

# FETAL TISSUE RESEARCH & ABORTION: CONSCRIPTION, COMMODIFICATION, AND THE FUTURE OF CHOICE

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*The use of fetal tissue in medical research has emerged from obscurity to the center of the abortion debate. So far, the political positions taken on either side of the fetal tissue research debate have mirrored those of the pro-choice/pro-life camps, with self-described feminists largely coming out in support of the use of aborted fetuses in medical research. This Article re-opens the question of whether fetal tissue research is actually good for women. Surely the right to abortion, and women who exercise it, are necessary for the continuation of fetal tissue research. But is the benefit mutual? Do the practitioners and beneficiaries of fetal tissue research give anything back to the women who supply their raw materials and support those women's right to access safe abortion services? Or is the relationship between fetal tissue research and abortion somehow exploitive of women's reproduction? While aborting women are barred from receiving any form of remuneration for fetal tissue donations, that does not apply to the upstream medical companies that process the tissue into usable clinical and pharmaceutical products.*

*In this Article, I will discuss data on the demographic characteristics of women who have abortions and on the industrial process by which the aborted fetus becomes a commodity. Ultimately, I conclude that cutting women out of the industrial proceeds of fetal tissue research constitutes exploitation of their sexual and reproductive capacities—and disproportionately so for poor women and women of color. To make meaning of this conclusion, I argue that the policy discussion around the relationship between fetal tissue research and abortion should be re-framed in terms of reproductive justice. I will examine feminist and critical race jurisprudential and bioethical theories to develop a critique of the fetal tissue economy, and imagine what policy interventions, if any, might mobilize that economy towards reproductive justice.*

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## INTRODUCTION

Until recently, the issue of fetal tissue research had been off the radar for decades. Politicians and pundits did not talk about it, and it certainly did not form part of the abortion debate. It was made into an issue by the Center for Medical Progress (“CMP”)—an anti-abortion activist group that engaged in a years-long operation to shed light on the fetal tissue industry and level accusations that Planned Parenthood clinics were unlawfully trading in aborted fetal cadavers and organs for profit.<sup>1</sup> CMP operatives created a fake biomedical company as a guise to obtain high-level meetings with Planned Parenthood and other companies and released undercover videos of their conversations with abortion providers and companies that collect and sell fetal tissue samples to researchers.<sup>2</sup> Since CMP entered the public discourse, fetal tissue research has emerged from the shadows of science in a major way. Three Committees of the House of Representatives have launched investigations into CMP’s allegations,<sup>3</sup> and countless media outlets have covered the controversy,<sup>4</sup> but it is unclear to what extent the controversy has changed anybody’s mind on the fundamental issue of abortion rights.

A survey of the news- and social-media coverage of the fallout from the CMP videos shows that public opinion on CMP’s allegations splits largely along ideological lines. On one side, those fundamentally opposed to abortion for moral or political reasons invoke the vocabulary of the anti-abortion movement, calling fetal tissue “baby parts” in describing the content of the videos.<sup>5</sup> On the other side, defenders of the right to abortion, including most self-described feminists, have defended fetal tissue research with practically the same zeal with which they defend abortion rights. The *Feminist Daily Newswire* called fetal tissue research “an important area of work that has led to medical advancements such as the development of the polio vaccine.”<sup>6</sup> Planned Parenthood CEO Cecile Richards likewise emphasized in her testimony before Congress that “[fetal tissue research] offers the potential of

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<sup>1</sup> See Rachana Pradhan, *The Man Behind the Planned Parenthood Sting Videos*, POLITICO (Aug. 26, 2015), <http://www.politico.com/story/2015/08/abortion-planned-parent-hood-sting-videos-david-daleiden-121747> [https://perma.cc/LVZ7-WPT8].

<sup>2</sup> Corporate intelligence firm Fusion GPS, hired by Planned Parenthood to analyze the CMP videos, found that the short-form videos were edited by CMP to support its allegations that Planned Parenthood was profiting off of fetal tissue donations. The “full-length” videos released by CMP lasting hours were found to be missing up to 30 minutes of film, which CMP claimed owed to the omission of “bathroom breaks and waiting periods between meetings.” Jackie Calmes, *Planned Parenthood Videos Were Altered, Analysis Finds*, NY TIMES (Aug. 27, 2015).

<sup>3</sup> *Accountability: House Investigation into Planned Parenthood*, GOP.GOV, [http://www.gop.gov/solution\\_content/plannedparenthood/](http://www.gop.gov/solution_content/plannedparenthood/) [https://perma.cc/2MC3-TMGF].

<sup>4</sup> A Google News search for “Center for Medical Progress” conducted Sept. 9, 2016, yielded 7,220 results.

<sup>5</sup> See, e.g., GOP.GOV, *supra* note 3 (statement of John Boehner from Oct. 23, 2015).

<sup>6</sup> *Claims Against Planned Parenthood Repeatedly Proven Bogus*, FEMINIST DAILY NEWSWIRE, <https://feminist.org/blog/index.php/2015/09/01/claims-against-planned-parenthood-repeatedly-proven-bogus/> [https://perma.cc/8R9Q-NDAH].

lifesaving research,” and defended Planned Parenthood’s facilitation of fetal tissue donation.<sup>7</sup> A statement which Planned Parenthood released on its website in response to the videos framed its provision of fetal tissue from abortions as “help[ing] patients who want to donate tissue for scientific research.”<sup>8</sup> In this framework, it appears almost as though abortion patients themselves are beneficiaries of fetal tissue research. The media, too, has largely emphasized the positive aspects of fetal tissue research, with defense of the field echoing from *Mother Jones*<sup>9</sup> to *Time*<sup>10</sup> to the *Washington Post*.<sup>11</sup>

This Article re-opens the question of whether fetal tissue research is good for women. Surely the right to abortion, and women who exercise it, are necessary for the continuation of fetal tissue research. But is the benefit mutual? Do the practitioners and beneficiaries of fetal tissue research give anything back to the women who supply their raw materials and support those women’s right to access safe abortion services? Or is the relationship between fetal tissue research and abortion somehow exploitive of women’s reproduction? A definitive answer to any of these questions may be impossible to pin down given the value judgments about the status of the fetus and about the degree to which sex inequality continues to define gender relations in the United States today. Nevertheless, this Article will seek to inform those value judgments with facts rather than recycled political tropes masquerading as such. Ultimately, it will argue that the policy discussion around the relationship between fetal tissue research and abortion should be re-framed as a component of reproductive justice rather than a conflict of rights. To sketch what reproductive justice in this field might look like, I will examine feminist and critical race jurisprudential and bioethical theories from the late twentieth century and adapt them to today’s scientific and political climate.

The Article will proceed in four parts, moving from a more static presentation of law and data to a dynamic analysis of policy and theory. In Part I, I briefly describe the legal regime governing abortion and fetal tissue re-

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<sup>7</sup> Ryan Teague Beckwith, *Planned Parenthood Head Defends Fetal Tissue Research Before Congress*, TIME, <http://time.com/4053715/planned-parenthood-video-cecile-rich-ards-congress/> [<https://perma.cc/8R9Q-NDAH>].

<sup>8</sup> *Press Release: Statement from Planned Parenthood on New Undercover Video*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/about-us/newsroom/press-releases/statement-from-planned-parenthood-on-new-undercover-video> [<https://perma.cc/B6MF-J4NQ>].

<sup>9</sup> See Becca Andrews, *How the Attack on Planned Parenthood is Hindering Cures for Deadly Diseases*, MOTHER JONES (Oct. 26, 2015), <http://www.motherjones.com/politics/2015/10/planned-parenthood-attack-videos-hurting-fetal-tissue-research> [<https://perma.cc/4S5N-M82E>].

<sup>10</sup> See Alice Park, *Why We Still Need Fetal-Tissue Research*, TIME, <http://time.com/3965176/fetal-tissue-research-planned-parenthood-video/> [<https://perma.cc/Y3S4-WKKH>].

<sup>11</sup> See Editorial Board, *Defunding Fetal Tissue Research Would be a Mistake*, WASH. POST (Oct. 23, 2015), [https://www.washingtonpost.com/opinions/dont-let-abortion-outrage-trump-medical-needs/2015/10/23/4a9e70a8-679b-11e5-9223-70cb36460919\\_story.html](https://www.washingtonpost.com/opinions/dont-let-abortion-outrage-trump-medical-needs/2015/10/23/4a9e70a8-679b-11e5-9223-70cb36460919_story.html) [<https://perma.cc/T8QP-S2XS>].

search in order to delineate women's right to obtain abortion services, to informed consent prior to donating the products of her abortion, and to unaltered abortion procedures in the case of consent to donation. I also explain the criminal ban on the sale of fetal tissue by both women and abortion providers. Part II then surveys the factual universe of abortion and fetal tissue research. I will describe the medical and economic processes that come together to transform the fetal remains that result from an abortion into a commodity valued both medically and monetarily. I will trace the fetal tissue economy and introduce the women who provide its raw materials. In Part III, I will analyze the data presented in Part II to explain how fetal tissue donors subsidize industry stakeholders in an exploitive economic arrangement: women, disproportionately poor women and women of color, are made to pay for their abortion procedures and are barred from receiving compensation for fetal tissue donations obtained thereby. Their medical expenditures are thus transformed into surplus value embedded in the tissue as it enters the process of production. Contending that this process is generally bad for women, I will explore alternative policies that might end or mitigate this exploitation. Finally, in Part IV, I will look at this exploitation through an intersectional feminist lens, suggesting a relocation of the fetal tissue debate from the discourse of rights to a framework of reproductive justice.

## I. THE LEGAL FOUNDATIONS OF ABORTION AND FETAL TISSUE RESEARCH

This Part will briefly lay out the legal regime under which the right to abortion established in *Roe v. Wade* interacts with the limited privilege to donate the products of abortion for medical uses. First, I will summarize the contours of the right to abortion as they exist today. Then I will describe the legal framework for fetal tissue donation and research. The two pieces together constitute the bundle of rights with which a pregnant woman faces the decision to abort and donate the aborted fetus to medicine.

### A. *The Right to Abortion*

As a matter of constitutional law, a woman in the United States has a privacy right to terminate her pregnancy before the point of viability, that is, before the fetus could survive outside the womb.<sup>12</sup> Recognizing this right for the first time in *Roe v. Wade*, the Supreme Court explicitly addressed the issue of fetal personhood and held that “the word ‘person,’ as used in the Fourteenth Amendment, does not include the unborn.”<sup>13</sup> States may regulate abortion for the purpose of promoting childbirth by any means short of imposing an “undue burden” on the woman’s right to abort prior to fetal viabil-

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<sup>12</sup> See *Roe v. Wade*, 410 U.S. 113, 153 (1973).

<sup>13</sup> *Id.* at 158.

ity.<sup>14</sup> And the government has no affirmative duty to subsidize a woman's abortion, even if she is unable to afford the procedure.<sup>15</sup> This doctrinal relationship between the woman, the fetus, and the state will be imported into the discussion of fetal tissue research. The ultimate abortion decision is exempt from direct state interference up until the point of viability—only after viability may the state step in to protect fetal life. Prior to that, the woman has both autonomy over and financial responsibility for the disposition of the fetus as she desires.

The question of fetal status in abortion law should determine the legal status of the woman's relationship to a fetus *after* a legal abortion. Under the current law on fetal tissue donation, though, the fetus acquires a more person-like status after its potential for life has been lawfully terminated. Ironically, the legal basis for distinguishing termination from criminal homicide in the first place hinges on the fetus's *non*-personhood. This instability may shape the future of fetal tissue donation law as demand for fetal tissue grows and supply wanes.<sup>16</sup> If the pre-viable fetus is a non-person *in utero*, and states may not alter that status to any degree that will affect the abortion right, lawmakers seeking to facilitate fetal tissue research may choose to reclassify the aborted fetus from an inalienable organ-holder to an alienable bioproduct like eggs, blood, or sperm. I turn now to the current state of fetal status in the tissue donation laws to continue to lay the foundation for the discussion of fetal futures.

### B. *Legalization and Regulation of Fetal Tissue Donation and Research*

Fetal tissue research has been practiced in the United States for several decades, and is currently subject to both federal- and state-law regulations. This section will focus on federal law, the provisions of which are largely replicated in the thirty-eight states that explicitly allow fetal tissue donation and research. For the purposes of this Article, the fact that six states cur-

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<sup>14</sup> *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992). Most constitutional litigation over abortion, including the recent case of *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), involves questions of whether restrictive state laws constitute undue burdens on the abortion right. Because these questions do not typically touch upon the legal status of the fetus, this Article will not further elaborate on the contours of the undue burden standard.

<sup>15</sup> *See Harris v. McRae*, 448 U.S. 297, 317–18 (1980). Catharine MacKinnon sharply criticized the *Harris* decision as an effective overturning of the right to abortion:

The denial of funding for Medicaid abortions obviously violates this right. The Medicaid issue connects the maternity historically forced on African American women integral to their exploitation under slavery with the motherhood effectively forced on poor women, many of whom are Black, by deprivation of government funding for abortions. For those who have not noticed, the abortion right has already been lost: this was when.

Catharine MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1320 (1991).

<sup>16</sup> *See infra*, Part II.

rently prohibit fetal tissue research and nine more have similar, restrictive legislation in the works is not particularly relevant as long as the demand for fetal tissue is met by legal suppliers.<sup>17</sup> Were the number of donation-prohibiting states to increase measurably and contribute to tissue shortages, a re-evaluation could be necessary.

Fetal tissue donation and research is legal under federal law.<sup>18</sup> The law governing fetal tissue donation and research defines “human fetal tissue” as “tissue or cells obtained from a dead human embryo or fetus after a spontaneous or induced abortion, or after a stillbirth.”<sup>19</sup> Such tissue may be used in research and transplantation for therapeutic purposes under certain conditions.<sup>20</sup> First, the woman donating the tissue must give her informed consent, in writing, to the donation.<sup>21</sup> Consent to tissue donation is only valid if given subsequent to consent to the abortion itself,<sup>22</sup> and with full disclosure of any interest the physician has in the research and any medical or privacy risks that may be associated with the donation.<sup>23</sup> The patient must not specify, nor be informed of the identity of, the recipient of the tissue.<sup>24</sup>

With respect to the interaction between the woman’s interest in safe abortion procedures and the entry of the products of abortion into the stream of commerce that is the subject of this Article, two provisions of the law stand out as especially important. First, the physician performing the abortion procedure must affirm in writing that “no alteration of the timing, method, or procedures used to terminate the pregnancy was made solely for the purposes of obtaining the tissue.”<sup>25</sup> This provision is meant to safeguard the primacy of the woman’s health as the patient in the abortion procedure against any countervailing medical interest in the physical integrity of the fetus for tissue-collection purposes, which may demand a more invasive, or

<sup>17</sup> For information on current and proposed state laws restricting fetal tissue research, see Andrews, *supra* note 9; Katha Pollitt, *Fetal-Tissue Bans Are All About Making Abortion Providers Look Like Monsters*, NATION (Oct. 8, 2015), <http://www.thenation.com/article/fetal-tissue-bans-are-all-about-making-abortion-providers-look-like-monsters/> [<https://perma.cc/LN29-4XBK>].

<sup>18</sup> The interesting and fraught history of fetal tissue research law is outside the scope of this Article. For thorough accounts, see generally Gregory Gelfand & Toby R. Levin, *Fetal Tissue Research: Legal Regulation of Human Fetal Tissue Transplantation*, 50 WASH. & LEE L. REV. 647 (1993); Jose L. Gonzalez, *The Legitimization of Fetal Tissue Transplantation Under Roe v. Wade*, 34 CREIGHTON L. REV. 895 (2001).

<sup>19</sup> 42 U.S.C. § 289g-1(g) (2012).

<sup>20</sup> *Id.* § 289g-1(a).

<sup>21</sup> *Id.* § 289g-1(b)(1).

<sup>22</sup> *Id.* § 289g-1(b)(2)(A)(i).

<sup>23</sup> *Id.* § 289g-1(b)(2)(C).

<sup>24</sup> *Id.* § 289g-1(b)(1)(B–C). The ban on directed donations has been subject to scholarly analysis, but is not explored here. See, e.g., John A. Robertson, *Abortion to Obtain Fetal Tissue for Transplant*, 27 SUFFOLK U. L. REV. 1359 (1993) (arguing that the ban on directive fetal tissue donation is unconstitutional and conceiving to abort is morally acceptable); Joanna H. Kinney, *Restricting Donative Choice: Fetal Tissue Transplantation and Respect for Human Life*, 10 J.L. & HEALTH 259 (1996) (arguing against directed donation as immoral instrumentalization of human life).

<sup>25</sup> 42 U.S.C. § 289g-1(b)(2)(ii)(2012).

differently-timed procedure. The other provision that bears significantly over the subject of this Article is the prohibition that “any person . . . knowingly acquire, receive, or otherwise transfer any human fetal tissue for valuable consideration if the transfer affects interstate commerce.”<sup>26</sup> This provision, nearly identical to the federal ban on trade in human organs,<sup>27</sup> is meant to foreclose the possibility of fetal tissue sales from women or abortion providers to medical researchers. But once Science comes into ownership of the tissue, the law allows for its sale on the market: “[V]aluable consideration’ does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ. . . .”<sup>28</sup> The profit margin at which payments for these services would cease to be reasonable is not stated in the law. Also, as the fetal tissue originally obtained from an abortion is processed into stem cells, implanted into laboratory animals, or cultured into therapeutic pharmaceutical products, it can no longer be categorized as “human fetal tissue”; its byproducts can no longer be subjected to restraints on marketability. Taken together, then, the law allows for the entry of fetal tissue as a commodity into the medical marketplace while denying the aborting women who supply that tissue any share in its value.

The law governing fetal tissue donation and research regulates the relationship between aborting women, the state, and the medical industry, illuminating several tensions between those groups. I have identified three interrelated tensions that will underlie and interweave this Article’s analysis. First, the relationship between the state and the medical industry gives rise to a tension between the regulatory goals of the legislation. Measures like the informed consent requirement support an interest in safeguarding medical ethics. At the same time, the exemption of market actors who use fetal tissue in the development of medical products from the ban on monetary transactions involving fetal tissue evinces an interest in promoting the growth of fetal tissue research. Women are not even a party to this tension, appearing instead as mere beneficiaries of medical ethics. But another measure in the law—the requirement that abortion procedures not be altered to preserve donated fetal tissue—creates a second tension, this time directly between women and the medical industry. This patient-protective measure limits the supply of usable fetal tissue to that which can be obtained through whatever abortion procedures women choose to undergo. And as I will discuss in Part

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<sup>26</sup> *Id.* § 289g-2(a). Somewhat relatedly, and perhaps unenforceably, the statute prohibits the acquisition of fetal tissue from a fetus known to have been conceived for the purpose of providing such tissue. *Id.* § 289g-2(c)(1). Nor can non-humans be used to gestate human embryos or fetuses for the purpose of providing fetal tissue. *Id.* § 289g-2(c)(2).

<sup>27</sup> See 42 U.S.C. §274e(a)(2012) (making it “unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce”).

<sup>28</sup> *Id.* § 274e(c)(2).



III, expanding access to birth control, contraception, and safe early-term abortions will ultimately decrease the quantity of fetal tissue available to the medical industry. Indeed, this tension pits the medical industry's own profit motive in serving women's health needs against its interest in appropriating the products of abortions.

The third tension is more conceptual than concrete, born of women's relationship with the state. This tension is between understanding women as subjects of government protection (or even agents of state power) on the one hand, and as objects of governmental control on the other. To avoid excessive abstraction, this tension can be illustrated by juxtaposing two ways of framing the prohibition against compensating donors for fetal tissue. In the first light, the ban on compensation for fetal tissue donations can be seen as protecting economically vulnerable women from being forced to resort to abortion as a livelihood. In the second light, the ban cuts aborting women out of the fetal tissue economy so as to limit the way women may instrumentalize their bodies for financial gain.<sup>29</sup> I do not pretend to resolve this tension but merely to introduce it, as it will rise to the surface recurrently throughout this Article.

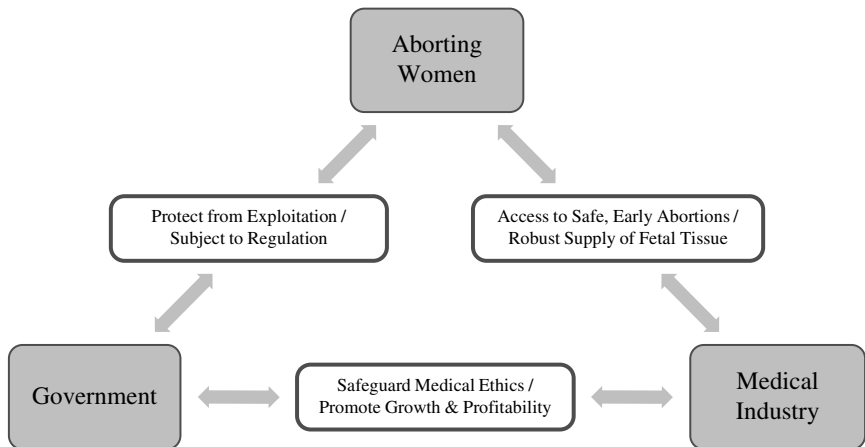


FIGURE 1

These tensions did not originate with the legal and technological creation of a new fetal tissue industry built around the products of elective abortions, but they do reside there. In Part III, I will discuss the degree to which alternative policy prescriptions in fetal tissue research and abortion may improve women's position relative to a medical industry and regulatory apparatus currently indifferent, at best, to the aborting women at the base of the

<sup>29</sup> I take up the possibility of allowing compensating for fetal tissue donors at length *infra*, Part III.B.2.

fetal tissue economy. I turn to that economy now to lay out the stakes of that discussion.

## II. FETUS FACTS: DATA ON ABORTION AND FETAL TISSUE RESEARCH

In this Part, I will detail the real-world medical and economic stakes of the fetal tissue debate. Understanding the science and economics of fetal tissue research and abortion provides deeper insights into which tensions are resolvable and which tensions are likely to force policymakers to pick winners and losers. Here I will attempt to convey such an understanding so that the policy discussion that follows will be driven by data where possible. First, I will look at how fetal tissue is obtained from abortion procedures: which types of procedures yield usable tissue and which do not? Where is abortion science headed in the United States and what implications might that have for fetal tissue research? Second, I will survey the state of fetal tissue science: its applications, its future potential, its limitations, and its supply needs. Third, I trace the fetal tissue industry and identify the major stakeholders along the supply chain. Finally, I focus on the one stakeholder left out of the fetal tissue economy—aborting women—by asking who has abortions and why, and what are their needs. Part III will then utilize these data in a critical reimagining of fetal tissue policy.

### A. *Obtaining Fetal Tissue from Abortions*

This section looks at the ways in which fetal tissue usable for medical transplantation and research is gathered from abortions. Factors such as gestational age and abortion procedure type delineate the population of women who “serve” the medical community as potential sources of fetal tissue. If only certain types of procedures at certain gestational ages can yield usable fetal tissue, the fetal tissue research community requires the continued provision of abortions using those procedures at those gestational ages to maintain its supply flow of fetal tissue. Part III will analyze whether these demands of the medical research community are compatible with those of women seeking the safest, least-intrusive abortions available.

Fetal tissue can only be secured from surgical abortion procedures and stillbirths; it cannot be obtained from non-surgical medical abortions.<sup>30</sup> Nearly 80% of abortions in the United States are surgical.<sup>31</sup> The most common form of surgical abortion is by aspiration, where a small vacuum tube

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<sup>30</sup> See Kinney, *supra* note 24, at 266 (“Since the [medically aborted] fetus is expelled in the woman’s home, it is impossible to harvest the cells under sterile conditions”).

<sup>31</sup> Karen Pazol et al., *Abortion Surveillance—United States, 2011: Surveillance Summaries*, CTRS. FOR DISEASE CONTROL 6, 28–29 tbl.11 (Nov. 2014) [hereinafter *CDC Abortion Surveillance*].

or suction syringe is used to evacuate the contents of the uterus.<sup>32</sup> Nearly 90% of surgical abortions are performed in the first trimester, that is, at or before thirteen weeks gestation.<sup>33</sup> First-trimester fetal cadavers extracted through aspiration are able to provide tissue samples from various organs usable in clinical research and transplantation therapies.<sup>34</sup>

Later-term abortions—though much less common—can provide larger, more differentiated, developed tissue samples for research and transplantation purposes, but can be more difficult to acquire. For one, the Born-Alive Infants Protection Act and the Partial-Birth Abortion Ban grant full legal status to a living fetus upon expulsion from the uterus and provide criminal punishment of doctors who kill such a fetus.<sup>35</sup> To ensure that later-term abortion procedures after 18 weeks gestation do not result in a live birth, “many abortion providers have begun to induce and document fetal demise before an abortion begins” by injecting chemical feticides into the patient’s uterus.<sup>36</sup> Feticides like the commonly used digoxin cause fetal tissue to exhibit “abnormal cell morphology, poor cell viability and variable RNA quality,” limiting its research value.<sup>37</sup> Regardless, fetal tissue research depends at least in part on specimens extracted from more developed fetuses.<sup>38</sup> And these later-term fetal tissue products pose the highest cost in terms of health risk to the aborting woman and risk of a live-born fetus in the necessary abortion procedure.

Medical abortions, which are usually offered up to nine weeks gestation in most states, are carried out by taking a combination of medications to induce the shedding and expulsion of the uterine lining, and with it the implanted fetus. They are swiftly ascending as a choice for abortion patients, having grown from comprising just 6% of all U.S. abortion procedures in

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<sup>32</sup> *What are the Kinds of In-Clinic Abortion?*, PLANNED PARENTHOOD (2015).

<sup>33</sup> *CDC Abortion Surveillance*, *supra* note 31, at 28 tbl.11.

<sup>34</sup> Tetsuya Ishii & Koji Eto, *Fetal Stem Cell Transplantation: Past, Present, and Future*, 6 *WORLD J. STEM CELLS* 404, 405, 408–13 (2014) (listing several clinical studies utilizing five- to thirteen-week old fetuses for tissue samples, and one using a sixteen-week old fetus).

<sup>35</sup> See 1 U.S.C. § 8 (2012) (defining “born alive” as “the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.”); 18 U.S.C. § 1531 (2012) (criminalizing the killing of a fetus whose head presents outside of the mother).

<sup>36</sup> Justin Diedrich & Eleanor Drey, *Induction of Fetal Demise Before Abortion*, 81 *CONTRACEPTION* 462, 462 (2010).

<sup>37</sup> E. Micks et al., *Effects of Digoxin and Delayed Dilatation and Evacuation on Fetal Tissue Quality: Maximizing Opportunities for Research Participation*, 92 *CONTRACEPTION* 367, 367 (2015).

<sup>38</sup> E.g., J. Igor Irurretagoyena et al., *Differential Changes in Gene Expression in Human Brain During Late First Trimester and Early Second Trimester of Pregnancy*, 34 *PRENATAL DIAGNOSIS* 431, 432 (2014).

2001 to 23% of all nonhospital abortions in 2011.<sup>39</sup> The portion of medical abortions among all abortions performed at up to nine weeks' gestation jumped 10% between 2008 and 2011, from 26% to 36%.<sup>40</sup> And the share of abortions performed at early gestational ages at which medical abortions are increasingly available is also on the rise: 64.5% of all abortions in 2011 were performed at or before eight weeks' gestational age, marking a 6% increase since 2002.<sup>41</sup> These trends suggest that women will continue to seek and obtain abortions earlier in their pregnancies, and that medical abortion will continue to grow as a safe, non-intrusive, and effective procedure to terminate early pregnancies.<sup>42</sup>

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In summary, fetal tissue can be obtained from the type of abortions that currently make up the majority of the procedures in the U.S. These surgical abortions are slowly on the decline as medical abortions become more easily available at less expensive rates. Fetal tissue researchers may therefore see medical abortions as a serious threat to their supply chain unless they can overcome the hurdles currently preventing them from effectively salvaging the products of medical abortions.<sup>43</sup>

### B. *How is Fetal Tissue Used in Medical Research?*

This section looks to the various past, present, and likely future medical uses of fetal tissue in the development of vaccines, transplantation, and stem cell research. All three areas of medicine pose unique demands on the availability of fetal tissue, and provide unique benefits to medicine.

#### 1. *Vaccine Development*

Fetal "donors" have been instrumental in the development of some of the most familiar vaccines on the market. The vaccines for rubella, chicken pox, hepatitis A, shingles, and rabies are all cultured from cell lines derived from fetuses aborted in the 1960s.<sup>44</sup> "No new or additional fetal cells are

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<sup>39</sup> Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 PERSP. ON SEXUAL & REPROD. HEALTH, 4, 8 (2014); see also Sabrina Tavernise, *New F.D.A. Guidelines Ease Access to Abortion Pill*, NY TIMES (Mar. 30, 2016) (detailing new regulations allowing medical abortion "further into pregnancy and with fewer visits to the doctor"), [http://www.nytimes.com/2016/03/31/health/abortion-pill-mifeprex-ru-486-fda.html?\\_r=0](http://www.nytimes.com/2016/03/31/health/abortion-pill-mifeprex-ru-486-fda.html?_r=0) [https://perma.cc/EQ6W-3L4N].

<sup>40</sup> Jones & Jerman, *supra* note 39, at 8.

<sup>41</sup> CDC *Abortion Surveillance*, *supra* note 31, at 6.

<sup>42</sup> *Id.* at 8.

<sup>43</sup> ANDERS BJÖRKLUND & ANGELA CENCI, RECENT ADVANCES IN PARKINSON'S DISEASE PART II: TRANSLATIONAL & CLINICAL RESEARCH 277 (2010).

<sup>44</sup> Liz Neporent, *What Aborted Fetuses Have to Do With Vaccines*, ABC NEWS, <http://abcnews.go.com/Health/aborted-fetuses-vaccines/story?id=29005539> [https://perma.cc/7PE7-L43P]; Coll. of Physicians of Phila., *Human Cell Strains in Vaccine Development*,

required in order to sustain” the cell lines from which these vaccines are manufactured today, as the original fetal host cells have been made to reproduce themselves in perpetuity in what the scientific literature calls an “immortalized culture.”<sup>45</sup> And the use of fetal tissue in vaccine development continues today, for example, in trials pursuing an Ebola vaccine.<sup>46</sup> Because vaccines can potentially benefit the whole of society, the use of fetal tissue in their development is one of the most compelling justifications for its continued provision to medical researchers. Given the ultimate use of immortalized cultures for vaccine manufacture, this area of medicine represents only a moderate demand for fetal tissue.

## 2. *Humanized Animal Research*

A more obscure form of fetal tissue research is conducted through the “humanization” of laboratory animals, especially mice and rats. Animal humanization serves two purposes: to incubate and grow human fetal organs for future transplantation and to more accurately predict human responses to toxic and therapeutic stimuli.<sup>47</sup>

In the first track of humanization research, researchers have implanted intact human fetal organs into rats to cultivate them into fully developed human organs with hopes to help fill the demand for organ transplants.<sup>48</sup> One such study that involved the transplantation of seventeen- to eighteen-week old fetal kidneys into adult rats found that “[h]uman fetal kidney transplants exhibited remarkable growth in size and were capable of supporting the life of” rats whose kidneys had been removed.<sup>49</sup> The author of that study has also transplanted fetal hearts into rats, telling *LiveScience*, “This technology is applicable not just to the kidney, but to every kind of [blood-supplied] organ in the body.”<sup>50</sup> The future plans of his team are “to transplant the kidneys into larger animals, such as pigs, where the organs could grow large enough to be transplanted back into people.”<sup>51</sup> According to the U.S. Department of Health and Human Services, 122,526 people are currently

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HISTORY OF VACCINES, <http://www.historyofvaccines.org/content/articles/human-cell-strains-vaccine-development> [<https://perma.cc/ZGW4-M7VX>].

<sup>45</sup> Coll. of Physicians of Phila., *supra* note 44.

<sup>46</sup> Collin Binkley & Carla K. Johnson, *Scientists Say Fetal Tissue Remains Essential for Vaccines and Developing Treatments*, PBS, <http://www.pbs.org/newshour/rundown/medical-researchers-say-fetal-tissue-remains-essential/> [<https://perma.cc/K9AJ-GUBB>].

<sup>47</sup> Tanya Lewis, *Growing Human Kidneys in Rats Sparks Ethical Debate*, *LIVESCIENCE*, <http://www.livescience.com/49503-human-kidneys-grown-in-rats.html> [<https://perma.cc/PD4P-YHRV>].

<sup>48</sup> *Id.*

<sup>49</sup> Nan-Kuei Chen et al., *Arterial Flow Regulator Enables Transplantation and Growth of Human Fetal Kidneys in Rats*, 15 *AM. J. TRANSPLANTATION* 1692, 1692 (2015).

<sup>50</sup> Lewis, *supra* note 47.

<sup>51</sup> *Id.*

awaiting organ transplants, and 22 people die each day waiting.<sup>52</sup> Were the use of animals as incubators for fetal organs cleared as a means to supply donor tissues, then demand for intact fetal organs, perhaps at later gestational ages like those used in the rat study, would increase dramatically.

The other track of animal humanization research proceeds by similarly injecting fetal tissue (typically bone marrow, liver, and thymus) into the host animal (typically mice) with the purpose of transforming the host's immune system, or a specific host organ, into something more closely resembling a human immune system or organ.<sup>53</sup> From there, the immunologic responses of humanized mice to various stimuli like exposure to diseases and medications are studied to better understand pathologies and to develop and test curative therapies prior to the clearance of such treatments for use on human test subjects. For example, a current study underway at Massachusetts General Hospital is using humanized mice infected with HIV to test out novel therapies that would not yet be safe for use in human subjects.<sup>54</sup>

Researchers working with humanized mice constitute a major source of demand for fetal tissue. One researcher from the University of North Carolina at Chapel Hill, Lishan Su, recently told *Nature* magazine that his research requires one fetal liver per month, between fourteen and nineteen weeks gestation.<sup>55</sup> Su insists that other types of stem cells are unable to humanize mice the way fetal tissue can.<sup>56</sup> And the demand for fetal tissue in labs like Su's working with humanized mice is continuous: "the [humanized] mouse's average lifespan is relatively short, at only around 8.5 months, because the animals tend to develop cancers of the thymus. And the humanized immune system is not inherited, so the model must be created again and again—leading to the constant demand for fetal tissue."<sup>57</sup>

### 3. *Stem Cell Research & Transplantation*

The transplantation of fetal tissue cells and stem cells marks one of the most controversial, and possibly one of the most promising, uses of the products of abortions. Fetal tissue transplantation is being explored as a pos-

<sup>52</sup> *Why Organ, Eye, and Tissue Donation?*, ORGANDONOR.GOV, <http://www.organdonor.gov/index.html> [<https://perma.cc/MS27-JGP4>].

<sup>53</sup> THE JACKSON LAB., JAX MICE, CLINICAL & RESEARCH SERVICES CATALOG: JUNE 2015–MAY 2016 at iv, 84 (2015) (advertising hu-CD34 mice "[p]roduced by injecting CD34+ cells from fetal liver, these models yield robust multilineage immune systems with good T cell maturation and function for long-term studies," and the higher-line hu-BLT mice "[t]ransplanted with CD34+ cells and fetal liver and thymus fragments, these models generate a well-developed adaptive immune system . . .").

<sup>54</sup> *Project Information: 5P01AI104715-03*, NIH PROJECT REPORTER, [https://projectreporter.nih.gov/project\\_info\\_description.cfm?aid=8788498&icde=25462082](https://projectreporter.nih.gov/project_info_description.cfm?aid=8788498&icde=25462082) [<https://perma.cc/VS2V-LV2A>].

<sup>55</sup> Meredith Wadman, *The Truth About Fetal Tissue Research*, 528 NATURE 178, 178 (2015).

<sup>56</sup> *Id.*

<sup>57</sup> *Id.* at 180.

sible cure for diseases including Parkinson's, Alzheimer's, Amyotrophic Lateral Sclerosis (ALS), stroke, chronic liver failure, diabetes, spinal cord injuries, and more.<sup>58</sup> A recent overview of the medical literature on fetal stem cell transplantation described the distinct advantages of fetal tissue over both adult and embryonic stem cell transplantation: "The rationale of fetal tissue transplantation lies in the potential for fetal cell proliferation and differentiation, and fetal grafts may be integrated into the host without inducing immune rejection."<sup>59</sup> In other words, fetal stem cells can reproduce inside the transplant recipient's affected organ(s) in order to make up for his or her organ deficiencies caused by various degenerative diseases. And the adaptability of the cells decreases the likelihood the host's body will reject the transplant.

In treating Parkinson's disease, the transplantation of fetal brain tissue has given rise to great hope in the search for a cure.<sup>60</sup> A high-impact study from 2001 found that Parkinson's patients aged sixty and under experienced reductions in motor symptoms following fetal neuron grafts, in which dopamine neurons obtained from aborted fetuses were surgically placed in the affected areas of patients' brains.<sup>61</sup> A 2014 retrospective study on patients who received fetal neuron grafts more than a decade prior found that the fetal dopamine neurons "remain[ed] healthy and functional for decades."<sup>62</sup> But each graft surgery requires at least three fetal brains to generate the tissue needed for the patient,<sup>63</sup> and approximately 60,000 new cases of Parkinson's are diagnosed each year in the United States alone.<sup>64</sup> Should fetal dopamine neuron grafts prove an effective cure for the disease, the demand for aborted fetuses will soar unless and until another source of dopamine neuron stem cells is developed.

In addition to Parkinson's, fetal tissue transplantation has proven at least potentially effective in the treatment of other neurological diseases such as Cerebral Palsy and ALS. Chinese scientists conducting experimental fetal brain transplants on children with Cerebral Palsy found that the procedures, which involved one to two fetal brains per recipient, "improved the neurological function of the recipients, and did not cause significant side

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<sup>58</sup> See generally Ishii & Eto, *supra* note 34 (reviewing the past, present, and future areas of fetal stem cell transplantation research).

<sup>59</sup> *Id.* at 404–05.

<sup>60</sup> See, e.g., Penelope J. Hallett et al., *Long-Term Health of Dopaminergic Neuron Transplants in Parkinson' Disease Patients*, 7 CELL REPORTS 1755 (2014) (finding fetal neural implants produced lasting benefits).

<sup>61</sup> Curt R. Freed et al., *Transplantation of Embryonic Dopamine Neurons for Severe Parkinson's Disease*, 344 NEW ENG. J. MED. 710, 710 (2001). Other transplantation trials produced negative results. See Ishii & Eto, *supra* note 34, at 409 nn.96–98.

<sup>62</sup> Hallett et al., *supra* note 60, at 1759.

<sup>63</sup> Alison Abbott, *Fetal-Cell Revival for Parkinson's*, 510 NATURE 195, 195 (2014).

<sup>64</sup> *Statistics on Parkinson's*, PARKINSON'S DISEASE FOUNDATION, [http://www.pdf.org/en/parkinson\\_statistics](http://www.pdf.org/en/parkinson_statistics) [<https://perma.cc/97ZL-C8Q6>] (noting that up to one million Americans and "more than ten million people worldwide" are currently afflicted with Parkinson's).

effects.”<sup>65</sup> ALS researchers have begun to successfully transplant fetal spinal cord tissue into the spines of afflicted patients.<sup>66</sup> Only one fetus is needed for every spinal cord transplant,<sup>67</sup> and the hope that fetal tissue transplantation will eventually cure ALS has gained traction in the media.<sup>68</sup>

In sum, fetal stem cell transplantation marks perhaps the largest curative promise for fetal tissue research, especially with regard to degenerative central nervous system diseases like Parkinson’s and ALS. The idea that fetal stem cells may cure or greatly relieve those afflicted with these diseases may indicate an important medical need for fetal tissue to meet growing demand.<sup>69</sup> And given the prevalence of these diseases in the United States, that demand could easily soar in the event of a scientific breakthrough. To what lengths might stakeholders in curative treatments go to re-frame the debates around abortion and fetal tissue research in order to meet that demand? I now turn to identifying some of those stakeholders and their interests in the fetal tissue economy.

### C. *The Fetal Tissue Industry*

Much of the controversy around fetal tissue research references the concept of a “fetal tissue industry,” evoking images of shadowy trade in the organs and corpses of the unborn. In fact, the so-called “life sciences” comprise innumerable industries of varying sizes that deal in countless types of biological materials, from genetic sequences to human waste.<sup>70</sup> The fetal tis-

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<sup>65</sup> Lin Chen et al., *Intracranial Transplant of Olfactory Ensheathing Cells in Children and Adolescents with Cerebral Palsy: A Randomized Controlled Clinical Trial*, 19 CELL TRANSPLANTATION 185, 187–88 (2010); see also Zuo Luan et al., *Effects of Neural Progenitor Cell Transplantation in Children with Severe Cerebral Palsy*, 21 CELL TRANSPLANTATION S91, S96 (2012) (finding transplantations of a different type of fetal neurons “significantly improved the functional development of children with severe CP, and no delayed complications were noted . . . . But the rate of improvement decreased gradually with time after 3 months . . .”).

<sup>66</sup> Jonathan Riley et al., *Intraspinial Stem Cell Transplantation in Amyotrophic Lateral Sclerosis: A Phase I Safety Trial, Technical Note, and Lumbar Safety Outcomes*, 71 NEUROSURGERY 405, 406–07 (2012).

<sup>67</sup> *Id.* at 405.

<sup>68</sup> See Miriam Falco, *Stem Cell Treatment Goes from Lab to Operating Room*, CNN (May 4, 2010), <http://www.cnn.com/2010/HEALTH/05/04/stem.cells.lou.gehrigs/> [<https://perma.cc/H7U8-JQPJ>]; Cynthia Fox, *FDA-Approved Stem Cell Trial Dramatically Slows ALS*, BIOSCIENCE TECH. (May 30, 2013), <http://www.biosciencetechnology.com/articles/2013/05/fda-approved-stem-cell-trial-dramatically-slows-als> [<https://perma.cc/FNM8-9E7H>]; Mark Joseph Stern, *Fetal Tissue Gives Hope for One of the Worst Diseases*, SLATE (July 31, 2015), [http://www.slate.com/articles/health\\_and\\_science/medical\\_examiner/2015/07/fetal\\_tissue\\_research\\_for\\_als\\_planned\\_parenthood\\_videos\\_leave\\_out\\_that\\_donations.html](http://www.slate.com/articles/health_and_science/medical_examiner/2015/07/fetal_tissue_research_for_als_planned_parenthood_videos_leave_out_that_donations.html) [<https://perma.cc/SCM4-S2RW>].

<sup>69</sup> See also Ishii & Eto, *supra* note 34, at 412–14 (discussing the developments in embryonic stem cells and re-programmed adult cells known as “induced pluripotent stem cells” that may gradually replace fetal stem cells in transplantation therapies).

<sup>70</sup> For an overview of the descriptive and theoretical literature on the rapidly growing life sciences, see Stefan Helmreich, *Species of Biocapital*, 17 SCIENCE AS CULTURE 463, 467–69 (2008).



sue industry—that is, the profitable trade in and use of fetal tissue and its development into more sophisticated products and therapies—is only one of many mechanisms by which life is objectified to generate economic activity.

The commodification of fetal tissue is described in multiple ways throughout this Article, but a few basic terms bear definition at this point. First, I use the term “commodity” to refer to the concept as developed by Marx in Chapter One of *Capital*. Namely, a commodity is the basic unit of capitalist production: “a thing which through its qualities satisfies human needs of whatever kind . . . whether directly as a means of subsistence, i.e. an object of consumption, or indirectly as a means of production.”<sup>71</sup> The moment fetal tissue is used as a raw material—a means of production in some commercial process—it is a commodity. By the act of exchange, the tissue is commodified. Second, this Article refers to the “appropriation” of fetal tissue and the “exploitation” of aborting women. “Appropriation” describes the taking of fetal tissue for the purpose of commodification without paying for it.<sup>72</sup> This appropriation constitutes “exploitation” because the actors who take and process the tissue-as-commodity take all of its value; the donating woman is entitled to none despite having contributed her labor to the production of the tissue.<sup>73</sup> The value of a commodity is an expression of the labor embodied in it—the fetal tissue only has value because the woman conceived, partially gestated, and chose to abort the fetus—yet whoever takes the tissue free of charge takes with it the value created through the woman’s labor.<sup>74</sup> Because the woman’s labor is uncompensated and is only incidental to her subsistence, I frequently use the metaphor of the extractive industry in this Article to describe the donating woman’s role in the fetal tissue economy. “In the extractive industries, mines etc., . . . [t]he object of labor is in this case not a product of previous labor, but something provided by nature free of charge.”<sup>75</sup> Feminists have long criticized the equation of women with nature that is used to justify women’s sexual, reproductive, and economic exploitation.<sup>76</sup> And this critique provides a provocative backdrop for the following analysis of the fetal tissue industry.

With that in mind, this section will trace the fetal tissue industry from the point of raw-material extraction to end-use consumption. It will provide

<sup>71</sup> KARL MARX, *CAPITAL* 125 (Ben Fowkes trans., 1990).

<sup>72</sup> Admittedly, the law frames this appropriation as a gift given with the woman’s consent, but the following analysis should make clear that the absolute bar on valuable consideration for fetal tissue donations, in conjunction with the relative positions of the woman and whomever seeks her consent to donate, justify framing the transaction as an appropriation.

<sup>73</sup> See generally MARX, *supra* note 71, at 163–77 (describing the process by which commodities come to embody labor-power).

<sup>74</sup> *Id.*

<sup>75</sup> *Id.* at 751.

<sup>76</sup> See, e.g., Olivia Harris & Kate Young, *Engendered Structures: Some Problems in the Analysis of Reproduction*, in *THE ANTHROPOLOGY OF PRE-CAPITALIST SOCIETIES* 109 (J.S. Kahn & J.R. Llobera eds., 1981) (problematizing the trope of femininity-as-giving-nature as a function of sexism).

an economic snapshot of the costs and revenues of the major stakeholders at each stage.

First, abortion providers extract the raw materials from the aborting woman. Then, Tissue-Processing Organizations (“TPOs”) isolate, preserve, store, and distribute the usable elements of the fetal remains they receive. Next, researchers—whether working for non-profit universities or public institutions, or for for-profit corporations—study and experiment on the tissue with the purpose of creating medically therapeutic value. Once that value has been ascertained, pharmaceutical companies purchase patents and licenses to mass produce, market, and distribute the end-products of fetal tissue research. Finally, the potential consumers of fetal tissue derived medical products are represented in the aggregate by disease interest groups that lobby legislators and regulators to advance policies favorable to those afflicted with a given disease.

Beginning with TPOs, whose collection of fetal remains imbues the tissue with a value it does not have vis-à-vis the woman and her abortion provider, these stakeholders are “winners” in the fetal tissue industry. But under the current legal regime, the actual source of the raw fetal materials is excluded from the market altogether. To analogize to mining, aborting women are not the overlying landowners—they are the mines. This exploitation by the fetal tissue industry of the abortion patients excluded from its proceeds by law will be analyzed in Part III. But for now, let us meet our market actors.

### 1. *Abortion Providers*

Passing over the aborting woman for now, given her lack of entitlement to any valuable consideration in exchange for her donation of fetal tissue, the abortion provider is the first potential market actor in the fetal tissue industry. Abortion providers are able to recuperate reasonable expenses incurred in the extraction, preservation, and shipment of fetal tissue obtained from abortion procedures, but they may not sell that tissue for profit. So technically, they are just as barred as aborting women from participating in the fetal tissue economy. They are not seen as adding any value to the fetus by aborting it and extracting it from the woman’s body—they would have done so regardless of whether the woman chooses to donate. Only after the fetal tissue enters the market by the grace of the woman’s consent to donate does it become a commodity. Nevertheless, the popular detractors of the fetal tissue industry have painted abortion providers as abortion profiteers, and I will consider those accusations as I analyze abortion providers’ actual stake—if any—in the fetal tissue industry.

The public furor over the Center for Medical Progress videos centered around the accusation that Planned Parenthood was illegally selling fetal tis-

sue for profit.<sup>77</sup> Planned Parenthood president Cecile Richards clarified in a letter to Congress that affiliated clinics collected no more than “\$60 per tissue specimen.”<sup>78</sup> Sherilyn J. Sawyer, director of Harvard University and Brigham and Women’s Hospital’s “biorepository,” told reporters that such payments probably fall short of the costs of collecting the tissues.<sup>79</sup> Nevertheless, the allegations were bad enough publicity that Planned Parenthood announced it would no longer accept even reimbursement for its provision of fetal tissue to researchers.<sup>80</sup> So abortion providers who absorb the costs of providing fetal tissue for research without compensation lose money in the fetal tissue economy.

## 2. *Tissue Procurement Organizations (“TPOs”)*

Tissue Procurement Organizations are responsible for transforming aborted fetal tissue from a waste product—as it is treated in the large majority of abortions that do not result in tissue donations—into a valuable commodity. Even though there are fewer than a dozen TPOs in operation, they play an important role in supplying researchers with fresh fetal tissue suitable for use in medical experimentation. TPOs are hired by researchers to collect specified volumes and types of fetal tissue from abortion clinics and hospitals, process it to ensure quality and safety, and deliver it to research laboratories around the country.

There are two principle TPOs in operation today. The oldest TPO, Advanced Bioscience Resources (“ABR”), was founded in 1989 as a non-profit.<sup>81</sup> The self-described “largest provider of maternal blood and fetal tissue globally” is the for-profit StemExpress, LLC, founded in 2010.<sup>82</sup>

<sup>77</sup> For a detailed description of the specific accusations made by CMP with reference to video-recorded conversations they claim support those accusations, see Letter from David Daleiden, Exec. Dir., Ctr. for Med. Progress, to Rep. John Boehner et al. (Aug. 31, 2015), <http://www.centerformedicalprogress.org/2015/08/cmpps-open-letter-to-congress-in-reply-to-planned-parenthoods-aug-27-letter/> [https://perma.cc/CP9R-NL2R].

<sup>78</sup> See Letter from Cecile Richards, President, Planned Parenthood Fed’n of Am., to Rep. John Boehner et al. 5 (Aug. 27, 2015), [https://www.plannedparenthood.org/files/8314/4709/3497/PPFA\\_Letter\\_to\\_Congressional\\_Leadership.pdf](https://www.plannedparenthood.org/files/8314/4709/3497/PPFA_Letter_to_Congressional_Leadership.pdf) [https://perma.cc/N3SR-J4UJ]. Richards also noted that 99% of Planned Parenthood clinics do not participate in fetal tissue donation. *Id.*

<sup>79</sup> Dave Levitan, *Unspinning the Planned Parenthood Video*, FACTCHECK.ORG (July 21, 2015), <http://www.factcheck.org/2015/07/unspinning-the-planned-parenthood-video/> [https://perma.cc/9M4L-Y8QJ].

<sup>80</sup> Letter from Cecile Richards, President, Planned Parenthood Fed’n of Am., to Dr. Francis Collins, Dir., Nat’l Inst. Health (Oct. 13, 2015), [https://www.plannedparenthood.org/. . ./Second\\_NIH\\_Letter.pdf](https://www.plannedparenthood.org/. . ./Second_NIH_Letter.pdf) [https://perma.cc/R8B2-B2ZK].

<sup>81</sup> Carla K. Johnson, *Fetal Tissue Brokers Under Scrutiny After Anti-Abortion Videos*, ASSOCIATED PRESS (Sept. 18, 2015), <http://www.tbo.com/ap/fetal-tissue-brokers-under-scrutiny-after-anti-abortion-videos-20150918/> [https://perma.cc/XE9C-VAPD].

<sup>82</sup> Denise Grady & Nicholas St. Fleur, *Fetal Tissue from Abortions for Research is Traded in a Gray Zone*, N.Y. TIMES (July 27, 2015), [http://www.nytimes.com/2015/07/28/health/fetal-tissue-from-abortions-for-research-is-traded-in-a-gray-zone.html?\\_r=0](http://www.nytimes.com/2015/07/28/health/fetal-tissue-from-abortions-for-research-is-traded-in-a-gray-zone.html?_r=0) [https://perma.cc/8V3C-MUSC].

The process by which TPOs acquire, process, and distribute fetal tissue is fairly straightforward, and is practically identical among all TPOs. First, researchers submit a request for fetal tissue, specifying their needs in terms of volume and type of tissue, as well as gestational age.<sup>83</sup> From there, the TPO coordinates with the abortion providers with which it has established relationships in order to obtain the requested tissues on the specified timetable.<sup>84</sup> Documents provided to the Congressional investigative panel by StemExpress showed that abortion clinics provided StemExpress with information on the patients scheduled for abortions, including gestational ages of the fetuses.<sup>85</sup> Based on this information from clinic staff, StemExpress technicians sought out patients based on their customers' needs and obtained the patients' consent as they awaited their abortion procedures.<sup>86</sup> Technicians were paid bonuses based on the amount of donations they facilitated and collected.<sup>87</sup> Once collected, tissues were delivered to StemExpress clients, who were charged between \$715 and \$3,340 per organ.<sup>88</sup>

The profits generated by TPOs have been subject to much controversy throughout the CMP video releases and subsequent Congressional investigation. But "ABR's annual net income has never been more than \$1.5 million."<sup>89</sup> StemExpress has done better: "the company [has] grown more than 1,300 percent in three years. Its [2013] revenue was \$2.2 million, according to a report in August 2014 in *Inc.* magazine."<sup>90</sup> That revenue more than doubled to \$4.5 million in 2014.<sup>91</sup>

Given the recent congressional scrutiny of TPOs including both StemExpress and ABR in the wake of the CMP videos, the market in which they operate may undergo some additional regulation, and indeed anti-abortion legislators would like to do away with TPOs (and fetal tissue research) altogether.<sup>92</sup> TPOs are legally entitled to mark up the prices of fetal tissue and cells without limit, but the costs of the equipment, technology, and labor needed to perform tissue purification and cell extraction are likely to complicate any congressional efforts to cap their profit margins. StemExpress CEO Cate Dyer justified the high prices StemExpress charges researchers for fetal tissue to the *New York Times*: "These are hard processes, expensive

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<sup>83</sup> Letter from Rep. Marsha Blackburn to Jocelyn Samuels, Dir., Centralized Case Mgmt. Operations, Dep't Health & Human Servs. 2 (June 1, 2016), <https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/letters/20160603HIPAA.pdf> [<https://perma.cc/2GSG-ACF5>].

<sup>84</sup> *Id.*

<sup>85</sup> *Id.* at 3.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.* at attachment I.

<sup>88</sup> *Id.* at attachment J.

<sup>89</sup> Johnson, *supra* note 81.

<sup>90</sup> Grady & St. Fleur, *supra* note 82.

<sup>91</sup> Johnson, *supra* note 81.

<sup>92</sup> *See id.* ("No organization should be able to profit from the distribution of human tissue harvested from aborted fetuses, whether it's an abortion clinic or a middleman," Senate Judiciary Chairman Charles Grassley, R-Iowa, said.).

processes that take millions of dollars of equipment. Just to attempt to do some of these isolations can cost us thousands of dollars, and it may not even work.”<sup>93</sup> More recently, the *Washington Post* reported that StemExpress reported a total loss of \$7,000 on its transfers of fetal tissue in 2015, making its profits from the provision of other types of tissues.<sup>94</sup> But according to the ongoing Congressional investigation into StemExpress, “StemExpress overstated some of its labor costs, and claimed as expenses shipping, supplies, and infectious disease screenings. These were costs charged to researchers.”<sup>95</sup> The high input costs and the promise of fetal stem cell research discussed in the previous section demand the type of innovation that only a growth industry can likely provide in a market economy. So long as pharmaceutical research budgets out of which TPOs are paid swell, TPOs—essential to procuring raw materials—are likely to outlast the current storm and continue to expand.

### 3. *The Healthcare Industry*

The healthcare industry encompasses a massive amount of economic activity, and is far too complex to analyze here with the level of detail with which I examined TPOs. Several sectors of the healthcare industry have a stake in fetal tissue research, which I will simply identify in passing for the sake of filling in the picture of the fetal tissue industry. The major healthcare stakeholders in the fetal tissue industry are publicly-funded research laboratories and private pharmaceutical companies. Both public and private institutions have a financial stake in the development of marketable medical therapies, as both secure the intellectual property rights to innovations their researchers make through patent. Moreover, the public and private sectors are intimately entwined such that any distinctions between “public” (read “altruistic”) fetal tissue research conducted at universities and government-funded labs from “private” (read “profit-driven”) fetal tissue research are largely semantic. Indeed, private corporate interests are effectively able to use their financial power to set the research agenda across the industry.<sup>96</sup> To illustrate, I will now outline each.

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<sup>93</sup> Grady & St. Fleur, *supra* note 82.

<sup>94</sup> Danielle Paquette, ‘We Lose Money Doing This’: Tiny Company Caught in Abortion Debate Takes on Congress, WASH. POST (May 27, 2016), <https://www.washingtonpost.com/news/wonk/wp/2016/05/27/critics-say-theyre-selling-baby-body-parts-they-say-theyre-saving-lives/#comments> [<https://perma.cc/2H3F-JY4J>].

<sup>95</sup> INTERIM UPDATE TO THE U.S. HOUSE OF REPRESENTATIVES FROM THE CHAIRMAN AND MAJORITY MEMBERS OF THE SELECT INVESTIGATIVE PANEL ON THE TRANSFER OF FETAL TISSUE AND RELATED MATTERS 41 (2016), [https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160714Interim\\_Update.pdf](https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160714Interim_Update.pdf) [<https://perma.cc/SX3H-VQWC>].

<sup>96</sup> Israeli physician and public health scholar Mayer Brezis reported that “trials funded by the industry are 2 to 5 times more likely to recommend an experimental drug compared with trials funded by nonprofit organizations. . . . [F]unding over 80% of trials, [the industry] now sets up most of the research agenda, which is guided more by

Public fetal tissue research, for this Article's purposes, is any fetal tissue research receiving government funding. Most government funding for fetal tissue research is channeled through the National Institutes of Health (NIH), which has spent about \$280 million on fetal tissue research since 2011.<sup>97</sup> In 2014 alone, NIH spent \$76 million on fetal tissue research grants at "more than 50 universities."<sup>98</sup> States also provide public funds for fetal tissue research: the taxpayer-funded Center for Regenerative Medicine in California spends \$3 billion per year on stem cell—including fetal stem cell—research.<sup>99</sup> But the returns on these public investments, while arguably shared by the beneficiaries of fetal tissue research and the medical advancements they generate, are also concentrated in private hands.

University labs that receive government funding for fetal tissue research transfer the wealth generated therefrom into the private sector in multiple ways. For one, universities patent their discoveries for the sake of securing a share of the financial proceeds thereof.<sup>100</sup> Pharmaceutical corporations with larger manufacturing, marketing, and distribution infrastructure can buy or license those patents to generate profits. Additionally, individual researchers regularly move from university labs into the private sector. For example, the author of the breakthrough study implanting human fetal kidney tissue into rats mentioned above conducted the study as a medical student at Duke University; at the same time, he founded Ganogen, Inc., a biotech company of which he is the CEO.<sup>101</sup> This revolving-door phenomenon is typical of large public/private industrial complexes. Breakthrough discoveries out of university labs enhance their prestige, attract talent, and offer promise to private donors; in turn, pharmaceutical giants recruit from those labs, buy up patents from their research, and market the therapeutic and technological products they produce.

Smaller, private-sector pharmaceutical companies engage in fetal tissue research as well. As of June 2014, seven out of eleven active clinical trials

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marketing than by clinical considerations." Mayer Brezis, *Big Pharma and Health Care: Unsolvably Conflict of Interests Between Private Enterprise and Public Health*, 45 *ISR. J. PSYCHIATRY & REL. SCI.* 83, 84–85 (2008).

<sup>97</sup> Jessica Firger, *Is Fetal Tissue Essential to Science?*, *NEWSWEEK* (Jul 25, 2015), <http://www.newsweek.com/fetal-tissue-essential-science-357264> [<https://perma.cc/X24M-7SDS>].

<sup>98</sup> Recipients included "Columbia, Harvard, the Massachusetts Institute of Technology, Stanford, Yale and the University of California in Berkeley, Irvine, Los Angeles, San Diego and San Francisco," and NIH plans to spend the same amount in 2015 and 2016. Grady & St. Fleur, *supra* note 82.

<sup>99</sup> Kathy Robertson, *Local Biomedical Company Loses Customer Over Abortion Controversy*, *SACRAMENTO BUS. J.* (Aug. 5, 2015), <http://www.bizjournals.com/sacramento/news/2015/08/05/local-biomedical-companyloses-customer-over.html> [<https://perma.cc/A5ZE-D2EZ>].

<sup>100</sup> For a famous example, see the discussion of *Moore v. Regents of the University of California*, text accompanying *infra* notes 164–72.

<sup>101</sup> Lewis, *supra* note 47. Gu's study was privately funded, but the mere fact it bears Duke's name is enough to illustrate the collapse of the public/private divide in the biomedical industry.

involving fetal stem cell transplantation were being conducted by private corporations.<sup>102</sup> Three were being conducted by StemCells, Inc., and three by its chief rival Neuralstem, Inc.<sup>103</sup> Both companies culture the neural stem cells they acquire from TPOs, meaning that they are less reliant on a consistent inflow of fetal tissue in order to supply their clinical trials.<sup>104</sup>

These culture-based stem cell manufacturing technologies may eventually reduce the need for fresh fetal tissue in stem-cell transplantation therapies. Still, the future of fetal tissue research, including humanized animal research, the potential cultivation of human fetal-derived organs in animals for transplantation, and direct fetal-cell transplantation, forecasts continued demand for raw tissue. Indeed, the very development and improvement of the cell isolation technology will require a continuous supply of fresh fetal tissue against which to test the clinical efficacy of culture-grown cells.

#### 4. *Disease Interest Groups*

The final stakeholders in the fetal tissue industry that I will examine are the interest groups that have formed around the diseases hoping for fetal tissue derived treatments and cures. Non-profit disease interest groups do not stand to profit off of fetal tissue research financially. Rather, they are the financial embodiment of the interests of would-be fetal tissue end users. They raise millions of dollars each year, which they invest in research, patient care, and political advocacy.<sup>105</sup> Disease interest groups constitute powerful lobbying forces that seek to influence federal and state legislatures to pass legislation that facilitates and funds research into curing their respective diseases. A 2012 longitudinal study looking at fifty-three diseases found that “each \$1,000 spent on lobbying [was] associated with a \$25,000 increase in research funds the following year.”<sup>106</sup> These groups have an interest in fetal

<sup>102</sup> Ishii & Eto, *supra* note 34, at 411 tbl.1.

<sup>103</sup> *See id.*

<sup>104</sup> StemCells, Inc.’s website boasts of its patented stem cell line, “Expandable and bankable, HuCNS-SC cells can ultimately be ‘manufactured’ at commercial-scale as ‘stem cells in a bottle,’ then distributed for patient doses, much like an off-the-shelf pharmaceutical product for on-demand use.” *Manufacturing*, STEMCELLS, INC., <http://www.stemcellsincl.com/Clinical-Programs/Manufacturing> [https://perma.cc/LP6F-7XTE]. Although their clinical trials have not yet rendered any FDA-approved cell therapies or drugs, they “are prepared to scale [their] processes as needed to meet the requirements of future clinical trials and commercialization.” *Id.* Similarly, Neuralstem, Inc. claims its “technology enables the isolation and expansion of human neural stem cells from . . . the developing central nervous system (CNS) in virtually unlimited numbers from a single donated tissue.” *Neuralstem Cell Therapy: Repairing and Replacing Damaged Cells*, NEURALSTEM, INC., <http://www.neuralstem.com/cell-therapy> [https://perma.cc/9C34-S4Y9].

<sup>105</sup> *See generally* Rachel Kahn Best, *Disease Politics and Medical Research Funding: Three Ways Advocacy Shapes Policy*, 77 AM. SOC. REV. 780 (2012) (discussing the policy outcomes obtained by disease-group lobbying).

<sup>106</sup> *Id.* at 787 (listing diseases covered by the study, including those mentioned as potential beneficiaries of fetal research like ALS, Alzheimer’s disease, diabetes, Huntington’s disease, and Parkinson’s disease).

tissue research inasmuch as it holds promise for curing and treating the diseases they represent. So if fetal tissue research yields hopeful findings, one or more disease interest groups can be expected to wield financial and political power to ensure access to raw materials. I will now briefly look at a few of the organizations dedicated to the victims of the diseases discussed above and at what kind of finances might be available from these private sources to advocate for expanded fetal tissue research in the event of a breakthrough.

People with Parkinson's Disease, often cited as a potential beneficiary of fetal tissue therapies, have several multi-million dollar non-profits working on their behalf. The largest is the Michael J. Fox Foundation for Parkinson's Research, bringing in more than \$82 million in 2014 to place its net assets at over \$117 million.<sup>107</sup> 89% of its spending directly sponsors research.<sup>108</sup> On the political side, Parkinson's patients count on the Parkinson's Action Network ("PAN") to make sure their voices are heard in the federal government.<sup>109</sup> PAN represents all Parkinson's organizations, collecting hundreds of thousands of dollars from them to sponsor its more than \$600,000 worth of lobbying activities in both the executive and legislative branches.<sup>110</sup> Efforts by the Parkinson's lobby have successfully pushed disease-specific legislation through Congress.<sup>111</sup> Parkinson's disease alone, through a number of different organizations, brings in more than \$100 million each year in donations to sponsor both privately funded research and services, and lobbying for increased public funding.

Parkinson's is not the only disease commanding large financial and political resources. The ALS Association's 2014 total revenue was nearly \$140 million, spurred on by the now-famous "ice bucket challenge."<sup>112</sup> Recall that ALS, along with Parkinson's, is currently the subject of clinical trials involving fetal-tissue transplantation. This snapshot of their interest groups is meant to illustrate the breadth of the financial and political power that people affected by a disease can generate. Their ability to pass disease-specific legislation even amidst congressional gridlock is illustrative of the power disease groups have. Should there be a breakthrough in fetal tissue research,

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<sup>107</sup> MICHAEL J. FOX FOUND. FOR PARKINSON'S RESEARCH, 2014 ANNUAL REPORT 52–53 (2015), <http://www.joomag.com/magazine/the-michael-j-fox-foundation-2014-annual-report/0190774001438282084?short> [<https://perma.cc/J84Z-HENQ>].

<sup>108</sup> *Id.* at 50–51.

<sup>109</sup> *About PAN*, PARKINSON'S ACTION NETWORK, <http://parkinsonsaction.org/about-pan/> [<https://perma.cc/C7QW-2ZQN>].

<sup>110</sup> *Our Financials*, PARKINSON'S ACTION NETWORK, <http://parkinsonsaction.org/about-pan/financials/> [<https://perma.cc/4JVY-2HZM>]; *see also* PARKINSON'S ACTION NETWORK, *THE UNIFIED VOICE: ANNUAL REPORT 2014* at 7 (2015) (detailing the lobbying deliverables by PAN in 2014, including 303 "in-person Hill meetings by PAN staff and grassroots advocates.").

<sup>111</sup> *See* Morris K. Udall Parkinson's Disease Research Act of 1997, Pub. L. No. 105-78, § 603, 111 Stat. 1467 (codified as amended at 42 U.S.C. §§ 201, 284f, 284f (2012)).

<sup>112</sup> ALS ASS'N, 2015 ANNUAL REPORT: THE ICE BUCKET MIRACLE 9 (2015), <https://issuu.com/alsassociation/docs/020816-fy-2015-annual-report-websit?e=2279079/33325237> [<https://perma.cc/JP7P-TDSJ>].



disease interest groups will be a powerful voice in Congress to advocate for whatever policy changes are needed to secure its broadest implementation for patients.

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This sketch of the fetal tissue research industry is not meant to exhaustively account for every penny made and spent on fetal tissue. Rather, by tracing the commodification of fetal tissue from its origins as valueless waste to its potential value as curative medicine, I have attempted to identify the major stakeholders that policymakers and advocates can expect to find lobbying on behalf of expanded availability of fetal raw materials in the future. On the opposite side of their vested interest is the interest of women who provide the fetal tissue by way of abortions. Not only are these women barred from the financial profits of the fetal tissue industry, their very health might be subject to the changing demands that industry places on fetal tissue supply. I look now to who these women are and what their needs might be to put a face on the conflict of interest brewing between the increasing demand and decreasing supply of fetal tissue.

#### D. *Who Gets Abortions?*

In 2011, over one million abortions were performed in the United States.<sup>113</sup> The abortion rate—the number of women aged 15–44 per 1,000 who obtained an abortion—was 16.9.<sup>114</sup> Although this number represents a continuation in the general decline in the abortion rate since it peaked at 29.3 in the early 1980s,<sup>115</sup> it is still significant: approximately 30% of women in the U.S. will have an abortion by the age of 45.<sup>116</sup> The demographic profile of women who have abortions is diverse, but certain trends in the abortion rate along race, class, and family lines indicate a greater tendency among non-white, low-income, unwed mothers to seek and obtain abortions. As a result, these women constitute a greater share of the donation pool for fetal tissue.

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<sup>113</sup> Jones & Jerman, *supra* note 39, at 5.

<sup>114</sup> *Id.* at 7.

<sup>115</sup> GUTTMACHER INSTITUTE, FACT SHEET: INDUCED ABORTION IN THE UNITED STATES (2016), [https://www.guttmacher.org/pubs/fb\\_induced\\_abortion.html#2](https://www.guttmacher.org/pubs/fb_induced_abortion.html#2) [<https://perma.cc/3EGG-SYRC>].

<sup>116</sup> Rachel K. Jones & Meghan L. Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 *OBSTETRICS & GYNECOLOGY* 1358, 1358 (2011).

### 1. *Race and Ethnicity*

Black women are nearly four times as likely to have an abortion than white women, while Hispanic women are twice as likely as whites.<sup>117</sup> The abortion rate is 29.7 for black women and 16.6 for Hispanics, compared to just 8 for white women.<sup>118</sup> Black women account for 36.2% of all abortions, and Hispanic women 19.7%: Together, then, black and Hispanic women obtain more than 55% of annual abortions in the United States.<sup>119</sup> Whites, constituting 72.4% of the United States population, account for a disproportionately low 37.2% of abortions.<sup>120</sup> Whether attributable to higher pregnancy rates,<sup>121</sup> lower use of contraception,<sup>122</sup> or lower income available for child-rearing,<sup>123</sup> black and Hispanic women account for a disproportionately large share of annual abortions in the U.S.

The risks of abortion procedures are also borne disproportionately by non-white women. According to the most recent abortion mortality study conducted by the American College of Obstetricians and Gynecologists, black and other non-white women were 2.4 times more likely to die from abortion-related complications than white women.<sup>124</sup> One explanation could

<sup>117</sup> *CDC Abortion Surveillance*, *supra* note 31, at tbl.12. Data on race and ethnicity were reported by twenty-seven “reporting areas” to the CDC’s 2011 survey, excluding large states such as California (181,730 abortions in 2011), Florida (84,990 abortions in 2011), Washington (21,880 abortions in 2011), and Pennsylvania (36,870 abortions in 2011). See Jones & Jerman, *supra* note 39, at 7 (providing state-by-state numbers of abortions). “Reporting areas” in the CDC data refers to the fifty states plus New York City and the District of Columbia.

A 2008 study by the Guttmacher Institute created a nationally representative sample, which found a similar breakdown between white women (36.1%) and combined black/Hispanic women (54.5%), but with a greater share of non-white abortions coming from Hispanic women (24.9%) and a correspondingly lower share coming from black women (29.6%). The Guttmacher study was not able to calculate abortion rates by subgroup. RACHEL K. JONES ET AL., GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS, 2008, at 4, 6 (2010). This discrepancy may owe to the CDC’s exclusion of California and Florida, both home to large Hispanic populations.

<sup>118</sup> *CDC Abortion Surveillance*, *supra* note 31, at tbl.12.

<sup>119</sup> *Id.*

<sup>120</sup> *Id.*; KAREN R. HUMES ET AL., U.S. CENSUS BUR., OVERVIEW OF RACE AND HISPANIC ORIGIN: 2010, at 4 tbl.1 (2012); see also JONES ET AL., *supra* note 117 (finding 36.1% of abortions were obtained by white women).

<sup>121</sup> STEPHANIE J. VENTURA ET AL., *Estimated Pregnancy Rates By Outcome for United States, 1990–2004*, 56 NAT’L VITAL STATISTICS REP. 3 (2008) (finding pregnancy rates for black and Hispanic women “each about two-thirds higher than the rate for non-Hispanic white women”).

<sup>122</sup> KIMBERLY DANIELS ET AL., *Current Contraceptive Status Among Women Aged 15–44: United States, 2011–2013*, 173 NCHS DATA BRIEF 2 (2014) (“A higher percentage of non-Hispanic white women (65.3%) was currently using contraception compared with Hispanic women (57.3%) and non-Hispanic black women (57.9%).”).

<sup>123</sup> CARMEN DE NAVAS-WALT & BERNADETTE D. PROCTOR, U.S. CENSUS BUREAU, INCOME AND POVERTY IN THE UNITED STATES: 2013, at 7 (2014) (“[T]he ratio of Black to non-Hispanic White income was 0.59, and the ratio of Hispanic to non-Hispanic white income was 0.70.”)

<sup>124</sup> Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 732 (2004).

be that black women are more likely to have abortions after eight weeks gestation,<sup>125</sup> when the risk of death begins to climb exponentially.

## 2. *Class*

Women from poor and low-income households are most likely to obtain abortions.<sup>126</sup> More than two thirds of women obtaining abortions lack financial security: 42% of abortion patients in 2008 were poor and an additional 27% were low-income.<sup>127</sup> This financial insecurity has predictable effects on the kinds of health insurance women have at the time of their abortions. Among all abortion patients in 2008, there was a fairly even distribution between the uninsured (33%), those with private insurance (30%), and those on Medicaid (31%).<sup>128</sup> However, 85% of poor women who had abortions were either uninsured or on Medicaid (36% and 49%, respectively), with only 10% covered by private insurance.<sup>129</sup> A majority of low-income women (65%) were similarly without insurance or reliant on Medicaid (38% and 27%, respectively), with 30% covered by private insurance.<sup>130</sup>

Lower incomes and lower levels of insurance coverage among the majority of abortion patients heighten the importance of the cost of abortions. For abortion-related services, women on Medicaid are similarly situated to women without insurance because federal law prohibits the use of federal funds for abortions except in cases of rape, incest, and danger of the mother's death.<sup>131</sup> A minority of states, however, provide Medicaid funds for abortions, which 20% of abortion patients utilized in 2008.<sup>132</sup> Still, the majority of women (57%) pay for their abortions out of pocket.<sup>133</sup> In 2011 and 2012, the average cost women paid for surgical abortions at or before ten weeks' gestation was \$480, slightly less than the \$504 average cost of less-intrusive medical abortions during the same gestational period.<sup>134</sup> At twenty weeks' gestation, the average cost of an abortion increases to \$1,350.<sup>135</sup>

The relative financial insecurity of most abortion patients renders the costs of abortions critically important, as a woman's access to abortion pro-

<sup>125</sup> See *CDC Abortion Surveillance*, *supra* note 31, at 39 tbl.23.

<sup>126</sup> I follow the Guttmacher report's definition of "poor" as at or below the federal poverty line, and "low income" as 100%–199% of the federal poverty line. JONES ET AL., *supra* note 117, at 8.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* at 9.

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*

<sup>131</sup> See Consolidated Appropriations Act 2016, Pub. L. No. 114-113, tit. V, §§ 506–507, 129 Stat. 2241, 2649 (2015).

<sup>132</sup> JONES ET AL., *supra* note 117, at 10.

<sup>133</sup> *Id.*

<sup>134</sup> Jenna Jerman & Rachel K. Jones, *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, 24-4 WOMEN'S HEALTH ISSUES e419, e422 (2014).

<sup>135</sup> *Id.*

cedures may depend on her ability to produce the required sum of money.<sup>136</sup> Delays in obtaining abortions caused by lack of funds lead to higher costs for later-term abortions, thus creating a vicious cycle. And such delays are not uncommon, especially among poor women. For a variety of physical and psychological health-related reasons, women who decide to have abortions generally wish to do so as quickly as possible. Indeed, 59% of women who had abortions wish they had done so sooner, including 67% of poor women.<sup>137</sup> The cost of delay is not only psychic, but mortal: “The risk of death increase[s] exponentially by 38% for each additional week of gestation.”<sup>138</sup> Indeed, “[u]p to 87% of deaths in women who chose to terminate their pregnancies after 8 weeks of gestation may have been avoidable if these women had accessed abortion services before 8 weeks of gestation.”<sup>139</sup> The most common reason those women were delayed in making arrangements to procure abortions was that they needed more time to come up with the money for the procedure—26% of all women who would have preferred to have their abortion earlier could not do so for financial reasons.<sup>140</sup> Even more were delayed in discovering their pregnancies (36%).<sup>141</sup> And a sizeable plurality of women who would have rather aborted earlier (39%) was delayed because it took them a long time to decide how to handle their unwanted pregnancies.<sup>142</sup> Corollary to these findings, women who have abortions would benefit from earlier pregnancy detection, quicker decision making, and lower economic barriers to obtaining abortion services.

### 3. *Family Status*

Unmarried women predictably account for a greater share of abortions than married women, although the relationship statuses of women getting abortions are more complex than marital status alone. More than 85% of women who had abortions in 2011 were unwed.<sup>143</sup> However, in 2008 “only 12% reported that they had not been in a relationship with the man who had gotten them pregnant.”<sup>144</sup> So even among unmarried women, a majority of those obtaining abortions were in a relationship with the man who contrib-

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<sup>136</sup> See generally Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 *CONTRACEPTION* 334 (2006) (discussing how financial limitations make it more difficult for some women to obtain early abortions).

<sup>137</sup> *Id.* at 341.

<sup>138</sup> Bartlett et al., *supra* note 124, at 729.

<sup>139</sup> *Id.*

<sup>140</sup> Finer et al., *supra* note 136, at 341.

<sup>141</sup> *Id.* at 335.

<sup>142</sup> *Id.*

<sup>143</sup> *CDC Abortion Surveillance*, *supra* note 31, at 7. Data on marital status were reported by thirty-seven reporting areas to the CDC’s 2011 survey. *Id.* The 2008 Guttmacher Institute study conducted on a nationally representative sample came up with the same figure of 85%. JONES ET AL., *supra* note 117, at 5.

<sup>144</sup> JONES ET AL., *supra* note 117, at 5.

uted to their pregnancy. Indeed, more than half (56.4%) of unmarried women had been in a relationship with the man responsible for their pregnancy for over a year. But almost two thirds (65.7%) of unmarried women did not live with their male partners in the month before their abortions.<sup>145</sup> Although women obtaining abortions are frequently in relationships with the men who contributed to their pregnancy, these relationships are not typically formalized through marriage or cohabitation.

Whereas the data on aborting women's marital status may align at least partially with social and cultural expectations,<sup>146</sup> the fact that most women who get abortions already have children likely does not. The Guttmacher Institute's national study on the characteristics of abortion patients summarized:

Abortion and motherhood are often regarded as opposing interests, and it is often assumed that women who obtain abortions do not want to be mothers because they are unable or unwilling to assume the responsibilities of raising a child. But 61% of women obtaining abortions in 2008 already had children, including 34% who had two or more.<sup>147</sup>

The likelihood that the abortion patient has children increases dramatically with age, with 89% of patients 35 and older having previously given birth.<sup>148</sup> Additionally, almost half of the women who obtain abortions have had a prior abortion.<sup>149</sup> This share also increases with age—67% of women 35 and older obtaining abortions were not doing so for the first time.<sup>150</sup> Women getting abortions thus have complex prior histories of pregnancy with most having given birth before having an abortion, and many having multiple abortions throughout their reproductive lives.

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To summarize, women obtaining abortions are more likely to be black or Hispanic than white; poor or low-income than well-off; and unmarried mothers than childless wives. Given abortion patients' interests in aborting

<sup>145</sup> *Id.*

<sup>146</sup> See Amanda Marcotte, *The Demographics of Abortion: It's Not What You Think*, AM. PROSPECT (Jan. 22, 2013), <http://prospect.org/article/demographics-abortion-its-not-what-you-think> [<https://perma.cc/9M86-EJM3>] ("The only thing that hasn't changed [since the 1970s] is that women seeking an abortion tend to be unmarried.").

<sup>147</sup> JONES ET AL., *supra* note 117, at 8; see also *CDC Abortion Surveillance*, *supra* note 31, at 36 (finding that 60.1% of women in 40 reporting areas had given birth at least once prior to obtaining an abortion in 2011).

<sup>148</sup> JONES ET AL., *supra* note 117, at 8.

<sup>149</sup> *Id.*; see *CDC Abortion Surveillance*, *supra* note 31, at 37 (finding that 47.3% of women in 38 reporting areas had induced abortion at least once prior to obtaining an abortion in 2011).

<sup>150</sup> JONES ET AL., *supra* note 117, at 8.

as early in gestation as possible and the relative economic and health benefits of early-term abortions, women seeking abortions would generally benefit from cheaper and earlier methods of pregnancy detection and abortion procedures. I will now attempt to ascertain how well the current policy environment around abortion and fetal tissue research is meeting women's needs, and what role the fetal tissue industry plays in improving or worsening women's lives.

### III. FETAL POLICY: ADJUSTING THE RELATIONSHIP BETWEEN THE MEDICAL PROFESSION AND ABORTING WOMEN

Thus far, this Article has looked at the legal and practical interactions between fetal tissue research and abortion. The health risks associated with the later-term abortions that provide larger, more differentiated fetal tissue samples for use in research creates a tension between maximizing women's access to safe, early, and affordable abortion services on one hand, and maximizing the supply of fetal tissue usable for medical research on the other. The importance of fetal tissue research in the development of existing medical advancements like vaccines, and the promise of fetal stem cell research for the future treatment of diseases like Parkinson's cannot be ignored.<sup>151</sup> But neither can women's fundamental role in that science.

This Part will analyze the data presented in Part II to try to determine whether fetal tissue research and the advancement of women's reproductive rights are irreconcilable, or if there is a policy solution that could benefit both women and science. Section A will imagine aborting women as agents in the fetal tissue economy, which they currently serve as uncompensated providers of raw materials. I will situate fetal tissue donation within the existing property regime governing donors' rights to biomaterials, arguing that aborting women have more than a negligible interest in the disposal of their fetal remains. From there, I show how the current system subjects aborting women to a form of economic exploitation that a more just reproductive health policy should seek to eliminate.

Section B will offer three potential policy solutions that seek to reconcile women's interests in economic autonomy as market actors with their bodily integrity and reproductive dignity: (1) ban all fetal tissue research; (2) allow unregulated compensation for fetal tissue; or (3) allow limited cost-covering compensation for donors so as to eliminate the forced subsidy of the fetal tissue industry by aborting women. To evaluate these policies, I will analogize the fetal tissue industry to other economies of sex and reproduction such as prostitution, surrogacy, and egg donation. Examining feminist positions on those issues, I will articulate feminist arguments for and against each of the proposed policy interventions. Ultimately, I conclude none of

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<sup>151</sup> See *supra* Part II.B.

these alternatives is much better for women than the status quo. As a result, in Part IV, I will argue for a wholesale paradigm shift focused on reproductive justice rather than rights. Rather than argue for discrete policy changes, I will propose a set of priorities for feminists and their allies to keep in mind as the science of abortion and fetal tissue research develops.

### A. *Mines of Medicine: Women's Exploitation in Fetal Tissue Research*

Several data points presented in Part II demonstrate an upward redistribution of wealth from women who donate fetal tissue to the biotech and healthcare industries. This section will use that data to further examine the economic exploitation carried out through the commodification of fetal tissue.

As the section on the fetal tissue industry showed, several actors have a financial stake in the continued availability of fetal tissue for medical research. While all of these stakeholders bear costs specific to the tasks they perform to constitute the value of fetal tissue, the raw tissue itself enters the production line practically free of charge. Abortion providers that provide fetal tissue to TPOs face scrutiny over whatever legally permissible “reasonable fees” they collect for their services—recall that Planned Parenthood no longer accepts any reimbursement for fetal tissue.<sup>152</sup> So the industry actors that convert fetal tissue into a valuable medical commodity can simply appropriate the raw materials they receive by “donation” without assuming the costs of extracting them. Given the high costs of processing those raw materials, their availability for free becomes essential to the profitability of the fetal tissue industry.

Meanwhile, the women who provide free fetal tissue pay for their abortion procedures—the primary resource extraction in the supply chain of the fetal tissue industry. This payment directly subsidizes the fetal tissue industry. Bearing the cost of the abortion/extraction, which would otherwise form a part of the industrial stakeholders’ overhead, transfers wealth from aborting women to the beneficiaries of the industry. More than two-thirds of abortion patients are poor or low-income and more than half are racial or ethnic minorities, yet they are required in most cases to pay for their abortions out of pocket. And the financial burden on poor women of obtaining abortions can force them to delay their procedures and run the serious health risks associated with later-term abortions.<sup>153</sup> So these women, sometimes risking their lives to subsidize the fetal tissue industry, are disproportionately drawn from the most structurally disadvantaged populations in the United States. They are the losers in the fetal tissue economy. But that is not how the issue is

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<sup>152</sup> See Richards, *supra* note 78, at 2; Tamar Lewin, *Planned Parenthood Won't Accept Money for Fetal Tissue*, N.Y. TIMES, [http://www.nytimes.com/2015/10/14/us/planned-parenthood-to-forgo-payment-for-fetal-tissue-programs.html?\\_r=0](http://www.nytimes.com/2015/10/14/us/planned-parenthood-to-forgo-payment-for-fetal-tissue-programs.html?_r=0) [https://perma.cc/K3ZP-WN3E].

<sup>153</sup> See Bartlett et al., *supra* note 124, at 729.

currently framed in the public discourse; not by abortion rights advocates, and not by the fetal tissue industry.<sup>154</sup> The fetal tissue industry sets the tone of the discussion and abortion rights advocates defensively follow suit.<sup>155</sup> I look now to the way that discussion erases the exploitation inherent in the status quo.

The fetal tissue industry, and the legal regime governing fetal tissue donation, treats fetal tissue as a special kind of waste product. StemExpress CEO Cate Dyer expressed this argument thus: “We’re collecting biohazardous waste, discarded waste . . . . [Procurement technicians] go to a hospital or to a facility that does terminations and collect tissues from those waste products.”<sup>156</sup> The waste framework is also bolstered by the law gov-

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<sup>154</sup> The only voice that has framed the fetal tissue industry in terms of exploitation is the anti-abortion Center for Medical Progress. See Daleiden, *supra* note 77, at 1 (“Planned Parenthood’s sale of aborted baby parts is an issue . . . involv[ing] . . . the exploitation, commodification, and commercialization of vulnerable women and their children”). CMP makes a bad bedfellow for feminists looking for a fairer shake for women in the fetal tissue industry. See Frances Olsen, *Unraveling Compromise*, 103 HARV. L. REV. 105, 128 (1989) (“The possibility of valuing fetal life from an early stage exists because of the systematic undervaluation of women’s lives. If women were taken seriously, early fetal life would not be valued by society at large unless and until the woman carrying the fetus valued it.”).

<sup>155</sup> Perhaps it is really the anti-abortion movement setting the tone of the debate (“abortion is murder”), and abortion rights advocates looking to fetal tissue research as a utilitarian defense mechanism (“but it saves countless lives!”). The Democratic Party’s rhetoric in the 2015 Congressional hearings over allegations of Planned Parenthood’s wrongdoing is illustrative. The narrative revolved around the fact that most of Planned Parenthood’s healthcare services were not abortion-related; that abortion-related services did not receive federal funding; and that fetal tissue research made possible by abortion saves lives. In this way, the Democrats evaded, rather than confronting, the moral argument against abortion by underplaying its significance. Their moral force came not in the validity of abortion as a life-choice for women, but from the lifesaving potential of fetal tissue research. See, for example, Rep. Ted Lieu, *Rep. Lieu at Oversight Committee Hearing on Planned Parenthood*, YOUTUBE (Oct. 1, 2015), <https://www.youtube.com/watch?v=HhnRky5rUMo> [<https://perma.cc/H7SS-UDX7>], for the following exchange between Democratic Representative Ted Lieu and Cecile Richards of Planned Parenthood:

Lieu: [Fetal tissue research] has made enormous, lifesaving changes for millions of Americans and people across the world. Isn’t that correct?

Richards: That’s right.

Lieu: In fact, fetal tissue research has resulted directly in the development of the polio vaccine, vaccines for Hepatitis A, Rubella, Chicken Pox, Shingles, and Rabies. Anyone in America that has had a family member or themselves been affected by Multiple Sclerosis, ALS, and other central nervous system diseases, you can thank fetal tissue research for making advancements in that field. If anyone has been affected by age-related macular degeneration, by all sorts of cancer, by diabetes, by cardiovascular disease, by immune system issues, and by glaucoma, you can thank fetal tissue research for making advancements in those areas.

As politics, emphasizing the benefits of fetal tissue research to support access to abortion services seems defensible, so long as women’s role in the fetal tissue industry is properly recognized. I will explore this issue *infra* Part IV.B.

<sup>156</sup> Grady & St. Fleur, *supra* note 8282; see also Wadman, *supra* note 55, at 180–81 (“We are not happy about how the material became available, but we would not be willing to see it wasted and just thrown away.” (quoting “Larry Goldstein, a neurobiologist



erning the donation process: the doctor must first secure informed consent to the abortion procedure, and only thereafter can fetal tissue donation be raised.<sup>157</sup> When confronted with the request to donate at this point, the concept of the fetus as waste carries moral weight as well: by choosing *not* to donate, the woman is letting a perfectly useful fetus go to waste.<sup>158</sup> Such being the case, why should the aborting woman have any rights in what she has chosen to discard for her own sake?

### 1. *Donor's Rights in Biomaterials*

Perhaps supporting the waste framework, the legal regime governing donors' rights in biomaterials explicitly forecloses on an individual's right to profit from discarded tissues subsequently used in medical research.<sup>159</sup> Medical researchers using human tissues to develop marketable therapies operated for most of the twentieth century in a lawless environment at what was for a long time the frontier of scientific experimentation.<sup>160</sup> It was not until 1990 that John Moore "became the first person to assert a right to his cells," exposing to the public and to the legal community the medical industry's appropriation of donor tissue for profit.<sup>161</sup> Courts to date have sided with the medical industry against tissue donors. I will now look to their rationale in so doing before asking whether it applies to fetal tissue as well.

Moore had his fourteen-pound spleen removed in 1976 at the UCLA Medical Center.<sup>162</sup> He continued giving samples of blood and bone marrow pursuant to his follow-up treatment over the next several years, until he was approached with a bizarre release form in 1983 asking him to sign over all rights to cell lines generated from his spleen.<sup>163</sup> Moore refused, but it turned

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at the University of California San Diego School of Medicine in La Jolla" who works with fetal neural tissue on Alzheimer's treatment)).

<sup>157</sup> See *supra* Part I.B. The bioethical literature on fetal tissue donation calls this the separation principle.

<sup>158</sup> See Julie Kent, *The Fetal Tissue Economy: From the Abortion Clinic to the Stem Cell Laboratory*, 67 J. SOC. SCI. & MED. 1747, 1752 (2008) ("[T]he reproductive labour of women is closely tied to notions of wastefulness; for example, constructions of menstrual blood as waste, and women 'wasting' eggs and embryos which have the potential for life, mobilizes specific cultural values about what their role is and reinforces social obligations of women to be productive in specific ways. . . . Following this analysis, women who terminate a pregnancy are especially 'wasteful', and by inference morally suspect.").

<sup>159</sup> Indeed, the regime is so complicated that I do not pretend to treat it here with the depth it warrants. For an excellent treatment of donors' rights in tissues, see Joanne Belisle, Note, *Recognizing a Quasi-Property Right in Biomaterials*, 3 U.C. IRVINE L. REV. 767 (2013).

<sup>160</sup> By now, U.S. tissue banks have more than 500 million human-derived samples on hand, coming from more than 178 million Americans. *Id.* at 768.

<sup>161</sup> See Belisle, *supra* note 159, at 772.

<sup>162</sup> John Vidal & John Carvel, *Lambs to the Gene Market: What do Tracy the Sheep and John Moore Have in Common? Millions of Pounds Can Be Made From Cells Taken From Their Bodies*, THE GUARDIAN, Nov. 12, 1994, at 25.

<sup>163</sup> *Id.*

out his permission would not be necessary. The Regents of the University of California patented the “Mo cell” line derived from his spleen in 1984, listing his physician as co-inventor.<sup>164</sup> Genetics Institute, Inc., and Sandoz Pharmaceuticals Corporation purchased the rights to the patented cell line, which was estimated to generate billions of dollars in profit.<sup>165</sup> In the seminal case of *Moore v. Regents of the University of California*, Moore sued for a share of those profits and lost: the California Supreme Court ruled that Moore had no property rights in the Mo cell line.<sup>166</sup> Moore’s spleen was necessarily removed pursuant to his cancer treatment, so the court found that he “clearly did not expect to retain possession of his cells following their removal.”<sup>167</sup> With no expectation for use or possession of his cancerous spleen, Moore gave up his rights when the cells left his body.

But he did not give up autonomy over his health decisions. The court found that the physician who took Moore’s cells for the purpose of using them in medical research violated his fiduciary duty to the patient to obtain informed consent.<sup>168</sup> However, informed consent was only required to the extent that the physician had a “personal interest[ ] unrelated to the patient’s health, whether research or economic, that may affect his medical judgment.”<sup>169</sup> The purpose is purely medical: where the doctor’s medical judgment may be affected by her financial interest in the collection of certain tissues, the patient may use that knowledge to seek a second opinion to ensure that the recommended procedure is in her medical interest. The informed consent obligation does not require disclosure of information that may affect the patient’s financial or dignitary interests short of the decision to accept or refuse treatment.<sup>170</sup>

Moore eventually received “a small settlement and token damages” for his doctor’s failure to inform him about the commercialization of the Mo cell

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<sup>164</sup> *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 482 (Cal. 1990).

<sup>165</sup> *Id.*

<sup>166</sup> *Id.* at 492 (“[T]he subject matter of the Regents’ patent—the patented cell line and the products derived from it—cannot be Moore’s property. This is because the patented cell line is both factually and legally distinct from the cells taken from Moore’s body.”).

<sup>167</sup> *Id.* at 488–89.

<sup>168</sup> *Id.* at 485.

<sup>169</sup> *Id.*

<sup>170</sup> Scholars have pointed out multiple ways in which this limiting principle of the informed consent requirement inadequately protects patients from economic exploitation in the commercialization of their tissues. See, e.g., Donna M. Gitter, *Ownership of Human Tissue: A Proposal for Federal Recognition of Human Research Participants’ Property Rights in Their Biological Material*, 61 WASH. & LEE L. REV. 257, 304–10 (2004) (discussing the exposure of research participants to economic exploitation at the hands of profit-driven physicians and non-fiduciary pharmaceutical companies under the current informed consent regime); Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 339–41 (1999) (noting that “where a patient’s health is improved at the expense of his ‘non-medical’ dignity interests, *Moore* will not provide relief.”); Belisle, *supra* note 159, at 783 (noting that most patient-donors have cells removed as a medical necessity, barring them from compensation).

line.<sup>171</sup> But he was not made whole. Doctors, he said, “claim[ed] that my humanity, my genetic essence, was their invention and their property. They viewed me as a mine from which to extract biological material. I was harvested.”<sup>172</sup> But Moore was neither the first nor the last mine of medical-industrial exploitation. And those most vulnerable have been most prone to being used thanklessly in pursuit of cures that sell.<sup>173</sup> One now-famous example is Henrietta Lacks, a poor black woman from Virginia whose contribution to medicine went unrecognized until recently. Lacks’s cervical cancer cells, appropriated in 1951, became the first immortalized cell line. The so-called HeLa line has led to several medical breakthroughs, served as the basis for over 11,000 patents, and made drug companies billions of dollars in profits—none of which she knew about, much less benefited from, in her lifetime.<sup>174</sup> But what about aborting women—are they unwitting victims like Moore and Lacks? Or are they just purveyors of one useful kind of biological waste?

The *Moore* framework yields no potential economic interest for aborting women in the profits of the fetal tissue industry. First, an aborting woman has no property right to her fetus where property rights in biomaterials are defined by the donor’s expectation to keep or use the excised tissues.<sup>175</sup> Like John Moore’s cancerous spleen, a woman seeking an abortion engages medical services precisely to rid herself of the fetus.<sup>176</sup> Second, the informed

<sup>171</sup> Vidal & Carvel, *supra* note 162. Failure to inform is in fact an understatement: Moore’s physician lied to Moore, telling him that he needed to travel from his home in Seattle to UCLA for several medically necessary visits. At each visit, the doctor took samples of blood, blood serum, skin, bone marrow, and sperm from Moore, all for the sole purpose of developing the lucrative Mo cell line. See *Moore*, 793 P.2d at 481. This background from John Moore’s story is relevant to the discussion of fetal tissue research as it is one of the most detailed public records of the ways in which the profit motive corrupts medical professionals and exploits patient-donors, even while producing life-saving therapies.

<sup>172</sup> Vidal & Carvel, *supra* note 162; see also *Moore*, 793 P.2d at 516 (Mosk, J., dissenting) (“There is . . . a third party to the biotechnology enterprise—the patient who is the source of the blood or tissue from which all these profits are derived. While he may be a silent partner, his contribution to the venture is absolutely crucial . . . but for the cells of Moore’s body taken by defendants there would have been no Mo cell line at all. Yet defendants deny that Moore is entitled to any share whatever in the proceeds of this cell line. This is both inequitable and immoral.”).

<sup>173</sup> In the infamous Tuskegee Study, which spurred the creation of the legal regime governing human subjects research, black men were tricked by the U.S. Public Health Service into serving as unwitting test subjects to study the effects of untreated syphilis over forty years. See generally JAMES HOWARD JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT* (1992).

<sup>174</sup> Liz Hunt, *The Immortal Life of Henrietta Lacks: A Bittersweet Legacy*, TELEGRAPH (June 21, 2010), <http://www.telegraph.co.uk/news/science/7845119/The-Immortal-Life-of-Henrietta-Lacks-a-bittersweet-legacy.html> [<https://perma.cc/XG3K-NWYW>]. For an excellent biography of Henrietta Lacks interweaving discussion of the bioethical and racial issues associated with the commodification of bioproducts, see REBECCA SKLOOT, *THE IMMORTAL LIFE OF HENRIETTA LACKS* (2010).

<sup>175</sup> See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 485 (Cal. 1990).

<sup>176</sup> Women sometimes retain control over fetal remains in cases of miscarriage, fetal malformation, ectopic pregnancy, and other terminations of voluntary pregnancies. See,

consent requirement from *Moore* would not entitle an aborting woman to information about the potential profitability of her fetal tissue. In fetal tissue donation, the exclusion of abortion providers from the profits of the fetal tissue industry practically ensures that the only party *required* to disclose financial interests in research—the physician—will have none.<sup>177</sup> The TPOs with a financial interest in the research, who frequently take responsibility for obtaining consent to tissue donation as in the case of StemExpress, are not in a fiduciary doctor–patient relationship with the woman and are thus not required to make any financial disclosures. So not only is the abortion patient barred from receiving compensation for her fetal tissue donation, she is not even entitled to information about the profit potential her donation carries.

The right to information about profitability is not trivial. With timely access to the information Moore was entitled to know about his cells, he could have bargained for a share of the profits generated by the Mo cell line even though he had no pre-existing property right in the cells as waste.<sup>178</sup> If Moore’s doctor refused to share profits with Moore after informing him of his cells’ economic potential, Moore could have taken his business to a doctor who would.<sup>179</sup> But the information right that would make such a bargain possible disappears when the financial stake in the cells belongs to a non-fiduciary. So even if the ban on compensation for fetal tissue donations were lifted, aborting women would be left to fend for themselves in accessing information about fetal tissue profitability in order to bargain for recognition as “silent partners” in the venture.

But perhaps the *Moore* framework does not apply to fetal tissue donations. Perhaps fetal tissue is something unlike a cancerous spleen; something unique that is not covered in the existing legal framework, something that requires a feminist legal perspective from outside of the law’s androcentric eye.<sup>180</sup>

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*e.g.*, Kelly Sundstrom, *After a Miscarriage: Caring for Baby’s Remains*, PARENTING.COM, <http://www.parenting.com/article/after-miscarriage-caring-babys-remains> [https://perma.cc/XL7E-SARK].

<sup>177</sup> See Richards, *supra* note 78, at 4.

<sup>178</sup> The statutory prohibition on trade in organs lists types of tissue over which Moore could not have bargained. Spleens, blood, sperm, and ova are not on the prohibited list. See 42 U.S.C. § 274e(c)(1) (2012) (“The term ‘human organ’ means the human (including fetal) kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin or any subpart thereof and any other human organ (or any subpart thereof, including that derived from a fetus) specified by the Secretary of Health and Human Services by regulation.”). The Mo cell line was derived from Moore’s blood and/or spleen, neither of which is on the list.

<sup>179</sup> Nor is this pure speculation: Ted Slavin was a hemophiliac whose doctor informed him of his cells’ therapeutic potential. He began selectively selling and donating his blood and tissue to doctors and researchers, keeping apprised of the latest scientific developments affecting the value of his biomaterials. Belisle, *supra* note 159, at 796–97.

<sup>180</sup> See MacKinnon, *supra* note 15, at 1309 (“The legal system has not adequately conceptualized pregnancy, hence the relationship between the fetus and the pregnant woman. This may be because the interests, perceptions, and experiences that have shaped the law have not included those of women. The social conception of pregnancy that has

## 2. *Fetal Tissue: Not Just Any Tissue*

The differences between fetal tissue and other types of tissue create a distinct interest of the aborting woman in her fetal remains. One difference is implicit in the statutory informed consent requirement for fetal tissue donations. Unlike the health-protective consent requirement articulated in *Moore*, the statutory fetal tissue donation consent requirement is moral: it arises out of respect for the woman's bodily integrity and whatever connection she might have to the potential life lost through abortion.<sup>181</sup> So even though Congress foreclosed upon a proprietary relationship between a woman and her aborted fetus by banning tissue sales, by choosing to legislate a non-medical informed consent requirement it classified the fetus as something more than mere biohazardous waste. But what exactly is it?

To state the obvious, fetal tissue is nothing less than the aborted fetus itself—it is the would-be baby of the aborting woman. Catharine MacKinnon has described how the metaphorical descriptions of the fetus as body part and person, by the political left and right respectively, fail to describe what a fetus is to a pregnant woman.<sup>182</sup> “From the standpoint of the pregnant woman,” MacKinnon writes, “it is both me and not me. It ‘is’ the pregnant woman in the sense that it is in her and of her and is hers more than anyone’s. It ‘is not’ her in the sense that she is not all that is there.”<sup>183</sup> A focus-group study conducted by Naomi Pfeffer on British aborting women’s attitudes on fetal tissue donation gives voice to the paradoxical status of the fetus in relation to the aborting woman.<sup>184</sup> One participant echoed MacKinnon when asked if donating an aborted fetus is different from donating other

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formed the basis for its legal treatment has not been from the point of view of the pregnant woman, but rather from the point of view of the observing outsider, gendered male.”)

<sup>181</sup> See REPORT OF THE HUMAN FETAL TISSUE TRANSPLANTATION RESEARCH PANEL 6 (1988) [hereinafter HFTTR PANEL REPORT] (“Disputes about the morality of her decision to have an abortion should not deprive the woman of the legal authority to dispose of fetal remains. She still has a special connection with the fetus and she has a legitimate interest in its disposition and use.”); James F. Childress, *Ethics, Public Policy, and Human Fetal Tissue Transplantation Research*, 1 KENNEDY INST. OF ETHICS J. 93, 112 (1991) (summarizing the deliberations of the HFTTR Panel).

<sup>182</sup> MacKinnon, *supra* note 15, at 1314–16.

<sup>183</sup> *Id.* at 1316 (“The child that I carry for nine months can be defined *neither* as me nor as not-me.”(citing ADRIENNE RICH, *OF WOMAN BORN* 64 (1976))).

<sup>184</sup> Naomi Pfeffer, *What British Women Say Matters to them About Donating an Aborted Fetus to Stem Cell Research: A Focus Group Study*, 66 SOC. SCI. & MED. 2544 (2008). Pfeffer’s study observed four focus groups of women who had had abortions and two groups of women who had not. Although the number of women asked to donate fetal tissue to research is not documented, the transcripts suggest that only three participants had been asked to consent to fetal tissue donation, two of whom did so. *Id.* at 2546. It would be a stretch to generalize the experiences and reflections of the 31 participants in Pfeffer’s study who had had abortions to the diverse women having abortions in the United States—especially since “six out of every seven participants described themselves as ‘white British’”—but their reflections are nonetheless useful in the project of explaining the difference between fetal tissue and biological waste. *Id.* For this Article, I will only refer to participants who had had abortions.

body parts: “Yeah, it’s been made by somebody else as well and it’s also another person, it’s kind of, well not another person, but it’s not you, it’s not your organ, . . . it doesn’t belong to you, it’s growing inside of you. . . .”<sup>185</sup>

Beyond this unique subjective relationship between the pregnant woman and her aborted fetus, focus group participants in Pfeffer’s study identified at least three specific aspects of donating fetal tissue to medical research that distinguish the fetus from other organs or tissues and strengthen the aborting woman’s interest in the fetus. The first interest, which largely gives rise to the other two, can be understood as deriving from the woman’s autonomy. The *Moore* court defined the legal autonomy interest as “the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment.”<sup>186</sup> But the aborting woman’s autonomy interest in the fetal remains is not identical because the control she exercises extends over more than just her own body, and considers more than just her own health.<sup>187</sup> As expressed by Pfeffer, the abortion decision is made under a different process of voluntariness from medically necessary procedures like Moore’s splenectomy: “women initiate an abortion on social grounds—it is their decision—whereas most other medical procedures are recommended by a doctor.”<sup>188</sup> Few elective abortions are sought over maternal health concerns.<sup>189</sup> Fetal industrialists may take this as a point in their favor—by choosing to abort, to prevent the non-person fetus from becoming a baby, the pregnant woman is casting it off willingly and breaking whatever ties bind it to her.<sup>190</sup> But the voluntariness of the decision to abort is not reducible to a one-way legal formality. For one, as MacKinnon has argued, “Wo-

<sup>185</sup> *Id.* at 2552. *See also id.* at 2549 (“There’s nothing more personal to a woman than being pregnant because it’s the only thing that a woman can do totally by themselves that they have to do by themselves. Whereas tissue from a muscle or even part of the skin, it can come from a woman, man or anybody. . . . But [the fetus i]s something that no one else will have exactly the same as you ever.”).

<sup>186</sup> *Moore v. Regents of the University of California*, 793 P.2d 479, 482 (Cal. 1990) (citing *Cobbs v. Grant*, 502 P.2d 1, 9 (Cal. 1972)).

<sup>187</sup> This imprecise working definition of the particular type of autonomy interest an aborting woman has in the fetal remains eludes a more concrete statement and seeks to sound in a register of subjectivity through the quoted statements that follow. I beg the reader’s patience, and indulgence, in refraining from concluding that I have asserted a claim about fetal personhood.

<sup>188</sup> Pfeffer, *supra* note 184, at 2548.

<sup>189</sup> Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 110, 113 (2005) (“Seven percent of women cited health concerns for themselves or possible problems affecting the health of the fetus as their most important reason in 2004. . . .”); *see also* Antonia Biggs, Heather Gould & Diana Greene Foster, *Understanding Why Women Seek Abortions in the U.S.*, 2013 BIOMED CENTRAL WOMEN’S HEALTH 7 (reporting 12% of respondents mentioned health-related reasons in an open-ended survey).

<sup>190</sup> Anti-abortionists have made a similar argument against placing the authority to consent to donation in the aborting mother. *See* James F. Childress, *Ethical Criteria for Procuring and Distributing Organs for Transplantation*, 14 J. HEALTH POL. POL’Y & L. 87, 111 (1989) (“Critics . . . contend that when the pregnant woman ‘resolves to destroy her offspring, she has abdicated her office and duty as the guardian of her offspring, and thereby forfeits her tutelary powers.’” (quoting James Bopp & James Tunstead Burtchaeil,

men often do not control the conditions under which they become pregnant,” calling the individual origin of the abortion decision into question.<sup>191</sup> Instead, the abortion decision, *like the fetus itself*, is created out of a complex network of social relations of which the woman is the center. So her autonomy interest in making the abortion decision extends to her interest in controlling the disposal of her aborted fetus.<sup>192</sup> The same cannot be said for, say, a tumor, or even a kidney.

The second distinctive characteristic of fetal tissue arises from what Pfeffer calls the “duty of care” pregnant women tend to feel towards their fetus, which “[o]ther body parts do not require.”<sup>193</sup> Expressing this duty, one focus group participant said: “my initial reaction was well there’s no way I’d do anything to my aborted fetus, you’d have *that ownership thing* even though you’re aborting it you still have. . . . oh but it’s still mine. . . .”<sup>194</sup> Despite the anti-abortion stereotype of the aborting woman as self-centered and indifferent to the potential life embodied by the fetus, women frequently obtain abortions with the interests of their unborn children in mind. In a 2005 U.S. study on the reasons women get abortions, an impoverished nineteen-year-old single mother of three commented, “It’s a sin to bring the child here and not be able to provide for it. . . . This is just in the best interest for me and the children—no, my children and this child.”<sup>195</sup> Another study from 2013 reports a twenty-one-year old aborting woman saying, “I don’t feel like I could raise a child right now and give the child what it deserves.”<sup>196</sup> Both referred to their aborted fetuses as their children, not as waste. These women and others “have abortions as a desperate act of love for their unborn children.”<sup>197</sup> Whether choosing to abort rather than to subject a child (and in many cases her living siblings) to a life of poverty or to

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*Human Fetal Tissue Transplantation Research Panel: Statement of Dissent*, in REPORT OF THE HUMAN FETAL TISSUE TRANSPLANTATION RESEARCH PANEL, 45, 47 (1988)).

<sup>191</sup> MacKinnon, *supra* note 15, at 1312.

<sup>192</sup> This is essentially a feminist way of paraphrasing the HFTRR PANEL REPORT, *supra* note 181, when it supported the statutory informed consent requirement. *See also* MacKinnon, *supra* note 15, at 1317 (“However difficult an abortion decision may be for an individual woman, it provides a moment of power in a life otherwise led under unequal conditions which preclude choice in ways she cannot control.”).

<sup>193</sup> *See* Pfeffer, *supra* note 184, at 2548 (explaining that the duty “involves ensuring the baby’s physical well being through ‘body management’, that is, the performance of intimate physical tasks such as feeding, cleaning, and so on.”).

<sup>194</sup> *Id.* (emphasis added).

<sup>195</sup> Finer et al., *supra* note 189, at 115. 73% of respondents in the Finer study had abortions for lack of financial resources and 48% cited relationship-related concerns. *Id.* at 113 tbl.2.

<sup>196</sup> Biggs et al., *supra* note 189, at 4–5. Although the explicit category “Want a better life for the baby than she could provide” was only cited by 12% of aborting women in this open-ended, questionnaire-based study, several of the most-cited reasons for seeking abortions incorporate a woman’s concern for the well-being of her fetus: 40% cited financial reasons, 31% cited partner-related reasons, and 29% cited a need to focus on other children. *Id.* at 6 tbl.2.

<sup>197</sup> MacKinnon, *supra* note 15, at 1318.

shield her from an unstable or abusive relationship,<sup>198</sup> the duty of care can motivate women to choose abortion over childbirth and create a strong sense of attachment to the aborted fetus.

Finally, the duty of care gives rise to the aborting woman's concern that fetal tissue donation "might somehow allow the fetus a biographical existence beyond the abortion."<sup>199</sup> Stated another way, an aborting woman has a closure interest in the disposition of her fetus that is surrendered when she consents to donating her fetal tissue. When the women in the focus group study were given information about stem cell research, they reacted strongly against the idea that their fetuses would "live on" through laboratory research and cell-line development. One said, "You wouldn't want for it to be living for ages not knowing if this thing that you produced is still alive or not, would you? I'd be really horrified."<sup>200</sup> Another noted, "It's something that you're choosing to donate to research that had a chance of life and it's something that it just begs questions in your own mind, . . . it's something you've chosen to terminate but then might be going off elsewhere to do something else . . . ."<sup>201</sup> The closure interest in controlling, or at least knowing, what becomes of a donated fetus following an abortion was felt by two participants as "ethical responsibility . . . as well as personal security."<sup>202</sup> The narrow informed consent requirement for fetal tissue donation does not require anything like the type of disclosure women desired when they were told the basics of stem cell research.

The current regime subordinates a woman's interests in her aborted fetus to the demands of the fetal tissue industry. Her autonomy interest in controlling the final disposition of the fetus, enhanced by the duty of care and her interest in closure following her abortion, is unprotected by the statutory informed consent requirement. Despite the moral basis for the requirement, it does not entitle the aborting woman to information about the final destination of her fetus, nor about the potential profits her fetal tissue might generate for TPOs and researchers who make use of it. The consent forms used by StemExpress, whose procurement technicians obtain consent from patients in the clinics where it collects tissue, predictably omit their and their employer's financial interest in the patient's acquiescence. Instead, they emphasize the benefits of fetal tissue research. They begin:

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<sup>198</sup> *Id.* ("When women in a quarter to a third of all American households face domestic violence, this motivation cannot be dismissed as marginal. Some women conceive in part to cement a relationship which dissolves or becomes violent when the man discovers the conception. Even where direct abuse is not present, sex inequality is. Many abortions occur because the woman . . . faces the fact that she cannot give this child a life. Women's impotence to make this not so may make the decision tragic, but it is nonetheless one of absolute realism and deep responsibility as a mother.").

<sup>199</sup> Pfeffer, *supra* note 184, at 2550.

<sup>200</sup> *Id.* at 2551.

<sup>201</sup> *Id.* at 2552.

<sup>202</sup> *Id.*



Research using donated tissue and blood is currently underway to uncover causes of and ultimately find cures for things like: Heart Disease, Diabetes, Parkinson's Disease, Sickle Cell Anemia, Leukemia, Lymphoma, Cancer, Spinal Cord Disease, and many more. Tissue can be obtained as a result of donation of pregnancy tissue after an abortion. Before you give your consent to donate pregnancy tissue and/or a blood sample, read each of the following statements. If there is any statement you do not understand, or if you have any questions, someone will discuss them with you. Your participation is entirely voluntary.

Before this consent was ever offered to me, I had previously decided to have an abortion and signed an informed consent document.

I agree to donate the tissue from the abortion and/or miscarriage, and a blood sample if needed, as a bodily gift to be used for the advancement of medical science. . . . The benefits of consenting to donation today include furthering medical research in finding cures for diseases like diabetes, leukemia, lymphoma, Parkinson's disease and more. The risks to this donation are minimal in that your abortion procedure will not change in any way; . . . . The alternative to this donation is to refuse consent.

. . . I have not been informed of the identity of any individual who will receive the tissue that I am donating, and I understand that cells derived from the donation may be stored for years.

. . .

I understand there will be no payment to me for the donated tissue for any product, process or service that may result from this donation.

I understand the method, timing or procedure of abortion cannot and will not be substantively altered for the purpose of obtaining the tissue. I understand that I may refuse to donate pregnancy tissue, and this will not affect my current medical care or my ability to get any future medical services at this clinic.<sup>203</sup>

Nowhere is the word "fetus" mentioned. The consent form leads with the lifesaving potential of fetal tissue research, and does not specify what procedures the aborted fetus will undergo in order to become useful to science. Nor does it mention the technician's discrete financial stake in the donation. As discussed in relation to the medical consent requirement from *Moore*,

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<sup>203</sup> Blackburn, *supra* note 83, at Attachment N \*73-\*75.

only medical fiduciaries—which TPOs are not—are required to make financial disclosures as part of the consent process.

The findings of the focus group study suggest that the more information aborting women have about fetal tissue donation and research, the more they tend towards rejecting the option to donate. “In all of the focus groups,” Pfeffer writes, “we observed a clear pattern where participants changed their position on the core question of the rights and wrongs of donating a fetus for stem cell research as they gained information and thought more carefully about the implications of such a decision.”<sup>204</sup> The result of participants’ careful thinking was that “[b]y the end of the focus groups, participants had co-produced a tendency to refuse.”<sup>205</sup> Watering down the informed consent process may produce the benefit of providing moral respite in scientific altruism for women making the already-difficult decision to abort. But to the degree that any or all of the interests in fetal remains expressed by the British focus group participants might cause aborting Americans to think twice before donating when properly informed, those benefits may not outweigh the costs. And the economic exploitation inherent in the forced subsidy aborting women pay to the fetal tissue industry does not even exist in the British context because of the free availability of abortion services, and prenatal and postnatal healthcare, through the NHS.<sup>206</sup> Taking these considerations—and women’s legitimate right to know about them—together, the current regime begins to look less like donation with informed consent and more like expropriation.<sup>207</sup>

This point is important because it undermines the legitimacy of the status quo. If indeed the current legal framework around abortion and fetal tissue donation allows for a profit-generating industry to grow on top of the exploitive extraction of women’s fetal remains, and demands a subsidy from the women who provide those remains, some policy intervention is needed to undo this sex-based burden on women. I will now look at possible interventions that may hope to correct the underlying unfairness inherent in the current regime.

### B. *Reforming the Fetal Tissue Economy*

This section presents and analyzes three policy changes in the governing structure of the fetal tissue industry that might end or mitigate the economic exploitation of aborting women at its base: banning the use of fetal tissue in research altogether, removing the ban on exchanging fetal tissue for valuable consideration, and a hybrid approach allowing only the cov-

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<sup>204</sup> Pfeffer, *supra* note 184, at 2553.

<sup>205</sup> *Id.*

<sup>206</sup> See Kent, *supra* note 158, at 1748.

<sup>207</sup> See generally Childress, *supra* note 190, at 87 (“Evaluating different methods of acquisition of human body parts—donation (express and presumed), sales, abandonment, and expropriation”).

ering of abortion costs for donors. The harm of the status quo is suffered by aborting women whose reproductive capacities are commodified in the service of for-profit medicine. Given the androcentric viewpoint typically presented as objective in policy discussions, this section evaluates feminist policy arguments on either side of each proposal in order to fashion a policy “remedy” around a specifically sex-based harm. After briefly discussing and dismissing the possibility of a ban on fetal tissue research, I will identify the main opposing camps of feminist legal thought—libertarian and radical. Based on past commodification debates to which more scholarly attention has been dedicated, I will attempt to triangulate their likely positions on fetal tissue research and come down on the side of the radicals with a few caveats.

### 1. *Banning Fetal Tissue Research*

Banning fetal tissue donation and/or research and thereby eliminating most of the fetal tissue economy would end the exploitive use of women as providers of fetal raw materials in a profit-generating industry. Six states have passed legislation to ban fetal tissue donation and/or research,<sup>208</sup> five states currently have new or enhanced bans in the legislative pipeline,<sup>209</sup> and

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<sup>208</sup> Most states’ bans affect both donation and research, with the exception of North Carolina, banning only donation. See N.C. GEN. STAT. § 130A-131.10(a) (2015) (“[A]ll medical or research laboratories or facilities to which the remains of terminated pregnancies are sent shall dispose of the remains in a manner limited to burial, cremation, or . . . approved hospital type of incineration.”). See also ARIZ. REV. STAT. ANN. § 36-2302(A) (2015) (“A person may not use a human fetus or embryo or any part, organ or fluid of the fetus or embryo resulting from an abortion in animal or human research, experimentation or study or for transplantation, except for [diagnostic or remedial procedures or a pathological study]”); KY. REV. STAT. ANN. § 436.026 (2015) (“Any person who shall sell, transfer, distribute, or give away any live or viable aborted child or permits such child to be used for any form of experimentation shall be guilty of a Class B felony.”); LA. STAT. ANN. § 40.1061.24 (“No person shall experiment on an unborn child or on a child born as the result of an abortion, whether the unborn child or child is alive or dead, unless the experimentation is therapeutic to the unborn child or child.”) *invalidated by* Margaret S. v. Treen, 597 F. Supp. 636 (E.D. La. 1984), *aff’d sub nom* Margaret S. v. Edwards, 794 F.2d 994 (5th Cir. 1986); N.D. CENT. CODE § 14-02.2-02 (2015) (“A person may not use a fetus or fetal organs or tissue resulting from an induced abortion in animal or human research, experimentation, or study, or for animal or human transplantation except for diagnostic or remedial procedures, the purpose of which is to determine the life or health of the fetus or to preserve the life or health of the fetus or mother, or pathological study.”); OHIO REV. CODE ANN. § 2919.14 (West 2015) (“No person shall experiment upon or sell the product of human conception which is aborted.”); S.D. CODIFIED LAWS § 34-23A-17 (2016) (“Any tissue, organ, or body part of an unborn or newborn child who has been subject to an induced abortion, other than an abortion necessary to prevent the death of the mother, may not be used in animal or human research or for animal or human transplantation.”).

<sup>209</sup> Ohio and Arizona are among the states proposing further restrictions on fetal tissue donation and research, and Republicans in California, New Jersey, and Wisconsin, have proposed banning research in their states. Stephanie Armour, *State Lawmakers Target Fetal-Tissue Research*, WALL ST. J. (Aug. 20, 2015), <http://www.wsj.com/articles/state-lawmakers-target-fetal-tissue-research-1440028500> [<https://perma.cc/QC8D-4CA4>]. The Wisconsin proposal “would make it a felony to conduct research on aborted fetal tissue,” and has already passed the committee stage in both houses of the state

federal lawmakers have introduced a bill to amend the federal law to ban research on aborted fetuses.<sup>210</sup> These Republican-sponsored bans on fetal tissue research arose out of a belief in fetal personhood, rather than a concern for women's autonomy.<sup>211</sup> But their effect of barring corporate actors like TPOs from commoditizing a woman's fetal remains, partially on the woman's own dime, follows nonetheless. Due in part to the discomfort of making a political alliance with anti-abortionists, liberal feminist voices have largely sounded in opposition to fetal tissue research bans as veiled attacks on abortion rights.<sup>212</sup> But radical feminist voices opposed the medical use of aborted fetuses at the dawn of the policy debate in the 1980s and 1990s, and have been silent in the wake of the CMP videos. I will revive their arguments now and analyze whether their commitment to a fetal tissue research ban holds promise in ending the exploitive arrangement under the current regime.

When the bill that went on to legalize fetal tissue research in the United States was going through committee hearings on Capitol Hill, radical feminist bioethicist Janice Raymond was the lone witness opposed to its passage.<sup>213</sup> Raymond predicted,

A system of regulation that would allow fetuses to be used for medical research and treatment begins a process that is likely to end with the widespread use of fetal remains for a variety of purposes—experimental, therapeutic, and commercial. The line between therapeutic and commercial blurs when, for example, human fetal remains are transferred from clinics to tissue processors to medical labs and transplant centers—for a price, a processing fee, a rental fee for clinic space, or a “reimbursement” for each tissue sample.<sup>214</sup>

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legislature. *Wisconsin Senate Leader Hopes to Pass Fetal Tissue Ban*, ASSOC. PRESS (Sep. 15, 2015), <http://www.jsonline.com/news/statepolitics/wisconsin-senate-leader-hopes-to-pass-fetal-tissue-ban-b99577164z1-327747811.html> [<https://perma.cc/S3DG-TFLZ>].

<sup>210</sup> H.R. 3171, 114th Cong. § 1 (2015) (“PROHIBITION ON USE OF TISSUE OBTAINED PURSUANT TO ABORTIONS.—Human fetal tissue may be used in research carried out . . . only if the tissue is obtained pursuant to a stillbirth.”).

<sup>211</sup> Indeed, the administration of George H.W. Bush rejected the recommendations of an NIH Special Advisory Committee empaneled to study the science and ethics of fetal tissue research in 1988, explaining that “permitting the human fetal research at issue will increase the incidence of abortion across the country.” See James F. Childress, *Deliberations of the Human Fetal Tissue Transplantation Research Panel*, in *BIOMEDICAL POLITICS* 215, 235 (Kathi E. Hanna ed., 1991).

<sup>212</sup> See, e.g., Andrews, *supra* note 9; Pollitt, *supra* note 17. Passed in order to protect fetal rights, rather than women's rights, these bans are fundamentally anti-abortion. For an influential liberal feminist argument against the radical feminist alliance with the religious right in support for anti-pornography legislation, see Lisa Duggan, *False Promises: Feminist Anti-Pornography Legislation*, 38 N.Y.L. SCH. L. REV. 133 (1994).

<sup>213</sup> JANICE G. RAYMOND, *WOMEN AS WOMBS* 185 (1993).

<sup>214</sup> *Id.* at 184.

She distinguished the legalization of fetal tissue research from the legalization of abortion, noting that “[t]he incentive for legal regulation of fetal tissue is coming from the medical profession and the fetal tissue processors, not from the women directly involved.”<sup>215</sup> “[G]iving the legal go-ahead to a system of routinely harvesting fetal tissue” in which women had neither a stake nor a say, Raymond argued, would inevitably expose abortion patients to being “cast . . . as mere environments and containers for the fetus,” their own emotional, economic, and physical needs subordinated to medical research.<sup>216</sup> Although some of Raymond’s warnings about the growth of the fetal tissue industry reflect the industrial landscape I have described, the prohibitionist approach she advocates comes with significant costs that call into question whether a ban would indeed be better for women than the status quo.

First, there is probably a medical cost that a fetal tissue research ban would impose on the medical profession and on society at large. When Raymond wrote in 1993, stem cell technology was unheard of, and the blood-flow regulators making way for the growth of human organs in animals had not yet been invented.<sup>217</sup> The clinical isolation of fetal stem cells has qualitatively altered the prospects of fetal tissue research.<sup>218</sup> And even though no major breakthroughs have resulted from new technologies like fetal stem cell transplantation yet, the potential for the use of fetal tissue—in developing new vaccines, in reversing debilitating degenerative diseases, and in understanding human development for the purpose of identifying and treating a host of health issues affecting all of us—seems too serious to stamp out.

Second, a ban on fetal tissue research and/or donation in the United States might simply outsource the exploitation.<sup>219</sup> Demand for fetal tissue would not disappear, even if the supply were to be dramatically reduced. In place of fetal tissue obtained from aborting women in the United States, women in other countries—likely vulnerable women in poor countries—could become suppliers for foreign TPOs, stem cell labs, and researchers.<sup>220</sup>

<sup>215</sup> *Id.*

<sup>216</sup> *Id.* at 186, 181.

<sup>217</sup> See Lewis, *supra* note 47 and accompanying text.

<sup>218</sup> See Ishii & Eto, *supra* note 34, at 409 (tracing the evolution of fetal tissue research).

<sup>219</sup> Given the need for “fresh” fetal tissue in stem cell research, international (or at least trans-oceanic) shipping arrangements from clinics to researchers are unlikely to be feasible on a large scale. See *supra* Part II.C.2. More likely, researchers and the money backing them would relocate to wherever fetal tissue were readily available. Eager to attract the investment and prestige that comes with cutting-edge medical research, poor countries would likely compete to accommodate the fetal tissue industry if it were to be banned from the U.S. Indeed, the fact that the federal government currently invests more than \$75 million per year in fetal tissue research is a strong indication of the U.S.’s commitment to facilitating a robust domestic fetal tissue industry.

<sup>220</sup> See RAYMOND, *supra* note 213, at 180–81 (“It is a real possibility that the medical demand for fetal tissue could increase the trafficking in fetuses from Third World countries, rivaling the demand for babies, and be equally exploitative of women.”).

So a nationwide ban could produce negative externalities internationally as well.

Finally, a ban may pose an economic opportunity cost for aborting women when compared with the possibility of continuing fetal tissue research and including women in the fetal tissue economy. Even if fetal tissue research were banned, women would still get abortions and would still be required by law to pay for their abortions. Poor women in particular would still struggle to afford reproductive autonomy, which the abortion right is supposed to protect. So the only win for women from a ban would be whatever peace of mind comes with knowing that no one will profit from their abortions. I now examine whether compensating fetal tissue donors might pose a better, non-exploitive alternative to the status quo.

## 2. *Compensating Donors: A Fetal Free Market*

Lifting the ban on compensating fetal tissue donors and abortion providers would both preserve the positive potential of fetal tissue research and mitigate the exploitation of women inherent in the current fetal tissue economy. As described in the previous section, not only are aborting women providing the inputs to the industrial production of fetal tissue products free of charge, they are subsidizing the industry by bearing the costs of their tissue-generating abortions. The law barring valuable consideration for fetal tissue forces women to provide that subsidy. But what might a compensation regime look like?

One possible way to lift the compensation ban would be to open fetal tissue to market forces and allow supply and demand to determine the value of fetal tissue. Though the “fetal free market” embodies the image of evil conjured up by Republican lawmakers and anti-abortion activists in the wake of the CMP videos, it should not be dismissed as a radical break from either the current status quo or the mainstream policy positions of both Democrats and Republicans. In one way, this approach takes the liberal ideal of women’s bodily autonomy to its logical extreme. It re-purposes the rhetoric of “my body, my choice” popular in the pro-choice movement from the realm of constitutional rights to economic rights in much the same way that some feminists have advocated for the de-regulation of sex work.<sup>221</sup> At the same time, the fetal free market is consistent with the *laissez-faire* capitalism championed by Republicans once the notion of fetal personhood is taken out of the equation.<sup>222</sup> But as I will now discuss, the fetal free market perpetuates

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<sup>221</sup> For an extensive, if not exhaustive list of the literature on sex work emerging from liberal notions of women’s economic autonomy and sexual freedom, see Catharine MacKinnon, *Trafficking, Prostitution, and Inequality*, 46 HARV. C. L. REV. 271, 272–73 n.2 (2011) [hereinafter *Trafficking, Prostitution, and Inequality*].

<sup>222</sup> Indeed, Democratic Congressman Gerald Connolly raised this issue in the congressional hearings over Planned Parenthood funding in the wake of the CMP videos: “This is about a conservative philosophy that says, . . . ‘We believe in rugged individual-

its own potential for sexual and economic exploitation that women and feminists should avoid rather than embrace.

On the “liberal” side,<sup>223</sup> the arguments from individual autonomy that might be leveled in support of women’s full participation in the fetal tissue economy are at the heart of the rhetoric of choice. The law announced in *Roe* empowered women to choose whether or not to bring a pregnancy—wanted or unwanted—to term. A woman could exercise that choice because the fetus, prior to the point at which it could survive outside the womb, was not a person.<sup>224</sup> Nor was it cast as an organ, because it is parasitic rather than supportive of the woman’s life and health.<sup>225</sup> Instead, it was imagined as a part of the woman’s body. More specifically it was a part of her sexuality, which the Constitution protected from state intervention through the implicit right to privacy.<sup>226</sup> Now that the commodity value of fetal tissue is apparent, the relationship between bodily and economic autonomy with respect to aborted fetal remains must be examined as the potential move to a fetal free market is considered.

To delineate this relationship, I will look briefly to other areas of law—prostitution, commercial surrogacy, and egg donation—where unsettled debates between opposing feminist theorists rage and simmer over the commodification of women’s sexual and reproductive capacities.<sup>227</sup> Feminist positions in these long-fought ideological battles are instructive as to where various types of feminists might fall on the fetal tissue debate, as little feminist legal scholarship has thus far addressed the issue. At the risk of overgeneralizing, I organize my exposition of feminist thought on commodification of women’s sex and reproduction around two poles. On one side are sexual libertarian feminists, also called “sex positive” or “postmodern” feminists who generally support women’s right to sell sexual and reproductive services as an extension of their autonomy and even as a form of em-

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ism and personal liberty’—with one big carve-out, though. There’s an asterisk in that assertion. And that is, except when it comes to women controlling their own bodies and making their own health decisions.” DEMOCRACYNOW!, “*The Questioning Was Clearly Sexist*”: Rep. Brenda Lawrence on Republican Planned Parenthood Hearings, [http://www.democracynow.org/2015/10/1/the\\_questioning\\_was\\_clearly\\_sexist\\_rep](http://www.democracynow.org/2015/10/1/the_questioning_was_clearly_sexist_rep) [<https://perma.cc/2EDE-Y679>] (showing videoclip excerpt of the hearings).

<sup>223</sup> The word “liberal” appears in quotes to signify that I am referring to liberalism here as the converse of political conservatism. The modern strands of both derive from classical liberalism. The joint interests of liberals and conservatives on the fetal free market issue derive from their common ideological roots in classical liberalism.

<sup>224</sup> See *supra* Part I.A.

<sup>225</sup> For a vivid illustration of the parasite-host model of the fetus-woman relationship, see MacKinnon, *supra* note 221, at 1314 (“Physically, no body part takes as much and contributes as little. The fetus does not exist to serve the woman as her body parts do. The relation is more the other way around; on the biological level, the fetus is more like a parasite than a part.”).

<sup>226</sup> See *Roe v. Wade*, 410 U.S. 113, 153 (1973).

<sup>227</sup> I acknowledge that this is not an exhaustive list of contested forms of bodily commodification, but feel that they are the best analogies for fetal tissue research.

powerment.<sup>228</sup> On the other side are radical or “dominance” feminists who tend to favor prohibitory regulations against the commodification of women’s bodies, arguing that commodification is necessarily a form of oppression under conditions of sex inequality.<sup>229</sup> The free market position has decidedly won two of these three battles on the U.S. policy front, and is making serious strides towards decriminalizing prostitution as well. So should fetal tissue fall into contested territory, it is highly plausible that it too would be made available for open exchange.

*a. Prostitution: Sex Work or Sexual Exploitation?*

Prostitution involves the commodification and sale of women’s sexual labor.<sup>230</sup> The feminist debate over prostitution provides insights on where feminists might stand on the question of a fetal free market—both issues raise fundamental questions about the relationship between women’s bodily integrity and economic autonomy.<sup>231</sup> Prostitution is typically thought of in the context of criminal law whereas fetal tissue sales are brought up in the legal realm of abortion rights. But the prohibitions on the sale of fetal tissue at the federal and state levels are criminal in nature,<sup>232</sup> making the parallel perhaps closer than appears at first blush. In both prostitution and fetal tissue research, the state prohibits women from using their bodies in certain ways. So feminist thought on selling sex will help to understand feminist thought on selling fetal tissue.

Liberal defenders of prostitution emphasize the unification of bodily and economic autonomy in the sale of sex: It is not female subordination that sets the stage for the transaction of sex for money, but female agency.<sup>233</sup>

<sup>228</sup> For an influential book-length articulation of postmodern legal feminism, see MARY JO FRUG, *POSTMODERN LEGAL FEMINISM* (1992). See also JUDITH BUTLER, *GENDER TROUBLE: FEMINISM AND THE SUBVERSION OF IDENTITY* (1990) (formulating postmodern feminist theory from a philosophical perspective).

<sup>229</sup> For the foundational text of dominance feminism, see CATHARINE MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* (1989).

<sup>230</sup> Of course, men and boys also sell sex as prostitutes, but as MacKinnon notes, “men are not found selling sex in anything like the numbers women are.” MacKinnon, *Trafficking, Prostitution, and Inequality*, *supra* note 221, at 291 n.70.

<sup>231</sup> Radical feminist Evelina Giobbe has gone so far as to assert, “Prostitution isn’t like anything else. Rather, everything else is like because it is the model for women’s condition.” Evelina Giobbe, *Confronting the Liberal Lies About Prostitution*, in *THE SEXUAL LIBERALS AND THE ATTACK ON FEMINISM* 67, 76 (1990). See also Khiara M. Bridges, *On the Commodification of the Black Female Body: The Critical Implications of the Alienability of Fetal Tissue*, 102 *COLUM. L. REV.* 123, 151–54 (2002) (discussing the parallels between selling sex and selling fetal tissue from a critical race perspective).

<sup>232</sup> See 42 U.S.C. § 289g-2(a) (2012) (“It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human fetal tissue for valuable consideration if the transfer affects interstate commerce.”); (“Any person who violates subsection (a), (b), or (c) shall be fined in accordance with title 18, subject to paragraph (2), or imprisoned for not more than 10 years, or both.”).

<sup>233</sup> The liberal position is perhaps best crystallized in Martha Nussbaum’s work where prostitutes are imagined as individual workers choosing to enter into one industry over another. Her point of departure boldly leaves sex inequality out of the picture:



Some postmodernist “sex-positive” feminists take the additional step of *endorsing* sex work as a form of women’s liberation and empowerment that challenges the patriarchal moral code that controlled women by repressing their sexuality.<sup>234</sup> Catharine MacKinnon summarizes this “sex work” approach as “sometimes if not always actually a model of sex equality” in which “sex workers, most of them women, control the sexual interaction, are compensated for what is usually expected from women for free, and have independent lives and anonymous sex with many partners—behaviors usually monopolized by men, hence liberating for women.”<sup>235</sup>

In a fetal tissue free market, conceiving to abort for the purpose of “donation” would be recognized as a valuable form of women’s biolabor. Like prostitution to the feminist decriminalization camp, women’s ability to profit off of their sexual and reproductive capacities would carry the liberatory promise of enhanced economic independence and even better reproductive healthcare.<sup>236</sup> If the fetus and the reproductive labor that goes into its creation is just an extension of the woman’s body, selling it is no different than selling sex.

In the prostitution debate, the sexual libertarian view has been highly influential with policymakers. “The Netherlands, Germany, New Zealand, Victoria in Australia, as well as ten counties in Nevada” have legislated some form of decriminalized prostitution, eliminating criminal sanctions for buyers and facilitators of prostitution as well as for the prostituted women

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All of us, with the exception of the independently wealthy and the unemployed, take money for the use of our body. Professors, factory workers, lawyers, opera singers, prostitutes, doctors, legislators—we all do things with parts of our bodies for which we receive a wage in return. Some people get good wages, and some do not; some have a relatively high degree of control over their working conditions, and some have little control; some have many employment options, and some have very few. And some are socially stigmatized, and some are not.

Martha Nussbaum, “*Whether from Reason or Prejudice*”: *Taking Money for Bodily Services*, 27 J. LEGAL STUD. 693, 693–94 (1998). See also David A.J. Richards, *Commercial Sex and the Rights of the Person: A Moral Argument for the Decriminalization of Prostitution*, 127 U. PA. L. REV. 1195, 1239 (1979) (“Legal enforcement of a particular sexual ideal fails . . . to accord respect for individual autonomy.”).

<sup>234</sup> See, e.g., Valerie Jenness, *From Sex as Sin to Sex as Work: COYOTE and the Reorganization of Prostitution as a Social Problem*, 37 SOC. PROBS 403 (1990) (describing the inception and growth of the sex-positive prostitutes’ rights movements); WHORES AND OTHER FEMINISTS (Jill Nagel ed., 1997) (compiling feminist writings of sex workers and allies); Wendy McElroy, *Prostitutes, Anti-Pro Feminists and the Economic Associates of Whores*, in PROSTITUTION: ON WHORES, HUSTLERS, AND JOHNS 333 (James Elias, Veronica Elias & Vern L. Bulloch eds., 1998) (arguing for wholesale decriminalization based on the positive experience of prostitution by non-streetwalkers).

<sup>235</sup> MacKinnon, *Trafficking, Prostitution, and Inequality*, *supra* note 221, at 272-73.

<sup>236</sup> If women were paid to have abortions and donate fetal tissue, they would not need to worry about affording access to abortion services. Cf. Carlin Meyer, *Decriminalizing Prostitution: Liberation or Dehumanization?*, 1 CARDOZO WOMEN’S L.J. 105 (1993) (arguing that decriminalizing prostitution would lead to improvements in the working conditions of prostitutes).

themselves.<sup>237</sup> Even Amnesty International recently adopted a decriminalization approach to sex work on a global scale.<sup>238</sup>

But in the United States, restrictions on prostitution persist.<sup>239</sup> As enforced, the persistence of the regulation of prostitution may indeed owe to paternalistic state denial of women's ownership over their bodies.<sup>240</sup> But the radical feminist critique of prostitution calls for the abolition of commercial sex through laws and policies directed at the purchasers, promoters, and purveyors of prostituted women, while ending the criminalization of women who sell sex.<sup>241</sup> In what MacKinnon calls the "sexual exploitation approach," prostitution is

[A] product of lack of choice, the resort of those with the fewest choices, or none at all when all else fails. The coercion behind it, physical and otherwise, produces an economic sector of sexual abuse, the lion's share of the profits of which goes to others. In these transactions, the money coerces the sex rather than guaranteeing consent to it, making prostitution a practice of serial rape. In this analysis, there is, and can be, nothing equal about it.<sup>242</sup>

This radical feminist vision evokes the prohibitionist opposition to fetal tissue research espoused by Janice Raymond above.

These two poles of the prostitution debate bear illustration at this point because the debates around every other form of sexual and reproductive commodification fit more or less neatly into this framework. If the economic exploitation I have identified in the fetal tissue industry becomes problematic in the consciousness of women and policymakers, or if a medical breakthrough creates a major spike in demand for fetal tissue, this framework will

<sup>237</sup> MacKinnon, *Trafficking, Prostitution, and Inequality*, *supra* note 221, at 274.

<sup>238</sup> AMNESTY INT'L, *Sex Workers' Rights Are Human Rights* (Aug. 14, 2015), <https://www.amnesty.org/en/latest/news/2015/08/sex-workers-rights-are-human-rights/> [<https://perma.cc/TK5U-KTWN>]

<sup>239</sup> For an overview of the state law prohibitions of prostitution and related conduct, see Danielle Augustson & Alyssa George, *Prostitution and Sex Work*, 16 *GEO. J. GENDER & L.* 229, 233–40 (2015).

<sup>240</sup> "Virtually all of those law enforcement resources [enforcing penalties against commercial sex] are directed at punishing women who sell sex for money, rather than towards protecting them from violence and abuse." Sylvia A. Law, *Commercial Sex: Beyond Decriminalization*, 73 *S. CAL. L. REV.* 523, 608 (2000) (citing Neal Kumar Katyal, Note, *Men Who Own Women: A Thirteenth Amendment Critique of Forced Prostitution*, 103 *YALE L. J.* 791, 795–96 (1993)). Moreover, "Most U.S. states impose more serious penalties on people who sell sex than on those who buy." *Id.* at 565.

<sup>241</sup> See, e.g., Beverly Balos & Mary Louise Fellows, *A Matter of Prostitution: Becoming Respectable*, 74 *N.Y.U. L. REV.* 1220, 1297 (1999) (advocating a private cause of action for coercing women into prostitution); Margaret A. Baldwin, *Strategies of Connection: Prostitution and Feminist Politics*, 1 *MICH. J. GENDER & L.* 65, 75–76 (1993) (discussing drafting legislation to protect women in prostitution); Catharine MacKinnon, *Prostitution and Civil Rights*, 1 *MICH. J. GENDER & L.* 13, 20 (1993) (arguing that prosecutorial focus on prostitutes constitutes unconstitutional sex discrimination).

<sup>242</sup> MacKinnon, *Trafficking, Prostitution, and Inequality*, *supra* note 221, at 274–75.

likewise guide the arguments on either side of whatever policy intervention will replace the current regime.

*b. Commercial Surrogacy and Sexual Libertarianism*

Unlike prostitution, the debate around commercial surrogacy contracts has been largely resolved in favor of the woman's right to sell her gestational services to couples or individuals unable to conceive on their own. Despite some state laws banning surrogacy arrangements, the national trend decidedly favors legalization.<sup>243</sup> Indeed, a robust surrogacy market even provides capital inflows as U.S. women work as surrogates for wealthy foreigners from countries like France, Germany, Italy, and Spain, where commercial surrogacy is prohibited.<sup>244</sup> Women who are considering renting their bodies to couples seeking a genetically related baby can hope to make between "\$39,450 to \$52,450, depending on factors including the type of pregnancy and the number of previous pregnancies (surrogate mother experience)."<sup>245</sup> And surrogacy can be a career with advancement opportunities: "For each additional pregnancy, surrogate mothers receive an additional \$5,000."<sup>246</sup> The bodily invasion supposed by carrying a pregnancy to term, and the commodification of women's reproductive capacity it entails, have been largely accepted by society whereas prostitution, and fetal tissue sales, have not—yet.

Surrogacy shares some obvious characteristics of fetal tissue sales: both involve the impregnation of a woman who does not plan to keep and raise a child as a result of the pregnancy.<sup>247</sup> Indeed, commercial surrogacy seems like an even more extreme form of commodification when compared with fetal tissue sales. The invasion of the surrogate's body is much more intensive than that of the aborting woman. The burden of carrying a pregnancy to

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<sup>243</sup> For comprehensive coverage of the differences in state surrogacy laws, see Tamar Lewin, *Surrogates and Couples Face a Maze of Laws State by State*, N.Y. TIMES (Sep. 17, 2014), <http://www.nytimes.com/2014/09/18/us/surrogates-and-couples-face-a-maze-of-laws-state-by-state.html?action=click&contentCollection=U.S.&module=RelatedCoverage&region=Marginalia&pgtype=article> [https://perma.cc/JZ9Z-QX7M].

<sup>244</sup> EUR. PARLIAMENT DIRECTORATE GEN. FOR INTERNAL POL., A COMPARATIVE STUDY ON THE REGIME OF SURROGACY IN EU MEMBER STATES 15–16 (2011) [hereinafter E.U. SURROGACY REPORT]. International competition has raised the relative cost of a U.S.-born baby, sending couples elsewhere: The portion of U.S.-surrogate-born Spanish babies dropped from 80% to just 15%, with the majority of Spaniards now hiring surrogates in Ukraine. *Unas 800 Parejas Españolas Contratan Cada Año Ventres de Alquiler en el Extranjero* [Some 800 Spanish Couples Rent Wombs Abroad Each Year], EL MUNDO (May 5, 2014) <http://www.elmundo.es/espana/2014/05/01/5362240a268e3e8d1b8b456f.html> [https://perma.cc/S7DA-9JRB].

<sup>245</sup> *How Much do Surrogates Get Paid?*, CONCEIVEABILITIES <https://www.conceiveabilities.com/surrogates/surrogate-mother-pay> [https://perma.cc/5KM8-LGKH].

<sup>246</sup> *Id.*

<sup>247</sup> The similarities have been raised at least once before. See Bridges, *supra* note 231, at 151 ("Understanding the arguments for and against surrogacy contracts is useful, because the sale of fetal tissue closely parallels the sale of a gestational surrogate's womb: The woman's body is merely a conduit for a priceless good.").

full term over the course of nine months, plus the long-term hormone treatments required to prepare the gestational surrogate for implantation, cannot be overstated.<sup>248</sup> An aborting woman spending a matter of weeks pregnant without undergoing any hormone treatments bears a comparatively light load—early term abortions are safe procedures with quick recovery times compared to live birth.<sup>249</sup> What makes surrogacy appear more socially acceptable than selling fetal tissue is the fact that surrogacy ideally delivers a live baby to the custody and care of parents who want to raise it.<sup>250</sup> In fetal tissue sales, the end product is a disaggregated set of tiny organs which may abstractly contribute to medical progress.

But despite its mainstream acceptance, surrogacy has not escaped feminist critique. Many feminists came out in virulent opposition to surrogacy arrangements when they first came under the public spotlight in the aftermath of the *Baby M* case in the late 1980s.<sup>251</sup> In *In the Matter of Baby M*, the New Jersey Supreme Court held that a surrogacy contract was unenforceable and amounted to an unlawful “sale of a child,” reversing the trial court’s

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<sup>248</sup> One gestational surrogate, who unwittingly ended up with twins, relayed the process:

Take an injection of hormones to knock her fully functional cycle off its orbit and suppress ovulation. Take synthetic estrogen via pill and patch and inject progesterone suspended in oil through a twenty-five-gauge needle (it’s big) into her bottom for six weeks. Along with her husband, abstain. Endure the hormones ‘wreaking havoc on my system,’ as she describes it. Shuttle back and forth to a lab two hours away for weekly blood tests to make sure said hormones had reached adequate levels, that her uterus had resumed an amplified, robotic version of its normal cycle.

Once the uterus is deemed hospitable for in-vitro fertilized embryos, fill bladder to bursting, lie back in stirrups, and be mildly sedated so that a catheter delivering the thawed zygotes could be threaded through her cervix and into her womb. Then return home and resume the hormone regimen for another six weeks, including the daily self-administered injections, even after the morning sickness kicks in.

Jennifer Block, *The Other Side of Surrogacy: What Gestational Surrogates Really Go Through*, *BABBLE* (Apr. 13, 2009), <http://www.babble.com/pregnancy/gestational-surrogacy-how-to-be-a-surrogate-mother/> [<https://perma.cc/BPP3-F59G>].

<sup>249</sup> *Compare Physical Recovery After an Abortion*, *AFTERABORTION.COM*, <http://www.afterabortion.com/physical.html> [<https://perma.cc/CT7T-FEQP>] (explaining that most restrictions on activities and lingering symptoms will be gone within two to four weeks), *with Recovering From Birth*, *WOMENSHEALTH.GOV*, <http://www.womenshealth.gov/pregnancy/childbirth-beyond/recovering-from-birth.html> [<https://perma.cc/99LH-YCV9>] (explaining the relatively more serious post-delivery restrictions on activity and symptoms following live birth).

<sup>250</sup> For a glowing account of gestational surrogacy from the point of view of an intending mother using a surrogate to carry her and her husband’s biological child, see Alex Kuczynski, *Her Body, My Baby*, *N.Y. TIMES MAG.* (Nov. 28, 2008), <http://www.nytimes.com/2008/11/30/magazine/30Surrogate-t.html> [<https://perma.cc/FH7M-RK96>].

<sup>251</sup> See, e.g., Elizabeth S. Anderson, *Is Women’s Labor a Commodity?*, 19 *PHIL. & PUB. AFF.* 71, 80–87 (1990); Margaret Jane Radin, *Market Inalienability*, 100 *HARV. L. REV.* 1849, 1928–36 (1987); see generally PHYLLIS CHESLER, *SACRED BOND: THE LEGACY OF BABY M* (1988) (attacking surrogacy as a form of patriarchy through the story of Mary Beth Whitehead, the surrogate mother of Baby M).

ruling upholding the contract.<sup>252</sup> However, because of other factors, the court held that the child's best interests demanded that custody be granted to the intending parents.<sup>253</sup> According to Elizabeth Scott, "By the time the trial concluded with a judgment upholding the contract, feminists and women's groups presented a united front in opposition to surrogacy; few defended the judge's decision."<sup>254</sup>

In the radical feminist camp, Janice Raymond spoke out against surrogacy, echoing the sexual exploitation view of prostitution. She called surrogacy "a system in which women are movable property, objects of exchange, brokered by go-betweens mainly serving the buyer"; surrogate contracts in her view are "reproductive purchase orders where women are *procured* as instruments in a system of breeding."<sup>255</sup>

Nevertheless, as quickly as the feminist anti-surrogacy movement rode the momentum of the *Baby M* fallout in the late 1980s with surrogacy bans enacted in several U.S. states,<sup>256</sup> it practically disappeared. Today, the most vocal opposition to surrogacy doesn't come from feminists but from religious-affiliated organizations like the Center for Bioethics and Culture,<sup>257</sup> and from groups of disenchanted children of surrogacy who organize online.<sup>258</sup> Throughout the 1990s, feminist discourse shifted from seeking state intervention to protect women from sexual violence and exploitation to emphasizing women's autonomy interests, especially in exercising the right to abortion.<sup>259</sup>

As the mainstream feminist movement began to adopt the libertarian viewpoint, like the one expressed in the sex-work approach to prostitution, surrogacy came to be seen as another economic and reproductive choice women could make as autonomous actors in the free market.<sup>260</sup> Carmel Shalev's *Birth Power: The Case for Surrogacy* explicitly proposed a contract-based free market in reproductive services as a means of women's lib-

<sup>252</sup> *In re Baby M*, 537 A.2d 1227, 1248 (N.J. 1988).

<sup>253</sup> *Id.* at 1258.

<sup>254</sup> Elizabeth S. Scott, *Surrogacy and the Politics of Commodification*, 72 L. & CONTEMP. PROB. 109, 116 (2009).

<sup>255</sup> RAYMOND, *supra* note 213, at xxii.

<sup>256</sup> See Scott, *supra* note 254, at 117.

<sup>257</sup> See CTR. FOR BIOETHICS & CULTURE, [www.cbc-network.org](http://www.cbc-network.org) [<https://perma.cc/7J2Y-GU2R>] (last visited Dec. 29, 2015). CBC produced a documentary film, *Breeders: A New Subclass of Women?*, featuring several interviews with former surrogates who shared their stories of exploitation by the assisted reproduction industry. See BREEDERS: A NEW SUBCLASS OF WOMEN? (Ctr. for Bioethics & Culture 2014).

<sup>258</sup> See, e.g., DONORCHILDREN.COM, [www.donorchildren.com](http://www.donorchildren.com) [<https://perma.cc/7TEJ-X7M8>] Blog: I AM A PRODUCT OF SURROGACY, [theothersideofsurrogacy.blogspot.com](http://theothersideofsurrogacy.blogspot.com) [<https://perma.cc/7DJK-X9BQ>].

<sup>259</sup> See Scott, *supra* note 254, at 142 ("The claim that women lacked agency because of coercive circumstances always seemed to be in tension with the commitment to preserving women's autonomy in other reproductive contexts—particularly abortion.")

<sup>260</sup> See generally CARMEL SHALEV, *BIRTH POWER: THE CASE FOR SURROGACY* (1989) (advocating surrogacy as a way to redefine women's relationship with reproduction and sexually and economically empower women).

eration. At the heart of her argument is an articulation of the exploitation critique to uncompensated fetal-tissue research I raised in section A above: “[T]he failure to acknowledge the economic value of female reproductive labor is blind folly for those who wish for equity in women’s social situation.”<sup>261</sup> She takes this premise to the extreme of an unregulated market in which she assumes women will exercise full agency as market actors: “The contractual scheme for reproductive relations that I propose is part of a feminism that . . . insists that to overcome the psychological constraints of patriarchy women must regard themselves as subjects, actors, and agents of their individual sexual and reproductive activity.”<sup>262</sup> But Shalev’s book was the only major piece of feminist scholarship dedicated to arguing in favor of surrogacy.

Unlike the prostitution debate, liberal and libertarian feminists were not heavily involved in pro-surrogacy advocacy. Their support for surrogacy was given tacitly through non-intervention as the lobbying efforts of the growing reproductive technology industry saw state after state legalize reproductive service contracts. As Scott described it, “The *withdrawal* of women’s advocates implicitly recognizes that endorsing paternalistic government restrictions on women’s reproductive choices in this context is incompatible with the broader feminist agenda . . . [U]ltimately it became clear that support for restrictions on surrogacy undermined pro-choice advocacy.”<sup>263</sup> Perhaps mainstream feminists’ support of uncompensated fetal tissue donation reflects a similar adherence to women’s reproductive agency—the choice to donate is seen as an extension of the choice to abort, and if the legitimacy of the former choice is called into question, the latter will be undermined. At the same time, liberal and libertarian feminists’ support for surrogacy as voiced by Shalev hinged a great deal on the financial benefits surrogates were able to reap from the use of their reproductive capacities. Indeed, one feminist scholar explicitly made the connection between fetal tissue and surrogacy in 2001:

What about the rights of women who want to sell their fetal tissue?  
Like surrogacy, this issue raises serious consideration of an individual’s right to do what she wants versus what is good for the

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<sup>261</sup> *Id.* at 160.

<sup>262</sup> *Id.* at 156.

<sup>263</sup> Scott, *supra* note 254 at 143–44 (emphasis added). The failure of Catharine MacKinnon and Andrea Dworkin’s legislative anti-pornography project to withstand constitutional scrutiny, *see* *Am. Booksellers Ass’n v. Hudnut*, 771 F.2d 323 (7th Cir. 1985), *aff’d*, 475 U.S. 1001 (1986), and mobilize mainstream feminist support, *see* Duggan et al., *supra* note 212, at 134–35, is also frequently cited as a reason for the discursive shift towards a focus on agency. For an account of the shift written in its midst, *see* Kathryn Abrams, *Sex Wars Redux: Agency and Coercion in Feminist Legal Theory*, 95 COLUM. L. REV. 304 (1995).

society. If donating tissue pays for her children's food and clothes, it is difficult to argue against her right to do this.<sup>264</sup>

As more information about the fetal tissue industry becomes known in the ongoing policy debate over fetal tissue research, perhaps mainstream liberal and libertarian feminists will revive Shalev's pro-surrogacy position that women's sexual and economic autonomy are inseparable.

*c. Donor Eggs on the Market: A Fetal Foreshadow*

Egg "donation"<sup>265</sup> for the purpose of in-vitro fertilization (IVF) was subject to the same critiques as surrogacy by Raymond and other radical feminists,<sup>266</sup> but faced even less controversy in mainstream U.S. political culture.<sup>267</sup> Only Louisiana prohibits the sale of human ova;<sup>268</sup> every other state either provides regulations for egg donation or is silent on the issue.<sup>269</sup> Egg donors are typically offered between \$6,500 to \$15,000 for each donation, again benefitting from repeat transactions "with increased compensation for subsequent cycles."<sup>270</sup> And other, more eugenic, factors are also considered to pay premium prices to "superior" donors. "Some high-end fertility clinics and egg-donor agencies . . . pay more for eggs from particularly attractive donors: actresses, models, Asians, Jewish women and Ivy League students with high SAT scores."<sup>271</sup> Egg donation for IVF represents

<sup>264</sup> Sarah Bauerle Bass, *Why Can't a Fetus Be More Like a Sperm? The Woman's Role in Fetal Tissue Research and How Women are Left Out of the Discussion*, 1 GENDER ISSUES 19, 30 (2001).

<sup>265</sup> "Donation" appears in quotes because, at least in the U.S., women who provide eggs for others are paid to do so, purportedly "for time and labor." The eggs are thus sold, not donated. The language of altruism and donation serves to conceal what Debora L. Spar, president of Barnard College, called "the yuck factor of commodifying human eggs." Tamar Lewin, *Egg Donors Challenge Pay Rates, Saying They Shortchange Women*, N.Y. TIMES (Oct. 16, 2015), <http://www.nytimes.com/2015/10/17/us/egg-donors-challenge-pay-rates-saying-they-shortchange-women.html> [<https://perma.cc/35KD-87DJ>].

<sup>266</sup> See RAYMOND, *supra* note 213, at 45.

<sup>267</sup> Indeed, egg donation is often compared to sperm donation, the legality and morality of which are rarely challenged. But even sperm donation is more complex than simply being paid to masturbate. For a sardonic first-person account of the sperm-donation process, see Sean Berkeley, *6 Terrifying Things Nobody Tells You About Donating Sperm*, CRACKED.COM (Nov. 12, 2011), [http://www.cracked.com/article\\_19497\\_6-terrifying-things-nobody-tells-you-about-donating-sperm.html](http://www.cracked.com/article_19497_6-terrifying-things-nobody-tells-you-about-donating-sperm.html) [<https://perma.cc/2EBC-724V>].

<sup>268</sup> 9 LA. REV. STAT. ANN. § 9:122 (2015) ("The sale of a human ovum, fertilized human ovum, or human embryo is expressly prohibited.")

<sup>269</sup> *Egg Donation Laws*, CREATIVE LOVE EGG DONOR & SURROGACY AGENCY, <http://www.cledp.com/intended-parent-101/110.html> [<https://perma.cc/Y7J4-95VG>]. See generally Jacob Radecki, Note, *The Struggle to Promote Egg Donation Through a More Protective Regulatory Regime*, 90 CHI.-KENT L. REV. 729 (2015) (detailing the practice and regulatory regime around egg donation).

<sup>270</sup> *Egg Donor Compensation*, EGG DONATION INC., [www.eggdonor.com/donors/egg-donor-compensation](http://www.eggdonor.com/donors/egg-donor-compensation) [<https://perma.cc/SG3S-NL5H>].

<sup>271</sup> Lewin, *supra* note 265. Sperm banks engage in similar discrimination, refusing prospective donors on account of their race, height, educational achievement, or even hair color. See Berkeley, *supra* note 267.

a free market triumph in the commodification of women's reproductive capacities, and consequently in the woman's right to choose to sell her eggs to couples who cannot conceive.

But there is one facet of the human egg trade that has been shielded from the free market, which is of particular interest to our discussion of fetal tissue research. Egg donors are barred from receiving compensation for donations to science for use in human embryonic stem cell research ("hESCR").<sup>272</sup> Radhika Rao pointed out several incoherencies in the regime that allows compensation for egg donation to IVF patients but bars it for egg donation to medical advancement.<sup>273</sup> Against the commodification critique of compensating donors to stem cell research, Rao retorts,

[T]here is no question that everyone else involved in the production of human embryonic stem cells *is* entitled to compensation. The researchers who invest intellectual capital and the companies and universities that invest financial capital will surely share in any profits resulting from human embryonic stem cell research, so why not those who provide human capital in the form of their own bodies? . . . [W]hy should everyone but the donor possess property rights and profit from hESCR?<sup>274</sup>

Rao's questions echo the exploitation critique I raised to the compensation ban for fetal tissue donations. Fetal tissue research also presents "a context in which the body has already been alienated from the person, and is fragmented, instrumentalized, commercialized, and treated as a species of property for everyone else."<sup>275</sup>

Eggs also have more in common with aborted fetuses than just their potential for marketability. Eggs donated for the purpose of being fertilized for use in hESCR require conception (albeit non-coital) without intent to realize the concomitant potential for life. Given the low success rate of IVF, at least half of the eggs donated with the intent to give birth can be expected to "die" after conception.<sup>276</sup> So again, the move to a free market in fetal tissue would not be without precedent, despite the loaded language of anti-abortion advocates decrying the sale of baby parts.

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<sup>272</sup> See NAT'L RES. COUNCIL & INST. MED., GUIDELINES FOR HUMAN EMBRYONIC STEM CELL RESEARCH 82-89 (2005).

<sup>273</sup> Radhika Rao, *Coercion, Commercialization, and Commodification: The Ethics of Compensation for Egg Donors in Stem Cell Research*, 21 BERKELEY TECH. L.J. 1055, 1056 (2006).

<sup>274</sup> *Id.* at 1061.

<sup>275</sup> *Id.* at 1066.

<sup>276</sup> *Frequently Asked Questions*, SOC'Y FOR ASSISTED REPROD. TECH., [http://www.sart.org/SART\\_Frequent\\_Questions/](http://www.sart.org/SART_Frequent_Questions/) [<https://perma.cc/2M7G-SE64>] ("The average live delivery rate for IVF in 2005 was 31.6 percent per retrieval.").



It is important to reiterate here that at least *under the law of abortion*, which forecloses on fetal personhood before viability, the fetus at abortion is just as much a part of the woman's body as her sex, her uterus, or her ova. The consistent position of sexual libertarians supporting market transactions over sex, pregnancy, and ovulation would be to fight for women's autonomy in the fetal tissue economy as well. Sexual libertarians are likely to have an ally in the powerful medical industry in the fight for freedom to profit from one's reproductive labor in termination. Researchers will need new ways to meet the demand that will accompany the approval of new therapeutic and biotechnological uses of fetal tissue, especially as the portion of non-tissue-rendering medication abortions continues to rise. A fetal free market will allow researchers' demand for fetal tissue to generate supply through the offer of compensation to donors. Stringent informed consent requirements would at least formally protect women from being duped into taking excessive risks for money. And to sexual libertarians, women would have another way to liberate themselves sexually and economically through the informed consensual use of their bodies in the market.

But the arguments favoring a fetal free market assume away problems of exploitation under conditions of sex inequality, and would create unjustifiable health risks for economically and racially subordinated women.<sup>277</sup> A free market places a monetary value on everything, including, in the case of fetal tissue, risky late-term fetuses.<sup>278</sup> Financial desperation, which often leads women to choose to abort rather than raise a (or another) child in the first place, would push women into having whatever abortions carried the biggest payout. I use the extreme of an unregulated fetal free market, even though any policy intervention is likely to impose some regulations to protect women's health to a degree, because its logic would undergird any policy allowing any compensation for fetal tissue. This warning that opening the door to compensation would open the floodgates of exploitive commodification is meant as a caveat to the final possible policy intervention I will explore in my attempt to balance women's interests with the continued use of fetal tissue in research.

### 3. *Covering Costs*

Rather than opening up a fetal free market similar to the IVF egg trade, policymakers looking to protect women from exploitation by the fetal tissue industry might allow fetal tissue beneficiaries to cover the abortion costs of women who provide their raw materials. From the outset this approach is flawed in that it does not compensate the provision of fetal tissue—it merely

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<sup>277</sup> See *infra* Part IV.A. See also Bridges, *supra* note 231 (arguing against market alienability of fetal tissue because of its likely exploitive outcomes for black women).

<sup>278</sup> See Radin, *supra* note 251 (arguing against market alienability of bodies and body parts as an affront to human dignity).

ends the forced subsidy donors pay to the industry.<sup>279</sup> But this approach carries advantages over the free market model. It would not incentivize risky late-term abortions, nor would it induce women to abort who otherwise would not.<sup>280</sup> Indeed, it would have positive health externalities for women who would otherwise be forced to delay their abortions for lack of funds.<sup>281</sup> There are international precedents for a cost-covering model, and I will argue that it would be a net gain for women in the United States with substantial caveats. A one-shot policy change alone is unlikely to secure women's interests in the long term. In the next Part, I will imagine how fetal tissue research might be regulated under a framework of reproductive justice.

*a. International Precedents*

In the United Kingdom, a cost-covering approach governs egg donation for stem cell research among IVF patients. Before 2006, compensation for egg donation was barred in the UK and British stem cell researchers resultantly faced a shortage of embryos for use in their work. To address the shortage, the Human Fertilisation and Embryology Authority approved of what they called “egg sharing” as a means to recruit donors: “Under the scheme, patients undergoing IVF would receive treatment at a reduced cost in exchange for some of the eggs collected during standard treatment procedures.”<sup>282</sup> Stem cell researchers would pay for the subsidies to donors' IVF treatments, promising women “access to treatment they may not otherwise be able to afford” while spurring research “towards stem cell therapies for conditions such as diabetes, Alzheimer's Disease and Parkinson's Disease.”<sup>283</sup> The scheme generated 467 fresh eggs from 42 women between 2008 and 2010, and their live birth rate (LBR) compared to IVF patients who did not donate eggs did not suffer as a result.<sup>284</sup> Participating women were given a discount of £1,500 off of an IVF price tag ranging from £3,200–£3,700.<sup>285</sup>

The UK has also been a pioneer in fetal tissue banking. A recent article covering the history and potential of the banking system explains: “The Human Developmental Biology Resource (HDBR), based in London and

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<sup>279</sup> This assertion assumes that the value of fetal tissue is or could be greater than the cost of the abortion procedure, which on average for an early-term surgical termination is \$480. See text accompanying *supra* note 134.

<sup>280</sup> Women who would otherwise be unable to afford abortion-related services may have access to desired abortions under this scheme; however, the cost-covering would only enable them to realize their reproductive choice—it would not shape the choice itself. Stated differently, cost-covering would not induce women to conceive for the sole purpose of aborting.

<sup>281</sup> See *supra* Part II.D.2.

<sup>282</sup> Celia Roberts & Karen Throsby, *Paid to Share: IVF Patients, Eggs and Stem Cell Research*, 66 *SOC. SCI. & MED.* 159, 159 (2008).

<sup>283</sup> *Id.* at 160.

<sup>284</sup> Meenakshi Choudhary et al., *Egg Sharing for Research: A Successful Outcome for Patients and Researchers*, 10 *CELL STEM CELL* 239, 239 (2012).

<sup>285</sup> *Id.*

Newcastle, UK, was established to provide embryonic and fetal material for a variety of human studies . . . . Increasingly, HDBR material is enabling the derivation of stem cell lines and contributing towards development in tissue engineering.”<sup>286</sup> Women who donate fetal tissue in the UK, like women who do not, pay nothing for their abortions. In 2014, 98% of abortions in the UK were funded by the National Health Service (NHS).<sup>287</sup> Perhaps related to the free provision of abortion services, “92% of abortions were carried out at under 13 weeks gestation, 80% were at under 10 weeks,” and “[m]edical abortions accounted for 51% of the total.”<sup>288</sup> Unlike the egg donation scheme described above, fetal tissue researchers in the UK are not directly subsidizing the abortion procedures that generate raw materials for their experimentation. Rather, both researchers and women are beneficiaries of robust public health services. Women are not forced to subsidize fetal tissue research by paying for their abortions, and there are no profit-driven middlemen. Early access to safe abortion services is in no way compromised by the consensual provision of fetal tissue to researchers.

*b. Domestic Challenges*

Needless to say, the United States is not the UK, and socialized medicine is not on the American political horizon. Therefore, the egg-sharing scheme from the British private sector is more instructive for United States policymakers and advocates than the tissue-banking model. Is it plausible and desirable to secure fetal tissue supplies by requiring researchers and other stakeholders to pay for donors’ abortions as a cost of doing business?

Legal hurdles and practical complexities make this question extremely difficult to answer from both a policy and a feminist perspective. A policy incorporating the cost-covering approach to fetal tissue procurement would look a lot like the current scheme, but instead of banning all valuable consideration in exchange for fetal tissue donations, it would ban only valuable consideration in excess of the cost of the abortion procedure.<sup>289</sup> This way, unlike in a fetal free market system, women would not be coerced into conceiving to abort for financial gain. But several questions emerge from this framework that complicate the parsimonious elegance of such a policy.

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<sup>286</sup> Dianne Gerelli et al., *Enabling Research with Human Embryonic and Fetal Resources*, 142 DEVELOPMENT 3073, 3073 (2015).

<sup>287</sup> DEPT. OF HEALTH, ABORTION STATISTICS, ENGLAND & WALES: 2014 at 5 (2015).

<sup>288</sup> *Id.* The U.S. numbers on early-term abortions are not dissimilar, with 91.4% at or before thirteen weeks’ gestation and 64.5% at or before eight weeks’ gestation. *CDC Abortion Surveillance*, *supra* note 31, at 6.

<sup>289</sup> *See* 42 U.S.C. § 289g-2(a) (2012).

First, who exactly would pay for the abortions? The Hyde Amendment prohibits the use of federal Medicare funds for abortion services.<sup>290</sup> So, in order to build the abortion costs into research proposals, researchers would be forced to secure private funding to sponsor that part of their overhead.<sup>291</sup> This challenge may not be insurmountable, though. Pharmaceutical companies would not be subject to restrictions on public funding. Disease interest groups could subsidize abortions to supply studies involving fetal tissue.<sup>292</sup> Additionally, TPOs could cover abortion costs in mutually beneficial arrangements with abortion patients and clinics; legalizing abortion cost-covering in exchange for fetal tissue donations could legitimize the controversial and currently exploitive operation of TPOs, as discussed previously.

But even if a cost-covering policy would be plausible as a matter of law, it may still come at a cost to women. For one, a cost-covering scheme would severely complicate the statutory requirement that consent to the abortion procedure be secured *before* the issue of fetal tissue donation is raised.<sup>293</sup> As discussed, women frequently struggle to pay for abortions—advanced notice of the possibility to donate tissue in exchange for a free abortion would be necessary to avoid such hardships and preclude cost-related delays in administering abortions. Once women access information about the option to obtain free abortions in exchange for tissue donations, consent to fetal tissue donation would become meaningless. The decision to *not* donate—to have the remains disposed of—would come with a \$480 (or higher) price tag.

Moreover, problems would arise over whose abortions to pay for. Given the difficulties inherent in obtaining usable fetal tissue discussed in Part II, a pre-operation cost-covering arrangement would force the payer to sponsor abortions that end up rendering nothing of value. But conditioning cost-covering or reimbursement on the provision of usable fetal tissue would pressure women and their physicians to alter procedures in order to better preserve fetal remains. This outcome would be illegal under the current framework,<sup>294</sup> and changing the law to allow it could expose women to additional health risks. Additionally, offering cost-covering to all abortion pa-

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<sup>290</sup> Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, tit. V, § 506–07, 129 Stat. 2241, 2649 (2015). The law provides for the narrow exception of cases involving rape, incest, or a threat to the woman’s life.

<sup>291</sup> Given the comparative advantages of the private-funding approaches identified here, I will pass on discussing overturning the Hyde Amendment until Part IV.

<sup>292</sup> See *supra* Part II.C.4. Disease interest groups already sponsor studies using human embryonic stem cells, and a true commitment to finding a cure would likely overcome any moral opposition some donors might have to abortion. Elegantly expressing this fact, “M. Samuelson, a sufferer of Parkinson’s disease, said [in testimony before a congressional panel on excluding fetal tissue research from federal research funding], ‘In the United States . . . those of us depending on this work are hostages of abortion politics.’” Bass, *supra* note 264, at 24.

<sup>293</sup> See 42 U.S.C. § 289g-1(b)(2)(A)(i) (2012).

<sup>294</sup> See 42 U.S.C. § 289g-1(b)(2)(ii).

tients might cause costs to exceed benefits for would-be private sponsors, pushing them to make free abortions available only to some smaller, geographically convenient group of women and maintaining the status quo for everyone else.

The problems associated with the cost-covering model were largely foreshadowed by the concerns with a fetal free market expressed above, and arise inevitably from the commodification of fetal tissue. Still, covering the cost of abortions for women who agree to donate fetal tissue is a form of compensation that includes the woman in the fetal tissue economy in the least exploitive way possible—at least under a capitalist healthcare system. It may recognize the woman's economic interest in not subsidizing the overhead costs of fetal tissue industry actors. But, reduced to property, her body and reproductive capacity and her health and welfare are left exposed to market forces and manipulations. Her bodily integrity is violated in a way that only a woman's can be. So any market-based solution that extends the commodification of women's reproduction in the form of fetal tissue is bound to carry costs for women, and the short-term lens of policy-fixing is poorly suited to advancing women's interests without a broader reproductive justice agenda of which a fairer system of fetal tissue provision is just one element.

#### IV. TOWARDS REPRODUCTIVE JUSTICE

The British model outlined above, in which abortion services are free to all and the fetal tissue economy is mostly state-run, is a model to emulate. However, it is also unlikely to be replicated in the United States anytime soon given the fierce resistance to "socialized medicine" among the American political class. So how, then, might feminists navigate between the economic exploitation in the current fetal tissue economy, and the bodily commodification that participation in that economy assumes? A first step towards finding an agreeable middle ground involves a turn from rights-based discourse around abortion and economic autonomy to one of reproductive justice. As many feminist and critical race theorists have pointed out, the privacy-based reproductive rights selectively granted to women by the Supreme Court have fallen woefully short of guaranteeing the sort of reproductive freedom necessary to build a more equal society. In this Part, I will incorporate intersectional perspectives from black and Latina scholars to inform an outline of this shift. Finally, I will include some potential reproductive justice priorities that might guide feminist approaches to fetal tissue policy in the future.

### A. *Intersectionality in Abortion Politics and Commodification*

In the preceding discussion of opposing feminist positions on women's agency and the commodification of their bodies and reproductive capacity, questions of race and ethnicity have been touched on only tangentially. But the majority of women who get abortions are non-white: a black woman is four times as likely as a white woman to have an abortion; a Latina woman is twice as likely.<sup>295</sup> As Kimberlé Crenshaw pointed out in her seminal article on the marginalized experience of black women at the intersection of racism and sexism, "ideological and descriptive definitions of patriarchy are usually premised upon white female experiences."<sup>296</sup> So black and Latina women's experiences of abortion and of sexual and reproductive commodification must be addressed explicitly to properly inform the reproductive justice agenda this Article proposes as a guide to replacing the exploitive status quo in fetal tissue donation and research.

From the outset, black and Latina women turn to abortion for different reasons than white women do. For example, both black and Latina women were more likely than white women to cite their inability to afford a (or another) child as a reason for aborting.<sup>297</sup> Black women were nearly three times as likely as white women to attribute their decision to abort to needing to provide for their other dependents,<sup>298</sup> and twice as likely to report that pregnancy and childbirth would interfere with their education or careers.<sup>299</sup> Relationship concerns also motivated a large portion of black and Latina women to terminate their pregnancies: a higher portion of Latinas than any other racial group reported relationship problems,<sup>300</sup> and "[w]omen who gave partner related reasons were significantly more likely to be African American."<sup>301</sup> These disparate reasons suggest that black and Latina women

<sup>295</sup> See *supra* Part II.D.1.

<sup>296</sup> Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 156 (1989). See also Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 588 (1990) ("[I]n feminist legal theory, as in the dominant culture, it is mostly white, straight, and socioeconomically privileged people who claim to speak for all of us. Not surprisingly, the story they tell about 'women,' despite its claim to universality, seems to black women to be peculiar to women who are white, straight, and socioeconomically privileged."). See generally ELIZABETH V. SPELMAN, *INESSENTIAL WOMAN: PROBLEMS OF EXCLUSION IN FEMINIST THOUGHT* (1988) (critiquing the implicit white perspective in feminist theory).

<sup>297</sup> *Finer et al.*, *supra* note 189, at 115.

<sup>298</sup> 60% of black women cited this reason. Latina women (51%) were also slightly more likely than white women (41%) to cite having completed childbearing or providing for dependents. *Id.*

<sup>299</sup> *Id.* at 114.

<sup>300</sup> 56% of Latinas compared to 49% of whites cited relationship problems. *Id.* at 115.

<sup>301</sup> Biggs et al., *supra* note 189, at 8 (reporting on a survey conducted between 2011–2013). However, the *Finer* study conducted in 2004 found that a slightly lower percentage of black women (45%) cited relationship or partner related reasons for aborting than white women (49%). *Finer et al.*, *supra* note 189, at 115. So the assertion in the Biggs article may be more complicated than the reporting appears.

experience the abortion decision differently. The history of race relations in the United States similarly paints a different experience of bodily commodification for women of color than for white women.

For black women, uncompensated commodification of sex and reproduction has been the rule—not the exception—throughout their history in America.<sup>302</sup> Under slavery, the whole person was commodified, but “female slaves were expected to do the same work as male slaves while carrying the additional burdens of sexual abuse and exploitation of their reproductive capabilities.”<sup>303</sup> “Slave breeding” was the process by which slavery “forced its victims to perpetuate the very institution that subjugated them by bearing children who were born the property of their masters.”<sup>304</sup> Although the property relationship of chattel slavery has been abolished, the vast economic, social, and political inequality that slavery left in its wake continues to define the reproductive lives, and restrict the reproductive freedom, of black women.<sup>305</sup>

Latinas suffer from similar curtailments of their reproductive freedom that go far beyond the criminalization of abortion. Latinas with non-citizen immigration status or limited English proficiency face a unique set of structural disadvantages in exercising control over their reproductive lives.<sup>306</sup> And even American-born, English-speaking Latinas suffer the consequences of

<sup>302</sup> See generally, DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* (1997) (tracing the history of Black women’s sexual subordination).

<sup>303</sup> Pamela D. Bridgewater, *Reproductive Freedom as Civil Freedom: The Thirteenth Amendment’s Role in the Struggle for Reproductive Rights*, 3 J. GENDER RACE & JUST. 401, 410 (2000) [hereinafter *Reproductive Freedom*]. Perhaps this double exploitation was inefficient, though, as Thomas Jefferson once wrote, “I consider the labor of a breeding woman as no object, and that a child raised every 2 years is of more profit than the crop of the best laboring man.” Pamela D. Bridgewater, *Reconstructing Rationality: Towards a Critical Economic Theory of Reproduction*, 56 EMORY L.J. 1215, 1221 (2007) [hereinafter *Reconstructing Rationality*] (quoting Letter from Thomas Jefferson to John Jordan (Dec. 21, 1805), in RONALD T. TAKAKI, *IRON CAGES, RACE AND CULTURE IN 19TH-CENTURY AMERICA* 44 (1990)).

<sup>304</sup> ROBERTS, *supra* note 302, at 24.

<sup>305</sup> In many ways, Dorothy Roberts’s *Killing the Black Body* is a survey of slavery’s legacy in all contemporary reproductive politics, from the birth control movement’s involvement with eugenics and racially-targeted forced sterilization, to welfare reform, to assisted reproductive technologies. See *id.* at 6–7. See also Melanie M. Lee, *Defining the Agenda: A New Struggle for African-American Women in the Fight for Reproductive Self-Determination*, 6 WASH. & LEE RACE & ETHNIC ANC. L.J. 87 (2000) (tracing reproductive subjugation from slavery through the 20th century).

<sup>306</sup> See, e.g., *Racial and Ethnic Disparities in Women’s Health Care Coverage and Access to Care: Findings from the 2001 Kaiser Women’s Health Survey* 5, KAISER FAM. FOUND. (2004), <http://kff.org/disparities-policy/issue-brief/racial-and-ethnic-disparities-in-womens-health/> [<https://perma.cc/3VPL-LARV>] (describing language and cultural barriers as one of the reasons why Latinas express the greatest concern over the quality of their healthcare). See generally Tamara Forsys, *Left Out in the Cold: How the United States’ Healthcare System Excludes Immigrants*, 17 ANN. HEALTH L. 351 (2008) (discussing the interaction between immigration law and access to healthcare).

historical subordination under a white supremacist racial order.<sup>307</sup> For example, in the twentieth century, Latinas of Puerto Rican, Dominican, and Mexican descent were victimized by forced sterilization on a massive scale.<sup>308</sup> “Latinas are faring worse than other racial and ethnic groups in terms of poverty level, income, and labor force participation.”<sup>309</sup> Relatedly, “over one-third (37%) of Latinas in the United States do not have health insurance, the highest rate of uninsured among any racial/ethnic group.”<sup>310</sup> One factor contributing to this low rate of coverage is the exclusion of recently arrived immigrants from Medicaid.<sup>311</sup> Consequently, Latinas exhibit disproportionately poor reproductive health characteristics as a group including higher

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<sup>307</sup> See Richard Delgado, *Derrick Bell's Toolkit—Fit to Dismantle That Famous House?*, 75 N.Y.U. L. REV. 283, 290–96 (2000) (describing the multiple levels of racial subordination mobilized against non-whites).

<sup>308</sup> For detailed accounts of forced sterilization programs targeting different Latina populations, see Angela Hooton, *A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism*, 13 AM. U. J. GENDER SOC. POL'Y & L. 59, 70–71 (2005) (providing an overarching summary); Elena R. Gutiérrez, *Policing “Pregnancy Pilgrims”: Situating the Sterilization Abuse of Mexican-Origin Women in Los Angeles County*, in WOMEN, HEALTH, AND NATION: CANADA AND THE UNITED STATES SINCE 1945 379, 380 (Georgina Feldberg et al. eds., 2004) (focusing on Mexican-born women in L.A.); Iris Lopez, *Agency and Constraint: Sterilization and Reproductive Freedom Among Puerto Rican Women in New York City*, in SITUATED LIVES: GENDER AND CULTURE IN EVERYDAY LIVES 157 (Louise Lamphere et al. eds., 1997) (focusing on Puerto Rican women in New York); Jenny Rivera, *The Violence Against Women Act and the Construction of Multiple Consciousness in the Civil Rights and Feminist Movements*, 4 J.L. & POL'Y 463, 480 (1996) (“Puerto Rican women, in fact, have the highest global rate of sterilization: thirty-five percent.”).

<sup>309</sup> Hooton, *supra* note 308, at 74 (“While the overall poverty rate for single mothers in 2002 was 28.8%, 36.4% of Latina single mothers lived in poverty. . . . The median income for Latinas in 2001 was only \$12,583, compared to \$16,282 for black women and \$16,652 for non-Hispanic white women.”).

<sup>310</sup> *Id.* at 72.

<sup>311</sup> See 8 U.S.C. § 1613 (2012). Indeed, a recent administrative rule expanding the definition of “child” for Medicaid purposes to include unborn children seems to provide a pathway for undocumented and recently arrived immigrants to access prenatal care “because they are carrying citizen-fetuses now covered by the SCHIP program as children.” Hooton, *supra* note 308, at 80–81. This limited benefit to Latinas (it does not entitle them to post-natal care) is subject to criticism by the mainstream pro-choice movement because it represents another instance of the government conferring rights unto fetuses. *Id.* at 81 (“The policy is . . . problematic from a feminist perspective because it elevates the health status of the fetus above that of the mother. . . .”).



rates of HIV/AIDS and other STIs,<sup>312</sup> poor or non-existent prenatal care,<sup>313</sup> reduced access to contraception,<sup>314</sup> and high teen birth rates.<sup>315</sup>

Critical race theorists and Latina legal scholars have repeatedly criticized the mainstream feminist movement's focus on abortion rights as the ultimate signifier of reproductive freedom while black and Latina women's reproductive choices have been curtailed by unrelated policies like forced sterilization, state-law "family caps" for welfare recipients, and the criminalization of pregnant women suffering from drug addiction.<sup>316</sup> The following insights from their work carry particular relevance to the fetal tissue commodification debate.

First, the negatively defined privacy right to abortion is disproportionately available to wealthy white women and unresponsive to the reproductive liberty interests of women of color. The right announced in *Roe v. Wade* was merely a bar against state laws criminalizing abortions for those who could afford them. The interests of those protected by the abortion right in *Roe* dominated the pro-choice movement. But, as Angela Davis notes, "During the early abortion rights campaign, it was too frequently assumed that legal abortions provided a viable alternative to the myriad problems posed by poverty. As if having fewer children could create more jobs, higher wages, better schools, etc."<sup>317</sup> The invisibility of the needs of women of color in the mainstream movement for abortion rights may be traced back to the involvement of the early movement for birth control's alliance with the racist eugenics movement. Dorothy Roberts recounts how "[t]he alliance of

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<sup>312</sup> "The AIDS case rate is six times higher among Latinas than white women, and AIDS is the fourth leading cause of death among Latinas ages twenty-five to forty-four. Latinas, especially Latina teenagers, also have a higher infection rate of syphilis, gonorrhea, and Chlamydia than white women." Hooton, *supra* note 308, at 77.

<sup>313</sup> *Id.* at 79 ("Latinas are less likely to receive prenatal care during the first trimester than white women (74.4% compared to 88.5%, respectively). Over six percent of Latinas did not receive prenatal care until the third trimester or received no prenatal care at all in 2000, compared to 3.3% of white women. . . . this lack of access contributes to disparities in maternal mortality, of which the rate among Latinas . . . 1.7 times the rate among white women."). *Id.*

<sup>314</sup> *Id.* at 78 ("Only fifty-nine percent of Latinas between the ages of fifteen and forty-four reported using some type of contraception in 2002.").

<sup>315</sup> *Id.* ("Latinas presently have the highest teen birth rate of all major ethnic groups. In 2002, the Latina teen birth rate was 83.4 per 1,000, almost double the national average of 43 per 1,000.").

<sup>316</sup> Cf. Dean Spade, *Intersectional Resistance and Legal Reform*, 38 SIGNS 1, 6–7 (2013) (arguing that the reproductive justice movement should "[c]onceptualiz[e] the politics of reproduction through population control . . . turn[ing] away from the individual-rights narrative that centers on the question of whether the government is affirmatively and explicitly blocking a given woman from accessing abortion or contraception. Instead, it argues that all of the conditions that determine reproductive possibilities—subjection to criminalization, displacement, immigration enforcement, or environmental destruction; the unequal distribution of wealth and access to health care; and more—are the terrain of contestation about the politics of reproduction.").

<sup>317</sup> Angela Davis, *Racism, Birth Control, and Reproductive Rights*, in FROM ABORTION TO REPRODUCTIVE FREEDOM: TRANSFORMING A MOVEMENT 15, 17 (Marlene Gerber Fried ed., 1990).

the eugenics and birth control movements bolstered the contemporaneous struggle for women's emancipation. At a time when white women were largely confined to the domestic realm, eugenics included women as active participants in a crusade of scientific and political importance."<sup>318</sup> The birth control movement Roberts is referring to was led by Margaret Sanger's American Birth Control League (ABCL), which later became the Planned Parenthood Federation of America. ABCL believed that providing more abortions for "less fit" black and poor women, administered by a white pro-woman medical community, would improve American society.<sup>319</sup>

This historical paternalism of the birth control movement towards women of color may evince the same tendency to prioritize white experiences as the reflexive defense of the fetal tissue industry that characterized Planned Parenthood's response to the CMP videos. The repeated insistence that patients are eager to donate their aborted fetuses in search of a silver lining in the hard abortion decision reflects a privileged white perspective through which donating fetal tissue for the advancement of curative science *is* compensation. Meanwhile, the medical industry's appropriation and commodification of black fetal tissue for profit evokes the alienation of reproduction suffered by black women under slavery—the products of conception, whether conceived in love or by force, become the property of an economically and racially dominant class.<sup>320</sup>

Should the fetal tissue economy undergo policy reforms, it is not difficult to imagine ways in which racial inequity might get hardwired into the new system. For example, clinics offering "free" abortions in exchange for fetal tissue donations could be selectively located in white localities, health conditions could be used as a proxy for race to exclude minority women on seemingly race-neutral grounds, or clinical procedures requiring multiple consultations designed to better preserve fetal remains could place a hurdle in the way of working minority women who could not afford to make the extra trip to the clinic.<sup>321</sup> The reproductive justice movement must be on guard against the racist tendency to exclude and undervalue black and Latina women as the fetal tissue industry is re-structured.

Perhaps in tension with the commodification critique, some intersectional scholarship argues that contract and economic rights can be powerful empowerment tools for historically disenfranchised groups. Patricia Williams's rich first-person defense of contract rights as a possible medium for

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<sup>318</sup> ROBERTS, *supra* note 302, at 76.

<sup>319</sup> *See id.* at 81.

<sup>320</sup> *See Bridges, supra* note 231, at 158–61 (describing, in the fetal tissue context, the effects of dehumanization and "internalized oppression" suffered uniquely by black women in systems of bodily commodification).

<sup>321</sup> The exclusionary effect of such a policy would be similar to that imposed by legislative waiting periods, which "make the choice of abortion more expensive and time consuming." Michele Estrin Gilman, *Welfare, Privacy, and Feminism*, 39 U. BALT. L.F. 1, 18 (2008) (citing Walter Dellinger & Gene B. Sperling, *Abortion and the Supreme Court: The Retreat from Roe v. Wade*, 138 U. PA. L. REV. 83, 102 (1989)).

the equal recognition of black people may be mobilized in partial support of black women's entry into the fetal tissue economy.<sup>322</sup> Williams describes being "engaged in a struggle to set up transactions at arm's length, as legitimately commercial, and to portray myself as a bargainer of separate worth, distinct power, sufficient rights to manipulate commerce."<sup>323</sup> Pamela Bridgewater incorporated a similar argument in partial defense of gestational surrogacy arrangements in which surrogates charge a sufficient sum of money to compensate the totality of the service provided.<sup>324</sup> But she was careful to condition her defense of surrogacy on the recognition of surrogates—"disfavored reproducers"—as subjects and not objects in reproductive services contracts.<sup>325</sup> Similarly, Williams conditions her support for commercial contract rights on their ability to protect, rather than to undermine and objectify, the personal boundaries of rights-holders.<sup>326</sup> To apply this liberationist vision of rights in the fetal tissue industry would be to argue for full inclusion of aborting women in accessing the medical and financial benefits the industry generates without objectifying them in the process.<sup>327</sup> In the following section, I propose a holistic way to do just that, which will move from the specific issue of fetal tissue research to the general framework of reproductive justice.

### B. *Reproductive Justice Policy*

The tensions drawn out throughout this Article between women's economic autonomy and bodily integrity largely arise out of a conflict of rights—rights that have not yet transcended the social norms of objectifica-

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<sup>322</sup> See generally, PATRICIA J. WILLIAMS, *THE ALCHEMY OF RACE AND RIGHTS*, 146–165 (1991).

<sup>323</sup> *Id.* at 148.

<sup>324</sup> Bridgewater, *Reconstructing Rationality*, *supra* note 303, at 1233.

<sup>325</sup> *Id.* at 1234.

<sup>326</sup> See WILLIAMS, *supra* note 322 at 165 ("Give to all of society's objects and un-touchables the rights of privacy, integrity, and self-assertion; give them distance and respect.").

<sup>327</sup> Dorothy Roberts incorporates Williams's rights advocacy in articulating a project of reproductive liberty rooted in a larger race conscious social justice agenda.

Racism has stunted Americans' imagination of reproductive freedom and stymied development of liberating reproductive policies that benefit everyone. Only by eradicating racism's hold can we hope to envision and achieve reproductive justice.

... Once we understand liberty as requiring the eradication of oppressive structures rather than opposing these changes [to reproductive health policy], it makes no sense to privilege liberty over equality. A far better approach for theorists committed to protecting individual autonomy is to explore how social justice could be made central to their conception of rights, of harms, and of the value of procreation.

ROBERTS, *supra* note 302, at 311–12.

tion and exploitation.<sup>328</sup> In laying out the agenda for reproductive justice this Article incorporates, Robin West problematized the centrality of rights in feminist legal and political thought today: rights, she said, “run the risk of legitimating the injustices we sustain in the insulated privacy [they] create[ ]; they denigrate the democratic processes that might generate positive law that could better respond to our vulnerabilities and meet our needs; and they truncate our collective visions of law’s moral possibilities.”<sup>329</sup> In the case of fetal tissue research, rights discourse traps women between a rock and a hard place.

I have argued that the currently exploitive legal regime governing fetal tissue donation should be amended to eliminate the forced subsidy aborting women pay to the beneficiaries of the fetal tissue industry in the form of the costs of the abortion procedures that produce the raw materials for their industrial processes. However, I have admittedly failed to advance a viable policy that would accomplish that goal. It seems as though a profit-driven, privatized medical industry that relies on free tissue donations in its production cycles is poised against women’s interests—especially economically and socially marginalized women. To craft a policy that protects women’s health in earnest, feminists and their allies in government should frame their efforts as part of a strategic move towards reproductive justice. West describes reproductive justice thus:

Reproductive justice requires a state that provides a network of support for the processes of reproduction: protection against rape and access to affordable and effective birth control, healthcare, including but not limited to abortion services, prenatal care, support in childbirth and postpartum, support for breastfeeding mothers, early childcare for infants and toddlers, income support for parents

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<sup>328</sup> In a review of Williams’s book, Robin West describes the bridge to her vision of rights:

There is a considerable distance between our present liberal conception of rights and the utopian conception toward which Williams urges us to aspire. A conception of rights freed of the right to objectify, to murder the spirit, to refuse to regard those whose lives depend upon our regard, would require not just the liberation of the object from the enslavement of property, but a transformation of property law itself, and a transformation of the property-owning self that is its subject. Williams’ account of rights is ultimately, then, not in any sense whatsoever a defense of extant liberal rights; rather, it is a utopian vision of a possible social future that builds upon but insists we move beyond particular historical moments of relative nobility.

Robin West, *Murdering the Spirit: Racism, Rights, and Commerce*, 90 MICH. L. REV. 1771, 1796 (1992).

<sup>329</sup> Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, in IN SEARCH OF COMMON GROUND ON ABORTION: FROM CULTURE WAR TO REPRODUCTIVE JUSTICE 19, 21 (Robin West, Justin Murray & Meredith Esser eds., 2014) [hereinafter *From Choice*].

who stay home to care for young babies, and high quality public education for school age children.<sup>330</sup>

Such goals have both short-term and long-term repercussions for fetal tissue collection.

In the short-term, reproductive justice demands that women not be forced to subsidize the fetal tissue industry. Feminists should militate in favor of a regime that avoids the privatizing pitfalls of cost-covering discussed above and *requires* stakeholders in the fetal tissue industry—TPOs, pharmaceutical companies, etc.—to sponsor the abortions of all women whose fetal tissue they use. Legally, this likely requires instituting some of the statutory changes proposed in the previous Part to permit the growth of a private cost-covering regime. Such a system would probably not be accessible to all women seeking abortions, including those who currently have the hardest time obtaining them. In some respects, it would resemble a private, and therefore more exclusive, version of the British tissue-banking scheme.<sup>331</sup>

But does cost-covering really *fully* recognize women's contribution to the fetal tissue industry? Will a free abortion in exchange for a woman's fetus exempt her from the objectification involved in the fetal tissue industry? As discussed above, the fetal tissue industry's exploitive commodification of women's reproductive capacities is not unprecedented. The profits generated through fetal tissue research represent only a small fraction of the billions of dollars made off of the buying, selling, and renting of women's sex and reproduction under the inherently exploitive dynamic of sex inequality. Aborting women solicited for fetal tissue donation are not alone on the losing side of the larger multi-sector sex industry—they are joined there by prostituted women, commercial gestators, victims of forced sterilization, mothers on welfare, and many more. A broader reproductive justice policy program should seek to level the playing field for all victims of sexual and reproductive objectification as an aggregate remedy to race/sex-based harm.<sup>332</sup>

The shift from reproductive rights to reproductive justice requires a shift from state inaction to state action. As Dorothy Roberts described,

[Black women's] reproductive freedom . . . is limited not only by the denial of access to safe abortions, but also by the lack of resources necessary for a healthy pregnancy and parenting relationship. Their choices are limited not only by direct government

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<sup>330</sup> *Id.* at 45.

<sup>331</sup> See *supra* Part III.B.3.

<sup>332</sup> Recognizing the commodification of sex and reproduction as a sex-based harm fits with Dorothy Roberts's race-conscious social-justice approach to liberty. See ROBERTS, *supra* note 302, at 310 ("The social justice approach to liberty recognizes the connection between the dehumanization of the individual and the subordination of the group.").

interference in their decisions, but also by government's failure to facilitate them.<sup>333</sup>

The racial and economic inequality compounding women's sexual subordination exists largely in the so-called private sphere.<sup>334</sup> And in that sphere, Robin West reiterates, "court-generated rights perversely protect, rather than stand as a challenge to forms of oppression that are distinctively private."<sup>335</sup> So, as Catharine MacKinnon asserts, "if inequality is socially pervasive and enforced, equality will require intervention, not abdication, to be meaningful. But the right to privacy is not thought to require social change."<sup>336</sup> Reproductive justice, on the other hand, does. And recognizing the fetal tissue industry's exploitation of aborting women is just one step towards making that known.

### CONCLUSION

During the drafting of this Article, Robert Lewis Dear, Jr., shot and killed three people at a Planned Parenthood clinic in Colorado Springs, explaining his actions with the phrase, "no more baby parts."<sup>337</sup> During his first preliminary hearing, he shouted, "I am a warrior for the babies."<sup>338</sup> Center for Medical Progress founder David Daleiden "condemn[ed] the barbaric killing spree in Colorado Springs by a violent madman,"<sup>339</sup> while abortion-rights advocates blamed the virulent anti-abortion rhetoric of CMP

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<sup>333</sup> ROBERTS, *supra* note 302, at 300.

<sup>334</sup> Raising the Legal Realist critique of the public/private distinction in the discussion of black women's reproductive lives, Roberts says,

[T]his conception of individuals does not take into account the background social conditions that may have constrained their decisions. In this view, an indigent mother's reliance on government benefits does not diminish the voluntariness of her agreement to use Norplant in exchange for welfare payments. Nor do the limited range of women's economic opportunities or the parties' unequal social and economic positions diminish the voluntariness of a surrogate's agreement to sell her reproductive labor.

*Id.* at 295.

<sup>335</sup> West, *From Choice*, *supra* note 329, at 35.

<sup>336</sup> MACKINNON, *supra* note 229, at 191–92.

<sup>337</sup> Wesley Lowery, Danielle Paquette & Jerry Markon, 'No More Baby Parts,' *Suspect in Attack at Colo. Planned Parenthood Clinic Told Official*, WASH. POST (Nov. 28, 2015), [https://www.washingtonpost.com/politics/no-more-baby-parts-suspect-in-attack-at-colo-planned-parenthood-clinic-told-official/2015/11/28/e842b2cc-961e-11e5-8aa0-5d0946560a97\\_story.html](https://www.washingtonpost.com/politics/no-more-baby-parts-suspect-in-attack-at-colo-planned-parenthood-clinic-told-official/2015/11/28/e842b2cc-961e-11e5-8aa0-5d0946560a97_story.html) [https://perma.cc/52QC-PHKD].

<sup>338</sup> Paul Vercammen & Holly Yan, *Planned Parenthood Shooting Suspect Robert Dear Has Outbursts at Hearing*, CNN (Dec. 10, 2015), <http://edition.cnn.com/2015/12/09/us/colorado-planned-parenthood-shooting/> [https://perma.cc/RCP3-GG8S].

<sup>339</sup> *CMP Statement on Violence in Colorado Springs*, CTR. FOR MED. PROGRESS (Nov. 28, 2015), <http://www.centerformedicalprogress.org/2015/11/cmp-statement-on-violence-in-colorado-springs/> [https://perma.cc/FT5U-PVKM].

and the Republican Party for Dear's outburst.<sup>340</sup> The shooting doubtless further buried women's interests beneath political rhetoric; perhaps even my suggestion here that fetal tissue research exploits women will be taken by the pro-choice camp as a betrayal of women's health providers.

The divisive political rhetoric around abortion and fetal tissue research paints a grim picture of an unstable stalemate with tragic consequences. In that stalemate, the fetal tissue controversy sparked by the release of the CMP videos in summer 2015 presented an opportunity for both sides to step outside of their barricaded positions and shift the parameters of the debate. In the immediate aftermath, the narrative from the Planned Parenthood camp uncritically defending fetal tissue research and emphasizing how few abortions they perform marked a lost opportunity to find common ground towards reproductive justice. But that opportunity may not have passed. Planned Parenthood and others have called for a congressional inquiry into the fetal tissue industry, and the current congressional investigation focused around Planned Parenthood has also implicated TPOs. Recognizing the tension between women's interests and the fetal tissue industry and using that tension as a lens through which to re-frame the politics of choice around a racially inclusive vision of reproductive justice may be a promising way forward for feminists looking to shed the yoke of private oppression borne out through public policies of nonintervention. As Robin West notes, "Substantial parts of both sides . . . have an interest in minimizing the demand for abortion through minimizing the cost of mothering, enforcing and strengthening the rights of pregnant women, advocating the responsible use of birth control, insisting upon sensible anti-rape policies, and discouraging unwanted sex."<sup>341</sup> These reproductive justice priorities are hard to disparage, no matter one's politics. All they need is a movement.

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<sup>340</sup> E.g., Jonathan Martin, *Obama Says 'Enough Is Enough' After Colorado Shooting*, N.Y. TIMES (Nov. 28, 2015), <http://www.nytimes.com/2015/11/29/us/colorado-springs-planned-parenthood-obama-responds-to-gun-violence.html> [<https://perma.cc/ZNX7-HDVY>].

<sup>341</sup> West, *From Choice*, *supra* note 329, at 51.

