REPRODUCTIVE TIME IN LAW

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Abstract

Time is an inherent and omnipresent aspect of family-building processes. From the 'biological clock' indicating the diminishing timeline of fertility, to the pregnancy timeline governing the development of new life and the transformative moment of childbirth establishing parent-child kinship, time is an intrinsic dimension of these natural processes. This Article, however, presents a timely challenge to the taken-for-granted role of time in these processes when it comes to the law and jurisprudence.

The Article argues that reproductive time, often mistakenly assumed to be limited to physical or genetic processes, is, in fact, also constructed and organized—sometimes even manipulated—through legal practices. The legal manipulation of reproductive time is becoming particularly evident today as scientific and social advancements modify the 'natural' timeline of family-building, yet the law continues to enforce it in various contexts. Critical and inter-contextual exploration is required if we are to assess how our construction of time upholds traditional ideologies of procreation and parentage, falsely presenting them as 'natural.'

The Article thus explores the multidisciplinary idea of time-as-social-construct and applies it across three different contexts where reproduction comes under legal scrutiny: fertility preservation; pregnancy termination; and parentage recognition. In each context, the Article (i) theorizes the social construction of reproductive time, exposing the legal framework by which time is administrated and distributed unequally, thereby perpetuating various forms of subordination; (ii) problematizes the impacts of this construction of time, evaluating its harms in tangible terms but also in the more subtle, discursive realm; and (iii) reorients this construction, discussing potential avenues for mitigating these detrimental effects.

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The value of juxtaposing these different contexts through the lens of time-as-social-construct lies in illuminating how different forms of subordination—rooted in patriarchal, racist, class-based, and heteronormative structures—operate and interconnect across different stages of the family-building process. Such inter-contextual analysis renders these inequalities easier to see, harder to ignore, and less defensible. Armed with this thicker understanding, advocates may be better positioned to challenge restrictive practices, ensuring fairer and more equitable treatment of individuals involved in the process of becoming—or not becoming—a parent.

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Introduction

We often neglect to acknowledge how time structures our everyday lives. Despite its seemingly abstract nature, time is omnipresent, a pervasive—and inherent—aspect of our existence. The latter aspect of time is particularly palpable in the context of human reproduction, where time expresses itself through, and is co-produced with, the body.[1] From the 'biological clock' serving as a ticking timeline of fertility that diminishes with age, to the pregnancy timeline governing the development of new life, and the date on the calendar when a first-born comes into the world, signaling the creation of a

[1] *See* Caroline H. Bledsoe, Contingent Lives: Fertility, Time, and Aging in West Africa 4 (2002).

parent-child kinship—time, in some important ways, is intrinsic to genetic and physical processes.[2] However, it is precisely this reality that gives rise to a further framing—one that is misleading yet almost universally accepted: namely, that, because time in the context of reproduction is natural, it is therefore unchangeable, objective, and unquestionable, a phenomenon governed solely by the laws of biology rather than cultural norms, political choices, or legal decision-making.[3]

This Article challenges this ostensibly neutral portrayal of time as a *matter of law*, demonstrating how reproductive time is constructed and organized—and sometimes manipulated—through medical-legal policies to reinforce traditional family ideologies on the premise of its being 'natural.'[4] This phenomenon manifests, among other contexts, in the age-related barriers that are written into fertility-preservation laws,[5] the paradigms governing pregnancy timelines, and presumptions about the recognition of pregnancy enshrined in the law of abortion.[6] And it also finds expression in the institutional time-keeping that is enshrined in parentage law—the law concerned with establishing the legal parent-child relationship.[7]

The manipulation of reproductive time is becoming particularly evident today as scientific and social advancements modify the 'natural' timeline of family-building processes, yet the law continues to enforce it, regardless—and sometimes asymmetrically, prioritizing certain collectives over others.[8] To reveal how reproductive time is manipulated, a critical and inter-contextual exploration of this concept is essential.[9]

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[2] *Cf.* Rene Almeling, *Reproduction*, 41 Ann. Rev. Socio. 423, 429 (2015) (discussing the "dominant, if somewhat implicit" understanding in the social scientific literature that reproduction "occurs primarily *within* women's bodies") (emphasis added).

[3] Theorists have long argued that culture inevitably shapes our understanding of biological categories. Informed by this perspective, legal scholars have suggested that biological arguments in law can subtly perpetuate societal hierarchies while appearing impartial (*infra* notes 52–53). The Article seeks to contribute to this conversation by adopting the lens of time to render taken-for-granted assumptions about family-building processes more visible.

[4] Emphasizing the social construction of reproductive time does not deny biology's central role. On the contrary, reproductive time derives its potency precisely from its close connection to natural processes. By selectively invoking certain biological facts, the law portrays regulatory choices as 'inevitable,' effectively recasting political decisions as mere reflections of nature. In this way, the law effectively produces a constructed sense of reproductive time—one that profoundly shapes how people experience, manage, and internalize what they often assume to be purely "natural" rhythms.

[5] *See infra* Part II.A.

[6] *See infra* Part III.A.

[7] *See infra* Part IV.A.

[8] *See infra* Parts II.A, III.A, & IV.A.

[9] Scholars have examined various aspects of reproductive rights but have paid less attention to the interlocking regulation of family-building processes, especially along temporal lines. For leading accounts of interlocking regulation between Medically Assisted Reproduction (MAR) and parentage, see, e.g., Douglas NeJaime, *The Nature of Parenthood*, 126 Yale L.J. 2260 (2017); Courtney Megan Cahill, *Reproduction Reconceived*, 101 Minn. L. Rev. 617 (2016). For an illuminating account of how pregnancy is being

To pursue this inquiry, the Article begins by synthesizing some of the analytical principles underlying the idea of time-as-social-construct, from multiple scholarly disciplines (*inter alia*, sociology, anthropology, obstetrics, political science, and gender studies). This scholarship highlights three fruitful insights into time-as-social-construct: (i) its governing aspect, which is concerned with how time organizes and standardizes human actions, thereby constructing their meanings;[10] (ii) its naturalizing aspect, referring to its hidden political function;[11] and (iii) its economic aspect, which considers time as a distributable resource, the allocation of which reflects and perpetuates power relations.[12]

Despite the fact that topics relating to equality are among the most extensively covered in legal scholarship on reproduction and parentage,[13] theories about this crucial nexus between time and subordination are absent from this scholarship.[14] Yet, in the context of human reproduction, this nexus is worth particular attention because the construction of time is inherently unobtrusive due to its unquestionable link to *biological* reproductive processes. It is thus easier to obscure behind scientific reasoning and seemingly natural—ergo, unquestionable—explanations. Hence, the Article brings these two bodies of research into a new and fruitful conversation. It applies the idea of time-as-social-construct across three contexts where reproduction comes under legal scrutiny: fertility preservation; pregnancy termination; and parentage recognition.[15]

The Article offers a three-step analysis for each of these contexts. It *theorizes* three significant forms of 'reproductive time' embedded in the law, each located at different points on the temporal continuum of becoming—or not becoming—a parent. The three forms are: (i) fertility time, referring to the period during which a person is biologically able to become a genetic parent;

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regulated through surrogacy law, see e.g., Courtney G. Joslin, *Surrogacy and the Politics of Pregnancy*, 14 Harv. L. & Pol'y Rev. 365 (2020).

[10] *See infra* Part I.A.

[11] *See infra* Part I.B.

[12] *See infra* Part I.C.

[13] *See infra* notes 142, 158, 214, and accompanying text.

[14] With few exceptions in the legal scholarship, time is merely an implicit or unremarkable aspect of most analyses on reproduction and family-building mechanisms, rather than constituting a focus in its own right. This Article offers such a focus, in a systematic account. For accounts of time in the context of fertility and abortion, see, e.g., Lolita Buckner Inniss, *It's About Bloody Time and Space*, 41 Colum. J. Gender & L. 146, 147 (2021); Ruth Fletcher, *On Chronolegality: Reproducing Legal Time with Periodic Abortion Law* (Queen Mary L. Rsch. Paper No. 402, 2023), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4477604 [https://perma.cc/6PGP-VHGG]. In the context of parentage, see, e.g., Dara E. Purvis, *Intended Parents and the Problem of Perspective*, 24 Yale J.L. & Feminism 210, 211–12, 229–30 (2012); Courtney G. Joslin, *(Not) Just Surrogacy*, 109 Cal. L. Rev. 401, 439–42 (2021).

[15] While other reproductive issues, such as contraceptive access, surrogacy arrangements, or adoption procedures, also involve important temporal dimensions, these three contexts—fertility preservation, abortion, and parentage—were selected for the clarity with which they demonstrate the law's role in structuring reproductive time at key junctures.

(ii) gestational time, referring to the precise period during which a person is pregnant; and (iii) parentage time, referring to the point at which the law considers a person to become a parent. The Article appraises how each form of time is constructed and organized by the law—both formally (law in the books)[16] and practically (law in action). This inquiry illuminates how, at different family-building milestones, reproductive time among certain groups is constructed in such a way that it imposes a disproportionate and subordinating effect on them. This externally-imposed construction primarily affects: women who wish to preserve their fertility;[17] women who recognize their pregnancy at a later stage of gestation, who are statistically more likely to be women of color or from lower socio-economic backgrounds;[18] and same-sex couples who wish to become parents through Medically Assisted Reproduction (MAR).[19]

Next, the Article *problematizes* the disparate impacts of this construction of time in each setting, evaluating its harms in tangible terms but also in the more subtle discursive realm.[20] By appraising how these harms are fueled by outmoded norms and common misconceptions—rather than exclusively by objective, fixed, and inexorable factors—this analysis underscores the feasibility of, and need for, a legal construction of reproductive time that is fairer and more equitable.

Finally, speaking directly to this need, the Article calls for the law to be *reoriented* to enable these harmful effects to be mitigated. In each setting, it discusses the rationales underlying current restrictive practices and offers considerations to guide advocates as they work to challenge them, while also acknowledging the difficulties or trade-offs that may arise in certain contexts.[21] This Article does not intend to provide specific desirable solutions but to stimulate further advocacy and policy dialogue toward more equitable legal treatment of procreation and parentage.

Taken as a whole, this inquiry seeks to explicate how subordinated experiences of time—mostly rooted in patriarchal,[22] racist and class-based,[23] and heteronormative[24] structures—operate and interconnect across different stages of the family-building process. This inter-contextual analysis renders these inequalities easier to discern and less defensible. Equally, in terms of

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[16] The Article explores legislation, court decisions, policies of administrative agencies, and legal standards. While it primarily focuses on the United States, it draws on examples from other countries in the context of fertility preservation, given the lack of regulation in this area within the United States. *See infra* note 63.

[17] *See infra* Part II.A.

[18] *See infra* Part III.A.

[19] *See infra* Part IV.A.

[20] *See infra* Parts II.B, III.B, & IV.B.

[21] *See infra* Parts II.C, III.C, & IV.C.

[22] Such patriarchal experiences of time are reflected in the construction of fertility time. *See infra* notes 93–96, 114–37, and accompanying text.

[23] Such racial and socio-economic-status-based experiences of time are reflected in the construction of gestational time. *See infra* notes 155–62, 173, 184, and accompanying text.

[24] Such heteronormative experiences of time are reflected in the construction of parentage time. *See infra* notes 229–32, 240, and accompanying text.

policy and practice, this analysis could be instrumental in prompting advocates to be more acutely attuned to the ever-evolving challenges of the post-*Dobbs* era, particularly for certain subordinated groups. The implications of the *Dobbs* decision,[25] which overturned the constitutional right to abortion, are far-reaching, potentially affecting other reproductive issues including contraception, in-vitro fertilization (IVF), and parentage.[26] This requires us to be attentive to the ways in which forms of reproductive injustice are interconnected, if only conceptually.

This inquiry proceeds in five parts. Part I introduces the theoretical lens of time-as-social-construct that will accompany us throughout the Article. Part II focuses on the construction of fertility time by evaluating the law surrounding fertility cryopreservation. Part III focuses on the construction of gestational time by examining the regulation of abortion. Part IV focuses on parentage time by discussing the law as it relates to parentage recognition. The conclusion summarizes the main contributions made by the conceptual juxtaposition of these three forms of reproductive time analyzed here.

Although these three contexts—fertility preservation, abortion, and parentage—may appear disparate, each reveals how legal timing mechanisms privilege certain groups and values. Together, they illuminate how subordination operates through time. Scholars have long documented disparities based on gender, race, class, and sexuality in the realm of reproduction. This Article, however, reveals how the law's management of time in these processes is itself a source of subordination. By appraising and juxtaposing various temporal structures that underpin and connect these forms of inequality—sometimes in intersectional ways—it exposes the architecture of power that others have treated as mere background.

I. Time and Reproduction

The social theory literature that deals with the concept of time challenges our traditional understanding of it, encouraging us to cease viewing time as a mere *a priori* category or a natural (and thus taken-for-granted) aspect of our lives that simply operates in the background while social events unfold.[27] Instead, it considers time to be a product of human construction. Clearly, this politically charged construction of time is interwoven with the law, by virtue

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[25] *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

[26] *See generally* Maya Manian, *The Ripple Effects of* Dobbs *on Health Care Beyond Wanted Abortion*, 76 SMU L. Rev. 77 (2023) (discussing the effects of the Dobbs decision on forms of medical care other than abortion); Robin S. Maril, *Queer Rights After* Dobbs v. Jackson Women's Health Organization, 60 San Diego L. Rev. 45 (2023) (analyzing the potential implications of the Dobbs decision for queer rights).

[27] *See, e.g.*, Emile Durkheim, The Elementary Forms of Religious Life 11–12 (2001); Henry J. Rutz, *The Idea of a Politics of Time*, *in* The Politics of Time 1 (Henry J. Rutz ed., 1992); Elizabeth Grosz, The Nick of Time: Politics, Evolution, and the Untimely 4 (2004).

of being an institutionalized mechanism that constitutes human actions and relations.[28] Therefore, turning our critical lens toward time is essential if we are to expose and critique its political function.[29]

Indeed, in recent years, the political aspect of time has been increasingly applied by socio-legal scholars to achieve a better understanding of the questions surrounding inequality and subordination in various contexts (vis-à-vis gender,[30] race,[31] and disability,[32] among others). But the application of time-as-social-construct to the legal context of *reproduction*—that is, spanning crucial points along the continuum toward becoming (or not) a parent—has yet to be as thoroughly explored.[33] This lacuna could be attributed to the omnipresence of time in this area,[34] or the misconception of time as inherent to physical and genetic processes and, therefore, unremarkable.[35] But the essential dimension of time in this context should not lead us to overlook its normative impacts.

Recognizing this deficiency, this Part surveys the multi-disciplinary literature on time to extract insights into the three aforementioned aspects of time-as-social-construct: governing, naturalizing, and economic.[36] Understanding the interplay between these aspects—even when they do not always manifest together—is vital for grasping the broader implications of time. It is these

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[28] *See, e.g.*, Emily Grabham, Brewing Legal Times: Things, Form, and the Enactment of Law 15 (2018).

[29] For early influential accounts of this lens within the legal system, see, e.g., Carol J. Greenhouse, *Just in Time: Temporality and Cultural Legitimation of Law*, 98 Yale L.J. 1631 (1989) (analyzing the relationship between cultural conceptions of time and the organization and management of legal institutions); Rebecca R. French, *Time in the Law*, 72 U. Colo. L. Rev. 663 (2001) (discussing the applications of interdisciplinary approaches to time to legal conceptions of time).

[30] *See, e.g.*, Marco Wan, *Queer Temporalities and Transgender Rights: A Hong Kong Case Study*, 30 Soc. & Legal Stud. 563 (2021) (using transgender rights in Hong Kong as a case study to argue that legal judgments can entrench normative temporal structures and impose tropes onto the life scripts of trans subjects); Emily Grabham, *Governing Permanence: Trans Subjects, Time, and the Gender Recognition Act*, 19 Soc. & Legal Stud. 107, 118 (2010) (analyzing how the temporal mechanisms of the United Kingdom's Gender Recognition Act determine the possibilities, hopes, and future-scapes of trans people).

[31] *See, e.g.*, Yuvraj Joshi, *Racial Time*, 90 U. Chi. L. Rev. 1625 (2023) (cataloguing how American law is inscribed with dominant experiences and expectations of time, producing unrealistic timelines for racial remedies and "neutral" time standards that disproportionately burden subordinated groups); Lisa Washington, *Time & Punishment*, 134 Yale L.J. 536 (2024) (analyzing the role of temporal marginalization in the family regulation system).

[32] *See, e.g.*, Ellen Samuels, *Six Ways of Looking at Crip Time*, 37 Disability Stud. Q. 1, 1 (2017) (reflecting on how 'crip time' has operated in the author's life as both a form of liberation and a site of loss and alienation).

[33] *See supra* note 14.

[34] *See infra* notes 40–46 and accompanying text.

[35] *See infra* notes 50–51 and accompanying text.

[36] This three-part framework serves as an analytical tool rather than a rigid classification. The distinctions between governing, naturalizing, and economic aspects are not absolute; rather, they highlight distinct ways that time wields power. In practice, these aspects often overlap, and examining their intersections is just as crucial as recognizing their differences, because it illuminates the fuller complexity of how time shapes family-building inequality.

insights into how time governs, hides, and distributes power that inform the framework of reproductive time developed in this Article.

A. The Governing Aspect

Drawing on the perspective that time is socially constructed, scholars have examined the implications of temporal patterns such as schedules, calendars, time zones, ages, and other normative codes.[37] They have discussed how these structured patterns not only make our daily routines more manageable but are also significant sources of authority—specifically, modes of governmentality[38]—exerting control over actions, behaviors, and values, often through discipline and regulatory practices.[39]

Indeed, as articulated by the philosopher Michel Foucault more than four decades ago, reproduction is but one human domain where time functions as a means of governmentality.[40] Human reproductive processes are marked by different expressions of time, including expected intervals between menstrual cycles;[41] the typical timeline from conception to birth;[42] fetal developmental milestones during pregnancy;[43] the anticipated duration of labor;[44] the interval

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[37] For early influential accounts of this inquiry, see, e.g., Edward Palmer Thompson, *Time, Work-discipline, and Industrial Capitalism*, 38 Past & Present 56 (1967) (investigating how the shift in 'time-sense' during the fourteenth to seventeenth centuries affected labor discipline and workers' personal understanding of time); Durkheim, *supra* note 27, at 12 (discussing the naturalization of time); Barbara Adam, Time 143–48 (2004) (describing the function of time as a social control).

[38] Michel Foucault, *Governmentality*, *in* The Foucault Effect: Studies in Governmentality 102–03 (Graham Burchell, Colin Gordon & Peter Miller eds., 1991).

[39] *Id.*; *see also* Carol Greenhouse, A Moment's Notice: Time Politics Across Culture 1 (1995) (arguing that time does not merely act as a means for creating uniformity; it also significantly constitutes an influential means to establish the conditions and limits of agency). This understanding has been echoed by the growing scholarship on time and law as well. *See, e.g.*, Renisa Mawani, *Law as Temporality: Colonial Politics and Indian Settlers*, 4 U.C. Irvine L. Rev. 65, 71 (2014) ("Law draws its meanings and gains its authorizing force through specifications and limits on time . . . and through the temporalities it inhabits and brings into being."); Michael Birnhack, *The Temporal Dimension of Surveillance*, Surveillance & Soc. 393, 395 (2023) (analyzing how the social construction of time functions as a mechanism of control, where "[p]olicymakers and surveilling agents construct and manipulate time to vindicate their activities").

[40] Michel Foucault, Discipline and Punish: The Birth of the Prison 152 (1977) ("Time penetrates the body and with it all the meticulous controls of power.").

[41] *See, e.g.*, Inniss, *supra* note 14, at 147 (cataloging the time-keeping function of menstruation).

[42] *See, e.g.*, Soo Downe et al., *Counting Time in Pregnancy and Labour*, *in* Childbirth, Midwifery and Concepts of Time 61, 63–66 (Christine McCourt ed., 2010) (describing methods of tracking pregnancy stages and their effects on perceptions of time and the actual birth).

[43] *See, e.g.*, Christine McCourt & Fiona Dykes, *From Tradition to Modernity: Time and Childbirth in Historical Perspective*, *in* Childbirth, Midwifery and Concepts of Time 17, 25–33 (Christine McCourt ed., 2010) (tracking the evolution of childbirth processes).

[44] *See, e.g.*, Wendy Simonds, *Watching the Clock: Keeping Time during Pregnancy, Birth, and Postpartum Experiences*, 55 Soc. Sci. & Med. 559, 561–62 (2002) (discussing obstetric, midwife, and self-help discourses on the time-markers of pregnancy).

between births;[45] and the duration of breastfeeding.[46] The multidisciplinary literature on time and reproduction shows how expressions of time are used to govern—organize, standardize, discipline, and self-police—various dimensions of reproduction.[47]

This Article incorporates this understanding into legal scholarship. It analyzes how the regulation of reproductive time not only governs this human process but also naturalizes and reinforces certain subordinated disparities within it. Responding to medical sociologist Professor Rene Almeling's call to view reproduction as a process rather than a series of events,[48] it examines the nexus between time and subordination as connecting different phases of the family-building timeline: fertility, pregnancy, and childbirth. Such an inter-contextual approach helps us uncover and question the naturalizing aspect of time, which becomes prominent in reproductive contexts.

B. The Naturalizing Aspect

Unlike other governing mechanisms, time's role is often implicit due to its abstract and neutral appearance.[49] Professor Elizabeth Freeman underscores this observation by stating that time, "far from being a set of empty containers—minutes, hours, days, weeks, months, years, decades, periods—into which our experience gets poured," actively functions as "a tool for the *naturalization* of power relations."[50] In her seminal book, *Time Binds: Queer Temporalities, Queer Histories*, Freeman introduces the idea of

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[45] Bledsoe, *supra* note 1, at 43.

[46] *See, e.g.*, Fiona Dykes, *'Feeding All the Time': Women's Temporal Dilemmas around Breastfeeding in Hospital*, *in* Childbirth, Midwifery and Concepts of Time 204 (Christine McCourt ed., 2010) (discussing women's temporal experiences of breastfeeding while in hospital).

[47] *See, e.g.*, Joanna White, *'But Isn't It the Baby that Decides When It Will Be Born?': Temporality and Women's Embodied Experiences of Giving Birth*, 34 Cambridge J. Anthropology 72, 81–82 (2016) (showing how, "despite labour remaining a time-segmented process moving towards progress in both popular perception and . . . medical representation, the reality can be distinctly different"); Sian M. Beynon-Jones, *Gestating Times: Women's Accounts of the Temporalities of Pregnancies that End in Abortion in England*, 39 Socio. Health & Illness 832, 843 (2017) (demonstrating that pregnant women feel the gestational threshold shapes their perception as a temporally-constrained subject, threatening their bodily autonomy); Dykes, *supra* note 46, at 203 (discussing "the clash of time frames for women between the irregularity and uncertainty of 'demand feeding' and the overarching cultural imperative to connect with clocks and linear time").

[48] Almeling, *supra* note 2, at 430.

[49] *See, e.g.*, Elizabeth F. Cohen, The Political Value of Time: Citizenship, Duration, and Democratic Justice 4 (2018) (asserting that "time can easily appear almost natural when compared to the normativity of something like rules about who is eligible to vote or to receive formal representation"); *id.* at 10–11, 153–55; Washington, *supra* note 31, at 563 (discussing how "the law with its retrospective focus, seeks to fix subjects in time" thereby binding individuals in ways that are politically charged but not immediately visible) (citation omitted).

[50] Elizabeth Freeman, *The Queer Temporalities of "Queer Temporalities"*, 25 GLQ: J. Lesbian & Gay Stud. 91, 93 (2019).

'chrononormativity' to describe how temporal logics, such as working hours and life stages, bind individuals to social norms, rendering time the perfect agent for perpetuating hierarchies while making them appear inevitable.[51]

Critical appreciation of how subordination is operationalized through ostensibly 'natural' or neutral forces is especially fruitful in the context of reproduction. Here, the political dimension of temporal logics is particularly inconspicuous due to time's undeniable link to biological processes, with the result that subordination is easy to mask with scientific justifications. Neglecting the temporal elements of this domain thus enables implicit forms of subordination to persist.

Indeed, theories have long emphasized that political factors shape our understanding of biological concepts, challenging the notion that they are purely objective.[52] Building on this view, legal scholars have highlighted how legal justifications for inequality, while rooted in biological differences, are mistakenly and selectively justified under the guise of objective neutrality.[53] This Article furthers this conversation by adopting the lens of time-as-social-construct to elucidate overlooked assumptions about human reproduction processes that are often accepted as givens.

C. The Economic Aspect

A further important insight is that time is not only a process but also a resource,[54] allocated by the State, through institutional policies and

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[51] Elizabeth Freeman, Time Binds: Queer Temporalities, Queer Histories 3 (2010).

[52] *See, e.g.*, Judith Butler, Gender Trouble: Feminism and the Subversion of Identity 9 (1990) (challenging the view that biological sex distinctions are more genuine than gender norms created by society); Sally Haslanger, *Gender and Race: (What) Are They? (What) Do We Want Them To Be?,* 34 NOÛS 31, 49 (2000) ("Any distinctions between kinds of sexual and reproductive bodies are importantly political and open to contest."); *see generally,* Paisley Currah, Sex Is as Sex Does: Governing Transgender Identity (2022) (providing an in-depth exploration of sex as a concept shaped by political and legal forces).

[53] *See, e.g.*, Katherine Franke, *The Central Mistake of Sex Discrimination Law: The Disaggregation of Sex and Gender*, 144 U. Pa. L. Rev. 1, 2 (1995) (critiquing the ways in which "sexual equality jurisprudence has uncritically accepted the validity of biological sexual differences"); Cary Franklin, *Biological Warfare: Constitutional Conflict Over "Inherent Differences" Between the Sexes*, 2017 Sup. Ct. Rev. 169, 169–70 (discussing how the U.S. Supreme Court has rejected race-based distinctions as pseudo-scientific, yet it continues to uphold sex-based distinctions by viewing biological differences between men and women as "enduring" and therefore more scientifically grounded); Douglas NeJaime, *Bigotry In Time: Race, Sexual Orientation, And Gender*, 99 B.U. L. Rev. 2651, 2669 (2021) (contending that beliefs about biological sex differences shield gender hierarchies and stereotypes from accusations of bigotry, while shaping views on marriage, reproduction, and parenthood); *see generally* Courtney Megan Cahill, *Sex Equality's Irreconcilable Differences*, 132 Yale L.J. 1065 (2023) (illustrating this view through the developments in LGBT law).

[54] *See e.g.*, Barbara Adam, *Feminist Social Theory Needs Time: Reflections on the Relation Between Feminist Thought, Social Theory, and Time as an Important Parameter in*

regulations, to govern its citizens. Unlike many other natural commodities, time is perceived as limited, which has drawn scholarly attention to its distribution—through institutional practices or policies—and the question of how it perpetuates social structures and roles. One notable example is the interest in how women experience 'time poverty,' which limits their opportunities for political participation and career advancement.[55] Another example is how inequality often reveals itself in postponed or delayed access to goods, services, or resources,[56] particularly vis-à-vis healthcare systems, where marginalized groups are made to wait while services are prioritized for members of the dominant group.[57]

Each form of reproductive time analyzed in this Article illustrates how the scarcity and allocation of time impact our ability to navigate key life decisions. Fertility time greatly affects the capacity of individuals to plan, prioritize, and make crucial life decisions impacting both personal and professional spheres. Gestational time (and, particularly, its measurement) has significant implications for access to abortion, reflecting its complex role in shaping personal choices and legal rights. Parentage time is a crucial factor in family-building processes: it sets the very foundation on which family structures are established, nurtured, and sustained. Considering the economic dimension of time deepens the normative discussion of how *reproductive* time is constructed. It renders its material and discursive impacts more explicit and urges us to examine the rationale for this construction.

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These insights into the three crucial aspects of time-as-social-construct have the potential to enhance emerging assertions about power dynamics as they operate in the legal system. Within the scope of this Article, these insights help unsettle presumptions about the neutrality and inevitability of disparities in the family-building process: between men and women,[58] between white women and women of color,[59] and between different-sex and same-sex couples.[60]

However, if we are to achieve more than a simple awareness of this unequal construction of time, we not only need to identify its mechanisms but also to evaluate the rationales behind it, including the less obvious ones. The time-as-social-construct lens should be accompanied by other appropriate methodologies. Hence, this Article employs a combined approach: synthesizing

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Social Analysis, 37 Socio. Rev. 453, 468–69 (1989); Valerie Bryson, Gender and the Politics of Time: Feminist Theory and Contemporary Debates 4 (2007).

[55] *See, e.g.*, Valerie Bryson, *Time-Use Studies*, 10 Int'l Feminist J. Pol. 135, 135–36 (2008); Nancy Fraser, *After the Family Wage: A Postindustrial Thought Experiment*, *in* Gender and Citizenship in Transition 9 (Barbara Hobson ed., 2002).

[56] Joshi, *Racial Time, supra* note 31, at 1635.

[57] *See, e.g.,* Margaret Waltz, *Waiting on Others: Gender in the Medical Waiting Room*, 32 Socio. Forum 816, 818 (2017).

[58] *See infra* Part II.A.

[59] *See infra* Part III.A.

[60] *See infra* Part IV.A.

empirical data on these reproduction-related processes, especially amid growing scientific innovations relevant to becoming a parent; conducting doctrinal analysis of family-building regulations, considering recent social developments around the legal institution of parenthood, among others; and integrating insights from humanities theories to consider how policymakers could bridge the gap between law and science on these fundamental human matters. Part II now builds on these insights to analyze the initial milestone of the family-building process: fertilization.

II. Fertility Time

In an era in which more reproductive technologies than ever before are available to assist people in becoming parents, 'fertility time'—the term I use to refer to the period during which a person is biologically able to become a genetic parent—is not solely intrinsic to the body but is also constructed through the regulation of these technologies. This Part focuses on this particular construction of reproductive time by appraising the regulation of cryopreservation (sperm or egg freezing).[61] It hypothesizes that this construction, while shrouded in ostensibly neutral or scientific language, may actually be rooted in conventional sex-related norms allied to age-defined reproduction and presuppositions about women's capability to make choices regarding their own bodies.

The argument is developed in three sections. *Section A* examines the medical–legal construction of fertility time by surveying the regulatory barriers imposed on fertility preservation in its various stages, both directly or indirectly, by the State.[62] (Given the lack of regulation of egg freezing in the United States,[63] this section refers also to countries with legal traditions similar to those of the United States or liberal nations with shared societal values.)[64] This survey demonstrates how age-related and other barriers—not

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[61] Gamete cryopreservation refers to the process of freezing and storing gametes (sperm, eggs, or embryo) to preserve their viability for future use.

[62] In this Article, I use 'State' to refer to government policies in a generic sense, while 'state' specifically denotes individual U.S. states.

[63] The United States is exceptional in this regard, with few direct restrictions, as the decision is largely left to the discretion of private-clinic medical personnel. Social egg freezing became accessible after the American Society for Reproductive Medicine (ASRM) lifted the 'experimental' label from it in 2012, thereby acknowledging its safety and efficacy. The Practice Committee of ASRM has issued guidelines, yet the implementation of these guidelines—like in the case of many other MAR—is subject to the clinics' discretion. *See generally Evidence-Based Outcomes After Oocyte Cryopreservation for Donor Oocyte in Vitro Fertilization and Planned Oocyte Cryopreservation: A Guideline*, 116 Fertility & Sterility 36 (2021).

[64] When engaging in comparative law analysis, American courts place significant emphasis on the legal frameworks of liberal, democratic nations. *See* Sarah H. Cleveland, *Our International Constitution*, 31 Yale J. Int'l L. 1, 80, 114 (2006). This analysis could be beneficial for the United States, as some clinics impose similar barriers—such as age-related ones—mirroring those stipulated by the regulatory frameworks of other countries.

least, financial—disproportionately impact women.[65] *Section B* appraises the harms of this sex-based disparity, considering both their explicit, tangible impacts and the more implicit, discursive ramifications. *Section C* expands on this understanding of time and sex-based subordination to discuss the justifications put forward to rationalize these regulatory barriers—and how advocates might challenge them.

A. The Medical-Legal Construction

Until what age can a person become a genetic parent?

Fertility time is relatively short for women, compared to men. While both men and women experience fertility declines over time, women's fertility tends to drop more sharply, particularly after the mid-30s. Men may remain capable of fathering children into older age, though they too face notable reductions in fertility as they grow older.[66]

For women, this non-negotiable biological roadblock creates disproportionate burdens on them, meaning that they have a more limited timeframe within which they might meet a suitable partner with whom to have children. Equally, due to the pressure exerted by time, women typically have less freedom than men to postpone their parenthood until they reach a point where they feel emotionally ready or attain financial independence.[67] They may also feel greater pressure than men to consider single parenthood (which can be especially challenging for women of a lower economic status),[68] and it may be more complex for them to reconcile the timing of trying for a baby with their career trajectory or other life objectives.[69]

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[65] While fertility cryopreservation has received much scholarly attention in recent decades, inequality in this context has been less closely scrutinized, barring a few notable exceptions in other fields. *See, e.g.*, Viki Moller Lyngby Pedersen, *Freeze the Biological Clock: Discrimination, Disrespect, and Fertility Preservation via Social Freezing*, 39 J. Applied Phil. 456 (2022). For notable legal works that discuss this technology from perspectives other than those offered here, see, e.g., June Carbone & Naomi Cahn, *The Gender/Class Divide: Reproduction, Privilege, and the Workplace*, 8 FIU L. Rev. 287 (2013); Seema Mohapatra, *Using Egg Freezing to Extend the Biological Clock: Fertility Insurance or False Hope?*, 8 Harv. L. & Pol'y Rev. 382 (2014).

[66] *See, e.g.*, Guido Pennings et al., *Social Sperm Freezing*, 36 Hum. Reprod. 833, 834 (2021) (explaining that "an important difference between men and women regarding fertility decline is that for women the decline reaches the bottom by age 50 while the decline for men only goes down to zero in their 7th or 8th decade of life" (citation omitted)). In addition to reduced fertility, studies have demonstrated a correlation between paternal age and increased risks of disorders in offspring, *see infra* note 96, as well as potential risks to the birth mother, *see infra* note 108.

[67] *See* Merav Amir, *Bio-Temporality and Social Regulation: The Emergence of the Biological Clock*, 18 Polygraph 47, 59–60 (2006).

[68] Angel Petropanagos, *Reproductive 'Choice' and Egg Freezing*, *in* Cancer Treatment and Rsch.: Oncofertility 231 (Teresa K. Woodruff et al. eds., 2010).

[69] *See generally*, Ralph L. Keeney & Dinah A. Vernik, *Analysis of the Biological Clock Decision*, 4 Decision Analysis 114 (presenting a general model of the biological clock decision).

The advent of oocyte cryopreservation technology, also known as egg freezing, goes some way toward challenging this disparity by alleviating some of the pressures associated with the biological clock and the burdens these impose on women.[70] This technology involves the woman having her ova harvested, which are then stored in a laboratory setting for possible future use. Eggs can be frozen either after fertilization (as inseminated oocytes) or before (as mature oocytes). Frozen eggs, once thawed ("vitrified oocytes"), present good survival and success rates.[71] In that sense, this procedure extends the reproductive cycle and prolongs the duration of fertility, slowing down cellular time to cryopreserved stasis.

Originating in the late 1980s, this method was designed to enable women to safeguard their viable, unfertilized eggs, especially when facing threats to their ovarian reserves due to health issues or aggressive treatments such as gonadotoxic chemotherapy.[72] The method has also found applications in MAR, including in IVF donor cycles.[73] As time has passed, a growing number of women are opting for egg freezing for non-medical purposes,[74] a modality known as social or elective egg freezing.

Yet, the possibility of opting for social egg freezing remains legally limited in a number of countries. European countries such as Austria, Hungary, Malta, Serbia, and Slovenia restrict the use of this technology to medical grounds, defined as precautionary actions against treatments or conditions that could impair fertility, such as cancer treatments or ovarian

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[70] *See, e.g.*, Julian Savulescu & Imogen Goold, *In Favour of Freezing Eggs for Non-Medical Reasons*, 23 Bioethics 47, 50–56 (2009) (dubbing the request for access to this procedure as "reproductive affirmative action"). Indeed, this perspective raises valid concerns about the impact of this technology more broadly, as I discuss in Part II.C. *See, e.g.*, Karey Harwood, *Egg Freezing: A Breakthrough for Reproductive Autonomy?*, 23 Bioethics 41, 46 (2009) (arguing that social egg freezing acts as a band-aid solution, worsening problems by ignoring the societal structures that render it difficult for women to balance family and career).

[71] For the influential studies, see Paul Katayama et al., *High Survival Rate of Vitrified Human Oocytes Results in Clinical Pregnancy*, 80 Fertility & Sterility 223 (2003); Masashige Kuwayama et al., *Highly Efficient Vitrification Method for Cryopreservation of Human Oocytes*, 11 Reprod. BioMed. Online 300 (2005). For more recent studies, see, e.g., Nao Suzuki et al., *Successful Fertility Preservation Following Ovarian Tissue Vitrification in Patients with Primary Ovarian Insufficiency*, 30 Hum. Reprod. 608, 612 (2015); Prac. Comms. of the Am. Soc'y for Reprod. Med. and Soc'y of Reprod. Biologists and Technologists, *A Review of Best Practices of Rapid-Cooling Vitrification for Oocytes and Embryos: A Committee Opinion*, 115 Fertility & Sterility 305 (2021).

[72] Rebecca Barnett et al., *Endometriosis and Fertility Preservation*, 60 Clinical Obstetrics & Gynecology 517, 517 (2017).

[73] Ana Cobo et al., *Oocyte Vitrification for Fertility Preservation for Both Medical and Nonmedical Reasons*, 115 Fertility & Sterility 1091, 1091 (2021).

[74] *See, e.g.*, Prac. Comm. of the Am. Soc'y for Reprod. Med., Evidence-Based Outcomes After Oocyte Cryopreservation for Donor Oocyte In Vitro Fertilization and Planned Oocyte Cryopreservation: A Guideline (2021), https://www.asrm.org/practice-guidance/practice-committee-documents/evidence-based-outcomes-after-oocyte-cryopreservation-for-donor-oocyte-in-vitro-fertilization-and-planned-oocyte-cryopreservation-a-guideline-2021/[https://perma.cc/Z6ZY-FHYZ].

disorders.[75] Other countries, including Denmark,[76] the United Kingdom,[77] and Belgium,[78] impose specific constraints exclusively on social egg freezing. These restrictions pertain to various stages of the fertility-preservation process from retrieval and storage to the fertilization of the stored egg and its implantation into the human body (IVF process). Some restrictions, for example, might establish an age ceiling for oocyte retrieval, usually set between thirty-five and forty years,[79] or stipulate the maximum number of years a woman can store her eggs (typically between five and ten years).[80] Other restrictions might impose an age ceiling for legally undergoing the IVF treatment, or condition this treatment on proof of previous attempts to conceive through unprotected sex for a certain period of time (typically between one and two years), even when the patient is a single woman or a woman in a same-sex relationship.[81]

Such regulatory barriers variably accentuate the disparity between the sexes, which explicitly arises when the State imposes limitations exclusively on women, while no such restrictions apply to men.[82] The degree of inequality

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[75] Carlos Calhaz-Jorge et al., *Survey on ART and IUI: Legislation, Regulation, Funding and Registries in European Countries*, 9 Hum. Reprod. Open 1, 9 (2020).

[76] *See* Amit Kaplan et al., *'My Choice, My Responsibility': Views of Danish and Israeli Female Students on Financing Egg-Freezing*, 24 Culture Health & Sexuality 1575, 1579 (2022) (surveying the five-year storage limit that applies only to social egg freezing).

[77] Emily Jackson, *'Social' Egg Freezing and the UK's Statutory Storage Time Limits*, J. Med. Ethics 738, 739 (2016) (surveying the storage limit, which was more restrictive with regard to social egg freezing until recently).

[78] Julie Nekkebroeck, *Ten Years of Egg Freezing – Is It Time for Re-evaluation*?, BioNews (Sep. 4, 2023), https://www.progress.org.uk/ten-years-of-egg-freezing-is-it-time-for-re-evaluation/ [https://perma.cc/2VYL-XZCR] (discussing the 10-year storage limit that applies only to social egg freezing).

[79] In some countries, like Norway, the age limit for using the retrieved eggs stored by egg freezing procedures is set at forty-six. Amendments to the Norwegian Biotechnology Act and Related Guidelines, DLA Piper (May 28, 2020), https://norway.dlapiper.com/en/news/amendments-norwegian-biotechnology-act-and-related-guidelines [https://perma.cc/A8MK-RTSM].

[80] In Denmark, Norway, and Romania, for example, there is a storage time-limit of five years. *See Pedersen, supra* note 65, at 457. In Belgium, Switzerland, and the United Kingdom, the limit is ten years, but recently, this limitation was lifted in the United Kingdom, allowing for the extension of this period. Nekkebroeck, *supra* note 78. It is worth noting that in Denmark, this limitation applies only to women; men can have their sperm frozen for an indefinite period. *See Pedersen, supra* note 65, at 457. As for Switzerland, see Federal Office of Public Health, National Advisory Commission on Biomedical Ethics NCE, Opinion No. 28: Social Freezing—Ethical Considerations 8 (2017), https://www.bag.admin.ch/dam/bag/en/dokumente/biomed/fortpflanzungsmedizin/nek-2017-social-egg-freezing.pdf.download.pdf/nek-2017-social-egg-freezing-en.pdf [https://perma.cc/J4V6-V72E].

[81] The guidelines published by the United Kingdom's National Institute of Health and Care Excellence (NICE), for example, recommend IVF treatment for "women aged under 40 years who have not conceived after 2 years of regular unprotected intercourse or 12 cycles of artificial insemination." National Institute for Health and Care Excellence, Fertility Problems: Assessment and Treatment (Sep. 6, 2017), https://www.nice.org.uk/guidance/cg156 [https://perma.cc/H6G4-ABQV] [hereinafter: NICE Guidelines].

[82] In Denmark, for example, the regulations pertaining to egg freezing are more restrictive compared to sperm freezing. Women can only freeze their eggs for a maximum of five years, unless they are freezing them for medical reasons. In contrast, men can even opt

differs from country to country. However, even in countries where these restrictions apply to both sexes, countries often impose regulatory barriers that place a heavier burden on women, adding to the biological disparity caused by the fact that they have fewer fertile years than men.[83] True, many women may remain unaffected by these restrictions. Some may choose not to utilize their preserved eggs, while others may opt to use them within the allotted time frame. Yet, the very existence of these regulatory barriers can be viewed as a sex-based disparity in the distribution of fertility time, placing women at a significant disadvantage compared to men.[84]

Another aspect of the sex-based disparity pertains to access to the egg freezing procedure. Even where social egg freezing is legally permitted, as the costs of this procedure remain relatively high, it is likely beyond the reach of many women who lack substantial financial resources, particularly in the absence of state subsidy for this treatment.[85] This is especially palpable in the United States, where egg freezing on non-medical grounds is legal, yet the costs of this procedure are not covered by most health insurance plans. Specifically, to date, twenty-one states plus the District of Columbia require insurers in their respective states to either offer or cover fertility treatments.[86] The type of coverage varies widely, from low-cost, low-yield treatments such as medical advice and medications, to high-cost, higher-yield treatments like IVF.[87] When insurance coverage is available for fertility services, certain procedures, such as diagnostic testing, are more frequently covered compared to

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to have their sperm frozen posthumously. *See Pedersen, supra* note 65, at 457. The same gender disparity exists with regard to the age limit for receiving MAR, where there is an upper limit of forty-five years that applies only to women. *See* Janne Rothmar Herrmann & Charlotte Kroløkke, *Eggs on Ice: Imaginaries of Eggs and Cryopreservation in Denmark*, 26 NORA – Nordic J. Feminist & Gender Rsch. 19, 24 (2018).

[83] In the United Kingdom, for example, the storage time-limit is uniformly applied to both egg and sperm freezing for social reasons, promoting a more equal approach to fertility preservation. *See Pedersen, supra* note 65, at 458. Despite these provisions in the United Kingdom, sex-based inequality persists throughout the NICE Guidelines on IVF-funded treatments. These recommend that the National Health Service not offer IVF treatments to women over forty-two, yet there is no mention of paternal age limits. *See* NICE Guidelines, *supra* note 81.

[84] Part II.C discusses the justification for these barriers.

[85] As of December 2023, a single egg freezing cycle typically costs approximately $16,000. This includes hormone stimulation, egg retrieval, lab processing, and storage costs. However, it does not cover additional expenses for thawing and fertilization, which can add several thousand dollars, or for embryo transfer, which may involve comparable costs. *See The Costs of Egg Freezing*, FertilityIQ, https://www.fertilityiq.com/fertilityiq/articles/the-costs-of-egg-freezing [https://perma.cc/87PD-KWAA]. Further, studies show that, on average, women typically undergo approximately 2.1 cycles of egg freezing. This suggests that the total cost of arriving at childbirth using this method could be at least $40,000. *See* Jess Faraday, *The Guide to Egg Freezing Costs in the US*, Family education (Aug. 10, 2023), https://www.familyeducation.com/pregnancy/trying-to-conceive/the-guide-to-egg-freezing-costs-in-the-us [https://perma.cc/URT5-8MYL].

[86] *Infertility Coverage by State*, RESOLVE.org, https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/ [https://perma.cc/R68R-FHX8].

[87] *Id*.

others like IVF.[88] And, even in those few states where insurance companies do cover the costs of IVF, coverage anticipates "medical" infertility, not "infertility due to age."[89] Therefore, in practice, social egg freezing often remains a costly option.

B. Sex-based Harms

Fertility time is an unevenly distributed resource. It disproportionately impacts how women plan, prioritize, and make life decisions, affecting both personal and professional realms. While men also face growing challenges in balancing work and family, the decline in fertility—in terms of decreased chances of conception—with age is not as significant for men.[90] And, while technological advances have enabled sperm freezing, men typically resort to this option due to specific health-related concerns, such as cancer-related infertility, or for posthumous reproduction purposes.[91] Hence, the regulatory barriers imposed on fertility preservation have a disparate impact on women. This particularly holds true for countries that prohibit social egg freezing outright but it is also applicable to countries that permit access to this technology but only within stringent time limits.

Consider, for example, the restriction imposed on the duration of oocyte storage. Women wishing to freeze their eggs beyond the predetermined time limit must repeatedly undergo the arduous process of egg retrieval. This imposes a heightened financial, psychological, and physical strain on women compared to men—even if these regulations are applicable for freezing sperm—but also potentially coincides with a decline in their fertility potential. Women who opt to freeze their eggs in their late thirties may find that a cryopreservation period of five or ten years suffices. But, for those women who choose to freeze their eggs before reaching 35, the storage period for their eggs could expire when they are still in their early forties. This may prompt some of them to feel the need to delay freezing their eggs until they are older, which reduces their chances of conceiving due to the declining quality of the eggs.[92]

Discursive implications should be on our radar as well. When the ability of women to defer childbearing is significantly hindered by these regulations, it risks subtly yet powerfully shaping the societal narratives surrounding the "ideal" trajectory of a woman's life. These deeply ingrained narratives

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[88] *Id*.

[89] *See supra* note 86.

[90] *See supra* note 66.

[91] *See, e.g.*, Limor Dina Gonen, *And When I Die: Theory of Planned Behavior as Applied to Sperm Cryopreservation*, 9 Healthcare 554, 555 (2021).

[92] *See, e.g.*, Lois Zoppi, *Fertility Charity Campaigns for 10-year Storage Limit on Frozen Eggs to be Extended*, News Med. Life Sci. (Oct. 30, 2019), https://www.news-medical.net/news/20191030/Fertility-Charity-Campaigns-for-10-Year-Storage-Limit-on-Frozen-Eggs-to-be-Extended.aspx [https://perma.cc/3HDH-G7WH].

perpetuate antiquated notions of motherhood and "youth," leading to greater criticism being aimed at some women for straying from the traditional pathway set out for them and pursuing later-life parenthood.[93] While there may be fair questions raised regarding social policies that incentivize having children within certain age ranges, it is important to be aware of how these policies impact societal perceptions and their ripple effects on women. Such narratives can unintentionally punish women who depart from traditional timelines, leading to stigmatization and influencing their reproductive choices to align with societal expectations rather than personal convictions.[94] Men, in contrast, are often able to delay having children until later in life with less, if any, criticism,[95] despite studies indicating risks associated with later-life fatherhood, both for the birth mother and their offspring.[96]

This is not to say that there are no plausible rationales whatsoever for limiting the emerging technology of cryopreservation. Yet, I contend that the discrepancy between men and women due to implications of the biological clock should encourage us to approach such rationales with more circumspection.

My plea in this regard is not a novel one. The nexus between time and sex-based subordination is well-acknowledged within gender studies. Scholars have been exhorting us for some time to scrutinize the disparities in time allocation between the sexes and the inequalities that arise from this distribution. Professor Christina Hughes, for example, discusses how the traditional linear career model, while built around the assumption of full-time,

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[93] It is worth underscoring that these narratives are embedded in social structures that effectively shorten women's reproductive lives compared to men's. In the United States, the trend of serial marriage is evident, characterized by high divorce and remarriage rates. Very often, in their second or third marriages, men marry younger women. Women's market value tends to decrease with age, while men's often increases in line with their accumulating resources. Consequently, men have lifelong access to biological reproduction through re-partnering, whereas women have less opportunity. For notable studies discussing this sex-based gap, see, e.g., Paula England & Elizabeth Aura McClintock, *The Gendered Double Standard of Aging in US Marriage Markets*, 35 Population & Dev. Rev. 797, 797 (2009); Kevin Shafer & Spencer L. James, *Gender and Socioeconomic Status Differences in First and Second Marriage Formation*, 75 J. Marriage & Fam. 544, 566 (2013). For similar trends outside the United States, see, e.g., Douglas T. Kenrick et al., *Age Preferences in Mates Reflect Sex Differences in Human Reproductive Strategies*, 15 Behav. & Brain Sci. 75 (2011); Bojan Todosijević & Suzana Ignjatović, *Gender Differences in Perception of the Appropriate Maturity Age for Men and Women: Age Norms of Reproduction-Related Life Events Between the Social Context and Evolutionary Foundations*, 63 Sociologija 289 (2021).

[94] *See* Nichole Wyndham et al., *A Persistent Misperception: Assisted Reproductive Technology Can Reverse the "Aged Biological Clock"*, 97 Fertility & Sterility 1044, 1046 (2012) (discussing how these narratives portray women who choose to delay motherhood as "selfish" and "unconcerned about starting a family").

[95] *See, e.g.*, Savulescu & Goold, *supra* note 70, at 52; Rene Almeling, *Social Inequalities, Reproductive Bodies, and Technological Interventions*, 38 J. Mktg. Mgmt. 473, 475 (2022).

[96] *See, e.g.*, Peter T.K. Chan & Bernard Robaire, *Advanced Paternal Age and Future Generations*, 13 Frontiers Endocrinology 1, 3–4 (2022) (surveying a number of studies that associate late fatherhood with health issues in offspring, such as birth defects including cleft lip or diaphragmatic hernia, disorders such as autism and schizophrenia, and genetic conditions).

uninterrupted paid work, does not align with the realities of women's lives, as they often find themselves taking breaks devoted to childcare and elder care.[97] Likewise, Professor Nancy Fraser highlights that the gendered division of labor contributes to women having notably less free time than men. This disparity is not only a matter of personal inconvenience but also fosters women's economic dependence and diminishes their political engagement.[98]

Here, though, I argue that we should extend this valuable sensibility to the jurisprudence surrounding fertility preservation. As the following section demonstrates, it is only by examining these regulatory constraints more closely—alongside other similar regulatory constraints that echo a similar rhetoric in other contexts—that we can spotlight the flawed reasoning underpinning them. This recognition could be pivotal in initiating a much-needed change in the policies in this area.

C. Reorienting the Legalities of Egg Freezing?

I begin this section by challenging the primary justification, in its various forms, for restricting social egg freezing: the protection of women's health.[99] I then draw parallels with similar reasoning in the abortion context. This two-stage analysis advances my hypothesis in this Part—namely, that the legal construction of fertility time not only upholds patriarchal norms but may, itself, be *driven* by them, too. By weaving between fertility and pregnancy contexts, this analysis renders this political construction more salient and less defensible.

Several core rationales underlie the legal approach that limits social egg freezing, each of which are reflected in legislative and academic debates surrounding these restrictions. These include, first, concerns around the physical risks associated with the hormonal stimulation phase that precedes egg retrieval[100] and the potential complications associated with pursuing pregnancy at an advanced age, such as hypertension, preeclampsia, gestational diabetes, placental insufficiency, and an increased likelihood of cesarean delivery.[101]

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[97] Christina Hughes, *Time*, *in* Key Concepts in Feminist Theory and Research 132 (2002).

[98] Fraser, *supra* note 55, at 9.

[99] Although the central justification for restricting social egg freezing remains women's health, some also invoke child-welfare concerns, noting higher risk of congenital abnormalities, low birth weight, or other complications among children born through ART. Yet these risks likewise apply to established practices such as IVF, which is broadly accepted, making it difficult to single out egg freezing as uniquely problematic for child welfare.

[100] This can potentially cause mild to moderate symptoms such as fatigue, nausea, headaches, or abdominal pain, along with breast tenderness and irritability. However, these adverse effects are generally manageable. *See* Dharani Suthersan et al., *Physical Symptoms Throughout IVF Cycles*, 14 Hum. Fertility 122, 124 (2011).

[101] While these risks exist for young women, they are generally heightened for older women. *See* Reeta Lampinen et al., *A Review of Pregnancy in Women over 35 Years of Age*, 3 Open Nursing J. 33, 33–36 (2009); M. Camille Hoffman et al., *Pregnancy at or Beyond Age 40 Years Is Associated with an Increased Risk of Fetal Death and Other Adverse*

Second, there is the concern that becoming a mother at an advanced age may be too heavy a psychological and physical burden to bear.[102] Third, there is the question of whether the widespread use of this technology could inadvertently encourage women to delay motherhood, potentially diminishing the likelihood of parenthood altogether.[103] And fourth, the risk that egg-freezing technology may foster false hope is also a concern, as its availability may give the impression that it is possible to insure against age-related infertility. The effectiveness of this technology is still questionable; the current data on pregnancy resulting from egg freezing are relatively limited and cover only a small population.[104] Indeed, in line with the precautionary principle—a medical ethical concept that advocates for limited use of technologies in the absence of conclusive information about their long-term effects—it is important to exercise caution in promoting egg freezing as a reliable solution.

All of these concerns are valid. Yet, the question still remains whether, taken as a whole, their use as a normative basis for the time-based limitation stipulated in the regulation of social egg freezing is justified. It is important to note that the risks associated with the procedure of egg freezing are akin to those attached to IVF. Both employ similar methods to artificially stimulate the ovaries to procure multiple eggs for harvesting.[105] Therefore, women of advanced age undergoing IVF face comparable risks. In some countries, however, these risks are not deemed significant enough to justify barring women from access to IVF, so long as they receive all relevant information.[106] In countries where these risks are a concern in the regulation of IVF treatment,

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Outcomes, 196 Am. J. Obstetrics & Gynecology, e13 (2007). This concern has been echoed in legislative debate in Denmark around whether to remove the current five-year storage limit on egg freezing. *See* Kaplan et al., *supra* note 76, at 1579.

[102] *See, e.g.*, Shiri Shkedi-Rafid & Yael Hashiloni-Dolev, *Egg Freezing for Non-Medical Uses: The Lack of a Relational Approach to Autonomy in the New Israeli Policy and in Academic Discussion*, 38 J. Med. Ethics 154, 156–57 (2012). This concern has been echoed in legislative debate in Denmark and the United Kingdom around the storage time limit applied on social egg freezing. *See* Herrmann & Kroløkke, *supra* note 82, at 30; Emily Jackson, *'Social' Egg Freezing and the UK's Statutory Storage Time Limits*, 42 J. Med Ethics 738, 739 (2016). Further, this concern has been raised as the primary one with regard to the use of social egg freezing by the Belgian Advisory Committee on Bioethics. *See* Belgian Advisory Comm. on Bioethics, Opinion No. 57 on the Ethical Aspects of the Freezing of Eggs in Anticipation of Age-Related Infertility 19–20 (Dec. 16, 2013), https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/opinion_57_web.pdf [https://perma.cc/3FB2-PGXG].

[103] *See, e.g.*, Shkedi-Rafid & Hashiloni-Dolev, *supra* note 102, at 156.

[104] *See, e.g.*, Anna-Lena Wennberg, *Social Freezing of Oocytes: A Means to Take Control of Your Fertility*, 125 Upsala J. Med. Sci. 95, 97 (2020); Cobo et al., *supra* note 73, at 1100.

[105] *See, e.g.*, Dimitra Katsani et al., *Social Egg Freezing—A Trend or Modern Reality?*, 13 J. Clinical Med. 390, 392 (2024).

[106] In the Netherlands, for example, eggs can be retrieved and frozen for women until the age of 40, where the age limit for access to IVF is 45. Nitzan Rimon-Zarfaty et al., *Between "Medical" and "Social" Egg Freezing*, 18 J. Bioethical Inquiry 683, 692 (2021); Gary Buswell, *Women's Healthcare in the Netherlands*, Expatica, www.expatica.com/nl/healthcare/womens-health/womens-healthcare-in-the-netherlands-100752/ [https://perma.cc/MG5U-YTKK].

they apply only to women.[107] This disparity, though, overlooks studies demonstrating that conception with a man of advanced age is more likely to result in miscarriage or stillbirth, which can jeopardize women's health.[108] In fact, as Professor Almeling observes, more generally, much of the data on these risks remains obscured or minimized, with attention to men's reproductive health being largely reduced to sperm quality and infertility, leaving out crucial aspects of how paternal age affects outcomes.[109]

As for the second and third concerns pertaining to late motherhood, the mere fact that women may take proactive measures to avoid undesired outcomes (thereby missing out on the chance to become mothers) does not necessarily mean they are overly reliant on these precautions.[110] Furthermore, late motherhood brings several advantages, as children born to older parents tend to enter a more stable home environment, at least financially.[111]

Finally, regarding the fourth concern ("false hope"), it is certainly troubling if the accessibility of social egg freezing leads women to believe that their prospects of becoming pregnant later in life are greater than they actually are. However, this concern does not constitute a valid reason for restricting access to this technology. Instead, it underscores the importance of implementing comprehensive measures for informed decision-making to mitigate the potential for unrealistic expectations and uninformed choices.[112] Indeed, it is challenging to provide accurate information on the risks of new treatments, especially when clinicians do not have access to data from extensive studies.[113] Yet, the realities can be communicated to the patient to empower them to arrive at their own decision, grounded in facts. This approach, while not able to completely mitigate the challenge of information gaps, would enable a fairer distribution of reproductive responsibilities between men and women.

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[107] Consider, for instance, the United Kingdom's NICE Guidelines, which state that the National Health Service will not offer IVF treatment to women over 42 but do not mention any upper age limit for men. *See* NICE Guidelines, *supra* note 81.

[108] Chan et al., *supra* note 96, at 3 (referring to studies that linked advanced paternal age with increased rates of miscarriage and a higher risk of late stillbirth). While IVF and Intracytoplasmic Sperm Injection may address certain sperm-related infertility issues, they do not eliminate the risk of miscarriage. *See* Nadia A. du Fossé et al., *Advanced Paternal Age is Associated with an Increased Risk of Spontaneous Miscarriage: A Systematic Review and Meta-Analysis*, 26 Hum. Reprod. Update 650, 665–66 (2020).

[109] Rene Almeling, GUYnecology: The Missing Science of Men's Reproductive Health, 91–116 (2020).

[110] *See, e.g.*, Goold & Savulescu, *supra* note 70, at 56.

[111] Mikko Myrskylä et al., *Advantages of Later Motherhood*, 50 Gynäkologe 767, 767 (2017); Tomáš Sobotka & Éva Beaujouan, *Late Motherhood in Low-Fertility Countries: Reproductive Intentions, Trends and Consequences*, *in* Preventing Age-Related Fertility Loss 22–23 (Dominic Stoop ed., 2018).

[112] This could include measures such as mandatory counseling sessions and a requirement for healthcare providers to publish detailed information on the success rates, risks, and limitations of the procedure.

[113] *Cf.* Joyce Harper et al., *When and How Should New Technology be Introduced into the IVF Laboratory?*, 27 Hum. Reprod. 303, 303 (2012) (discussing this challenge more broadly with regard to MAR).

What most of these concerns have in common is their express focus, ostensibly, on the best interests or well-being of the women involved.[114] This kind of paternalistic thinking warrants careful scrutiny, especially when it is predominantly directed toward an entire group of people, designating them incapable of making the "right decision" for themselves.[115] Such negative assessments of others' capacity to reason are even more troubling when directed toward a group that is already disadvantaged.[116] Here, the ostensible concerns over the harm to women associated with freezing their eggs target individuals whose bodily autonomy has always been—and remains—constrained by arguments "for their own good."

The interest in promoting the "for their own good" rhetoric may also partly explain the widespread use of age limits in the process of fertility preservation. Such limits are a temporal proxy for the *actual* physiological and fertility capability of the individual, steering women away from pursuing treatments that, statistically, may have little chance of success. While the authorities that impose such limitations justify them with data linking older age to reduced reproductive capacity,[117] this reasoning, when applied with a broad

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[114] Another argument, though less prominent compared to other justifications set forth, concerns the interests of the potential child. For a critique of the broader use of this argument in the context of MAR, see, e.g., I. Glenn Cohen, *Regulating Reproduction: The Problem with Best Interests*, 96 Minn. L. Rev. 423, 426 (2011).

[115] For prominent works and critiques on this expressive account of paternalism, see, e.g., Seana Valentine Shiffrin, *Paternalism, Unconscionability Doctrine, and Accommodation*, 29 Phil. & Pub. Affs. 205, 220 (2000); Nicolas Cornel, *A Third Theory of Paternalism*, 113 Mich. L. Rev. 1295, 1314–15 (2015). While I highlight here the concern about the expressive—sex-based subordinating—effects of this reasoning, my focus in this section is on the presumptions underpinning this reasoning, which, themselves, are subordinating. Sometimes, these two aspects are intertwined, as can be observed throughout the examples I provide. However, I believe it is more persuasive, for advocacy purposes, to emphasize the latter aspect. For a critique of the expressive theory of paternalism, see, e.g., Jonathan Turner, *On the Expressive Theory of Paternalism*, 15 Jurisprudence 307, 307 (2024).

I acknowledge that, in some cases, avoiding paternalistic action could be expressively problematic, as it may disregard the person's moral value by standing by while they make reckless decisions. *See, e.g.*, Anne-Sofie Greisen Hojlund, *What Should Egalitarian Policies Express? The Case of Paternalism*, 29 J. Pol. Phil. 519, 519 (2021). However, it is reasonable to argue that this consideration does not justify restricting egg freezing. One reason is the uncertainty over whether the potential self-regarding harm associated with this procedure is substantial enough to justify interference that potentially crosses the line into disrespect.

[116] *See, e.g.*, Cornel, *supra* note 115, at 1327–28. One counter argument here is that adopting this paternalistic reasoning only with regard to women is inevitable, as they are the ones who bear the risks associated with childbearing. This argument falls short for at least two reasons. First, while women's reproduction does involve greater risks than men's, this alone does not justify limiting women's decision-making in ways that could prevent them from pursuing what they perceive to be in their best interest. In fact, for some women, despite the potential risks of egg freezing, these risks may be more acceptable than the emotional distress of being unable to conceive a child. Second, it is worth emphasizing again that the risks associated with the fertility of older men—both for pregnant women and their offspring—are substantial. Yet, these risks are frequently ignored or downplayed, exposing the gender disparity on which this counterargument itself is built.

[117] Juliana Pedro et al., *What Do People Know about Fertility? A Systematic Review on Fertility Awareness and Its Associated Factors*, 123 Upsala J. Med. Sci. 71, 71 (2018).

brush, creates misleading narratives. It fails to acknowledge the individual nuances behind the statistical averages, medians, and probabilities, possibly sidelining older women who may retain fertility prospects comparable to, or even surpassing, those of their younger counterparts.[118] Furthermore, the fact that this regulatory barrier applies exclusively to women in certain countries[119]—despite the reality that men's fertility also declines with age, albeit differently[120]—suggests an implicit bias in how these policies are justified.[121] Establishing a cutoff point based on the intrinsic biological characteristics of each individual rather than a standard chronological age might present a more equitable,[122] albeit less efficient,[123] solution. Another way could be to use these upper age limits as benchmarks or considerations rather than incorporating them into directives as rigid, bright-line rules. This method may also apply to the storage stage, which, as mentioned, some countries restrict to a fixed duration without considering the intrinsic biological characteristics of each individual.[124]

To be clear, to the extent that policymakers set out to protect the health of women, this is not problematic per se. However, in pursuing this important goal, they should not base their decisions on overly broad and inaccurate generalizations regarding the differing capacities or inclinations of men and women. To see more clearly the flaw inherent in that thinking, it is instructive to look at how biology has historically been used—and is still used today—to justify restrictive laws pertaining to women and their reproductive autonomy in particular.

For instance, in the past, it was commonplace to point to biology to justify laws enforcing traditional sex roles. In *Muller v. Oregon*, for example, the U.S. Supreme Court justified laws restricting the working hours of women by referencing a woman's "physical structure and a proper discharge of her

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[118] For scholarship discussing this concern in the context of IVF, see, e.g., Giulia Cavaliere & James Rupert Fletcher, *Age-Discriminated IVF Access and Evidence-based Ageism: Is There a Better Way*?, 47 Sci. Tech. & Hum. Values 987, 995 (2021).

[119] *See supra* note 82 and accompanying text.

[120] *See, e.g.*, Mohamed A.M. Hassan, *Effect of Male Age on Fertility: Evidence for the Decline in Male Fertility with Increasing Age*, 79 Fertility & Sterility 1520, 1523 (2003) (demonstrating that men aged over forty-five were nearly five times as likely to experience a delay of more than a year in conceiving compared to men under twenty-five, and that this trend persisted even when the female partner was young).

[121] By highlighting this implicit bias, I am not suggesting that similar burdens should be imposed on men.

[122] *Cf.* Andrea Martani et al., *Deconstructing Age(s): An Analysis of the Different Conceptions of Age as a Legal Criterion for Access to Assisted Reproductive Technologies*, 9 J. L. & Biosciences 1, 10 (2022) (discussing this suggestion with regard to IVF).

[123] As Professor Alexander Boni-Saenz contends more generally, determining chronological age reduces the administrative costs and need for adjudications on the meaning of age in a particular context. *See* Alexander Boni-Saenz, *Legal Age*, 63 B.C.L. Rev. 521, 545–47 (2022). Yet, since genetic testing is already required before fertility treatment, this justification loses strength in this context. Moreover, with reproductive technologies advancing rapidly, relying on a fixed chronological age may be unlikely to stand the test of time. Updating these age limits also brings its own administrative costs.

[124] *See supra* notes 79–80 and accompanying text.

maternal functions."[125] Similarly, *Frontiero v. Richardson* critiqued conventional forms of sex discrimination that were often "rationalized by an attitude of 'romantic paternalism'" that, in practical effect, placed women "not on a pedestal, but in a cage."[126] These well-worn sex-based stereotypes may now be considered outdated in the public consciousness, yet their longevity and prevalence are far from trivial. This is particularly evident if we shift our gaze to the question of abortion.

Consider the anti-abortion rhetoric during the earliest days of the 19th century. Back then, as documented by Professor Reva Siegel, the rhetoric of the anti-abortion advocacy for criminalizing abortion was grounded, among other justifications, in supposed concerns over women's psychological and physical health.[127] The commonly cited premise was that a woman's wellbeing suffers if she deviates from the role she is destined to fulfill by her nature.[128] One can observe the similarity with social egg freezing. Now, in the 21st century, the countries that have prohibited or restricted this procedure, while not blatantly using this heteronormative language, still adopt a rhetoric of health and science to rationalize—and obscure—the gendered imaginaries and understandings related to the "appropriate" age for motherhood and the desire to control women's eggs, even in the frozen state.

A more modern twist on this apparently protective stance is the mandatory waiting period for abortion. These restrictions generally require pregnant women to wait 24–72 hours between requesting the intervention and undergoing the procedure.[129] While this requirement is ostensibly intended to safeguard women's autonomy by allowing time for thoughtful decision-making,[130] it can actually exacerbate the emotional distress associated with such a complex decision[131] while contributing to women's internalization of

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[125] Muller v. Oregon, 208 U.S. 412, 422 (1908).

[126] Frontiero v. Richardson, 411 U.S. 677, 684 (1973).

[127] *See, e.g.*, Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 Stan. L. Rev. 261, 280–323 (1992).

[128] Horatio Storer, the doctor who led the campaign to ban abortion, argued that childbearing was "the end for which [married women] are physiologically constituted and for which they are destined by nature." Reva Siegel et al., *Equal Protection in* Dobbs *and Beyond: How States Protect Life Inside and Outside of the Abortion Context*, 43 Colum. J. Gender & L. 67, 80, n. 62. (2022). Moreover, the 1871 Report on Criminal Abortion by the American Medical Association criticized a woman for terminating a pregnancy, arguing that "[s]he becomes unmindful of the course marked out for her by Providence, she overlooks the duties imposed on her by the marriage contract." *Id.*

[129] *See infra* note 170.

[130] *See* Reva Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 Duke Law J. 1647, 1665 n. 85 (2008) (illustrating how the anti-abortion camp has used the concern for psychological repercussions as a rationale for imposing waiting periods before a physician can perform an abortion); Brent L. Pickett et al., *Paternalistic State-Level Abortion Restrictions*, 3 Soc. Just. & Equity J. 75, 97 (2020).

[131] *See, e.g.*, Amanda Dennis et al., *Experiences with Health Care and Public Assistance in States with Highly Restrictive Abortion Policies: State Brief: Kansas*, 8 Reprod. Health 1, 8 (2014); Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for*

the sexist view that they are not fully capable of being morally decisive.[132] Understood thus, this enforced "cooling-off" period is less about women's well-being and more a validation of state policing of women's bodily autonomy. In effect, it subjects their reproductive timeline—deciding when to exercise their right to terminate a pregnancy—to external oversight.

Another recent example is the justification underpinning Mississippi's 15-week restriction on abortion,[133] evaluated in *Dobbs*. The law emphasized both fetal protection and the pregnant woman's health, positing that second-trimester abortions are riskier than childbirth.[134] Similar to cases of egg freezing, Mississippi implies a presumption of women's incapacity to weigh the relative health risks of continuing versus terminating their pregnancies. And, again similar to the context of egg freezing, this presumption, though seemingly grounded in empirical evidence, is unsubstantiated. It fails to consider that continuing a pregnancy can be physically riskier than having an abortion.[135] Further, it overlooks how advancements in abortion techniques, particularly in surgical methods and infection control, have significantly

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Abortion: Experiences among a Clinic-Based Sample of Women, 46 Persps. on Sexual & Reprod. Health 179, 184 (2016).

[132] *Cf.* Leah Hoctor & Adriana Lamačková, *Mandatory Waiting Periods and Biased Abortion Counseling in Central and Eastern Europe*, 139 Int'l J. Gynecology & Obstetrics 253, 256 (2017) (explaining that mandatory waiting periods reflect the assumption that women are "less capable than men of rational thought, considered decision-making, or responsible moral choice"); Fiona de Londras et al., *The Impact of Mandatory Waiting Periods on Abortion-Related Outcomes: A Synthesis of Legal and Health Evidence*, 22 BMC Pub. Health 1232, 1232 (2022) (describing the World Health Organization's recognition that cooling-off periods "demean[] women as competent decision-makers").

[133] Miss. Code Ann. § 41–41–191(4)(b) (2024).

[134] *Id*. at (2)(b)(i)(8) ("The majority of abortion procedures performed after fifteen (15) weeks' gestation are dilation and evacuation procedures which involve the use of surgical *instruments to crush and tear the unborn child* apart before removing the pieces of the dead child from the womb. The Legislature finds that the intentional commitment of such acts for nontherapeutic or elective reasons is a barbaric practice, *dangerous for the maternal patient*, and demeaning to the medical profession."). The state legislation also asserts that "[a]bortion carries significant physical and psychological risks to the maternal patient," including "depression; anxiety; substance abuse; and other emotional or psychological problems." *Id*. at (2)(b)(ii), (iv). The legislation declares that the "medical, emotional, and psychological consequences of abortion are serious and can be lasting." *Id*. at (2)(b)(v); *see also* Brief of Equal Protection Constitutional Law Scholars Serena Mayeri, Melissa Murray, & Reva Siegel as Amici Curiae Supporting Respondent, Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (No. 18-60868) (making a similar claim that Mississippi's rhetoric on women's "health" echoes antiquated sex-role stereotypes).

[135] *See, e.g.*, Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012) (reporting that "the risk of death associated with childbirth [is] approximately 14 times higher"); Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications after Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (indicating an approximately two percent abortion-related complication rate and noting that the majority of these complications are minor and readily treatable); *ACOG Practice Bulletin No. 190: Gestational Diabetes Mellitus*, 131 Obstetrics & Gynecology e49 (2018) (discussing how continuing a pregnancy to term can exacerbate underlying health conditions or cause new ones).

enhanced safety and reduced complications.[136] Consequently, the leveraging of women's wellbeing in this rhetoric rings hollow.

The analogy between social egg freezing and abortion elucidates how the nexus between reproductive time and sex-based subordination is institutionalized and objectified. Ostensibly, fertility preservation and pregnancy termination speak to two very different—even opposing—reproductive choices, from a woman's perspective. The choice to freeze eggs is about preserving the future possibility of becoming a mother when biological constraints may come into play. Conversely, the choice to terminate a pregnancy is designed to close off the very possibility of motherhood in the immediate or near term.[137] However, in both legal settings, the rhetoric deployed by the State to restrict these reproductive choices rests on the same conventional assumptions about the respective capabilities of men and women. Both regulatory contexts rely on the assumption and the argument that women will suffer if they avoid or defer the maternal role. Paradoxically, though, restrictions on fertility preservation may undermine the very future possibility of pregnancy, revealing an internal contradiction in the State's claim to protect women by restricting their reproductive choices. Ultimately, in both contexts, the State presents coercion as protection, thereby serving repressive political ends.

Before bringing this Part to a close, I wish to acknowledge that, in this highly contested and complex terrain, there are no panaceas, and that the scenario I propose—extending the fertility timeline—is not without its risks. Two notable concerns arise in this context.

First, permissive approaches can be as oppressive as restrictive ones. As bio-ethics commentators have rightly pointed out, the option to extend women's fertility window could lead to pressure on women to synchronize their natural body rhythms with societal expectations, especially those dictated by a capitalist, male-oriented labor market.[138] A related concern is that, when women use social egg freezing to delay childbearing until the right life-partner or co-parent comes along, it reinforces a gendered—subordinated—state of waiting and expectation.[139]

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[136] *See, e.g.*, Sharon Cameron, *Recent Advances in Improving the Effectiveness and Reducing the Complications of Abortion*, 7 F1000 Faculty Rev. 1, 4 (2018).

[137] Research demonstrates that, among women who were unable to obtain an abortion due to gestational age limits, only about nine percent chose to give the child up for adoption, with the vast majority opting to raise the child themselves. Gretchen Sisson et al., *Adoption Decision Making among Women Seeking Abortion*, 27 Women's Health Issues 136, 139 (2017).

[138] *See, e.g.*, Shkedi-Rafid & Hashiloni-Dolev, *supra* note 102, at 156; Angel Petropanagos et al., *Social Egg Freezing: Risk, Benefits and Other Considerations*, 187 Canadian Med. Ass'n J. 666, 668 (2015); Marie-Eve Lemoine & Vardit Ravitsky, *Sleepwalking into Infertility: The Need for a Public Health Approach toward Advanced Maternal Age*, 15 Am. J. Bioethics 37, 41 (2015); Catherine Rottenberg, *Neoliberal Feminism and the Future of Human Capital*, 42 Signs 329, 332 (2017).

[139] *See* Marcia C. Inhorn, *The Egg Freezing Revolution? Gender, Education, and Reproductive Waithood in the United States*, *in* Waithood: Gender, Educ., and Global Delays in Marriage and Childbearing 366–67 (Marcia C. Inhorn & Nancy J. Smith-Hefner eds., 2020).

However, my view is that, while these concerns may be worth considering when deciding whether to advocate for relaxing these regulatory limitations, they still do not, in and of themselves, provide a plausible justification for policymakers to limit access to this technology.[140] Just as the choice to bear children is not purely natural but is also socially constructed, the same is true of the choice to delay childbearing, which may not always be as voluntary as it appears. In other words, choice is a layered and complex concept in MAR.[141] But, just as this complexity should not be used to restrict access to such technologies, it should not restrict access to egg freezing. Instead, it should push us to consider the social barriers to autonomous decision-making processes.

Second, as we have seen, given the high cost of egg freezing procedures, this avenue is likely beyond the reach of women without substantial financial resources, particularly when there are no state subsidies for this treatment, as in the case of the United States. Additionally, the steps required for egg freezing and IVF—not least, multiple timed retrievals, taking days off for surgery and recovery, and managing side effects—pose significant hurdles. Even if the procedure were more affordable, its practical inaccessibility would persist for low-income women, especially hourly workers, as these treatments often do not fit their inflexible work schedules. Relaxing the access requirements for this technology, therefore, could potentially deepen existing societal disparities.[142]

Certainly, this form of social inequality raises legitimate concerns about the capacity of this technology to address the implications women face due to their biologically limited fertility time. Yet, my view is that the disparity

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[140] While addressing the full scope of advocacy strategies for this dilemma is beyond the scope of this Article, one point is worth clarifying. The view presented in numerous commentaries against social egg freezing attests to Article's main perspective: despite scientific advancements that allow us to alter the 'natural' family-building timeline, outdated social structures based on traditional gender roles—not biology—continue to shape reproductive experiences. However, such commentaries differ in their conclusions regarding how to respond to these advancements, suggesting that advocates should challenge labor market practices rather than promote procedures that further medicalize women's bodies.

While I recognize their concerns—one of them being that increasing autonomy over egg freezing may translate into a burden of forced responsibility—I believe their proposed solution oversimplifies the complexities of egg freezing by reducing it to either a restrictive or an empowering practice. A more nuanced approach would advocate for both relaxing barriers (with informed consent) and enacting structural changes, such as in the workplace. This dual strategy would better reflect the internal negotiations women themselves face when considering the use of this technology, balancing empowerment with constraint, as highlighted by empirical studies. *See, e.g.*, Nitzan Rimon-Zarfaty & Silke Schicktanz, *The Emergence of Temporality in Attitudes towards Cryo-fertility: A Case Study Comparing German and Israeli Social Egg Freezing Users*, 17 Hist. & Phil. Life Sci. 1, 19 (2022).

[141] *Cf.* Mohapatra, *supra* note 65, at 382 ("Technology can sometimes hamstring women's choices rather than liberate them.").

[142] For example, it could facilitate the professional growth of affluent women while doing nothing to alter the inherent structural and economic inequalities present in the workplace. *See, e.g.*, Carbone & Cahn, *supra* note 65, at 289, 308; Mohapatra, *supra* note 65, at 403.

does not, in itself, justify restricting this technology—especially considering that other fertility treatments sought for non-medical reasons, such as surrogacy or genetic embryo-testing, are also beyond the financial reach of many, partly because they are not typically covered by health insurance. Instead, I contend, this uneven access to non-medical egg freezing should compel us to scrutinize the rationales underlying the funding for egg freezing, including the distinction between medical and non-medical resort to this procedure.[143] Even more importantly, this valid concern illustrates how socio-economic status—not solely biology—shapes how women experience their reproductive time. Such an intersectional layer—specifically, with regard to how reproductive time is constructed, enforced by state institutions, and lived in practice—becomes increasingly pertinent as we consider the next phase of family-building: pregnancy.

III. Gestational Time

Gestational time, the period during which a woman is pregnant, is another form of time wherein the medical-legal construction explicates the intricate relationship between time and subordination. This Part appraises this construction of time by focusing on abortion regulation. It argues that, contrary to ostensibly neutral, universal, and uniform characteristics, the construction of gestational time is based on several misconceptions about the pregnancy timeline and pregnancy recognition. This construction devalues the variations in pregnancy experiences, exacerbating disparities among the women concerned, particularly in relation to race and class.[144]

The argument develops across three sections. *Section A* problematizes how gestational time is administered in abortion law. It outlines the definition

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[143] If infertility is considered a medical issue deserving of State subsidy, does the cause of infertility, whether disease-related or age-related, matter from a moral perspective? Should we differentiate between a woman anticipating infertility in the near future and one anticipating it in the distant future? After all, egg freezing, regardless of its classification as medical or social, does not treat or cure any ailment. Rather, it serves as a proactive measure to preserve the possibility of conceiving later in life. We should be mindful that the problem women seek to resolve by preserving their fertility is not, ultimately, about wanting to maintain their trajectory of progress in the workplace but, rather, about addressing the threat of aging on fertility. In asking these questions, I do not wish to suggest we overlook the fact that subsidizing social egg freezing with public funds raises legitimate concerns. (Problematic questions include: How pressing is the issue of social egg freezing compared to other health demands and resources? How much public support would be needed to ensure complete equality? Would this policy discourage people from considering the adoption of existing unparented children?) Notwithstanding, these questions are equally applicable to medical egg freezing.

[144] People of all gender identities have the capacity to get pregnant. The use of inclusive language such as "pregnant people" recognizes and respects the experiences of transgender men and non-binary people. However, the scholars that document the government actors imposing abortion limitations have primarily focused on regulating the actions of women. In their attempts to justify these restrictions, state actors have relied on sex-role stereotypes associated with women. To emphasize this aspect, here I employ gender-specific language.

of gestational time in abortion laws and contrasts it with the common scientific perspective. Drawing on an array of empirical studies, it shows how the misalignment between law and science disproportionately impacts women of color and those from lower socio-economic backgrounds, who are statistically more likely to realize they are pregnant later in the process. *Section B* maps the harms resulting from this racial and socio-economic disparity. It further demonstrates how, in today's post-*Dobbs* era, this disparity becomes tangibly harmful not only in states that have reduced the legal timeframe for abortion but also in states with less stringent regulations. *Section C* discusses how advocates could feasibly mitigate these harms, thereby fostering a more tolerable reproductive experience for women during these tumultuous political times.

Siting abortion alongside fertility preservation highlights the nuanced process of subordination through time. While Part II showed how imposing external regulatory patterns on fertility time carries sex-based subordinated implications, this Part explicates how devaluing certain groups' internal experiences of reproductive time can act, in and of itself, as an expression of race-and-class-based subordination. Such an inter-contextual perspective reveals how time becomes an exacerbating force in a system designed to control, police, and discipline those who are already micro-managed and forcefully standardized.

A. The Medical–Legal Construction

When does a person become pregnant?

According to the scientific consensus, represented in the United States by the American College of Obstetrics and Gynecology, pregnancy is considered to be established when the process of implantation is complete[145]—that is, only when the fertilized egg implants in the wall of the uterus (way beyond the half-way point of the individual's menstrual cycle). Crucially, however, the starting point of pregnancy in many states is *legally* taken to be the first day of the last menstrual period (LMP) (that is, at the very *beginning* of the cycle).[146] In very generalized terms, then, two weeks after a period begins, ovulation

[145] Despite the College of Obstetrics and Gynecology's position, obstetrician–gynecologists disagree on when pregnancy begins, whether at fertilization or at implantation. *See generally*, Grace S. Chung et al., *Obstetrician-Gynecologists' Beliefs about When Pregnancy Begins*, 206 Am. J. Obstetrics & Gynecology 132.e1 (2011) (studying the characteristics of obstetrician-gynecologists who believe pregnancy begins at fertilization or implantation).

[146] *See, e.g.*, Tenn. Code Ann. § 39-15-213(3) (2024); Ga. Code Ann. § 31-9B-1; (2024); Tex. Health & Safety Code § 171.201(2) (defining gestational age as the time that has elapsed since the woman's LMP); Ohio Rev. Code Ann. § 2919.201(A) (2024). In contrast, some states premised their position on the notion that pregnancy begins at implantation and not fertilization—among them, California, Colorado, Illinois, and Washington. *See* Cal. Health & Safety Code § 123464(b) ; Colo. Rev. Stat. § 25-6-402(2) (2024); 775 Ill. Comp. Stat. Ann. 55/1-10 ; Wash. Rev. Code Ann. § 9.02.170(3).

occurs (when a single egg is released from the ovary, creating the potential for fertilization soon after); and implantation usually occurs about one to one-and-a-half weeks after fertilization.[147] Therefore, implantation generally happens roughly three to three-and-a-half weeks after the LMP began.[148] Because gestational time dictates the window during which a person is legally considered pregnant with regard to abortion laws, this gap of approximately three weeks gives rise to a situation in which a woman is legally pregnant before she is *biologically* pregnant.[149]

Indeed, this legal calculation is used as a proxy for timing because pinpointing the exact moment of implantation is extremely difficult, and this method provides a standard measurement for healthcare providers.[150] Yet, it exemplifies how this medical-legal construction of time is out of sync with the biological reality of its legal subjects' timeline.

Furthermore, the medical-legal construction of gestational time does not necessarily align with the *subjective* experience of pregnant women at all. Typically, a pregnant woman may not experience noticeable symptoms or suspect a missed period until more than a month has passed since she last menstruated.[151] While the availability of home pregnancy tests might give the

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Moreover, the starting point of pregnancy can vary depending on the legal context. The way pregnancy is defined for abortion purposes may differ from how it is defined in cases of fetal assault (such as penalties for attacking a pregnant woman). *See, e.g.*, Rachel Benson Gold, *The Implications of Defining When a Woman Is Pregnant*, 8 Guttmacher Pol'y Rev. 7, 8 (2005).

This multiple variation—(a) among states regarding gestational age in abortion law and (b) within the same jurisdiction across different pregnancy contexts—while reflecting incoherence over the question of gestational age, also underscores how this determination is not universally fixed but, rather, politically constructed.

[147] Fertilization generally happens within twenty-four hours of ovulation, after which the fertilized egg (zygote) starts dividing and developing into a blastocyst. *See Conception,* Cleveland Clinic (Sept. 6, 2022), https://my.clevelandclinic.org/health/articles/11585-conception [https://perma.cc/56G4-CNFM].

[148] For further detail, see, e.g., Selena Simmons-Duffin et al., *The Surprising Science of How Pregnancy Begins*, Shots: Health News from NPR (Apr. 12, 2023), https://www.npr.org/sections/health-shots/2023/04/12/1159753316/pregnancy-start-conception [https://perma.cc/P7Y8-EURA].

[149] From a scientific standpoint, if a sperm fertilized an egg after intercourse but the fertilized egg failed to implant in the uterus, the woman was never pregnant. This condition can be described as menstruation rather than a miscarriage or spontaneous abortion. *See* Benson Gold, *supra* note 146.

[150] *See 1–2 Weeks Pregnant*, Am. Pregnancy Ass'n, https://americanpregnancy.org/healthy-pregnancy/week-by-week/pregnancy-week-1-2/ [https://perma.cc/GX89-TZM4].

[151] According to one of the most comprehensive research studies in this field, which examined the timing trends of pregnancy awareness among 17,406 women in the United States for live births from 1995 to 2013, gestational age at time of pregnancy awareness was 5.5 weeks, on average. *See* Amy Branum & Katherine A. Ahrens, *Trends in Timing of Pregnancy Awareness among US Women*, 21 Maternal & Child Health J. 715, 715 (2017). However, twenty-three percent only recognized their pregnancy at, or around, seven weeks. *Id.* Another comprehensive study, which examined 136,373 women in twenty-nine states in the United States who had had a live birth between 2000 and 2004, found that the average time taken to identify pregnancy was 5.9 weeks following the LMP. *See* Adejoke Ayoola et al., *Late Recognition of Pregnancy as a Predictor of Adverse Birth Outcomes*, 201 Am. J. Obstetrics & Gynecology 156e1, 156e2 (2009). Another study,

impression that women find out they are pregnant shortly after their LMP, this is not always the case. This is largely because only those who have reason to believe they may be pregnant—such as those intending to conceive—are typically attuned enough to consider using these tests at that early stage. In cases of unplanned pregnancy, especially when clear physical signs are absent, these tests might be taken much later.[152] In other words, it is the very women who are more likely to seek an abortion—those carrying an unplanned pregnancy[153]—who often find out the latest.

Clearly, concerns about counting unconscious pregnancy within abortion time limits—which are intensified in states where there is a gap between legal and scientific constructions of gestational time—are relevant to all pregnancies. Yet, such concerns become more troubling when considering that women from subordinated groups are more likely to remain unaware of their pregnancy longer than others.

Notably, contrary to a medical-legal construction of time in abortion law—and in contrast to the legal presumption enshrined in the landmark *Dobbs* decision[154]—the timing of pregnancy recognition is thus highly non-uniform. Research indicates that, while the majority of individuals find out they are pregnant within the first five or six weeks of gestation, about one-quarter realize at around seven or eight weeks.[155] Studies have further found that a majority of individuals seeking second-trimester abortions learned of their pregnancy more than eight weeks after their LMP.[156] And, crucially, there are three particular groups that are statistically more

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which analyzed 259 women from six U.S. states between 2016 and 2017, revealed that approximately thirty-three percent identified their pregnancy at six weeks or later, while around twenty percent recognized it after several more weeks had passed. *See* Lauren J. Ralph et al., *Home Pregnancy Test Use and Timing of Pregnancy Confirmation among People Seeking Health Care*, 107 Contraception 10, 10 (2022).

[152] *See, e.g.*, Sarah Earle & Gayle Letherby, *Conceiving Time? Women Who Do or Do Not Conceive*, 29 Socio. Health & Illness 233, 247 (2007).

[153] *See, e.g.*, Branum & Ahrens, *supra* note 151, at 722.

[154] Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 356 (2022) (Roberts, C. J., concurring in judgment) ("Pregnancy tests are now inexpensive and accurate, and a woman ordinarily discovers she is pregnant by six weeks of gestation.") (citation omitted).

[155] *See, e.g.*, Ayoola et al., *supra* note 151, at 2 ("More than a quarter (27.6%; 99% [confidence interval], 27.09–28.12%) of the women recognized their pregnancy late (i.e., after 6 weeks of gestation)."); Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (2014) (finding that, among women seeking first-trimester abortions, 37.8 percent cited a lack of recognition of their pregnancy as a reason for delay); Branum & Ahrens, *supra* note 151, at 721.

[156] *See, e.g.*, Diana Greene Foster et al., *Timing of Pregnancy Discovery among Women Seeking Abortion*, 104 Contraception 642, 642 (2021) ("Most women seeking second trimester abortions recognized their pregnancy more than 8 weeks after their LMP."); Eleanor A. Drey et al., *Risk Factors Associated with Presenting for Abortion in the Second Trimester*, 107 Obstetrics & Gynecology 128, 128 (2006) (finding that more than half of people seeking abortions in the second trimester do so because delays in recognizing and testing for pregnancy resulted in them missing the chance to abort earlier).

likely to experience late pregnancy recognition: women of color, women from backgrounds with a lower socio-economic status, and young women (aged 15–24).[157]

Legal scholars have long criticized the fact that abortion restrictions disproportionately affect women who live in poverty, many of whom are of color.[158] This Part extends this research base by highlighting how these women's lived experiences and perceptions of gestational time—largely overlooked in this scholarship—can provide insight into the realities of this intersectional stratified society.[159] It argues that acknowledging the variability in gestational time enables us to gain a more nuanced understanding of the conditions that create an intersectional axis of oppression.[160] Notably, the higher abortion rates among women of color, compared to their white counterparts,[161] reflect the influence of women of color's deviation from the law's construction of gestational time. And, importantly, the higher rate of *denied* abortion among these communities[162] reflects the systemic repressive forces that foist this construction of time upon them. It is this interplay between time, subordination, and legal systems that this Part seeks to explicate. To better discern this nexus, we should start by naming the harms caused by the devaluation of gestational time variations.

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[157] *See* Ayoola et al., *supra* note 151; Branum & Ahrens, *supra* note 151, at 724; Ralph et al., *supra* note 151, at 16. The literature does not explore the reasons for this asymmetry in pregnancy recognition. Yet, two factors in particular are likely contributors. First, young women and women of color are statistically more likely to experience unintended pregnancies, which are associated with later pregnancy recognition. Second, women of color are disproportionately affected by certain reproductive health conditions—or experience disparities in diagnosis and treatment. I elaborate on these factors in Part III.A. Another reason for this disproportionate delay is the longer gap between initial suspicion of pregnancy and its confirmation among this community. *See* Lawrence Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 338 (2006).

[158] For influential accounts, see, e.g., Linda Greenhouse & Reva B. Siegel, *Before (and After)* Roe v. Wade*: New Questions About Backlash*, 120 YALE L.J. 2028, 2036 (2011); Khiara M. Bridges, *Race in the Roberts Court*, 136 HARV. L. REV. 23, 45–46 (2022); Melissa Murray, *Race-ing* Roe*: Reproductive Justice, Racial Justice, and the Battle for* Roe v. Wade, 134 HARV. L. REV. 2025, 2093 (2021).

[159] *Cf.* COHEN, *supra* note 49, at 4 (contending that temporal injustice arises from processes that prioritize certain people's time over that of others).

[160] This understanding has been applied by various scholars in similar contexts of reproduction. For instance, Professor Kate Clancy, a biological anthropologist, observes that menstrual experiences have long been shaped by eugenic and race-science assumptions that center white, Western norms, marginalize global and Indigenous practices, and overlook the full diversity of people who menstruate. *See* KATE CLANCY, PERIOD: THE REAL STORY OF MENSTRUATION (2023), 5–6, 9–11. In a similar vein, this Part urges consideration of this social stratification by directing analytical attention toward abortion.

[161] *See, e.g.*, Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States*, *2008–2011*, 374 NEW ENG. J. MED. 843, 849 (2016); Bridges, *supra* note 158, at 42–44.

[162] *See infra* note 173.

B. Racial and Socio-Economic Harms

Gestational time is a high-value resource, carrying various implications when it comes to abortion access. Not least, the criteria governing the right to terminate a pregnancy have been structured around the progression of this reproductive experience. This is glaringly evident in jurisdictions where abortion laws permit termination only within a limited timeframe.[163]

In the United States, until recently, it was the viability point—the point of the pregnancy at which the fetus is capable of surviving outside the womb (currently determined to be around 24 weeks)[164]—that constituted the threshold for prohibiting abortion.[165] Now, however, post-*Dobbs*, this gestational time is at a particular premium because an increasing number of states have reduced the legal timeframe for abortion to the very earliest stages of gestation.[166] Some states stipulate laws closing the window during which abortion can be accessed by the end of the first trimester (twelve weeks' gestation).[167] Others have gone much further, banning abortion any later than six weeks' gestation.[168] This legal trend imposes strict (and, in some states, unrealistic)

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[163] *See generally*, Lisa Remez et al., *Global Developments in Laws on Induced Abortion: 2008–2019*, 46 Int'l Persps. Sexual & Reprod. Health 53 (2020) (discussing how limitations on the timeframe in which women can obtain an abortion are broadly underscored by modern understandings of the fetus's viability). Liberal countries with legal traditions akin to that of the United States (common-law systems)—such as Canada, the United Kingdom, and New Zealand—permit abortions up to the point of viability or around it. Most Western European countries restrict abortion after 12–14 weeks, but they typically have liberal and flexible exceptions to these limits compared to the United States.

[164] As medical advancements shift the threshold of fetal viability, it becomes clear that the experience of gestational time—shaped by this scientific notion—is neither fixed nor inherent. This becomes particularly significant with the development of artificial womb technologies, which further extend the boundaries of viability for a fetus to sustain independent life outside the womb. *See, e.g.*, Elizabeth Chloe Romanis, *Challenging the 'Born Alive' Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood*, 28 Med. L. Rev. 93, 96–99 (2020).

[165] Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 350–51 (2022) (discussing the viability line, which *Roe v. Wade*, 410 U.S. 113 (1973), *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), and subsequent decisions set as *Roe*'s central rule for the abortion framework). *Dobbs* overrules the previous precedent, allowing states to completely prohibit abortion before the point of viability.

[166] Exceptions for obtaining an abortion after this time threshold include cases in which a pregnancy is the result of rape or incest, or when a lethal fetal anomaly is identified. I should note that, to date, total bans on abortion have entered into effect in 12 states. *See State Bans on Abortion Throughout Pregnancy*, Guttmacher Institute, https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions [https://perma.cc/LXK4-7PRU].

[167] This includes states such as North Carolina or Nebraska. *See* N.C. Gen. Stat. § 90-21.81B(2) (2024); L.B. 574, 108th Leg., 1st Sess. (Neb. 2024).

[168] Known as "heartbeat laws," these prohibit performing abortion where fetal cardiac activity is detected, which typically occurs around six weeks after a woman's LMP. In September 2022, Texas became the first state to successfully implement such a law, with other states following suit (Georgia, Tennessee, Ohio, Florida, and South Carolina). *See* Ga. Code Ann. § 16-12-141(b) (2024); Tenn. Code Ann. § 39-15-216(c)(1) (2024); Fla. Stat. § 390.0111(A) (2024); S.C. Code Ann. § 44-41-630(B) (2024). Ohio enacted a similar law (Ohio Rev. Code Ann. § 2919.195(A) (2024)), but it was permanently enjoined

timelines for exercising the right to abort. This is due to several factors—psychological,[169] regulatory,[170] and bureaucratic[171]—that shape the timeline of exercising this right, beyond knowledge of the pregnancy itself. This harm is particularly acute for those—women of color and from lower socio-economic classes—whose realization of pregnancy does not always align with the most privileged experience of gestational time. Often, by the time these women confirm their pregnancies, it may already be too late to consider their options and gather sufficient resources to access abortion care.[172] Indeed, it may be *too* late to legally terminate. As these women often lack the resources to mitigate the impact of this systemic temporal disenfranchisement, this outcome further entrenches their marginalized societal position by compelling them into unwanted pregnancy and motherhood.[173]

This is not merely a problem associated with "red states" but is instead a national phenomenon. Anyone who does not discover their pregnancy within the first trimester is particularly vulnerable even in states with less stringent cutoffs, especially in the context of medication abortion. Medication abortion, recognized as a safe and effective option,[174] involves the administration

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and declared unconstitutional and cannot be enforced in *Preterm-Cleveland v. Yost*, No. A2203203 (Ohio Ct. Com. Pl. Oct. 24, 2024).

[169] *See, e.g.*, Carrie Purcell et al., *Access to and Experience of Later Abortion: Accounts from Women in Scotland*, 46 Persps. Sexual & Reprod. Health 101, 106 (2014); Catriona Ida Macleod, *Public Reproductive Health and 'Unintended' Pregnancies: Introducing the Construct 'Supportability'*, 38 J. Pub. Health e384, e384 (2016).

[170] In many states, abortion is subject to a mandatory waiting-period of 24–72 hours, usually accompanied by a mandatory in-person counseling session, which requires the pregnant woman to make two separate trips to the healthcare provider. This requirement exists mostly in states where the permissible time-window for an abortion is shrinking. *See, e.g.*, Tex. Health & Safety Code § 171.012 (West 2023) (24-hour waiting period); Ga. Code Ann. § 31-9A-3 (2024) (same); N.C. Gen. Stat. § 90-21.81(b)(1) (2024) (72-hour waiting period); Fla. Stat. § 390.0111(3)(a) (2024) (same); S.C. Code Ann. § 44-41-330(C) (2024) (same); Neb. Rev. Stat. § 28-327(1) (2024) (same).

[171] The pregnant woman needs to schedule an appointment in one of the available abortion clinics, which, depending on the region, may be no easy task; arrange time off work (or sacrifice potential earnings); and manage other logistical issues, such as transportation costs and organizing and paying for childcare. These hurdles become particularly problematic for women living in poverty or without insurance—many of whom are likely to be women of color, *see, e.g.*, Murray, *supra* note 158, at 2093; Bridges, *supra* note 158, at 44–46—who likely need more time to gather the resources to pay for these costs.

[172] If the financial burden of abortion is too high for these women, one can reasonably infer that the expenses of childbirth and raising a child would be even further beyond reach.

[173] Some women who possess sufficient financial means could circumvent these restrictions, either by consulting doctors already in their confidence who are willing to perform illegal abortions in secret, or by traveling to states where abortion is legal, covering also the associated logistical costs. Yet, those lacking financial means to travel to another state, many of whom are likely women of color, will be left with no choice but to carry the unwanted pregnancy to term.

[174] In 2020, medication abortions constituted over half of all abortions in the United States, with over ninety-eight percent of these involving a combined regimen of mifepristone and misoprostol. *See* Gilda Sedgh & Irum Taqi, *Mifepristone for Abortion in a Global Context: Safe, Effective and Approved in Nearly 100 Countries*, Guttmacher Pol'y Analysis (Jul. 2023), https://www.guttmacher.org/2023/07/mifepristone-abortion-global-context-safe-effective-and-approved-nearly-100-countries [https://perma.cc/T3VT-J9HD].

of a drug called mifepristone, taken orally, combined with misoprostol.[175] Crucially, the U.S. Food and Drug Administration (FDA) approves mifepristone for use only up to the tenth week of gestation,[176] given the risks of incomplete abortion, heavy bleeding, and increased infection linked with more advanced gestational age.[177] Therefore, anyone missing this cutoff of ten weeks is forced to undergo a surgical procedure, even in states with more relaxed stipulations. Such procedures, performed in clinics, are less private[178] and logistically more complicated than the medication route.[179] Since most women seeking abortions in the United States pay out-of-pocket,[180] and a large proportion of them are low-income,[181] the current cost of these services may render abortion financially inaccessible for many who require this form of healthcare.[182] Furthermore, in the post-*Dobbs* era, characterized by lengthy waiting lists for surgical abortions,[183] this surgical route becomes

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[175] Mifepristone operates by inhibiting the hormone progesterone, which is needed for a pregnancy to continue. Nonetheless, mifepristone alone may not always be sufficient to terminate a pregnancy, which is why it is typically administered alongside misoprostol. Misoprostol induces contractions that facilitate the expulsion of the fetus. *See* Irving M. Spitz & C.W. Bardin, *Mifepristone (RU 486): A Modulator of Progestin and Glucocorticoid Action*, 329 New Eng. J. Med. 404, 405 (1993).

[176] It should be highlighted that, initially, the FDA approved the drug as far as seven weeks of pregnancy. Only in 2016 did the FDA expand the use of medication abortion to ten weeks of gestation. *Questions and Answers on Mifespristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, U.S. Food & Drug Administration, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation [https://perma.cc/T797-Z8HT].

[177] *But see infra* notes 195–97 and accompanying text.

[178] Given that medication abortion can be performed at home with the supervision of health providers through videoconferencing or telephone consultations, it reduces the need for physically visiting a healthcare facility. This can be more private and potentially less stressful. This aspect is particularly relevant in the context of increasing abortion restrictions and harassment at clinics by anti-abortion activists.

[179] *See supra* note 171.

[180] *See, e.g.*, Sarah C.M. Roberts et al., *Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States*, 24 Women's Health Issues e211, e217 (2014).

[181] *See, e.g.*, Sabrina Tavernise, *Why Women Getting Abortions Now Are More Likely to Be Poor*, N.Y. Times (Jul. 9, 2019), https://www.nytimes.com/2019/07/09/us/abortion-access-inequality.html [https://perma.cc/3RED-22MV]; *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions*, Advancing New Standards Reprod. Health (Aug. 2018), https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf [https://perma.cc/HS7J-CMP4]; Dan Keating et al., *Abortion Access Is More Difficult for Women in Poverty*, Wash. Post (Jul. 10, 2019), https://www.washingtonpost.com/national/2019/07/10/abortion-access-is-more-difficult-women-poverty/ [https://perma.cc/E5JP-YVL7].

[182] *See* Rosalyn Schroeder et al., *Trends in Abortion Care in the United States, 2017–2021*, Advancing New Standards Reprod. Health 12 (2022), https://www.ansirh.org/sites/default/files/202206/Trends%20in%20Abortion%20Care%20in%20the%20United%20States%2C%202017-2021.pdf [https://perma.cc/AK87-PLW8].

[183] While delays in abortion care certainly occurred prior to the Dobbs decision, they worsened due to congestion at the closest clinics in neighboring states. Half of states ban or significantly limit abortion, which means that approximately half the providers will need to cover the demand for abortion services from the whole of the United States. *See, e.g.*, Daniel Grossman et al., *Care Post-*Roe*: Documenting Cases of Poor-Quality Care Since the* Dobbs *Decision*, Advancing New Standards Reprod. Health 15 (May 2023),

increasingly inaccessible for many. The extended wait times can result in women unwillingly exceeding the legal timeframe for abortions as the days tick by, even in those states without outright bans but with reduced permissible windows for the procedure.[184]

Against this backdrop, this Part urges legal actors to cultivate more awareness of, and sensitivity toward, the variability in women's experiences and perceptions of gestational time. This need not necessarily involve adjusting the gestational-age threshold to match the personal pregnancy consciousness of all women. Indeed, some of the rationales for these thresholds extend beyond pregnancy consciousness and instead concern pregnant women's health and moral considerations related to the status of the fetus.[185] However, while acknowledging the inevitability of these gestational-age thresholds, the insights provided here could inform advocacy to contribute to a more tolerable reproductive experience. This includes challenging the law's detrimental surveillance over gestational time and formulating measures that enhance the law's responsiveness to its variability. The next section details how these principles can be applied in practice.

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https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf [https://perma.cc/9XBP-FUCB]; Leigh Paterson, *As Demand for Abortions in Colorado Goes Up, So Do Wait Times for In-Person Care*, KUNC (May 2, 2023), https://www.kunc.org/news/2023-05-02/as-demand-for-abortions-in-colorado-goes-up-so-do-wait-times-for-in-person-care [https://perma.cc/6J4S-K7FL]; Kimya Forouzan, *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care*, Guttmacher Institute (Dec. 2023) https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care [https://perma.cc/S55D-FWMT].

[184] The fact that mifepristone is prescribed later than week ten by some doctors, off-label—prescribing medication for uses other than those the FDA has approved, which is a common practice among doctors in the United States—ostensibly mitigates some of the concerns discussed. Yet, healthcare providers are still reluctant to do this out of rational fears relating to liability. *Cf.* David S. Cohen et al., *Abortion Pills*, 76 Stan. L. Rev. 367, 371 (2024) (outlining the legal risks healthcare providers face for providing this care). Therefore, it should come as little surprise that, according to a recent study, only thirty-three percent of clinics provide medication abortions outside that timeframe. *See* Schroeder et al., *supra* note 182. Moreover, the assumption that off-label prescription truly addresses the ramifications arising from the legal construction of gestational time is erroneous. The opposite is true. Wealthy women are more likely to have the connections and wherewithal to find a physician willing to prescribe these drugs off-label and to be able to absorb the cost, which may not be covered by health insurance. Under current federal policy, states are permitted to use Medicaid (public health insurance) funds to cover abortion services only in limited circumstances—such as when the pregnancy results from rape or incest, or when continuing the pregnancy endangers the person's life. This policy makes it difficult for low-income women (many of whom are of color) to use Medicaid for abortion purposes outside these specific situations. *See* Temp. U. Center for Pub. Health L. Rsch., *Restrictions on Public Funding of Abortion*, LawAtlas.org (Nov. 1, 2022), https://lawatlas.org/datasets/restrictions-on-public-funding-of-abortion [https://perma.cc/3DRF-8TG7]; *see also* Alina Salganicoff et al., *The Hyde Amendment and Coverage for Abortion Services*, Kaiser Fam. Found. (Mar. 5, 2021), https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/ [https://perma.cc/MZ9F-SSVJ].

[185] *See supra* note 134 and accompanying text.

C. Reorienting Abortion Law?

The law, in general, is grounded in certain temporal logics, designed to secure uniformity, efficiency, and certainty, leaving subjective accounts outside their scope.[186] While this is true for many areas of law, it is particularly pronounced in the context of pregnancy.[187] Any gestational age threshold disadvantages some pregnant women relative to others due to the considerable biological and socio-economic disparities between them.

This reality should, at the very least, compel us to question the necessity of regulatory burdens that further obstruct women's control over their gestational time. A closer examination of the rationales underlying these constraints will remind us of the paternalistic approach—expressed as concern for the interest or well-being of the women involved—that was similarly discussed in the context of fertility preservation.[188]

Take, for example, the mandatory waiting period of 24–72 hours between requesting an abortion and undergoing the procedure. This burden is predominantly found in states that have shortened the gestational threshold to the first trimester.[189] The waiting period can extend to a week or more due to logistical factors[190] and is counted within the already-constrained gestational time, which risks preventing the pregnant woman from adhering to the legal threshold of abortion. While ostensibly intended to give women time to reconsider their decision,[191] under recent abortion laws, this requirement is more likely to directly *impede* the decision, effectively forcing them to continue with an unwanted pregnancy. It slows down the process at a critical juncture when women are nearing the deadline, rendering the pace of accessing abortion increasingly beyond their control. This outcome demonstrates the insidious manipulation inherent in this regulatory burden and acts as a reminder of the state's dominance over women's bodies.[192] But it also justifies advocating for the removal of time-consuming mandates in the already limited timeframe for abortion in the post-*Dobbs* era.

Another regulatory burden warranting challenge is the gestational threshold for medication abortion, in which, as previously discussed, the necessary

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[186] Liaquat Ali Khan, *Temporality of Law*, 40 McGeorge L. Rev. 55, 90–92 (2009) (noting that temporal patterns embedded in law are designed to achieve "efficiency and administrative convenience").

[187] *See, e.g.*, Noy Naaman, *Affective Reproductive Legality: Navigating the Borderland of Life and Death*, 35 Yale J.L. & Humans. 131, 154 (2024) (discussing the tensions over the gestational stage from which a stillbirth birth certificate is issued).

[188] *See supra* notes 115–16 and accompanying text.

[189] *See supra* note 170 and accompanying text.

[190] *See, e.g.*, Roberts et al., *supra* note 131, at 182.

[191] *See supra* note 130 and accompanying text.

[192] The impact of this outcome is not only discursive but also material: the waiting-period requirement often includes a mandatory in-person counseling session, necessitating two separate trips to the healthcare provider. This is especially challenging for indigent women and women of color, due to the time off work required, as well as difficulties with transportation costs and childcare arrangements.

drug is only approved by the FDA for use up to the tenth week of pregnancy.[193] Again, here, the rationale underlying this time threshold, as cited in the legal challenges to the FDA Approval of Medication Abortion Pills,[194] is ostensibly to ensure patient safety. Yet, this threshold stands in stark defiance of established and growing scientific studies that find self-managed medication abortion to be safe and effective beyond ten weeks.[195] Based on this latest evidence, the World Health Organization acknowledges the safety and effectiveness of medication abortion up to 14 weeks, while *recommending* the usage of mifepristone combined with misoprostol only within the first 12 weeks of pregnancy.[196] Several countries in Europe have already adopted this recommendation.[197]

The disparity between the scientific versus the legal timeline (reflected in the FDA regulations) may reflect "abortion exceptionalism," referring to various ways in which abortion is restrictively regulated compared to other healthcare procedures with similar degrees of complexity and safety,[198] or other legal procedures.[199] Such abortion exceptionalism, as Greer Donley rightly underscores, "is a part of a larger [political] pattern of bias … that has harmed women's health."[200] Abortion is undeniably a politically charged issue. However, the FDA, in its role as an administrative body, is obligated to adhere to its scientific mandate. This commitment has substantial and direct consequences for the lives of women. If the FDA were to approve medication abortion for additional weeks, in line with the WHO guidelines, abortion would become more accessible, as more health care providers would be encouraged to offer early abortion care. This would open up a more cost-effective,[201] logistically

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[193] *See supra* note 176 and accompanying text.

[194] Several anti-abortion groups, such as the American Association of Pro-Life Obstetricians and Gynecologists, have submitted petitions to request the Commissioner of Food and Drugs to revert to the seven-week approval period (as applied before 2016), basing their argument on the protection of women's health. *See, e.g.*, Citizen Petition, Am. Ass'n Pro-Life Obstetrics & Gynecology https://aaplog.org/wp-content/uploads/2021/01/Citizen-Petition-Final-FDA-Mif-REMS.pdf [https://perma.cc/UP3G-F6YA] ("Given the serious risks of failure, hemorrhage, infection, and ongoing pregnancy that increase as pregnancy advances, the gestational limit for the Mifeprex regimen should have never been increased.").

[195] *See, e.g.*, Katherine Whitehouse et al., *Medical Regimens for Abortion at 12 Weeks and Above: A Systematic Review and Meta-Analysis*, 2 Contraception: X 1, 10–11 (2020); Heidi Moseson et al., *Effectiveness of Self-Managed Medication Abortion Between 9 and 16 Weeks of Gestation*, 142 Obstetrics & Gynecology 330, 331–37 (2023).

[196] World Health Org., Abortion Care Guideline xxix (2022), https://www.who.int/publications/i/item/9789240039483 [https://perma.cc/62BD-SMMQ]. It should be noted that the WHO report, published in 2018, clarifies that its recommendations relied on these studies, among others. World Health Org., Medical Management of Abortion, 26–30 (2018), https://clacaidigital.info/bitstream/handle/123456789/1184/Medical%20Management%20abortion.pdf?sequence=5&isAllowed=y [https://perma.cc/KY8J-PRF8].

[197] *See, e.g.*, Sedgh & Taqi, *supra* note 174.

[198] *See, e.g.*, Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 Yale L.J. 1428, 1448 (2016).

[199] *See, e.g.*, Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 Wash. & Lee L. Rev. 1047, 1048–49 (2014).

[200] Greer Donley, *Medication Abortion Exceptionalism*, 107 Cornell L. Rev. 627, 668 (2022).

[201] *See supra* note 174 and accompanying text.

simpler, and safer option than the traditional alternative of a surgical procedure to many more women.

While these two suggestions—eliminating the waiting period requirement and extending the ten-week limit for abortion medication—do not directly tackle the disparities created by the medical-legal construction of gestational time, they would help alleviate their repercussions. In states with restricted abortion time frames, women who become aware of their pregnancies after the legal threshold may face legal barriers to abortion. However, adjusting other temporal aspects of the abortion procedure could make termination more feasible for those who realize their pregnancy status before reaching this threshold. Taking such actions can lead to a more tolerable reproductive experience at a time when the legal status of abortion rights is precarious.

Yet, it is crucial for advocates to also advance measures that enhance the law's responsiveness to subordinated experiences of gestational time beyond the legal framework of abortion. Each woman's temporal experience of pregnancy is closely linked to the circumstances of conception. For instance, unintended conception can delay pregnancy recognition.[202] This link could explain the higher incidence of late pregnancy recognition among indigent women and women of color, as these groups have been consistently found to have limited access to the most efficient family planning methods[203] and, thus, to have a higher chance of experiencing contraceptive failure.[204] Hence, expanding access to contraception is a vital strategy that should continue to be centered at the heart of advocacy,[205] especially in the post-*Dobbs* era, where ease of access to contraception is on an increasingly precarious path.[206]

Furthermore, it is essential to continue developing strategies to eliminate racial disparities in reproductive healthcare more broadly. Research has shown that women of color face disparities in the diagnosis and treatment

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[202] *See supra* note 152–53 and accompanying text.

[203] *See, e.g.*, Kywanna Alfred & Katherine M. Holmes, *The Intersection of Race and Class and the Use of Long Acting Reversible Contraception (LARC): A Quantitative Analysis*, 133 Obstetrics & Gynecology 10S, 10S (2019).

[204] *See, e.g.*, Andrea Jackson, *Racial and Ethnic Differences in Contraception Use and Obstetric Outcomes: A Review*, 41 Seminars Perinatology 273, 273 (2017); Theresa Y. Kim et al., *Racial/Ethnic Differences in Unintended Pregnancy: Evidence from a National Sample of U.S. Women*, 50 Am. J. Preventative Med. 427, 427 (2016).

[205] Equally important is the further development of contraceptive methods tailored to reflect the health risks disproportionately faced by women of color, given evidence that estrogen-based contraceptives (such as combination birth control pills) are associated with a heightened incidence of cardiovascular issues among African-American women. *See* Barbara A. Frempong et al., *Effect of Low-Dose Oral Contraceptives on Metabolic Risk Factors in African-American Women*, 93 J. Clinical Endocrinology & Metabolism 2097, 2100 (2008).

[206] *See, e.g.*, Manian, *supra* note 26, at 80 (arguing that, during this era, "restrictions on contraception will likely draw on religious objections to insurance coverage for contraceptives and false assertions about contraception operating as an abortion"); Megan L. Kavanaugh & Amy Friedrich-Karnik, *Has the Fall of Roe Changed Contraceptive Access and Use? New Research from Four U.S. States Offers Critical Insights*, 2 Health Affs. Scholar 1, 3 (2024) (finding that, two years after *Dobbs*, young people faced more difficulty in accessing their preferred contraception and received more contraceptive care but less high-quality, person-centered care).

of reproductive health conditions, such as polycystic ovary syndrome,[207] fibroids,[208] and endometriosis,[209] as well as being overrepresented in data tracking the prevalence of these conditions.[210] Such reproductive health conditions are known to cause irregular menstrual cycles and bleeding—two factors that significantly contribute to delayed pregnancy recognition.[211] Addressing these disparities can not only improve overall health outcomes for these women but also mitigate the delayed pregnancy recognition they often experience.

IV. Parentage Time

Shifting our focus from fertility and pregnancy, this Part focuses on a subsequent phase in the reproductive journey: the point at which a child is born. While the birth of a child legally signifies the emergence of a new parent, the notion that an individual becomes a parent at the point of birth is not a purely biological matter. It is also normatively constructed—an understanding captured in the term 'parentage time.' This Part appraises the construction of parentage time by focusing in on the law of parentage. It argues that, while ostensibly 'natural,' this construction of time is grounded in outmoded heterosexual norms regarding family formation.

The argument I present here progresses through three sections. *Section A* appraises and problematizes the socio-legal construction of parentage time. It demonstrates how the law imposes an undue burden on non-biological parenthood, and in a way that disproportionately impacts same-sex couples. This leaves many individuals in the troubling position of being parents while simultaneously being informed by the law that they are *not* (yet). *Section B* considers the harms resulting from this sexuality-based disparity, which are both material/visible and discursive/insidious. *Section C* discusses how the law could be feasibly reoriented to address this disparity, given recent judicial developments that lay the groundwork for potential reform.

It is worth underscoring that the focus here is not the lack of recognition of same-sex parentage but, rather, how—and, more specifically, *when*—this

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[207] *See, e.g.*, Katherine VanHise et a2l., *Racial and Ethnic Disparities in Polycystic Ovary Syndrome*, 119 Fertil. & Steril. 348, 352 (2023).

[208] *See, e.g.*, Jay M. Berman et al., *Uterine Fibroids in Black Women: A Race-Stratified Subgroup Analysis of Treatment Outcomes After Laparoscopic Radiofrequency Ablation*, 31 J. Women's Health 593, 593 (2022).

[209] *See, e.g.*, Onchee Yu et al., *Adenomyosis Incidence, Prevalence, and Treatment: United States Population-Based Study 2006–2015*, 223 Am. J. Obstetrics & Gynecology 94.e1, 94.e2 (2020).

[210] Erica Marsh, *Uncovering Drivers of Racial Disparities in Uterine Fibroids and Endometriosis*, Inst. for Healthcare Pol'y & Innovation, U. Mich. (2023), https://ihpi.umich.edu/news/uncovering-drivers-racial-disparities-uterine-fibroids-and-endometriosis [https://perma.cc/TL2P-MNST].

[211] Katie Watson & Cara Angelotta, *The Frequency of Pregnancy Recognition across the Gestational Spectrum and Its Consequences in the United States*, 54 Persps. Sexual & Reprod. Health 32, 34, 36 (2022).

recognition is granted.[212] Notably, even under regimes where same-sex parenthood is recognized, the sexuality-based disparity still looms large. As Professor Douglas NeJaime puts it, "courts and legislatures [often] aspire to inclusion and yet do so within frameworks that carry forward legacies of inequality."[213] While the legacies of inequality in parentage have been thoroughly discussed in the scholarship,[214] less attention has been given to the temporal aspect of this subordination.[215] Focusing on these unequal structures through the lens of time-as-social-construct provides a new way to understand how these disparities are perpetuated and naturalized. Furthermore, this focus attests to the conceptual understanding, centered at the heart of this Article, that reproductive time—in its various forms—is a determining, albeit implicit, factor of inequality.

A. The Socio-Legal Construction

When does a person become a legal parent?[216]

The birth of a child legally signifies "the birth of parenthood."[217] Parental status, when the adults in question constitute a different-sex couple, is typically conferred immediately upon birth or soon after. For the parent who bears the child, often women, the default rule under Anglo-American law is that this

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[212] Parentage time can be viewed as a derivation of parentage recognition—what makes a person a legal parent. Rather than addressing this question, this Part assumes the non-biological parent will eventually be recognized as a legal parent (as is feasible for same-sex couples in most jurisdictions in the United States) and examines the timing of this recognition. By emphasizing the sexuality-based disparity through the lens of timing—rather than the question of whether or not parentage will be recognized—this approach offers a more nuanced understanding of inequality.

[213] NeJaime, *supra* note 9, at 2316 n. 271.

[214] For an early influential account, see, e.g., Nancy D. Polikoff, *This Child Does Have Two Mothers: Redefining Parenthood to Meet the Needs of Children in Lesbian-Mother and Other Nontraditional Families*, 78 Geo. L.J. 459 (1990) (discussing how the legal system should assess the rights and responsibilities of same-sex parents upon divorce). For more recent contributions, see, e.g., Susan Frelich Appleton, *Presuming Women: Revisiting the Presumption of Legitimacy in the Same-Sex Couples Era*, 86 B.U. L. Rev. 227, 230–31 (2006); NeJaime, *supra* note 9, at 2331–34; Noy Naaman, *The Paradox of Same-Sex Parentage Equality*, 100 Wash. U. L. Rev. 229 (2022) (discussing the paradoxical results of Israel's Judicial Parental Order, which sought to increase parentage equality between heterosexual and homosexual parents).

[215] For examples of scholarship that address the temporal aspect of parentage more broadly, see, e.g., Purvis, *supra* note 14, at 211–12, 229–30 (discussing how parental intent is used in determining the precise point in time at which parents are legally recognized); Joslin, *supra* note 14, at 439–42 (discussing the option of establishing the parentage before the child's birth in surrogacy arrangements). Akshat Agarwal, '*New Parents' and the Best Interests Principle*, 35 Yale J.L. & Feminism 288, 346 (2024) (discussing the temporal aspect of the best-interests principle).

[216] Indeed, the concept in question presupposes that the *transition* to parenthood is defined by a singular event rather than a gradual process. This is a contested premise, as I have discussed elsewhere, demonstrating that while the law acknowledges the process of becoming a parent in some cases, it often reduces it to biological—primarily gestational—terms. *See* Noy Naaman, *Timing Legal Parenthood*, 75 Ark. L. Rev. 59, 87–94 (2022).

[217] *Id.* at 87.

person is the legal mother from the moment of birth.[218] The parental status of the birth mother's partner, as long as he is male, will likely be conferred simultaneously or shortly after the birth.

If they are married, the male partner will immediately be recognized as a parent through the marital presumption, whether in the case of sex-based conception or IVF, even if he has no biological relation to the child.[219] This is because, typically, the marital presumption is used as a basis for inferring that the husband is the biological father.[220] Besides the common-law presumption, in some states' statutes that define paternity in cases of artificial insemination with donor sperm (AID), the husband will automatically be recognized as the child's father at birth.[221]

If the parents are unmarried, the parental status of the birth mother's (male) partner may be established by completing a written form that they can request soon after the birth, if not at the hospital. This straightforward declaration that the partner is the legal parent goes by different names but, in the United States, it is known as the Voluntary Acknowledgement of Parentage (VAP).[222] In most U.S. jurisdictions, this procedure is available to any different-sex couple in which the man claims to be the child's genetic father.[223] The law formally provides that, if the man lacks a biological related to the child, he will only be recognized as the legal parent some considerable time after the birth, following a lengthy court adjudication process. Specifically, this recognition can be sought either through the second-parent adoption route[224]

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[218] David D. Meyer, *Parenthood in a Time of Transition: Tensions between Legal, Biological, and Social Conceptions of Parenthood*, 54 Am. J. Compar. L. 125, 127 (2006). The exception to automatic legal parentage at birth typically occurs in cases involving enforceable surrogacy agreements, where the surrogate, despite giving birth, does not receive legal parentage. Instead, the intended parents, as specified in the surrogacy agreement, are granted legal parentage at the child's birth.

[219] All U.S. state legislation maintains the marital presumption. Douglas NeJaime, *Who Is a Parent?*, 43 Fam. Advoc. 6, 7 (2021). This presumption remains the most common way of establishing the parentage of the husband. Jessica Feinberg, *Parent Zero*, 55 U.C. Davis L. Rev. 2271, 2280 (2022).

[220] *See, e.g.*, Katharine K. Baker, *Legitimate Families and Equal Protection*, 56 B.C. L. Rev. 1647, 1659 (2015); Douglas NeJaime, *Marriage Equality and the New Parenthood*, 129 Harv. L. Rev. 1185, 1242 n.338 (2016).

[221] *See* Courtney G. Joslin et al., Lesbian, Gay, Bisexual and Transgender Family Law § 3.3 (2024–25 ed. 2024).

[222] The person will continue to be the legal parent unless the VAP is rescinded within 60 days or successfully contested thereafter, a process permitted only under limited circumstances such as duress, material mistake, or fraud. *See* Jeffrey A. Parness, *Faithful Parents: Choice of Childcare Parentage Laws*, 70 Mercer L. Rev. 325, 351–53 (2019).

[223] This form is limited to a situation where the birth mother is the legal parent. Thus, this procedure is not applicable to surrogacy. *See id.* at 345. Twelve U.S. states currently allow the intended parents of a child conceived through MAR to sign this form even if they are not biologically related to the child. *See* GLBTQ Legal Advocates & Defenders, *FAQ: Voluntary Acknowledgment of Parentage (VAP)*, https://www.glad.org/voluntary-acknowledgment-of-parentage/#:~:text=By%20signing%20a%20VAP%2C%20a,agreement%20and%20outside%20of%20court [https://perma.cc/D3LD-W5YG].

[224] As for U.S. jurisdictions that adopted the second-adoption procedure, see NeJaime, *supra* note 9, at 2296–97, 2297 n.182, 2370–72.

or according to a *functional* parentage model.[225] *In practice*, however, parentage is likely to be conferred on the man regardless of whether he has any genetic relation to the child. This is because no proof of a genetic relationship is required when submitting this form.[226] Another reason for this discrepancy is that U.S. federal law forbids states from insisting on further steps—such as blood tests—to complete a VAP.[227] Under these circumstances, it is perhaps unsurprising that, according to some studies, the rate of parentage recognition among non-biological parents through VAP could be as high as thirty percent.[228]

In stark contrast, when the non-biological parent is of the same sex as the biological parent (as in the case of same-sex couples), in many states, the parental status of the former is more likely to be established, both formally and in practice, through post-birth judicial procedures. This results in a parentage recognition that occurs well after childbirth. Specifically, in states that still limit the marital presumption to different-sex couples[229] or still limit the parentage registration based on a written form signed immediately after the birth to unmarried heterosexual couples,[230] same-sex couples disproportionately experience this delay. The non-biological parent in same-sex couples can only

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[225] Parental function takes into account the role the adult plays in the child's life and the relationship that develops between them. For further reading on the functional parent doctrines in the United States, see, e.g., Courtney G. Joslin & Douglas NeJaime, *How Parenthood Functions*, 123 Colum. L. Rev. 319, 329 (2023).

[226] *See* Leslie Joan Harris, *Voluntary Acknowledgments of Parentage for Same-Sex Couples*, 20 Am. U. J. Gender Soc. Pol'y & L. 467, 479 (2012); Baker, *supra* note 220, at 1686–87.

[227] 45 C.F.R. § 302.70 (a)(5)(vii) (2024) (stating that, once a VAP is signed, it "must be recognized as a basis for seeking a support order without requiring any further proceedings to establish paternity," necessarily excludes requiring blood tests); *see also* Susan Hazeldean, *Illegitimate Families,* 59 Harv. C.R.-C.L. L. Rev. 157, 185 (2024) (explaining that "federal law forbids states from requiring a blood test to complete a VAP").

[228] *See* Tianna N. Gibbs, *Paper Courts and Parental Rights: Balancing Access, Agency, and Due Process*, 54 Harv. C.R.-C.L. L. Rev. 549, 602 (2019). Estimates of non-biological parentage through VAP vary, with studies suggesting rates between 10% and 30%. *See* Susan Ayres, *Paternity Un(Certainty): How the Law Surrounding Paternity Challenges Negatively Impacts Family Relationships and Women's Sexuality,* 20 J. Gender Race & Just. 237, 240–41 (2017).

[229] Several states include statutes requiring the gender-neutral application of this presumption in non-surrogacy conception to be made explicit. *See* Joslin et al., *supra* note 221, at § 5.22. In other states, where the legislators did not include these inclusive applications, courts have, nonetheless, held that the law must be interpreted in a gender-neutral manner, following Obergefell v. Hodges, 576 U.S. 644, 681 (2015), which required states to provide marriage rights to same-sex couples on the same terms afforded to heterosexual couples. Yet, this extension has not been accepted by all courts. *See, e.g.*, Turner v. Steiner, 398 P.3d 110, 115 (Ariz. Ct. App. 2017) (stipulating that "biology—the biological difference between men and women—*is* the very reason the presumption statute exists"); Paczkowski v. Paczkowski, 10 N.Y.S.3d 270, 271 (N.Y. App. Div. 2015) (holding that the lesbian spouse lacked standing to seek custody of a child born to her wife during the marriage because the statutory marital presumptions "do not provide her with standing as a parent, since the presumption of legitimacy they create is one of a biological relationship, not of legal status and, as the nongestational spouse in a same-sex marriage, there is no possibility that she is the child's biological parent" (citation omitted)).

[230] Twelve states allow the parent of a child conceived via MAR to execute a VAP, regardless of the parents' sex. *See* GLBTQ, *supra* note 223.

formalize their parental status through either (a) adoption, which may take months and involves an at-home visit from a specialist social worker[231] or (b) avenues based on the parental function, which by its very nature, requires the passage of time, sometimes two years or more, during which the person accumulates evidence to verify that they perform that role.[232]

The nuances of this impediment within this process merit meticulous observation. While most couples benefit from immediate legal recognition, others are forced to wait for the State—represented by myriad institutional actors such as judges, state attorneys, and, sometimes, welfare officers—to acknowledge them following a child's birth. Indeed, this legal impediment creates a sense of hierarchical priority and expedience to some family dynamics while leaving others facing delays and bureaucratic obstacles.

The disadvantageous treatment comes sharply into focus if we compare women conceiving a child through AID with either (a) the male spouse of a biological mother using artificial insemination or (b) the unmarried male partner of a biological mother. In the former case, as mentioned earlier, the man can be designated as the child's father through the marital presumption even when he does not have any biological relation to the child. In the latter case, the man can be designated as the child's father through the VAP without having to provide any evidence that he is, in fact, the biological father. This disparity is summarized in Table 1.

Table 1: Timing of Parentage Recognition

<table>
<tr><th>Same-Sex Couples</th><th colspan="2">Different-Sex Couples</th><th>Marital Status</th></tr>
<tr><td rowspan="4">Post-birth

(via adoption/ functional parenthood framework)</td><td>At-birth
(via marital presumption/ AID statutes)</td><td>Biological parent</td><td rowspan="2">Married</td></tr>
<tr><td>At-birth
(via marital presumption/ AID statutes)</td><td>Non-biological parent</td></tr>
<tr><td>At-birth
(via VAP)</td><td>Biological parent</td><td rowspan="2">Unmarried</td></tr>
<tr><td>At-birth
(via VAP in practice)</td><td>Non-biological parent</td></tr>
</table>

[231] NeJaime, *supra* note 9, at 2317.

[232] Consider, for example, the "holding out" presumption, stipulated in the Uniform Parentage Act 2017, which states that a person who has received the child into their home and has "held it [the child] out" as their own for a minimum of two years is presumed to be the child's legal parent. Unif. Parentage Act § 204(a)(2) (Unif. L. Comm'n 2017).

This disparate impact elucidates that the commonly accepted notion of becoming a parent at the point of birth is not solely biological but is also normatively constructed. While ostensibly "natural," this normative construction of parentage time does not systemically disadvantage non-biological parenthood per se. Instead, it disproportionately impacts same-sex couples. This manipulation comes into sharp focus in the current era of MAR in which the 'natural' timeline of family formation is rendered malleable. Individuals can now bring a child into the world even when there is no genetic relation and can assume parental roles from birth. Yet, the law insists on upholding the 'natural' timeline unequally—excluding those who depart from the traditional norms of reproduction and parenting. Let us now highlight the detrimental implications of this disparity.

B. Sexuality-based Harms

Parentage time sets the very foundation on which family structures are established, nurtured, and sustained. Let us start, then, with a brief overview of the importance of parentage recognition. Parentage recognition provides legal status, enabling transparency and reliance on the attributed legal position of that individual.[233] It allows a person to enjoy the bundle of rights (with their corresponding obligations) derived from their legal status as a parent and to freely fulfill the most significant facets of the parent-child relationship: the *nurturing* dimension, concerning the child's care and well-being; the *financial* dimension, relating to the benefits for the family unit derived from the parents' status as such; and the *identity* dimension, which concerns how the family members define themselves.

However, parentage recognition *per se* is insufficient. When it comes to the birth of a child, the timing of this recognition is critical to the realization of multiple facets of the parent-child relationship. Notably, at-birth recognition empowers the parent to fulfill their parental responsibilities without obstruction, thereby ensuring the stability and security of the relationship, which is necessary for the child's care and well-being and is protected under the law. At-birth recognition also enables the parent to enjoy the financial safeguards derived from parental status, such as unemployment benefits and insurance, immediately after the birth.[234] These benefits are especially necessary during that period, when the family may face significant challenges and vulnerabilities due to the newborn's needs and the adjustments required for their care. Finally, at-birth recognition is essential for fulfilling the self-identification of

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[233] *See* Jessica A. Clarke, *Identity and Form*, 103 Calif. L. Rev. 747, 790, 837 (2015).

[234] For the importance of these financial safeguards, see, e.g., Melanie B. Jacobs, *Micah has One Mommy and One Legal Stranger: Adjudicating Maternity for Nonbiological Lesbian Coparents*, 50 Buff. L. Rev. 341, 346–47 (2002); Courtney G. Joslin, *Travel Insurance: Protecting Lesbian and Gay Parent Families Across State Lines*, 4 Harv. L. & Pol'y Rev. 31, 32 (2010).

the parent. Postponing until long after birth—the event that culturally marks the commencement of parenthood—disrupts the natural progression of self-continuity, which plays a key role in forming the parental identity.[235] Notably, when a non-biological parent—who has lived the parenthood journey from the very outset (such as the decision to take the IVF route) or throughout the pregnancy—faces delays in their legal recognition, this legal impediment interrupts the developmental process that naturally accompanies any person's trajectory toward self-identification as a parent. That is, what should be a natural evolution is unjustly halted—unjustifiably frozen in time.

Moreover, this legal impediment interferes with the organic dynamic of the family, where both parents serve in that capacity from the moment of the child's birth. This discrepancy creates a divide, where one parent (the one biologically related to the child) is perceived as having a "natural" connection to him or her, while the other's equally authentic bond is subjected to state suspicion, scrutiny, validation procedures, and formal legal processes. This outcome creates a hierarchy between the parents concerning their respective places in the child's life.

The implications of this hierarchy are palpable, positioning the parties on an unequal footing. In the event of the relationship dissolving, either before or after the child's birth, the biological parent may attempt to sever contact between their ex-partner and their child.[236] Without legal recognition of this parental relationship, the non-biological parent may find themselves barred from making decisions relating to their child.[237] They may even be denied the right to make medical decisions for a sick child or denied the right to visit them in the hospital. Conversely, a non-biological parent can abdicate responsibility for the child more easily than the biological parent, leaving the child with the support of only the latter.[238] Either outcome, if taken to court, not only involves lengthy litigation but also imposes unnecessary emotional and financial strains on the child.[239]

Discursive ramifications can also be discerned. The systematic delay produces a situation in which the internal timeline of an individual's family formation does not align with the timeline envisioned by the law. That is, their family-building processes are constructed as less natural than—and out of sync with—the institutional rhythm enacted by the law. This institutional time-keeping positions the out-of-sync individual as the 'Other,' marking theirs as a type of kinship that is questionable and must be subjected to greater state scrutiny.

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[235] *See, e.g.*, Naaman, *supra* note 216, at 73–79 (elaborating on this point and building on theories of narrative identity).

[236] *See, e.g.*, Alison D. v. Virginia M., 572 N.E.2d 27, 28 (N.Y. 1991); K.M. v. E.G., 117 P.3d 673, 677 (Cal. 2005); In re Parentage of L.B., 122 P.3d 161, 163 (Wash. 2005);

[237] *See, e.g.*, Polikoff, *supra* note 214, at 471.

[238] *See, e.g.*, Elisa B. v. Superior Court, 117 P.3d 660, 664 (Cal. 2005).

[239] *See* Jacobs, *supra* note 234, at 346; Joslin, *supra* note 234, at 32.

On the meta scale, the imposition of waiting as a condition for parentage recognition expresses and reinforces the subordinated position of same-sex couples. It imposes a burden that reminds us of the mechanisms embedded in the statutory waiting period for abortion.[240] Specifically, this experience of time marks the State's surveillance of these couples, perpetuating the notion that they are only worthy of receiving the longed-for status once the State has undertaken its verification procedures by inspecting the relationships involved. Notably, when it comes to same-sex couples, it is the State—rather than the individual—that holds the monopoly on crafting the person's biographical narrative.

C. Reorienting the Law of Parentage?

To the extent that it is not solely biology that determines the parentage recognition of the birth-parent's partner, this prompts an important question from a normative perspective. Namely: why do the same regulatory avenues—the marital presumption[241] or the VAP[242]—not apply in the case of same-sex couples?[243]

While, in practice, the marital presumption and the VAP allow the birth-mother's male partner to be recognized as the legal parent even in the absence of a biological link, this fact, in and of itself, may not justify extending their equal application to same-sex couples, for there is yet another factor at play. Notably, as for marital presumption, one stance is that "genetic ties remain relevant because most parents who rely on the marital presumption are heterosexual husbands whose wives conceived through sexual intercourse."[244] That is, while the proxy for a genetic bond may serve as a legal fiction, it is a fiction that clearly cannot be applied to same-sex couples.[245] As for the VAP, in numerous jurisdictions, the relevant forms require the birth-mother and the putative father to affirm, under penalty of perjury, that, to the best of their knowledge, the man is the *biological* father of the child.[246]

However, a closer examination of the evolving *judicial* application of these avenues elucidates that, as a matter of law, at-birth parentage recognition may alternatively be grounded in the *mutual consent* between the birth-mother and her partner. Under the mutual-consent approach, if, at a certain point in time, the pregnant party and another party mutually agree that the

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[240] *See supra* notes 126–29 and accompanying text.
[241] *See supra* notes 219–20 and accompanying text.
[242] *See supra* notes 222–23 and accompanying text.
[243] For the few states that have applied the VAP to same-sex couples, see GLBTQ, *supra* note 223.
[244] Gregg Strauss, *Parentage Agreements Are Not Contracts*, 90 Fordham L. Rev. 2645, 2653 (2022).
[245] NeJaime, *supra* note 220, at 1242.
[246] Gibbs, *supra* note 228, at 576 (explaining that "[f]or the VAP process to produce the intended result—legally establish parentage for the child's *biological* father—the signatories' acknowledgments must be true, knowing, and voluntary like a contract").

latter will be the child's legal parent, then the law should confer parentage on that party.[247] This approach, which has most commonly been found in cases of MAR involving gamete donation,[248] is rationalized on values of mutual care[249] and family autonomy.[250] This suggested interpretation could lay the groundwork for one particular route via which advocacy could challenge the sexuality-based disparity embedded in the application of parentage recognition.[251]

As for the marital presumption, courts are known to apply this even when proof exists that the husband is not the biological father.[252] Additionally, in some instances, courts have utilized the marital presumption to preclude a genetic parent from being recognized as the legal parent.[253] Indeed, this outcome could be rationalized on the basis of the best interest of the child—namely, that the child could be harmed if the parentage of the husband (the non-biological parent, who has actively participated in raising the child) is rebutted.[254] However, it could also attest to the foundational premise that entering into a marital relationship indicates a mutual commitment

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[247] This consent has been used in the United States and other common-law jurisdictions as a key consideration in parentage recognition. For an early and foundational contribution on the intent-based model, see, e.g., Marjorie Maguire Shultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 Wis. L. Rev. 297, 302 (1990) (proposing that "legal rules governing modern procreative arrangements and parental status should recognize the importance and the legitimacy of individual efforts to project intentions and decisions into the future").

[248] John Lawrence Hill, *What Does It Mean To Be a "Parent"? The Claims of Biology as the Basis for Parental Rights*, 66 N.Y.U. L. Rev. 353, 370 (1991).

[249] *See e.g.,* Shultz, *supra* note 247, at 343–44 (contending that using mutual consent as a factor in at-birth parentage determination safeguards the expectations and dependencies that have developed based on agreements between all parties).

[250] *See e.g.,* Richard F. Storrow, *Parenthood by Pure Intention: Assisted Reproduction and the Functional Approach to Parentage*, 53 Hastings L.J. 597, 642 (2002) (discussing how theories grounded in autonomy justify intent-based parentage*).*

[251] I am not, of course, the first to discuss how the mutual consent approach could benefit same-sex couples. My modest contribution here is to highlight how this approach has already been evidenced in judicial cases around the application of marital presumption and the VAP with regard to different-sex couples. For literature on the benefits of this approach to same-sex couples, see, e.g., Katherine M. Swift, *Parenting Agreements*, *The Potential Power of Contract, and the Limits of Family Law*, 34 Fla. St. U. L. Rev. 913, 924–30 (2007); Yehezkel Margalit, *Intentional Parenthood: A Solution to the Plight of Same-Sex Partners Striving for Legal Recognition as Parents*, 12 Whittier J. Child & Fam. Advoc. 39, 41 (2013); Melanie B. Jacobs, *Parental Parity: Intentional Parenthood's Promise*, 64 Buff. L. Rev. 465 (2016).

[252] *See, e.g.*, Jessica Feinberg, *Restructuring Rebuttal of the Marital Presumption for the Modern Era*, 104 Minn. L. Rev. 243, 266 (2019); June Carbone & Naomi Cahn, *Jane the Virgin and Other Stories of Unintentional Parenthood*, 7 U.C. Irvine L. Rev. 511, 536–37 (2017).

[253] Consider, for example, the noteworthy case of Michael H. v. Gerald D., 491 U.S. 110 (1989). In this case, an unmarried biological father, involved in an extramarital relationship with the mother, was prevented from asserting parentage against the wishes of the mother and her husband. *Id.* at 114, 129–30. Such was the weight of California's conclusive marital presumption that its application was upheld and the wishes of the biological father set aside. *Id.* at 129–130.

[254] *See, e.g.*, Feinberg, *supra* note 252, at 266 ("A number of courts, in refusing to allow the presumption to be challenged or overcome on the basis that rebuttal would be

to jointly raise the child.[255] Furthermore, this interpretation reflects and supports worthy values—commitment, care, and trust—that are much-needed in the parenthood context.[256] Notably, preventing either spouse—the biological mother or her husband—from rebutting the husband's parental status is rooted in the mutual expectations and dependencies that develop from the commitment to jointly raise the child, established upon entering into marriage. This proposed interpretation aligns with the statutes existing in most states—that, when a married woman becomes pregnant through AID, her husband will automatically be recognized as the child's father. While most of these statutes condition the husband's paternal status on his consent to the insemination, there is a strong presumption that he gave such consent, in the absence of written confirmation.[257]

In a similar vein, courts have held that an acknowledgment of paternity based on the signed declaration on the VAP binds its signatories, even if the parties knew that the male signatory was not the genetic father at the time of signing.[258] This could attest to the increasing weight given to the couple's mutual consent—evidenced by the shared decision to sign the VAP form—as an additional basis for at-birth parentage recognition.[259]

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contrary to the best interests of the child, have relied on the fact that the husband had functioned in the role of the child's parent and had formed a parental bond with the child.").

[255] For scholarly discussion of this premise, see, e.g., Katharine K. Baker, *Bargaining or Biology?: The History and Future of Paternity Law and Parental Status*, 14 Cornell J.L. & Pub. Pol'y 1, 25 (2004) ("Traditionally, by agreeing to enter into that status, husband and wife were agreeing to support and raise any children born to the marriage. Because husband and wife agreed to raise children, they were bound to be father and mother, regardless of whether the children born to the marriage were biologically related."); June Carbone & Naomi Cahn, *Nonmarriage*, 76 Md. L. Rev. 55, 89 (2016) ("This result reinforces marriage as an institution that presumes the spouses undertake shared and equal commitments to the children they produce as part of the union—even without a biological tie."). Likewise, as both Professors Richard Storrow and Courtney Joslin have observed, marriage to the biological parent provides the strongest support for the intended-parent's parental status. Storrow, *supra* note 250, at, 639–40 (2002); Courtney G. Joslin, *Protecting Children(?): Marriage, Gender, and Assisted Reproductive Technology*, 83 S. Cal. L. Rev. 1177, 1189 (2010).

[256] For the importance of these values in this context, see, e.g., Ayelet Blecher-Prigat, Noy Naaman & Ruth Zafran, *The Non-Marital Presumption*, 73 Am. J. Comp. L. (forthcoming, 2025).

[257] Joslin et al., *supra* note 221, at § 3.8.

[258] *See, e.g.*, People ex rel. Dep't of Pub. Aid v. Smith, 818 N.E.2d 1204, 1205 (Ill. 2004); In re Paternity of H.H., 879 N.E.2d 1175, 1177 (Ind. Ct. App. 2008); Burden v. Burden, 945 A.2d 656, 669 (Md. Ct. Spec. App. 2008). Likewise, in other cases, courts denied the presumed legal father's request for a DNA test to rule out paternity. *See, e.g.*, Demetrius H. v. Mikhaila C.M., 827 N.Y.S.2d 810, 811 (N.Y. App. Div. 2006); State ex rel. Carnley v. Lynch, 53 So. 3d 1154, 1154 (Fla. Dist. Ct. App. 2011) (per curiam); *cf.* J.M. v. M.A., 950 N.E.2d 1191, 1193 (Ind. 2011) (holding that where a legal father is a minor at the time of signing and believes it is necessary for establishing guardianship, his signing constitutes a mistake that warrants setting aside the VAP, even if he knew he was not the biological father); Bedell v. Price, 828 S.E.2d 263, 268 (Va. Ct. App. 2019) (holding that a man who signed a VAP on the belief that he may be the father, which subsequently was proven to be incorrect, constituted a mistake sufficient to warrant reversing a finding that he was the child's legal father).

[259] Feinberg, *supra* note 219, at 2307; Strauss, *supra* note 244, at 2653–54.

My argument here is that, if mutual consent, be it implicit or explicit, has been used as a rationale underpinning the application of marital presumption or the VAP with regard to the biological mother's intimate partner, there is no coherent basis on which refusal to similarly apply it as a factor for *at-birth* parentage when the parties are of the same sex can be justified. Indeed, it appears particularly incoherent if we consider that the law already acknowledges same-sex parentage, albeit through less accessible and appropriate regulatory avenues. From this perspective, we can appreciate that the mutual consent to co-parent, regardless of the gender or sexual orientation of the individuals concerned, would provide a feasible—and convenient—way to correct the sexuality-based asymmetry that currently plagues parentage recognition.

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Before concluding, it is essential to recognize that aligning parentage recognition with the child's birth may not always be suitable in the complex realm of procreation and parenthood. There are situations where this legal impediment may, indeed, be justified. Yet, they raise several critical questions that warrant further consideration.

One such scenario occurs when a parent joins a child's life after birth, rather than when the child is born into a family with two (or more) parents. In this case, a function-based approach is appropriate, in which the law considers the active role the adult plays in the child's life and the relationship that develops between them. Demonstrating fulfillment of the parental function necessarily requires time for sufficient 'evidence' to accumulate. Yet, one question arising here is whether, in this scenario, the judicial order should be effective retroactively from the moment the adult joined the child's life or only from when the order is granted (which may be years later).[260] A related scenario arises when a non-biological parent enters into a relationship with the birth mother *during pregnancy* rather than before conception. While it is relatively straightforward to accept that joining before conception justifies at-birth recognition based on mutual consent—since both parents have jointly planned and embarked on the journey of parenthood from the outset—it is less clear whether joining during pregnancy justifies the same *at-birth* recognition, though it does not necessarily preclude that possibility, as I argue elsewhere.[261]

Another scenario arises when the birth mother is not intended to be the legal parent. In surrogacy contexts, for instance, some countries impose a waiting period—typically 24 hours to seven days after birth—during which the surrogate can reconsider and retain her parental rights. Only after this period can the intended parents be recognized as the child's legal parents. The

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[260] The retroactive application of a judicial parental order has both practical and psychological implications. Practically, it affects the timing of economic benefits tied to the child-parent relationship. Psychologically, it influences the narrative of when the family's biographical story officially starts. *See* Noy Naaman, *Israel: Judicial Parental Order as a Means of Recognizing Same-Sex Parenthood*, *in* International Survey of Family Law 2021 273, 281 (Margaret Brinig ed., 2021).

[261] *See* Naaman, *supra* note 214, at 251–54.

desirability of this cooling-off period has long been contested. It undeniably preserves the surrogate's choice to maintain parental rights if any doubts arise, rooted in the understanding that the transformative process of pregnancy can foster an unanticipated affective bond with the child.[262] Yet, this potential revocation poses challenges for all parties: for the intended parents, caught in an emotional and material limbo while their legal relationship with the child is delayed;[263] for the surrogate, who could be left with the unanticipated duty of raising the child if unforeseen circumstances cause the intended parents to reconsider during this period;[264] and for the child, who may experience disruptions in care and decision-making by the intended parents due to the lack of immediate legal parentage recognition.[265] Regardless of one's stance on the desirability of this cooling-off period, this revocation option merits careful attention as it echoes the reasoning behind other restrictive policies—such as in fertility preservation and abortion—that designate women incapable of making the 'right' decision for their reproductive wellbeing.

Conversely, to avoid the complications of delayed parentage, some states proactively establish parentage before the child's birth in surrogacy cases. This process involves the intended parents and surrogate signing an agreement, which the court then reviews to confirm the intended parents' legal status from birth. While this process allows intended parents to control their family timeline, it could easily fall into the trap of restricting the surrogate's control over her pregnancy timeline. Surrogacy agreements often include provisions allowing intended parents to terminate the pregnancy if fetal abnormalities are detected or selectively reduce it in cases of multiple fetuses.[266] These terms raise critical questions about how courts will rule when disputes arise over these provisions. Although it is debatable whether a court would automatically enforce these provisions, due to concerns over bodily autonomy,[267] surrogates might still feel pressure to comply with them due to prevailing practices.[268] This risk may even be intensified after *Dobbs*, which overturned the longstanding jurisprudence of reproductive autonomy grounded in the right to bodily autonomy. In this new landscape—in states where abortion is

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[262] For an influential account of this argument, see, e.g., Vicki C. Jackson, *Baby M and the Question of Parenthood*, 76 Geo. L.J. 1811, 1818–19 (1988); Jennifer Gerarda Brown, *The "Sophie's Choice" Paradox and the Discontinuous Self: Two Comments on Wertheimer*, 74 Denv. U. L. Rev. 1255, 1256 (1997).

[263] *See, e.g.*, Naaman, *supra* note 216, at 81–82.

[264] *See, e.g.*, Sara L. Ainsworth, *Essay, Bearing Children, Bearing Risks: Feminist Leadership for Progressive Regulation of Compensated Surrogacy in the United States*, 89 Wash. L. Rev. 1077, 1120 (2014).

[265] *See, e.g.*, Joslin, *supra* note 14, at 440.

[266] *See, e.g.*, Hillary L. Berk, *Savvy Surrogates and Rock Star Parents: Compensation Provisions, Contracting Practices, and the Value of Womb Work*, 45 L. & Soc'y Rev. 398, 417 (2020).

[267] *See, e.g.*, Joslin, *supra* note 14, at 418–19.

[268] *See, e.g.*, Berk, *supra* note 266, at 419–20 (2020) (arguing that "exercising that right to abortion in the case of surrogacy may constitute a breach of contract for which there are serious financial consequences that a surrogate cannot likely afford").

banned but surrogacy is allowed—it is increasingly uncertain how courts will respond to provisions compelling specific medical procedures or restricting certain behaviors during pregnancy.

What *is* clear is that, with the rapid medical advancements and evolving norms around procreation and parenthood, reproductive time is constantly being reconstructed. While this reconstruction may seem to align with egalitarian ideals, by supporting diverse family formations that challenge the 'natural' timeline, careful attention is warranted for the potential trade-offs it introduces. And it requires us to be particularly attentive to the ways in which forms of subordinations are interconnected—sometimes, implicitly—across the entire reproductive timeline.

Conclusion

This Article introduces the concept of reproductive time in law. It uses this conceptual lens to analyze how the experience of reproductive time across different phases of the family-building process is not intrinsically limited to either physical or genetic factors. Rather, this experience is enacted, distributed, and sometimes manipulated through various legal practices. By analyzing, challenging, and juxtaposing three forms of reproductive time, it makes three main contributions—descriptive, normative, and methodological—to the legal scholarship.

First, the Article uncovers how modes of governmentality concerned with temporal logics—and employing it for various ends—are not as neutral as they may initially appear to be. While presenting certain temporal logics as 'natural' (that is, aligned with biological aspects of reproduction and therefore non-negotiable),[269] these modes selectively uphold traditional ideologies of procreation and family. These modes of governmentality are expressed in various forms through legislation, administrative agency policies, and judicial decisions, and in practical enforcement practices across different legal contexts. What links these modes in each context is the manner in which "time" is deployed, both explicitly and implicitly, to reinforce and naturalize different forms of social subordination: sex-differentiated assumptions, racial and socio-economic asymmetries, and the imposition of heterosexual family norms. The neutral appearance of these logics renders these forms of social subordination less noticeable and all the more unquestionable.

Second, when we juxtapose different manifestations of reproductive time and scrutinize their rationales, these forms of subordination become harder to ignore and less defensible. In fertility preservation, for example, the rationale behind chronological thresholds, despite being presented in scientific—that is, unquestionable—terms, reinforces paternalistic assumptions about women's ability to make informed decisions regarding their bodies. In the context

[269] *See supra* notes 101–02, 134, 146–49, 194, 217–28, and accompanying text.

of parentage, while the presumed 'natural' milestone of becoming a parent at the moment of a child's birth arguably only reflects pure biological fact, it is also entangled in antiquated, sexual norms regarding family. With a more systematic understanding of reproductive time, the rationales underpinning restrictive policies become less persuasive and more open to challenge. The detrimental effects of certain temporal logics in law are harder to dismiss, especially when similar effects are observed even in jurisdictions with a more egalitarian commitment to these issues.

Third, while the Article focuses on the regulation of family-building processes, its contribution extends further, highlighting a nuanced interplay between inequality, time, and legal systems more broadly. Notably, the analysis illustrates that, in some instances, time *facilitates* forms of subordination. For example, the unequal distribution of parentage time—whereby the parentage recognition of same-sex couples is impeded[270]—extends the State's ability to police and discipline families that deviate from heteronormative norms.[271] Similarly, imposing time limits through legal barriers on fertility treatments such as cryopreservation, which disproportionately affect women,[272] aids the State's capability to enforce traditional maternity-related norms.[273] However, as the Article elucidates, in other instances, devaluing or dismissing the experience of certain groups' time may be a *derivation* of their status as subordinated. One striking example of this phenomenon is the disenfranchisement of those who discover their pregnancy relatively late, many of whom are women of color or of lower socio-economic status.[274] These women often do not have the means to alleviate the impact of this systemic—temporal—disenfranchisement, thus further exacerbating their subordinated position in society by forcing pregnancy and motherhood upon them.[275]

Turning our analytical focus toward this interplay between time and subordination illuminates an important phenomenon: temporal considerations are an aggravating factor for subordinated groups that are already micro-managed, standardized, and disciplined by the State for their life choices. It is this insight that could foster a productive dialogue across various contexts of family-building processes, enhancing the conceptual legal understanding of reproductive time as a factor contributing to inequality.

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[270] *See supra* notes 230–33 and accompanying text.
[271] *See supra* notes 214–15, 240 and accompanying text.
[272] *See supra* notes 82–84 and accompanying text.
[273] *See supra* notes 93–94 and accompanying text.
[274] *See supra* notes 158–62 and accompanying text.
[275] *See supra* notes 180–84 and accompanying text.