Equal Contractors

Most libertarian, contract, or marketplace theories assume the equal status of the contracting parties. The establishment of ethics itself within a libertarian or social contract theory requires free and equal participants who respect the autonomy of their peers, and specific contracts are generally considered unconscionable if one party to the contract has significantly greater power than the other(s). When contracts involve reproductive capacities, however, and especially when they involve reproductive technologies, the ideal of equal parties must be called into question at many levels.

Inequalities between children and parents, between women and men, and between patients and doctors all require attention in the context of reproductive exchanges. Annette Baier has articulated the scope and impact of a problem that is usually ignored.

> It is a typical feature of the dominant moral theories and traditions, since Kant, or perhaps since Hobbes, that relationships between equals or those who are deemed equal in some important sense, have been the relations that morality is concerned primarily to regulate. Relationships between those who are clearly unequal in power, such as parents and children, earlier and later generations in relation to one another, states and citizens, doctors and patients, the well and the ill, large states and small state, have had to be shunted to the bottom of the agenda, and then dealt with by some sort of 'promotion' of the weaker so that an appearance of virtual equality is achieved. ... This pretense of an equality that is in fact absent may often lead to desirable protection of the weaker, or more dependent. But it somewhat masks the question of what our moral relationships *are* to those who are our superiors or our inferiors in power. A more realistic acceptance of the fact that we begin as helpless children, [and] that at almost every point of our lives we deal with both the more and the less helpless, ... might lead us to a more direct approach to questions concerning the design of institutions structuring these relationships between unequals (families, schools, hospitals, armies) and of the morality of our dealings with the more and the less powerful.[81]

1. The Offspring

The most obviously unequal party to any reproductive exchange is the child produced by it, because unconceived children cannot accept or refuse to enter into any contracts regarding their own conception. A child will exist within the relationships of the family structure, and the child's autonomy will come into being in this context. Decisions that so profoundly affect a person's life prospects would normally be at least partly under one's own control, but unconceived children are, of course, simply unable to participate in autonomous negotiations regarding these fundamental life influences.

Because children cannot be equal contractors with adults, their guardians enter into negotiations on their behalf, making the child equal in representation if not in fact. However, transferring the exercise of a right of non-conception to a proxy does not help matters, since at the time of the agreement, there is no one in existence for the proxy to represent. An existing proxy might reasonably represent the future interests of a future child, but those interests are voided if the proxy exercises a right of non-conception on behalf of the future child. In other words, the proxy's authority (the interests of the future child) would be eliminated by the very act of asserting authority to deny conception. Since the child cannot be an equal contracting party — even by proxy — in his or her conception, it appears that the child is better understood to be the object of the reproductive contract made by adults.[82]

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[81] A.C. Baier, "The Need for More than Justice" (1989) 13 Can. J. Philosophy 41 at 52-53.

[82] See Part V.*B*, below.

2. Women and Men

Even in progressive, egalitarian marriages, women cannot fully overcome systemic and societal oppression.[83] The relative scarcity of female scientists, reproductive physicians, politicians, and policy regulators places women at a distinct disadvantage, both historically and currently, in influencing reproductive policies. Women's incomes are still lower than men's, women's political role is limited, and women do not control the media that so greatly shape our perceptions of "normal" men, women, and families. As Rosalind Petchesky observed,

> [t]he critical issue for feminists is not so much the context of women's choices, or even "the right to choose," as it is the social and material conditions under which choices are made. The "right to choose" means very little when women are powerless. ... [W]omen make their own reproductive choices, but they do not make them just as they please, they do not make them under conditions which they themselves create, but under social conditions and constraints which they, as mere individuals are powerless to change. The fact that individuals themselves do not determine the social framework in which they act does not nullify their choices nor their moral capacity to make them. It only suggests that we have to focus less on the question of "choice" and more on the question of how to transform the social conditions of choosing, working, and reproducing.[84]

Individual men also rarely have the power to change the broad social conditions under which they must make their reproductive decisions. Still, men are dominant in social policy discussions and in the decisions that have shaped the development and use of NRTs. Until women and men share equal influence over social, political, economic, and medical trends — or better, until women achieve the majority voice in reproductive matters that affect their lives more than the lives of men — women will remain unequal parties in medically assisted reproductive decisions.

When women are at a political, economic, or social disadvantage at the outset of the bargaining, it is reasonable to fear that they will be exploited. To be recognized as unequal leaves a woman in a precarious position: she might receive the pity and protection of bargainers in a stronger position, or her needs, like her social standing, might be devalued and dismissed. In a society that values free market forces, the weaker the bargaining position of one of the parties, the greater the danger of exploitation and objectification. Since reproduction involves the sexes differently, special concerns arise for women in reproductive contexts.

Several linguistic and visual images common in infertility clinics portray women as objects: women are often blamed for infertility, which is a medical

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[83] For a summary of evidence attesting to the continued inequalities between women and men, see S. Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992) at c. 1.

[84] R.P. Petchesky, "Reproductive Freedom: Beyond 'A Woman's Right to Choose'" (1979) 5 J. Women in Culture & Society 661 at 674-75.

condition, in common phrases like "you didn't ovulate," "you didn't get pregnant," and "you lost the baby."[85] In addition, the pornography commonly found in semen collection rooms typically portrays women as passive objects of sexual desire. Further, although women receive the vast majority of invasive infertility procedures, even when they are healthy and their partners infertile, women disappear completely in the description of infertility as a "disease of couples".[86] As Kathryn Morgan observes, women in infertility clinics are often not treated as integrated humans, but as "uterine environments" and "egg producers" from whom eggs are "harvested".[87] Frequently, women who "fail" to reproduce are berated by distressed partners, parents, and in-laws.[88] Pregnant women have been subject to imprisonment, unwanted caesarian sections, or other interventions designed to protect the future child's health, and many women still struggle to gain access to safe and legal abortions. While women are not *necessarily* reduced to the status of reproductive objects by NRTs or other reproductive policies, many current social forces and historical precedents do emphasize women's reproductive capacities above their other interests, and sometimes even above their lives. It is not inconceivable to think of women as "baby machines"[89] whose existence is validated by the babies — the products — they produce.

While I will not defend or critique a Marxist economic interpretation, the imagery of a worker's alienation from the products of his or her labour and exploitation for the advantage of owners and consumers seems especially apt for reproductive exchanges. If we can envision the products of labour as a part of oneself, a consumer's appropriation of them results in a form of alienation for the worker. It follows that the literal bartering of one's own flesh would be a diminishing experience. If we consider pregnancy from the woman's point of view, the infant is a flesh and blood extension of an experience that involves her entire self. Unlike other products, a fetus is not created out of external raw materials, cannot be left on a workbench to return to at another time, and has no existence apart from the body of the pregnant woman. A woman does not *do* pregnancy, as she might do carpentry

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[85] Note that we do not use equally blame-laden terms for men, who are told "you *have* a low sperm count" rather than "you aren't spermulating."

[86] M. Kirejczyk & I. van der Ploeg, "Pregnant Couples: Medical Technology and Social Constructions Around Fertility and Reproduction" (1992) 5 Issues in Reproductive & Genetic Engineering: J. Int'l Feminist Analysis 113.

[87] K.P. Morgan, "Of Woman Born? How Old-Fashioned! — New Reproductive Technologies and Women's Oppression" in E.-H. Kluge, ed., *Readings in Biomedical Ethics: A Canadian Focus* (Scarborough, Ont.: Prentice Hall Canada, 1993) 391.

[88] Historically, the blame for infertility has rested so strongly on women that Henry VIII divorced or beheaded five of his six wives for their failure to produce a son; the odds suggest that it was Henry whose fertility was compromised, and, of course, it was his sperm that determined Elizabeth's sex.

[89] This evocative phrase was coined by J.A. Scutt in her edited volume, *The Baby Machine: Commercialisation of Motherhood* (Carlton, Australia: McCulloch, 1988). She credits much of her inspiration to Gena Corea's work with a similarly evocative title, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artifical Wombs* (New York: Harper & Row, 1985).

or metaphysics; a woman *is* pregnant.[90] An infant is therefore not just a product made by a woman; the child is part of herself and in a transcendental relationship with her. If children are perceived as products or objects of autonomous exchange, however, the woman who produces the infant-product may be alienated from her labour and delivery, especially when an "infant supermarket" deems certain babies to be inferior, or when the woman's own interests are subverted for the creation or betterment of the infant-product.

a. Gestational Contracts

The objectification of women is clearest in "surrogacy" arrangements, or what should be called "contracted gestational parenting". A preconception adoption agreement is one in which a woman is inseminated on the agreement that she will give her own baby to the father and his social partner. True gestational contracts must involve NRTs for egg or embryo transfer. If one is entering into a contract with the objective of having a child, there seems to be no *prima facie* requirement that a couple's gametes or embryo be transferred to the genetic mother's womb rather than to someone else's for gestation. A rather extreme, but by no means unique, expression of the position I reject is the following from S. Geller:

> It is generally held that the child issued from a surrogate is her child even though she has only carried it, because she delivered it. ... This in my view, is a complete misunderstanding of the problem. The child of the surrogate does not belong to her any more than the child resulting from artificial insemination belongs to the donor, for the genetic contribution is exactly the same in both cases. The child belongs, we believe, to those who have conceived the project of having it: indeed without them this child would never have come to life.[91]

Geller ignores the fact that without the gestating woman's intention, labour, delivery, and literal flesh and blood contributions that transform a microscopic embryo into several pounds of infant, the child would never have come to life. Even when the child is the genetic offspring of the "surrogate", the woman who conceived and bore the child is relegated to the secondary role of the one who "only carried it". In contrast, those who arranged the contract are given moral precedence in claiming the right to raise the child. A woman who carries transferred eggs or embryos would have even less claim to the child than would a sperm donor; her pregnancy would count for nothing. Interestingly, however, parallel arguments are generally not raised in cases of NRTs with donor eggs or embryos, so that the recipient is reduced to "only" a gestating mother. The child, meanwhile, is depicted as an object which "belongs" to one claimant or another on the grounds of one's greater intention in initiating its production.

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[90] For articulations of pregnancy as a lived phenomenon, see E. Gatens-Robinson, "A Defense of Women's Choice: Abortion and the Ethics of Care" (1992) 30:3 Southern J. Philosophy 39; C. Mackenzie, "Abortion and Embodiment" (1992) 70 Australian J. Philosophy 136.

[91] S. Geller, "The Child and/or the Embryo. To Whom Does it Belong?" (1986) 1:8 Human Reproduction 561.

The "surrogate" mother is usually not described as a pregnant person who has an intimate relationship with the child she carries; she is merely the gestator that produces the contracting couple's baby in their stead, and could as easily be a mechanical womb. Even the word 'surrogate' thus objectifies the woman by focusing on the contracting couple's perspective to the exclusion of the birth mother's and child's points of view. In her dissent to the Australian National Bioethics Consultative Committee (N.B.C.C.) report endorsing gestational contracts, Sister Regis Mary Dunne eloquently identified the problem:

> In the discussion of surrogacy, the *experience* of pregnancy, and its significance, is too much discounted. The provision of sperm, even with the intention of fatherhood, is a transitory act. The donation of an egg, while more complicated, is done once, and for the donor it is over. The use of a uterus is not merely that, it is the involvement of the woman's whole body, a sharing of her life's substance, in a close bodily relationship, in the most intimate form of human communication, for nine months. For the mother, this may also be an experience of self discovery, but certainly she is the source of the initiation of self in the child. The term 'surrogate' denigrates the woman who enters into an agreement to bear a child for another. Whether her pregnancy is achieved by artificial insemination or in vitro fertilization, with an egg other than her own, it is her body which nourishes the fetus, resounds to its heartbeat, and its first movements, and pushes the baby out into the world.[92]

As the relationship between the mother and child is discounted in a contracted pregnancy, so too is the relationship between a woman and her own body. For a gestational mother to dissociate herself from the phenomenon of her pregnancy, because "it is not her baby" that she carries, is a form of psychological alienation which echoes the philosophical Marxist imagery. The woman is pregnant, however, so certainly it is *her* pregnancy and not someone else's. Pregnancy is the phenomenon of carrying a developing fetus; thus, if it is her pregnancy, the baby she delivers must be her baby, even if she intends someone else to act as the social parent(s), and/or even if she is not genetically related to the child. When a woman either feels or is told that the baby she carries is not *her* baby because of a contract, she alienates herself from the deeply meaningful experience in which she is involved. When the child is an object, the woman who herself gives rise to the child may come to be seen as an object: the "baby machine" produces goods for herself or for a contracting couple. The fact that the gestational mother and contracting couple may have autonomously entered the agreement does nothing to reduce the alienation and denigration of pregnancy that frequently occurs; indeed, emphasizing the contract tends to intensify these problems.

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[92] R.M. Dunne, "Dissenting View I" in National Bioethics Consultative Committee, *Surrogacy: Report I* (Australia: Ministers of Health, 1990) Appendix I at 49-50.

3. Doctors and Patients

Finally, there is good reason to reject the notion that medical care is properly provided in the context of contract negotiations between doctors and patients. The subject or purpose of such a contract would be medical care — the attempt to promote, maintain, and restore the patient's health — and in this venture it would be inappropriate to employ a typical vision of the contractors as equally self-interested. The Hippocratic tradition specifically *prevents* clinicians from pursuing their own interests by offering unnecessary, unproven, or risky treatments, even if the patient consents to or requests such interventions. The medical relationship is thus far better understood as one based on trust or fiduciary responsibilities than as a contracted service.

Patients need the knowledge that clinicians have; because of this expertise, doctors are permitted to ask deeply personal questions and to perform intimate examinations and procedures that give them more knowledge about individual patients. This personal information creates a knowledge/power nexus[93] that gives the clinician far greater practical and psychological authority to dictate the next step of any medical intervention, to encourage further interventions, and to end unilaterally the provision of medical treatment on the grounds of medical futility. Extreme paternalistic concern for the patient's physical or other interests may prompt the physician to make medical decisions without the patient's full knowledge or consent, and some patients cede decision-making authority to their doctors. Further, infertility patients often have limited options and support available to them outside the clinical setting, and may be suffering intense psychosocial turmoil, a crisis of gender or adult identity, or a profound sense of loss of control. Thus, in establishing the exchange of fees and services in the infertility clinic, the patient has unequal bargaining power with the physician. Even more important than the inclusion of non-exploitative terms in the medical contract is the fact that the patient may not be in position to decline entering the contract at all; the pace of the medical treadmill may be too fast for a patient to get off, and the psychosocial consequences of remaining childless may be too difficult to bear.

Children, women, and patients are thus all disadvantaged against adults, men, and medical practitioners, respectively. That most reproductive specialists are male makes female patients doubly prejudiced with regard to both gender and expertise. The social and psychological forces that transform infertility into a life crisis for many patients also create a subtly coercive context in which decisions about infertility treatments are made. In this light, it is a fiction to suggest that contracts or marketplace exchanges regarding reproductive services, and more specifically reproductive technologies, are made between free and equal parties. It is clear there-

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[93] M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A.M. Sheridan Smith (New York: Vintage Books, 1994); M. Foucault, *The History of Sexuality: An Introduction*, vol. 1, trans. R. Hurley (New York: Vintage Books, 1980); M. Foucault, *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, ed. by C. Gordon, trans. C. Gordon *et al.* (New York: Pantheon Books, 1980).

fore that contract or marketplace language is inadequate to characterize the moral status of claims to reproductive services. Legal constructions of reproductive contracts based on these ethical models are therefore similarly inappropriate.

V. Underlying Concepts

I have discussed at some length the problems with assertions of rights to procreate and rights to enter reproductive contracts. These concerns lead me to conclude that it would be legally and morally problematic to institute formal protection for procreative rights, and that the informal defence of procreative rights by reference to other reproductive rights should be avoided. If we reject procreative rights, what other options exist for describing reproductive options and regulating reproductive technologies? In this section, I will consider several concepts that are often taken for granted, but that may greatly shape our reproductive expectations.

A. Needs, Desires, and Disabilities

Classifying the desire to have children as a need or as a mere desire is complicated and politically charged. The perception of something as a need usually gives it legitimacy and importance not granted to mere desires. When resource allocation or political interests are at stake, as they certainly are in assisted conception, the label can be hotly contested and can lead to significantly different practical results.

Framing infertility as a *medical* need — and thus perhaps classifying infertility as a disability to which section 15 of the *Charter* could apply — raises more problems than it solves. Any progress on such a discussion requires a lengthy exploration of the purposes and goals of medicine, the basic concepts of health and disease, the limits of therapeutic as opposed to cosmetic or elective treatments, and the prioritization among many qualities of life and other values that involve our bodies. There is no incontestable definition of medical goals; we are free to define medical practices and institutions as we see fit.

It seems clear that in biological or medical terms, having a child is not a need in any sense comparable to the need for lifesaving treatment, food, water, oxygen, sleep, or other factors that keep a body alive and healthy. Infertility is not a terminal disease, rarely causes physical pain, and causes suffering, albeit genuine and intense, primarily in its frustration of one's social interactions and expectations. People are likely to have been infertile for quite some time without knowing it; the problems arise when a decision is made to have children or when a diagnosis is made. Even recognized infertility would cause no problems for people who do not wish to have children. As noted in *Skinner*, therefore, reproduction is necessary for the survival of the *species*, not of the individual.

On the other hand, initiating a pregnancy is a physical function, and the inability to do so is a physical limitation much like loss of mobility, impaired sense per-

ception, or illness. If there is no physical need to cure infertility, then there would seem to be no need to relieve complaints such as allergies or arthritis, since these sorts of disease are also generally not fatal. Many medical interventions typically deemed to refleet mere desires, such as cosmetic surgery, may assume the status of a need in the event of gross deformity that interferes with social interactions, mental health, or physical functioning. Further, while we tend to classify lifesaving interventions as medically necessary, there are times whcn such interventions are inappropriate and undesirable; the prevalence of advance directives and the refusal of lifesaving treatment demonstrate that saving life is not always the primary goal of health care. In medicine, the line between needs and desires is anything but clear except in the most extreme cases.

Strictly speaking, needs — both medical and non-medical — arise in response to a context. We might classify needs by borrowing Immanuel Kant's distinction between *hypothetical imperatives* (those resting upon conditionals and done for the sake of something else: if you want X, then you should do Y) and *categorical imperatives* (those binding in all circumstances: you should do Z).[94] Needs could then be expressed as hypothetical or conditional (if you want X, then you need Y) and categorical or absolute (you need Z). Observing that without life, all else is moot for human beings (notwithstanding the possibility of an afterlife), the most likely candidate for an absolute or categorical need would be something that prolongs life. However, we cannot live forever, and even when we have opportunities to save our own lives, we often rightly or reasonably choose not to do so; for example, soldiers may sacrifice themselves to save comrades or to defeat an enemy, political protesters may die in a hunger strike, and patients may opt to forego lifesaving treatment. Thus, while it is true that one needs nourishment, shelter, and, perhaps, medical attention in order to survive, these are largely hypothetical needs based on the desire to live rather than to die.

Following John Rawls, we could envision primary social goods as fundamentally important hypothetical needs,[95] since they are the sorts of things that allow an individual to compete with others for secondary social goods or to pursue chosen life plans. Freedom, education, fair access to material resources, and, perhaps, access to health care are all basic goods that make it possible for a person to acquire other desired goods. While having children is generally considered a positive element of one's life, it is a secondary good, a chosen life plan, rather than a primary good that enables one to choose life plans at all. Basic goods are those necessary for one's continued existcnce and success in the community, but a child (unlike adequate sheltcr, nutrition, and health care) is not necessary for one's continued existence. A child might aid in achieving success in a community, but this result is contingent upon the social value and social pressures placed upon procreation. Having a child is often a necessary requirement for *women* to achieve other goods

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[94] I. Kant, *Grounding for the Metaphysics of Morals*, trans. J.W. Ellington (Indianapolis: Hackett, 1981) at 25.

[95] J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Belknap Press, 1971) at 62, 90-95.

in society, since they are less likely than men to be rewarded for non-reproductive and non-sexual roles. This observation says less about children, though, than it does about gender role inequalities.

A need grounded in a more complex and realistic description of infertility as a predominantly psychosocial rather than physical problem might imply a right of infertile persons to request assistance and/or an obligation for others to provide that assistance. Emphasizing a right of request may lead us astray, however. Recognizing the right to ask for assistance commonly foeuses attention on the requested form of assistance, but does not inspire us to offer a more creative range of useful and appropriate options. That is, requests for assisted procreation lead us (if we are so inclined) to develop infertility treatments, but we have not been as attentive to relieving the psychological and social distress that accompanies childlessness. Framing society's moral interaction with infertile persons as a matter of *response* to distress rather than of obligation to meet a claim opens our eyes to a variety of morally appropriate mechanisms to relieve the suffering of infertility. We have ongoing responsibilities and response-abilities regarding the formation of families, our expectations for individuals, and assistance for suffering persons. We are not limited to an obligation to provide NRTs because they have been requested, nor are we granted the freedom to do nothing if the request for NRTs is shown not to entail a right to receive them.

B. Relationships

Procreation and parenting, by definition, involve relationships between parents and children. Procreating is not simply a matter of my seeking to complete my own life plan by having a child, as I would be by having a career; if I succeed in the attempt to reproduce, I have produced another person and substantially shaped that other person's life. In other words, my procreative actions affect *our* lives, not just my life. Having children thus fits into a category of establishing relationships rather than a category of pursuing individual goals.

The familiar positive/negative rights distinction here arises again in a new variation. While consenting parties generally ought to be able to establish and continue relationships without interference by governments or others, it does not follow that an individual has a complete or *unilateral* right to form a particular relationship, because a relationship, by definition, involves another. For example, I may have the negative right to marry whomever I choose without external interference, but I do not have the positive right to marry someone who does not consent to marry me. The very nature of a friendship, partnership, or family entails that a person claiming the right to establish these relationships has transcended the boundaries of the self, and thus one's claims as an individual are also transcended. Focusing attention on the unilateral, autonomous rights of prospective parents fails to account for the role and status of the child who is produced and who has no say in his or her creation or role in the family.

Our understandings of the term "having children" should also be clarified. We may speak of having children (or friends, or lovers, *etc.*) in several different ways, and most of their meanings can be located on a gradient of contrasting attitudes toward, or images of connection with, the other. At one extreme, the child is perceived to be an element or extension of oneself, perhaps as one might have brown eyes or a rapier wit. People who are unable to recognize the child as a separate individual, and who attempt to live through their children, often suffer from psychological immaturity or maladjustment, and may inflict serious emotional damage on the child.

At the other end of the gradient is a distanced attitude of acquisition that characterizes children as items to be had and collected rather like cars or houses. This acquisitive notion of "having" children reduces them to the status of desirable objects rather than persons, reinforces the image of women as baby machines, and is often accompanied by an attitude of control over others.

A third attitude toward having children may be found between the extremes of self-identification and distanced, objectified acquisition: the child is recognized as external to oneself, but also as part of an existentially self-defining relationship. In this third sense, the child is brought into the world and is connected in a unique way to the parent. Recognition of the child as an other who defines oneself captures a quality of transcendence; while not entirely of oneself, as are the brown eyes or rapier wit, the child is of the parent, reflects the parent, and allows the parent to revisit his or her own past. In this sense, the "having" statement is interchangeable with a "being" statement: "having children" is phenomenologically equivalent to "being a parent", much as having true friends is experienced as being a friend, or having a lover involves loving.[96] This attitude of transcendental recognition opens many positive possibilities for interaction, response, appreciation, and understanding of the child as a unique, developing individual.

A key problem with claims of a right to procreate is that they too often sound like claims to objects or material resources. It is significant that English lacks a gender-neutral personal pronoun, leading us commonly to refer to a fetus or infant as "it" — the word reserved for objects — which is a practice we avoid when speaking about unspecified adults.[97] Expressing reproductive options in terms of a right to procreate fails to encourage the relational notion of having children over an objectifying one.

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[96] The self-identification attitude may also sometimes be expressed with "being" statements, such that having a rapier wit is equivalent to being witty. Yet the relational sense of "having" and "being" is a more active sense of both terms: having children = being a parent = parenting = to parent; having a lover = being in love = loving = to love; *etc.* Having brown eyes is clearly not active at all; I am brown-eyed, but not brown-eyeing.

[97] Although significant progress has been made in banishing the use of "he" and "man" to reflect unspecified individuals and the human species, the lack of a gender-neutral pronoun continues to confound attempts to include women in much of our discourse.

C. *Creation and Procreation*

Procreative relationships are different from friendships, romances, partnerships, and even adoptions in the sense that the other with whom one establishes the parenting relationship is *created* specifically to form this relationship. In all other relationships, the partner is encountered, after which the relationship is recognized, defined or consciously initiated. It would be absurd to suggest that every act of reproduction is morally suspect just because children are being produced in order to form parental relationships. Nevertheless, persons who otherwise would not have existed come into being when we exercise our reproductive capacities; this fact ought to give us moral pause. In reproducing I am not making decisions only for myself, but necessarily for another who not only cannot consent or refuse, but who would not even exist if not for my choices.

It is implausible to suggest that any birth under any circumstances is to be considered positive, such that not coming into existence is itself a harm. If conception has not yet occurred, who exactly is harmed by not coming into existence? Accepting a claim that nonexistence is a harm to unconceived children undermines any attempts to prevent teen pregnancies, promiscuous men who father multiple unsupported children, and other known predictors of harm to children. The supposed harm of non-conception would also undermine the extensive support for contraception and fertility control. Thus, while we indeed have the capacity to bring others into existence, capacities do not justify their exercise. Procreation therefore seems better described as an awesome responsibility rather than as a right. A need for third party assistance in the enterprise does not alter the underlying moral weight of the act.

Claims of procreative rights are therefore, in yet another way, positive rights claims. The claimed right to have children is in essence the assertion of a right to create — or to have assistance in creating, or to have others create — offspring with whom to engage in a parenting relationship. While we may easily defend the unobstructed formation of mutually agreeable relationships among existing persons, it is something else entirely to suggest that someone has the right to have a partner produced for him or her. While governments ought not to interfere with marriages, society has no obligation to find or construct a spouse for a lonely heart. Similarly, there is no obligation to produce or assist in the production of children for those who want to be parents, nor even a clear right of adults to produce children (without third party assistance) for themselves.

D. *Are Children Objects or Persons?*

One way of describing the intuitive difference between the ideal and problematic cases of reproductive contracts[98] involves casting the child respectively as the

[98] See Part IV, above.

objective of the agreement, and as the *object* of it. The intentional objective or goal of having a child is usually unproblematic, and may be a worthy expression of love and commitment. Treating the child as an object to be bargained for, bought and sold, or created and destroyed at one's whim is quite a different matter. Once again, however, procreative rights claims and the autonomous exchange paradigm fail to assist in structuring the different outcomes.

One way to separate the child as person from the child as object is by distinguishing services from products. This involves a metaphysical distinction between actions and objects. Surgical procedures to clear blockages in a fallopian tube or vas deferens are services related to promoting the health and functioning of the patient, and are only indirectly related to the production of an infant. The distinctions between products and services in IVF and related treatments, however, are unclear. When successful, NRTs circumvent infertility by initiating a pregnancy, but do not cure infertility. When the protocol is literally to create and transfer an embryo, it is difficult to separate the service of combining ova and sperm from the production of an embryo, or a baby. It is likewise unclear whether gamete donation is a service or whether gametes are products. Even more perplexing is the claim that a gestational mother is merely providing the service of being pregnant; if the pregnancy does not go to term or if she keeps the child, it would seem that the gestator has provided no real service. Further, distinguishing compensated from altruistic gamete donation or gestation does not clarify the product/service distinction, and altruism does not prevent the objectification of gametes or infants. The R.C.N.R.T., for example, opposes "altruistic surrogacy" on the grounds of the offensiveness of offering a human child as a "gift" — an object — to others.[99] This insight is unusual in the literature on this subject, but one that I believe is correct.

Uncertainty of the outcome does not prevent us from envisioning NRTs as providing a child-product, because patients expect, or at least hope, to achieve a pregnancy. Clinicians actively encourage hope and perseverance by emphasizing success rates rather than failure rates, even after previous failures of treatment with the same patient.[100] In the minds of both the patients and the clinicians, it seems increasingly difficult to separate the engagement of a physician's services from the intention to produce a child. In this sense, the child may literally be the *object* of the contract for reproductive technologies, even if success is not guaranteed.

Finally, even if NRTs are truly services rather than exchanges for child-products, we should remember that the claim of clients merely to seek the services of physicians provides no *prima facie* distinctions between acceptable and unacceptable interventions. That is, provided that everyone has agreed fairly to the

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[99] *Report, supra* note 5 at 689.

[100] As an Australian clinician observed, "we try to encourage the patients to keep their spirits up and not to give up hope. We're learning new things all the time, and you never know what will work for a patient. One of our patients got pregnant on her 13th try!" (interview with K. Harrison, head of the clinical laboratory (1 June 1990) Queensland Fertility Group, Brisbane, Australia).

terms of the contract, there is no clear distinction between contracting for an embryo to be transferred to one's own (or one's partner's) body or to a contracted gestator. The service of combining gametes need not distinguish the couple's own gametes, donor gametes, and gametes sold to the highest bidder. The services of genetic testing, selective embryo transfer, abortion, and gene therapy cannot distinguish between the prevention of serious disease, the prevention of minor abnormality, and the promise of superficially desired characteristics such as sex or eye colour. When liberties, contracts, and autonomous agreements are emphasized in pursuing the *objective* of having a baby, there seems no reason to prohibit contracts for more specific objectives, such as producing a set of matched offspring. Some reproductive objectives can only be met by treating offspring as *objects* to be produced, manipulated, and destroyed according to the mutually agreed-upon terms of the reproductive collaborators. There is nothing within a contract model, however, to distinguish appropriate from inappropriate activities, nor to promote the objective of forming a healthy family rather than acquiring children as objects. Preventing this slide in perceptions and behaviour requires that any contract or agreement be framed in light of values and principles *external* to the autonomous exchange paradigm.

1. Counter-Claim: Infants Are Objects

Some have argued that infants do not have rights or morally compelling interests and are, in fact, more like objects than like persons. This argument posits that infants are not treated improperly when treated as disposable or custom-ordered commodities. Thus, while it would be wrong for moral agents to agree to barter or enslave another competent adult, we need not hesitate to treat fetuses or children as objects. H. Tristram Engelhardt approaches this extreme position in his discussion of personhood and the relative rights accorded to persons and non-persons.[101]

From an initial acceptance of the Kantian insight that ethical action necessarily involves the autonomous choices of free rational creatures, Engelhardt defines personhood with reference to an individual's ability to envision, to participate in, and to consent to a moral community. These activities require the capacities of self-consciousness, rationality, and moral sense. Zygotes, embryos, fetuses, and infants clearly lack these capacities, and so it is obvious that rational, autonomous persons must make choices on their behalf. More radically, however, even though they are biologically human, these non-rational entities are not persons in the morally important sense, and thus lack the rights claims that can be asserted by autonomous persons. It seems somewhat obvious to Engelhardt that when the needs or interests of persons conflict with the needs or interests of non-persons, the interests of persons should prevail.

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[101] H.T. Engelhardt Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 1986) at c. 4.

Engelhardt rejects the notion that potential personhood grants the standing of actual personhood; he thus protects the rights of persons over human non-persons. He stresses that the moral question is not whether the entity is human, but when during its development an entity becomes a person in the morally relevant sense. He does, however, want to avoid "imposing unjustifiable suffering on innocent organisms" and follows a line of logic reminiscent of Joel Feinberg's regarding future persons: damage to a currently existing non-person that will become a person in the future is damage that will at some future time be felt by a person who has the right not to be harmed.[102]

2. My Reply: Non-persons Evolve

Engelhardt is on the safest ground when he derives the implication that zygotes and embryos may be discarded, that fetuses may be aborted, and perhaps that infants need not be provided life-saving treatment. Since embryos and early fetuses are not persons in Engelhardt's definition, nor in Canadian and American legal decisions, no person is harmed by their destruction unless an actual person wanted them to exist (for example, for research or parenting purposes).

Less clear in a libertarian system like Engelhardt's is what ought to be done for those non-persons that are expected to become persons and that are brought into existence precisely because their creators want and intend them to become persons. This is not a standard potentiality argument about the moral status of embryos, fetuses, and infants; I am not making a claim about the moral status of currently undeveloped human beings with the potential to become autonomous agents. Rather, I am pointing to a conflict of attitudes about "having" children that seems to pervade rights-based procreative claims. Language involving the rights of adults to produce children may cast the child as an object, but the prospective parents themselves do not really want to have an object. People do not seek infertility treatment in order to produce offspring who will then be killed or shipped off while still immature, never to be seen again. They want a child who will grow into an autonomous being and who will continue to exist in a relationship with them. Stipulating that a procreative right does not imply a right to raise children is thus unhelpful; it denies the reality that people who seek reproductive assistance do not merely want to propagate their genes. Moreover, it establishes the absurdity of helping people to procreate only to remove the children shortly after birth.

Thinking of the child as something that one has the right to acquire, produce, or give to others thus results in a paradox for the parents: if children could ever be returned to the infant supermarket for failure to meet contracted specifications, the first to go would be profoundly handicapped children who will never develop full autonomy, precisely *because* they will remain non-autonomous rather than become self-sufficient, autonomous persons in Engelhardt's sense. The purpose of seeking infertility relief, and, more importantly, the very meaning of parenting, seem lost

[102] *Ibid.* at 115, 118; see also Feinberg, *supra* note 78.

when the discussion emphasizes the prospective parents' right to have children or to establish exchanges to produce them, because the product of the reproductive exchange is quite unlike anything else. When buying a new automobile, one may quite reasonably construct a dream car with the size, colour, and options that would create a fulfilling driving experience, and one could return it for failure to meet these specifications. Framing procreation as a right to engage in a fulfilling life experience too easily casts the child as an object much like the car. Cars will not grow up to be autonomous agents, however; children produced through reproductive interventions not only usually have the potential to do so, but are desired and expected to do so. Engelhardt's approach permits parents to reject their immature offspring, but offers inadequate guidance for *parenting*, or raising offspring to maturity, and guiding them to their anticipated autonomous agency and moral interactions.

It is true that prospcctive parents will have to shoulder the rcsponsibility of forming the family, because the nonexistent offspring are simply unable to participate in these decisions. This praetical realization, however, should not lead to Engelhardt's conclusion that offspring lack any moral status beyond that grantcd to them as objects desired by their crcators or owners. A child's utter vulnerability and inability to consent or refuse to join a family — which will over time shape the child's very being and future autonomy — creates a compelling moral considcration that must be acknowledged. The interests of a non-eonsenting child are not necessarily includcd in an adult's claim of a right to procreate or to make reproductive agrcements; these claims are typically one-sided, focus on the parents, and often distract us from serious consideration of the interests of children who are not appropriately "had" by others. Our reproductive ethics must include some coherent understanding of the offspring's transition from object to autonomous person within the continuous personal identity and relationships of the child; it is not at all clear how to do this within the parent-centercd models of rights to procreate and contraetual frecdom.

E. Causal Responsibility for Dysfunctional Families

The primary differenee between coital and noncoital reproduction is that, in the second, the infertility clinician plays a causal role in creating a child where none would have otherwise existed. The rccent Austin tragcdy,[103] for example, would not have occurred without artificial insemination and medical cooperation in a surrogacy arrangement. While most people manage fairly well through all sorts of reproductive outcomes, some pregnancies can reasonably be prcdicted to cause substantial harms to the pregnant woman, to the future child, and perhaps to a larger social community. Do infertility clinicians have any responsibility to prevent forcseeable reproductive tragcdies, or do all requesters have an cqual right to treatment,

[103] See "Death Spotlights Surrogate Parenting", *supra* note 1.

regardless of their personal situation?[104] This is the heart of the debate over access to NRTs and restrictions for non-medical criteria.

It is commonly observed that persons with all sorts of dysfunctional relationships, dire socioeconomic situations, and indicators of poor parenting skills are nevertheless able to have children, and we do not prevent them from doing so; is it not discriminatory, then, to prevent someone from having a child through NRTs simply because of infertility?

I agree that there is a hard-to-define line between preventing child abuse and negative social consequences and, alternatively, establishing dangerously restrictive legal definitions of "acceptable" parents. I am extremely suspieious of people who elaim to have a clear sense of who is fit or unfit to be a parent, and I worry about the political context of controlling such decisions; the reluctance to judge others or unfairly limit their options is thus generally a good thing. We must exercise this reluctance to judge very carefully, however, and avoid turning such reluctance into an all or nothing acceptance of, and even promotion of, irresponsible procreation. The desire not to restrict reproduction unfairly or coercively should not evolve into a tacit acceptance or even vigorous defence of irresponsible reproduction and incompetcnt parenting. Despite my hesitation to identify people who might be qualified to make such judgements, and the specific grounds upon which such judgements might be made, I rejeet the claims that such judgements ought never to be made, and that if they are, that they require the same level of justification as does interference with coital reproduetion.

One objection to the conflation of noncoital and coital reproductive freedoms involves the degree of interference that states or clinicians must exercise in order to prevent unfortunate births, and reflects the basic distinction between negative and positive rights. Prevention of coital reproduction requires physical separation of the reproductive partners, obtrusive monitoring of their sexual activities, coercive contraception, sterilization, or abortion. Removing existing children from existing families is the only option used widely in western nations to control child abuse, and this option is usually considered a last resort. All of these options are clearly enormous intrusions into the negative rights or liberties of persons, and there is a consensus that only extraordinary circumstances would justify such interventions. However, the prevention of a dysfunctional or abusive situation for possible future children is a much easier and far less intrusive matter when NRTs or other forms of reproductive assistance are involved. Rather than invading the body and sexual life of the prospective parents, requests for access and assistance may simply be denied.

We might compare hypothetical cases of two women convicted of child abuse whose offspring have been removed to foster care. One is offered the choice be-

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[104] Robertson, the O.L.R.C., the R.C.N.R.T., and others claim that the interests of the child might limit the right of the prospective parents to procreate; I have argued that framing this claim in a model of competing rights leads to a circular argument in which a nonexistent child could claim a right to prevent its own existence (see Part **III.B**, above).

tween a prison sentence and the insertion of Norplant to prevent the birth of further children. The other, who has already served her prison sentence but who still displays violent behaviour, seeks IVF to replace the children taken from her. While it seems best for neither woman to bear more children, our responses to the two cases differ. The first example pits the importance of preventing harm to possible future children against the rights of a woman not to be coerced into having long-lasting hormonal contraceptives placed in her body. The second example seems far less difficult: the woman's condition prevents the exercise of a dangerous choice, allowing us the luxury of not having to interfere at all. Recall that the United States Supreme Court noted in *Harris*, quoting *Maher*, that the government "may not place obstacles in the path of a woman's exercise of freedom of choice, but need not remove those not of its own creation."[105] Rather than requiring a violation of the negative right to bodily integrity or privacy, the prevention of child abuse in the second case merely involves the refusal to grant a request for positive assistance in producing the child. On most accounts, refusing to assist someone requires far less justification than does interference with his or her body, and a claimed right to assistance requires stronger justification than does a right of forbearance.

A related problem in Robertson's equating of coital and noncoital liberties is the failure to account for the clinician's responsibility as a causal agent in the reproductive process. Most infertility patients are well prepared to care for a child, and the doctor's causal role raises no problem. His or her assistance may become critical, however, when there is reason to worry about the welfare of possible future children. While it is true that many irresponsible, immature, abusive, or otherwise unprepared people manage to produce offspring, to do so is *their* choice, and thus their responsibility, even if the rest of us must look on with concern. When clinicians, donors, or governments provide the technology and assistance to produce an otherwise unlikely pregnancy, however, responsibility for the resulting child is shared by the parents and by those who assisted the conception. Doctors are quite happy to take responsibility for creating pregnancies when they advertise "their" success rates; they are, therefore, equally responsible for disastrous family situations that they might create, and are thus obliged to prevent foreseeable problems.[106]

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[105] *Harris*, *supra* note 71 at 316.

[106] The clinician's responsibility for IVF babies may be compared to the clinician's role in assisted suicide. If we grant a right to commit suicide, it may follow that justice requires assistance in carrying out the suicide for those physically unable to do so alone (*Rodriguez* v. *Canada (A.G.)*, [1993] 3 S.C.R. 519 at 577, (*sub nom. Rodriguez* v. *British Columbia (A.G.)*) 107 D.L.R. (4th) 342, Lamer C.J.C., dissenting). Even if there is a right to assisted suicide, however, it seems imperative that clinicians exercise caution in providing the means depending on the individual's competence, hope of improvement, and genuinely autonomous desires. The failure to evaluate potential euthanasia patients implies that the physician has committed a moral wrong; this charge is frequently laid against Jack Kevorkian. While we may not be able to stop people from taking their own lives, there is a special responsibility on one who assists suicide to ensure that a death that would not otherwise have occurred is an appropriate death.

The comparison of the causal role and responsibility in reproductive technologies and assisted suicide ought not to be confused with the larger distinction of killing and letting die that has dominated the euthanasia debate, because the active/passive distinction applies to euthanasia but not to

Unlike aging and death, initiating a pregnancy is not an inescapable fact of human living; it does not occur out of individual bodily processes (as would reproduction by sporing or budding), and it always requires activity, in the form of sexual intercourse if not IVF. Even if infertility is not a factor, one cannot argue that a person would end up procreating in any case.

We are faced with an unavoidable choice: either every infertile adult has an equal right to assisted conception because any healthy person could initiate a pregnancy if they wanted to, or we must establish some notion of responsible parenting and concern for the well-being of future children. Reluctance to judge whether some people should be parents may prevent abuses of power, but it too easily falls into an irresponsible compliance with demands made by people who make bad choices. More likely, access will be based on *ad hoc* judgements and inadvertently biased practices.

F. "Natural" Limits to Fertility

Menopause is often considered a natural dividing line between acceptable and unacceptable criteria for access to NRTs; most infertility clinics decline to treat women over the age of forty to forty-five, and the R.C.N.R.T. recommends that NRTs not be offered after "menopause at the usual age."[107] This limit appears to rest on the grounds that extending fertility beyond menopause is somehow "unnatural" (rather than just medically contraindicated). If this is true, then is the use of a ventilator to forestall or prevent death equally "unnatural"? Most medical interventions, it could be argued, are unnatural in the sense that they cause or allow our bodies to do things that they would normally be unable to do, and we must explain why "unnatural" fertility extension is any worse than "unnatural" life extension. For that matter, the Vatican has impugned IVF itself as an "unnatural" form of reproduction.[108]

An appeal to the natural processes of reproduction also cannot resolve the problem of initiating pregnancies through DI or NRTs for lesbian couples or for single heterosexual women, who do not "naturally" become pregnant in the absence of men. Should single and lesbian women therefore be categorically excluded from receiving infertility treatments, as are postmenopausal women? The R.C.N.R.T., among others, reverses itself and says no.

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pregnancy. That is, we may speak of the active role of a clinician in causing a death or causing a pregnancy where it would not have occurred otherwise. There is also a passive notion of euthanasia, which is allowing an imminent death to come unimpeded; there is, however, no passive form of pregnancy initiation.

[107] See *supra* note 21.

[108] Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation* (Washington, D.C.: Office of Publishing and Promotion Services, United States Catholic Conference, 1987).

People with all sorts of personal or environmental hindrances to effective parenting are able to initiate pregnancies without difficulty; nevertheless, it seems obvious that some situations are so conducive to child abuse or neglect, and/or harms to society, that decisions to initiate pregnancies under such circumstances are irresponsible and immoral. Abusive, teenaged, severely mentally handicapped, mentally ill, incarcerated, terminally ill, and impoverished people are all, like other groups in society, more likely than not to be fertile. A policy of equal access to NRTs for people who could have initiated pregnancies if they weren't infertile does not address the concern that for their own and especially for their child's sake, some individuals in certain circumstances really ought not to have babies. If it would be irresponsible, although not illegal or unnatural, for a person to have children under certain circumstances, it is equally irresponsible for a clinician to initiate an otherwise unlikely pregnancy under those same circumstances. Meanwhile, certain people are turned away from infertility clinics with little or no good justification beyond vague appeals to "natural" fertility. We may either admit and justify our values, engage in discrimination while pretending that we have no biases, or allow a free-for-all. While I do not presume to have the answers to these complicated problems, I think we must address them openly rather than obfuscate them with overly broad and inconsistently applied claims of non-discrimination.

G. Autonomy

NRTs are often presented as new options that enhance the autonomy of patients and of women more generally. Frequently, rights to procreate or to make agreements with others for assistance include some variation of the following: "IVF is my/their last hope — don't people have the right to choose to use it?" I have argued that several problems exist with claims of procreative rights and the right to enter reproductive contracts. There are additional problems with the appeal to autonomy, however, in the current context of IVF treatment protocols. I will consider the prevalent emphasis on autonomy in contrast to an alternative framing of infertility as a social or relational matter that would shift the burden of resolving the problem to the community. Embracing the patient and his or her infertility reduces feelings of isolation and opens up new, possibly non-medical, avenues of response to an infertile person's need for assistance.

A frequently unrecognized problem is that emphasizing autonomy may reinforce the infertile person's feeling of isolation from "normal" people, which is one of the most painful aspects of infertility. Autonomy is often perceived as the opposite of both dependence and interdependence; reinforcing autonomy as a moral and legal ideal may thus further isolate the frustrated patient from others who could provide support and relief. Having the freedom to make one's own decisions, to ask for help, and to contract for assistance may leave patients feeling overwhelmed by choices and left to fend for themselves to meet their needs. Illnesses and bodily malfunctions tend to make us feel that we have lost control, and infertile patients

must often make important choices while constrained by fear, anger, and helplessness. These feelings allow a treadmill of medical investigations and interventions to be initiated and perpetuated.

The images of independence, strength, and wider options conjured by an emphasis on autonomy create a double bond in which patients are led to expect greater control but are often actually undermined by clinical practices. The clinical course of NRTs is hardly an empowering experience, especially for female patients. Treatment is frequently viewed by patients as humiliating; at best it is an unpleasant necessity to be tolerated for the "greater good" of having the hoped for child, but very rarely is it viewed as a moment of self-actualization. Patients often speak of "turning myself over to the doctor" or "giving him my uterus" to be fixed.[109] While a patient's autonomy may have been expressed in agreeing to undertake IVF, once the nearly two-week protocol begins, every step of treatment and even basic daily schedules are dictated by the clinicians.

Further, the diminution of women in common clinical vocabulary and images is *inconsistent* with the couching of NRT decisions in the moral terminology of women's autonomous rights. Women are not empowered in an environment that supplies pornography, refers to them merely as parts of a "couple", and labels them as "failing to get pregnant" even when the physical condition rests with the male partner.

At a deeper level, the very notion of autonomy as self-directed choice is challenged by the recognition that our desires and our self-image are *themselves* constructed in response to the internalized messages, expectations, and images provided by others. The desire to be a parent and one's image of oneself as a future parent do not arise in a vacuum; they arise in a social context in which everyone is judged upon their adherence to social expectations. Very few patients are genuinely coerced by a partner or others into having infertility treatment, and even fewer are coerced by economic constraints (which would tend to make the expensive NRTs unattractive). Rather, they feel isolated, abnormal, and frowned upon by their friends, family, and even complete strangers. The desire to be "normal" is no doubt genuine and self-motivated. The definition of "normal", however, and the degree to which any particular abnormality causes a crisis of gender identity, obsession, and feelings of inadequacy, are established by internalized social and cultural messages over which the patient has little control. Thus even our most authentic and autonomous desires are substantially dependent upon the desires, goals, and expectations of others.

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[109] In addition to psychosocial aspects of infertility in the references, *supra* note 4, see also women's descriptions of their experiences with NRTs in R.D. Klein, *The Exploitation of a Desire — Women's Experiences with IVF* (Geelong, Australia: Deakin University Press, 1989); R.D. Klein, ed., *Infertility: Women Speak Out About Their Experiences of Reproductive Medicine* (London: Pandora Press, 1989); Gena Corea, *et al.*, *Man-Made Women* (Bloomington: Indiana University Press, 1987).

H. Informed Consent

The practice of NRTs in their current context also fails to meet the standards of informed consent — or better yet, informed choice — that derive from a principle of autonomy. Embedded within the theory of informed consent is a two-fold requirement: first, that the patient be informed of the available options, as well as their risks, expected benefits, and costs; and second, that the patient be genuinely able to choose or consent to one option from among the possibilities (rather than merely to assent or proceed without protest with a predetermined course of action). I think the current context of NRTs prevents the realization of both aspects of informed consent.

We are unlikely to have at our disposal a complete understanding of the ramifications of any choice, primarily because we cannot accurately foresee future outcomes. There is nevertheless a range of knowledge that seems central to distinguishing informed consent from random guessing. We lack basic studies of safety and efficacy of NRTs, and there is substantial concern about the long-term rates of cancer, cardiovascular disease, and other complications arising from the hormones used to hyperstimulate the ovaries. Patients may at best give uninformed agreement to proceed with the protocol because, in a vacuum of information, informed consent is impossible. In perhaps its most damning conclusion, the R.C.N.R.T. remarked:

> Commissioners believe that the current way IVF is being offered is unacceptable; it is unethical and unsafe to permit IVF to be used as a treatment for indications for which it has not been found effective. Allowing to persist the wide differences in how services are offered gives rise to risk, uncertainty, misinformation, and unfairness. The proliferation of indications for IVF, without demonstration of effectiveness for many of these indications, means that many Canadians, including responsible physicians, share the Commission's concern about the situation.[110]

It would seem that any consent to NRTs would have to be based on an understanding of the experimental nature of the undertaking. One problem with NRTs, however, is that even though basic safety and efficacy studies have never been completed, the techniques have been used for so long that clinicians and patients alike no longer consider them experimental. NRTs are thus presented by clinicians as proven medical interventions; when patients ask about risks of treatment, doctors can honestly say that there are no reputable studies indicating serious side effects, because indeed there are few conclusive studies available at all. Because the information that patients require in order to give informed consent to use NRTs is simply unavailable, genuine informed consent for the procedures is impossible. Those who emphasize patients' rights to take on risks in the pursuit of their goals are therefore offering an incomplete argument: if patients knew what risks and probabilities for benefits they truly faced, they could choose to accept them; if patients understood that even their doctors often do not know what to expect, perhaps patients could

[110] *Report*, *supra* note 5 at 499.

give meaningful consent to participate in experimental therapies; since patients are told neither of the risks they actually face nor that they are really undergoing unproven treatments, their consent is anything but informed.

The consent element of informed consent is also constrained by the context. The most significant limitation on genuine consent is the absence of a wider range of choices. There are few other realistic medical options for most diagnostic groups, little promise of breakthroughs in under-studied areas such as the treatment of male-factor infertility, limited options for matching unwanted children with adults who want to adopt, and few avenues of social and psychological assistance for accepting infertility and proceeding without children in one's life. The absence of other options for dealing with a devastatingly painful situation thus constrains the patient either to assent to the one hope of remedy that is offered or to settle for unrelieved distress.

I. A Wider Scope: Perceptions of Infertility and Infertility Treatment

To the question, "IVF offers my last hope; don't I have the right to try it?", one might offer one of the two obvious answers: "Yes, you have the right to try almost anything"; or "No, we will constrain your freedom because of uncertain risks to yourself and/or others." Framing NRTs as a matter of autonomy — as a right to procreate, a right to enter into agreements with others, or simply the right to seek procreative assistance — thus leads us to debate more generally paternalism, the limits of liberty, and public funding for elective procedures *but begs the question of whether NRTs really are the last hope for infertile persons.* By focusing on access to infertility treatments, we are too frequently distracted from investigating the range of other medical and non-medical options that may be more effective for relieving the distress of infertility.

The "hope" of NRTs is, for most patients, false; the treatments are usually unsuccessful in producing live offspring, and they expose those who undertake them to emotionally stressful, physically exhausting procedures with unknown long-term risks. Further, hope is a complicated emotion which can, when unrealistic, itself cause harm; by continually hoping for an unlikely outcome, the patient may be unable to begin a grieving and resolving process, and thus may remain obsessed with the desire for a child. An analogy between infertility and grieving for a soldier missing in action is an apt illustration of the problem: in both cases, the lingering hope of good news prevents the person from accepting and coping with the more likely negative outcome. The soldier's belongings and the baby clothes cannot be packed away, and the grieving and healing processes cannot begin in earnest. Hysterectomies and menopause are often met with relief, because they finally close the door on procreating. Some infertility patients even choose surgical sterilization to settle the matter more actively. Pregnancies in postmenopausal women are hailed as another option to expand women's autonomy, but they also seem to deny women the relief that menopause could naturally bring; even the universal infertility of feminine old age might be overcome if only the patient tries hard enough. In many

cases, offering NRTs as a hopeful option seems less a form of respect for the patient than a form of taunting and tempting. Opening some doors for some people may prevent others from closing doors that could shut out the causes of ongoing distress.

The autonomy principle and the focus on prospective parents in the moral and legal discussion of NRTs seems to miscast the problems of infertility. We have chosen to define infertility as essentially a medical problem; this views the body as a malfunctioning machine to be fixed by chemical and/or surgical intervention. We frequently downplay or ignore the psychological and social elements of infertility, which are usually its most painful aspects. Similarly, the emphasis on the procreative rights of the prospective parents downplays the inherently social nature of procreating, and reinforces the tendency to view infertility as a problem of fitting individuals (or perhaps couples) into procreative expectations. By emphasizing rights to procreate, we are often unable even to ask whether the social expectations for parenting are appropriate, let alone whether it is better to change the individuals rather than the social norms when the two do not match. By focusing on NRTs and justifying patients' rights to use them, we may be debating answers to the wrong problem.

Conclusion

Procreating is a fundamental human endeavour imbued with deep and complex meaning. It necessarily calls into question our values and assumptions about gender roles, sexuality, economic structures, family structures, power differentials, and notions of "normal" behaviour, beliefs, lifestyles, and bodily function. Assisted conception adds to the mix the values and expectations related to medical institutions, health care funding, and the difference between diseases and disappointment. I am not convinced that the law is flexible enough to settle these matters in a widely pluralistic society, and I do not presume to have clear solutions, but I hope that a few directions indicated in this essay provide some useful guidance.

Above all, I think it a profound mistake to affirm a right to procreate. While there are indeed several important reproductive rights that have been articulated, distinguishing these reproductive rights from a right to procreate is both conceptually possible and necessary. Both a specific affirmation of a right to reproduce and a casual derivation of procreative rights from other reproductive rights would have the same effect, which is likely to lead to dangerous outcomes for many children conceived both with or without assistance.

The language we use to shape the discussion tends to focus our attention on certain elements: the rights model focuses on the claimant, the infertile adult(s) seeking treatment. This paradigm distracts us from other morally significant elements of the situation, such as the offspring, the clinicians, and the society in which families are formed. The language we use can also mask disturbing attitudes that

we hold toward offspring, the status of women, and the roles of doctors and patients.

I suggest instead that the law, when it speaks to matters of assisted conception, emphasize the responsiblities inherent in reproduction. I need to emphasize that this conclusion does *not* imply any greater emphasis for the rights of embryos or fetuses, nor should it increase the state's involvement in pregnancy management or termination; the pregnant woman's interests remain paramount. This conclusion similarly should not validate coercive contraception or sterilization. Matters of bodily integrity are not raised by appeals for assistcd conception, as they are in the forcible prevention of reproduction or in intervention in pregnancy.

Children are the only parties to reproductive decisions who cannot voice their interests, and after birth they are the most vulnerable to abuse, neglect, and injury. However, I have shown that they cannot claim any rights prior to their conception, and framing reproductive decisions as matters of competing rights claims bctween adults and possible future childrcn leads to absurdities. Thus, while we cannot say that children have a right not to be conceived if they will be harmed in life, we can certainly say that people who are unable to meet the responsiblitics of parenting should not be assisted in procreating. Bringing children into the world is a profound action, and responsibility for doing so must rcst on all who participate in it.

Some more specific implications of this conclusion include the following: given the lack of evidence that single or homosexual people make worse parents than do married hcterosexuals, policies restricting access on the grounds of marital status or sexual orientation could rightfully be banned. By the same token, a marriage licence is no guarantee of maturity, stability, or patience. It would be reasonable for applicants for assisted conception techniques to demonstrate a minimal level of readiness for parenting, or perhaps to undergo a more thorough evaluation, as is standard in adoption proceedings. Although adoptions involve existing children rather than unconceived ones, in both cases third parties are in a position to form parent-child relationships where none would have existed before. The complaint that fertile people are not equally subjected to parenting evaluations should not hold sway; fertile people are not asking for assistance, and it would be extremely intrusive to restrict their procreative options. Their mistakes must be their own responsibility. Insurance coverage of safe and effective infertility treatment is appropriate, as the cost of treatment itself should not be a barrier to having children. However, although many impoverished people make excellent parents, the state has legitimate concerns not only in saving public funds but also in ensuring that children receive appropriate material support. It would not necessarily be discriminatory, therefore, to restrict access to assisted conception for those who cannot afford to raise the child without public support; such applicants should certainly not be abandoned, however, as we have an ongoing need to stabilize the economy and to help people get off welfare. Further, we should provide social and psychological supports to help all people cope with the grief of unrelieved infertility.

I realize that these recommendations remain vague, and more imporantly that they rest on enormous value judgements concerning appropriate parenting skills and other social norms. We have much work left to do before we will be able to resolve the ongoing tensions between freedom and irresponsibility, between careful judgement and prejudice, and between the rights and interests of adults and those of children. I am convinced, though, that defending nearly unrestricted access to assisted conception by appealing to a right to procreate is the wrong.way to go.