

WHEN “BAD” MOTHERS MAKE WORSE LAW: A CRITIQUE OF LEGISLATIVE LIMITS ON EMBRYO TRANSFER[©]

DEBORAH L. FORMAN*

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INTRODUCTION

On January 26, 2009,¹ Nadya Suleman delivered octuplets, setting off a media frenzy.

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* Professor of Law and J. Allan & Mary Schalling Cook Children’s Law Scholar, Whittier Law School; Of Counsel, International Fertility Law Group. I would like to thank Dean Penelope Bryan and the organizers of the University of Denver, Sturm College of Law conference on *Motherhood: Reclaiming our Past-Transforming our Future*, for inviting me to present an early draft of this article. I would also like to express my appreciation to my two excellent research assistants, Taylor Dudley and Heather Gutterud, for their invaluable assistance, and the Whittier Law School for its support.

¹ Randal C. Archibald et al., *Octuplets, 6 Siblings, And Many Questions*, N.Y. TIMES, Feb. 4, 2009, at A14, available at <http://www.nytimes.com/2009/02/04/world/americas/04iht-04octuplets.19914715.html>.

While initially greeted with amazement, public reaction quickly turned ugly, as details about the conception and Ms. Suleman, dubbed the “Octomom,” came to light. She was an unemployed, single mother who used a worker’s compensation settlement to finance her in vitro fertilization (IVF).² In a typical IVF cycle, the woman undergoes ovarian stimulation with fertility drugs, followed by an egg retrieval procedure. Suitable eggs are then combined with sperm in the laboratory. Eggs that successfully fertilize and develop into embryos of sufficient quality are eligible for transfer to the woman’s uterus.³ Suleman’s physician implanted twelve embryos, far more than recommended by the American Society for Reproductive Medicine (ASRM).⁴ To make matters worse, she already had six children, also conceived through IVF,⁵ three of whom were receiving public assistance for developmental disabilities.⁶

Reaction to the news was swift. The paparazzi swarmed, making Suleman an instant celebrity with her own reality-TV show.⁷ But the attention generated by Suleman and her octuplets did more than create another example of infotainment excess. It prompted rapid legislative response,⁸ investigation by the state medical disciplinary board⁹ and by the ASRM¹⁰ into the conduct of Suleman’s physician, the filing of a guardianship petition to monitor the octuplets’ finances,¹¹ and widespread debate among academics¹² and the public¹³ about the

² The Associated Press, *California Medical Board Probes Octuplet Birth*, Feb. 6, 2009, MSNBC.COM, <http://www.msnbc.msn.com/id/29057426/>; Dateline NBC, *Meet Nadya Suleman, Mother of Octuplets*, MSNBC.COM (Feb. 10, 2009), <http://www.msnbc.msn.com/id/291129311>.

³ See generally AM. SOC’Y FOR REPRODUCTIVE MED., ASSISTED REPRODUCTIVE TECHS.: A GUIDE FOR PATIENTS 4-9 (2008), available at http://www.asrm.org/uploadedFiles/ASRM_Content/Resources/Patient_Resources/Fact_Sheets_and_Info_Booklets/ART.pdf.

⁴ It was widely reported at the time of the birth that Suleman’s physician, Dr. Michael Kamrava, had transferred six embryos, two of which split into twins. Alan Duke, *Medical Society Boots Doctor Who Did IVF*, CNN.COM (Oct. 19, 2009), <http://www.cnn.com/2009/SHOWBIZ/10/19/octomom.doctor/index.html?iref=allsearch>. However, Dr. Kamrava admitted at his disciplinary hearing before the California Medical Board that he had transferred twelve embryos – all of the available fresh embryos from Suleman’s latest IVF cycle. Molly Hennessey-Fiske, *Suleman Doctor Says He Was Wrong; He Shouldn’t Have Implanted a Dozen Embryos, the Fertility Specialist Testifies*, L.A. TIMES, Oct. 22, 2010, at LATEXtra 1, available at <http://articles.latimes.com/2010/oct/22/local/la-me-1022-octuplets-doctor-20101022>.

⁵ *Id.*

⁶ Jessica Garrison & Garrett Therolf, *Octuplets’ Mother Receives Public Assistance*, L.A. NOW, Feb. 9, 2009, <http://latimesblogs.latimes.com/lanow/2009/02/nadya-suleman-w.htm>.

⁷ See Duke, *supra* note 4.

⁸ See *infra* text accompanying notes 28-31 (discussing various legislative responses to the octuplet’s birth).

⁹ After an extensive hearing, Administrative Law Judge Daniel Juarez found, *inter alia*, that Kamrava’s transfer of twelve embryos to Nadya Suleman, as well as an earlier transfer of eight embryos to her in an unsuccessful cycle, constituted gross negligence. *In the Matter of First Amended Accusation Against Michael Kamrava*, Proposed Decision, Dec. 20, 2010, at 32, ¶ 13 [hereinafter Kamrava, Proposed Decision]. He recommended that Kamrava retain his medical license but be placed on five years probation, during which time he would be required to take an ethics course and practice under supervision. *Id.* at 41-43. The California Medical Board rejected Judge Juarez’ recommendation of probation and is undertaking a review of the case before issuing a final ruling on license revocation. Molly Hennessey-Fiske, *Doctor Could Still Lose License*, L.A. TIMES, Feb. 10, 2011, at AA2.

¹⁰ Press release, Am. Soc’y for Reproductive Med., ASRM Reacts to Latest News about California Octuplets, [http://www.asrm.org/news/article.aspx?id=628&terms=\(+%40Publish_To+Both+Sites+or+%40Publish_To+ASRM+Only+\)+and+suleman](http://www.asrm.org/news/article.aspx?id=628&terms=(+%40Publish_To+Both+Sites+or+%40Publish_To+ASRM+Only+)+and+suleman) (last accessed Apr. 24, 2010).

¹¹ The Associated Press, *Court Rules in Favor of Octuplets’ Mother*, S.D. UNION-TRIB., Jan. 10, 2010, at

current use of assisted reproductive technology (ART) in our society. In particular, the case brought to the fore concerns over the perceived unregulated nature of ART practice.¹⁴

Calls for regulation of ART are nothing new.¹⁵ However, the reaction to Suleman was so vitriolic and inextricably related to her identity as a mother that it seemed appropriate to look more closely at the “post-Octomom” calls to action. For these reasons, this article will focus on those areas of concern and potential regulation that have been raised by the Suleman case and, more specifically, legislative efforts to limit the number of embryos transferred in any IVF cycle. Part I begins by considering what exactly is so troubling about the Octomom and identifying specific responses to those concerns. Part II hones in on one set of responses—proposed embryo transfer limits—and assesses their constitutionality, as constitutional law has served as an important bulwark against attacks on reproductive freedom.¹⁶ Part III considers whether, if such

A4; Tracey Garcia, *Octuplet Guardianship Proceedings Halted by State Appeals Court*, WHITTIER DAILY NEWS, Aug. 7, 2009, available at http://www.whittierdailynews.com/octuplets/ci_13017810.

¹² See Naomi Cahn & Jennifer M. Collins, *Eight Is Enough*, 103 NW. U. L. REV. 501 (2009); June Carbone, *Who Decides What Number of Children is “Right?”* 104 NW. U. L. REV. 109 (2009); Kimberly D. Krawiec, *Why We Should Ignore The “Octomom”*, 104 NW. U. L. REV. 120 (2009).

¹³ Jessica Garrison et al., *Octuplets’ Birth Spawns Outrage From Public*, L.A. TIMES, Feb. 7, 2009, <http://articles.latimes.com/2009/feb/07/local/me-octuplets7>.

¹⁴ Stephanie Saul, *Birth of Octuplets Puts Focus on Fertility Industry and Risks*, N.Y. TIMES, Feb. 12, 2009, at A1, available at <http://www.nytimes.com/2009/02/12/health/12ivf.html> (“The issue has taken on renewed scrutiny since . . . Nadya Suleman . . . gave birth to octuplets near here last month [U]nlike some other countries, the United States has no laws to enforce those guidelines.”); see Cahn & Collins, *supra* note 12, at 503; see Carbone, *supra* note 12.

Concern that ART lacks sufficient regulation predates the Suleman case. See, e.g., Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457 (2008) (stating that “Regulating reproductive technologies . . . is a theoretical issue right now because there is virtually no such regulation in the United States” and describing “the regulatory vacuum surrounding [ART]”); Jennifer Rosato, *The Children, Birth of ART (Assisted Reproductive Technology): Should the Law Protect Them from Harm*, 2004 UTAH L. REV. 57, 57, 62 (2004) (noting “very little oversight or regulation” of ART); Note, *Assessing the Viability of a Substantive Due Process Right to In Vitro Fertilization*, 118 HARV. L. REV. 2792, 2794-95 (2005) [hereinafter Note] (describing regulation as limited).

However, the perception of ART as the “wild, wild West” of medicine may not match the reality. The American Society of Reproductive Technology has issued a report asserting that ART is “already one of the most highly regulated of all medical practices in the United States.” *Oversight of Assisted Reproductive Tech.*, 12 ASRM BULLETINS, no. 18, May 25, 2010. See also G. David Adamson, *Does Self-Regulation Work for Implementation of Single Embryo Transfer*, in SINGLE EMBRYO TRANSFER 256 (Jan Gerris et al. eds., 2009) (describing ART in the U.S. as “very highly regulated,” despite the perception of a lack of regulation).

¹⁵ George J. Annas, *The Shadowlands-Secrets, Lies, and Assisted Reproduction*, 339 NEW ENG. J. MED. 935, 937 (1998); Judith F. Daar, *Regulating Reproductive Technologies*, 34 HOUS. L. REV. 609, 637-657 (1997); Lars Noah, *Assisted Reproductive Technologies and the Pitfalls of Unregulated Biomedical Innovation*, 55 FLA. L. REV. 603, 648-59 (2003). See Rosato, *supra* note 14, at 57.

¹⁶ While constitutional law has protected women’s right to abortion since *Roe v. Wade*, 410 U.S. 113 (1973), even during the most expansive period for substantive due process, the Supreme Court did not guarantee that everyone would have access to abortion through public funding. See *Harris v. McRae* 448 U.S. 297 (1980). For that reason (and others), feminists have questioned whether the emphasis on securing “rights,” as opposed to access, was the appropriate focus for advocates. See Sandra Berenknopf, *Judicial and Congressional Back-Door Methods That Limit the Effect of Roe v. Wade: There is No Choice If There Is No Access*, 70 TEMP. L. REV. 653, 698 (1997) (“By using back-door methods such as withholding Medicaid funding . . . Congress and the courts have consistently limited the force of *Roe v. Wade* in the lives of poor women [I]f a woman does not have access to abortion, then she cannot choose to have an

limits are constitutional, they can be justified as a matter of policy, and argues that these efforts need to be understood in the larger context of the ongoing assault on women's reproductive rights and the sexist treatment of women as patients and mothers. While we might think that regulation of ART is a gender-neutral construct, efforts to regulate ART in the wake of the Octomom case have been anything but neutral and reveal much about how society and the law treats women and mothers in particular. Finally, Part IV suggests that the existing system, which relies on physician self-regulation, the physician's duty to obtain informed consent, and patient and physician education, while not a perfect solution, remains the preferred approach given existing political and cultural circumstances.

I. WHY IS EVERYONE SO MAD ABOUT THE OCTOMOM AND WHAT CAN WE DO ABOUT IT?

A. *No Husband, No Job, No Sense*

The firestorm of criticism directed at Suleman centered on several aspects of her situation: the risk of harm to the children from such a high-order multiple birth;¹⁷ her seeming inability to support the children;¹⁸ and her questionable mental state.¹⁹ At the most basic level,

abortion."); April L. Cherry, *Choosing Substantive Justice: A Discussion of "Choice," "Rights," and the New Reproductive Technologies*, 11 WIS. WOMEN'S L.J. 431, 433 (1997) ("For example, most feminists have supported abortion in the terms of choice and bodily integrity, viewing any restriction regarding pre-viability access to abortion as working against the goal of equality for women."); Linda C. Fentiman, *Pursuing the Perfect Mother: Why America's Criminalization of Maternal Substance Abuse is Not the Answer – A Comparative Legal Analysis* 15 MICH. J. GENDER & L. 389, 456-457 (2009) (discussing the fragility of the constitutional right to abortion and abortion opponents' "multiple avenues to undercut women's ability to control" reproductive rights and access to abortion); Courtney Miller, *Reflections on Protecting Conscience for Health Care Providers: A Call For More Inclusive Statutory Protection in Light of Constitutional Considerations*, 15 S.CAL. REV. L. & SOC. JUST. 327, 340 (2006) (discussing the conscience clause movement in reaction to abortions rights groups' drive to make abortion access a Constitutional right rather than being merely permitted); Ronli Sifris, *Restrictive Regulation of Abortion and the Right to Health* 18 MED. L. REV. 185, 211-212 (2010) (arguing that restrictions on abortion violate the right to reproductive health; recognizing the connection between the right to health and the need for access to abortion.). Likewise, while much of the scholarship and advocacy around ART involves rights of those using the technology, the barriers to access to the technology present a pressing concern as well. See Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER L. & JUST. 18 (2008);

¹⁷ Saul, *supra* note 14, at A1; Andrews Health Law Litigation Rep., *California Medical Board Accuses 'Octomom' Doctor of Negligence*, 17 No. 9 ANDREWS HEALTH L. LITIG. REP. no. 9, Jan. 7, 2010, at 3; Alissa Stockage, *Regulating Multiple Birth Pregnancies: Comparing the United Kingdom's Comprehensive Regulatory Scheme with the United State's Progressive, Intimate Decision-Making Approach*, 18 MICH. ST. J. INT'L L. 559, 563-567 (2010).

¹⁸ *NBC Today Show Profile: Latest Controversies with Octuplet Mom Nadya Suleman* (NBC Television Broadcast Feb. 9, 2009); Sabrina Ghebremedin & Kimberly Brown, *ABC Nightline News: Octuplet Mom Nadya Suleman Says She's Struggling but Kids are Healthy*, ABCNEWS.COM (July 13, 2010), <http://abcnews.go.com/Nightline/octomom-octuplets-mother/story?id=11152828>; TMZ Staff, *Octomom Gets Reprieve From Foreclosure!* TMZ ONLINE, Mar. 24, 2010, <http://www.tMZ.com/2010/03/24/octomom-nadya-suleman-foreclosure-house-la-habra-mortgage-kids/>.

¹⁹ CNN: *Showbiz Tonight*, (CNN television broadcast Feb. 25, 2009), transcript available at <http://transcripts.cnn.com/TRANSCRIPTS/0902/25/sbt.01.html>; Raina Kelly, *Octomom Hypocrisy: Four Reasons Nadya Suleman Drives Us Crazy, and Why We're Wrong*, NEWSWEEK MAGAZINE, Mar. 3, 2009, <http://www.newsweek.com/2009/03/02/octomom-hypocrisy.html>; Kimi Yoshino, Jessica Garrison & Andrew Blankstein

many believe Suleman simply had way too many children. This criticism embodies two distinct concerns: (1) she had too many children at one time, putting the children at great risk for health problems and disabilities;²⁰ and (2) she had too many children in total. Common sense counseled that Suleman could not possibly care for that many children adequately, especially because she is single. Typical comments included the following:

It seems Nadya Suleman failed to take the elementary precaution of having a father around for her octuplets. Or any income to raise them. As if that wasn't irresponsible enough, the 33-year old already has six other children under the age of seven, including two year old twins, courtesy of IVF and a sperm donor. Sorry honey, that isn't a family: it's a train crash.²¹

To make matters worse, Suleman was unemployed and seemed unlikely to ever have the ability to provide adequately for her fourteen children.²² Even Suleman's mother openly questioned her ability to support her children.²³ In fact Suleman's main source of income after the octuplets' birth came from a reality TV show, which some view as exploiting the children.²⁴ Indeed, concern about her ability to support her children prompted a trial judge to appoint a guardian to oversee their finances, although a California appellate court subsequently overturned the appointment.²⁵ Critics feared that for all of these reasons, the burden of caring for the octuplets would fall on the state. To make matters worse, Suleman seemed mentally unstable, not just to the public spectators, but to her own family. Her mother revealed that Suleman kept the octuplet pregnancy a secret from her family by stating she had a tumor²⁶ and her father admitted that he "question[ed] her mental situation."²⁷

The Craze over Octomom Nadya Suleman, It's All Just So Octo-licious, Nadya Suleman Can't Seem to Get Enough Kids, and Media Audiences Can't Seem to Get Enough of Her, L.A. TIMES, Feb. 28, 2009, at 3.

²⁰ Saul, *supra* note 14, at A1.

²¹ Allison Pearson, *A miserable 'miracle'*, DAILY MAIL (last updated Feb. 17, 2009), at 15, available at <http://www.dailymail.co.uk/debate/article-1135370/ALLISON-PEARSON-The-day-nostalgia-fell-skies.html>.

²² *Latest Controversies with Octuplet Mom Nadya Suleman*, *supra* note 18; Shaya Tayefe Mohajer, *Octuplet Mom Nadya Suleman On Food Stamps, Three Kids Receive Disability*, HUFFINGTON POST (11:27 PM; Feb. 9, 2009), http://www.huffingtonpost.com/2009/02/10/octuplet-mom-nadya-sulema_n_165508.html.

²³ *Latest Controversies with Octuplet Mom Nadya Suleman*, *supra* note 18 (quoting Angela Suleman as asking: "How are you going to provide for them? What are you thinking?"); Katherine Thomson, *Does Nadya Suleman Think She's Angelina Jolie?*, HUFFINGTON POST (12:12 PM; Feb. 10, 2009), http://www.huffingtonpost.com/katherine-thomson/does-nadya-suleman-think_b_165617.html.

²⁴ *NBC Today Show Profile: Guardian Appointed to Oversee Finances of Nadya Suleman's Children*, NBC Broadcast (July 28, 2009); Johnny Dodd, *Octuplets Mom Inks TV Deal and Has Book in the Works*, PEOPLE MAGAZINE ONLINE (May 31, 2009), <http://www.people.com/people/article/0,,20282320,00.html>.

²⁵ *Suleman v. Super. Ct.*, 103 Cal. Rptr. 3d 651 (Cal. Ct. App. 2010); *Court Rules in Favor of Octuplets' Mother*, *supra* note 11; Garcia, *supra* note 11.

²⁶ *Showbiz Tonight: Octu-mom's Publicity Tour: Shocking Revelation from the Octu- Grandma; Inside the Obama White House; Hottest Hollywood Men Over 40* (CNN television broadcast Feb. 25, 2009), transcript available at <http://edition.cnn.com/TRANSCRIPTS/0902/25/sbt.01.html>.

²⁷ Sarah Westcott, *Octuplets Mum 'Absolutely Irresponsible' Says Her Dad*, DAILY EXPRESS, Feb. 21, 2009, <http://express.co.uk/posts/view/85752/Octuplets-mum-absolutely-irresponsible-says-her-dad>.

B. Legislatures Respond

In the wake of the octuplets' birth, a number of legislators across the country introduced legislation designed to prevent a similar ART debacle. These bills fell roughly into two categories. Some contained resolutions calling for study of the possibility of state regulation or of guidelines to be promulgated by medical professional societies.²⁸ Other bills went further, imposing specific limits on the number of embryos that could be transferred in a given IVF cycle. Missouri H.B. 810 prohibited physicians from implanting more embryos than recommended by ASRM.²⁹ Senate Bill 169, introduced in the Georgia legislature, provided specific proscriptions regarding the permissible number of embryos for transfer: Women under age 40 could receive no more than two embryos; women older than 40 were limited to 3 embryos, and women using donated eggs or embryos were limited to two, regardless of the woman's age.³⁰

Ultimately, none of the bills introduced in the wake of the octuplets' birth became law.³¹ Nonetheless, proposals to limit the number of embryos transferred through legislation continue to receive support in the literature³² and the popular press,³³ are already the norm in other countries,³⁴ and we likely have not seen the last of them here.

The other areas of concern—Suleman's utilization of ART when she already had six

²⁸ H. Res. 107, 25th Leg., Reg. Sess. (Haw. 2009); H. Con. Res. 130, 25th Leg., Reg. Sess. (Haw. 2009); Leg. Res. 236, 101st Leg., 1st Sess. (Neb. 2009).

²⁹ H. B. 810, 95th Gen. Assem., 1st Reg. Sess. (Mo. 2009).

³⁰ S. B. 169, Gen. Assem. (Ga. 2009). The provision in question (Provision 19-7-67) was included in the bill as first introduced. See http://www.legis.ga.gov/legis/2009_10/versions/sb169_As_introduced_LC_37_0857_2.htm.

³¹ H. Res. 107, 25th Leg., Reg. Sess. (Haw. 2009) Measure History available at http://www.capitol.hawaii.gov/session2009/lists/measure_indiv.aspx?billtype=HR&billnumber=107 (last visited July 17, 2010) (showing that the bill was referred to committee in April of 2009 and nothing has happened to the bill since); H. Con. Res. 130, 25th Leg., Reg. Sess. (Haw. 2009) Measure History, available at http://www.capitol.hawaii.gov/session2009/lists/measure_indiv.aspx?billtype=HR&billnumber=130 (accessed July 17, 2010) (showing that the bill was referred to WLO in March of 2009 and nothing has happened to the bill since); H. B. 810, 95th Gen. Assem., 1st Reg. Sess. (Mo. 2009) Bill Summary, available at <http://www.house.mo.gov/content.aspx?info=/bills091/bills/hb810.htm> (accessed July 17, 2010) (showing that no hearings are scheduled and the bill is currently on a calendar i.e. it is effectively dead); Legis. Res. 236, 101st Leg., 1st Sess. (Neb. 2009) History, available at http://nebraskalegislature.gov/bills/view_bill.php?DocumentID=9135 (accessed July 17, 2010) (showing that the bill was referred to Judiciary Committee on May 21, 2009 and nothing has happened to the bill since); S. B. 169, Gen. Assem. (Ga. 2009) Status History available at http://www.legis.state.ga.us/legis/2009_10/sum/sb169.htm (accessed July 17, 2010) (showing that the bill was sent to House Second Readers in March of 2009 and nothing has happened to the bill since).

³² NAOMI R. CAHN, TEST TUBE BABIES: WHY THE FERTILITY MARKET NEEDS REGULATION 196 (2009); Rosato, *supra* note 14, at 85; Siddharth Khanijou, *Multifetal Pregnancy Reduction in Assisted Reproductive Technologies: A License To Kill?* 8 DEPAUL J. HEALTH CARE L. 403, 423 (2005); Urska Velikonja, Comment, *The Costs of Multiple Gestation Pregnancies in Assisted Reproduction*, 32 HARV. J. L. & GENDER 463 (2009).

³³ See, e.g., LIZA MUNDY, EVERYTHING CONCEIVABLE 333 (2007) (arguing for federal limits on number of embryos transferred) [hereinafter Mundy, EVERYTHING CONCEIVABLE].

³⁴ Jan Gerris & Petra De Sutter, *Single Embryo Transfer: Concepts and Definitions*, in SINGLE EMBRYO TRANSFER 58 (Jan Gerris et al. eds., 2009) (describing Belgian restrictions based on age, regardless of funding method); Stephanie N. Sivinski, *Putting Too Many (Fertilized) Eggs In One Basket: Methods of Reducing Multifetal Pregnancies in the United States*, 88 TEX. L. REV. 897, 906-07 (2010) (describing, *inter alia*, Great Britain's Human Fertilisation and Embryology Authority (HFEA) which has capped the number of embryos at two and Sweden's legislation to make the transfer of a single embryo the norm for almost all IVF procedures).

children, especially in light of her marital and employment status and her mental state—did not provoke legislation but certainly contributed to the public outcry.³⁵ Some suggested that physicians, if not the state, should refuse treatment to women who already have children (or at least an excessive number of children).³⁶ For example, California State Senator Am Aanestad, a Republican, spoke out against establishing governmental standards for medical care—unless “taxpayer dollars” were spent for care of the children—“not just the eight now, but the previous six, over the course of their lifetime.”³⁷ Others called for mandatory psychological screening of prospective patients.³⁸ In fact, the California Medical Board cited Dr. Kamrava’s failure to refer Suleman for a mental health evaluation and to consider potential harm to her living children and any future offspring as evidence of gross negligence.³⁹ Recently introduced legislation also seems to be opening the door to mandatory mental health screening when assisted reproductive technology agencies are involved.⁴⁰

I have serious concerns about whether any of these restrictions are permissible or advisable. However, this Article will focus on the proposed limits on the number of embryos transferred, though the concerns that have animated the other two—what we might call irresponsible procreation or questionable parenting—will inform our understanding of the motives driving the first set of proposals. I turn now to an analysis of the constitutional implications of embryo transfer limits.

II. CONSTITUTIONAL CONCERNS

A. *Fundamental Rights At Stake*

Restrictions on access to and the practice of ART arguably raise due process constitutional concerns. Cases involving procreation, parenting, and medical care all potentially

³⁵ Jessica Garrison et al., *Octuplets’ Birth Spawns Outrage From Public*, L.A. TIMES, Feb. 7, 2009, <http://articles.latimes.com/2009/feb/07/local/me-octuplets7>.

³⁶ Tracee Cornforth, “Octo-Mom’s Fertility Doctor Implants at Least 7 Embryos in 49-Year-Old Woman,” ABOUT.COM (Feb. 13, 2009), <http://womenshealth.about.com/b/2009/02/13/octo-moms-fertility-doctor-implants-at-least-7-embryos-in-49-year-old-woman.htm>.

³⁷ Alison Stateman, *The Octuplets Mom Speaks, and the Questions Grow*, TIME.COM, Feb. 7, 2009, <http://www.time.com/time/nation/article/0,8599,1877962,00.html>. See also H.Con. Res. No. 107, 25th Leg., Reg. Sess. (Haw. 2009) (specifically addressing concerns generated by Suleman; “Whereas, there has been public outcry and concern over the ethics of implanting numerous embryos in patients that may not have the resources to care for the children that result from the fertility treatment.”).

³⁸ S. B. 509, 3d Leg., 2010 Sess. (Kan. 2009) (requiring reporting of information regarding fertility treatment to the state, including “the method of psychological screening used to evaluate prospective patients and donors.”).

³⁹ Kim Yoshino, *California Board Accuses Octuplets Doctor of Negligence*, L.A. TIMES, Jan. 5, 2010, <http://www.latimes.com/news/local/la-me-octuplets5-2010jan05,0,97780.story>. In a separate complaint, the California Medical Board cited Dr. Kamrava for failing to refer another patient with a quadruplet pregnancy or her husband or adult children for a “mental health evaluation to determine her willingness to undergo multi-fetal reduction.” Tony Barboza, *Medical Board Targets Doctor*, L.A. TIMES, July 14, 2010, at AA1. However, the Administrative Law Judge hearing the disciplinary charges against Kamrava found that failure to refer Suleman and the other patient for mental health evaluation did not constitute negligence. Kamrava, Proposed Decision, *supra* note 9, at 33, ¶¶18-19, 35, ¶¶34-35.

⁴⁰ S. B. 2240, 2010 Reg. Sess. (Fla. 2010). The bill died in committee on judiciary on Apr. 30, 2010.

impact the assessment of the constitutionality of embryo transfer limits. I will address each in turn.

1. The Right to Procreate

The Supreme Court has long recognized the right to procreate as fundamental. But what does it mean to identify a “right to procreate”? In fact, Supreme Court jurisprudence in this area has two facets: the Constitution limits the state’s ability to hinder procreation and its ability to compel procreation. These dual aspects of the right to procreate find expression in the first instance in the sterilization cases and in the second in the abortion and contraception cases. The sterilization cases seem most analogous to restrictions on ART, so I begin there.

Any discussion of the constitutionality of sterilization in the United States of course starts with *Buck v. Bell*, the case in which Justice Oliver Wendell Holmes famously declared “three generations of imbeciles are enough.”⁴¹ Carrie Buck, like her mother, was institutionalized in a Virginia mental hospital ostensibly because of feeble-mindedness.⁴² Consequently, the hospital sought to sterilize her under a Virginia statute allowing for sterilization of individuals suffering from inheritable conditions. The Court upheld the statute, and the sterilization of Carrie Buck, on an open eugenics rationale, reasoning that “[i]t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.”⁴³

Fifteen years later, the Court had another occasion to consider the states’ ability to sterilize an individual without his or her consent in *Skinner v. Oklahoma*.⁴⁴ In *Skinner*, the Court struck down an Oklahoma statute that provided for sterilization of habitual criminals. In doing so, the Court recognized that procreation is “fundamental to the very existence and survival of the race.”⁴⁵ However, the Court decided the case on equal protection grounds and refrained from explicitly overruling *Buck*. Indeed, although many have decried the *Buck* Court’s sanction of eugenics as a desirable rationale for sterilization,⁴⁶ and although the *Skinner* Court acknowledged the danger of discriminatory policies and genocide, some commentators have suggested that the Supreme Court today would likely reaffirm the central principle of *Buck*—that the state can prohibit individuals from procreating—at least in certain ways.⁴⁷ In fact, laws permitting

⁴¹ *Buck v. Bell*, 274 U.S. 200, 207 (1927).

⁴² *Id.* at 205.

⁴³ *Id.* at 207.

⁴⁴ 316 U.S. 535, 536-37 (1942).

⁴⁵ *Id.* at 541.

⁴⁶ PAUL A. LOMBARDO, THREE GENERATIONS, NO IMBECILES 277-78 (2008); Michelle Oberman, *Thirteen Ways of Looking at Buck v. Bell: Thoughts Occasioned by Paul Lombardo’s Three Generations, No Imbeciles* 59 J. LEGAL EDUC. 357, 361-65 (2010).

⁴⁷ See MICHELLE N. MEYER, NELSON A. ROCKEFELLER INSTITUTE OF GOV., STATES’ REGULATION OF ASSISTED REPRODUCTIVE TECHNOLOGIES: WHAT DOES THE U.S. CONSTITUTION ALLOW? (July 2009), available at http://www.rockinst.org/pdf/health_care/2009-07-States_Regulation_ART.pdf; Lombardo, *supra* note 46, at 271; Erika T. Blum, *When Terminating Parental Rights is Not Enough: A New Look At Compulsory Sterilization* 28 GA. L. REV. 977, 999-1004 (1994); *In re Conservatorship of Angela D.*, 83 Cal. Rptr. 2d 411 (1999) (upholding conservators’ rights to sterilize a mentally handicapped conservatee, noting the danger of rape and questionable ability to consent in mentally handicapped); CAL. PROB. CODE. § 1959 (describing the vulnerability of developmentally disabled persons to unlawful sexual conduct).

sterilization without the subjects’ consent currently continue to operate, though on a substantially smaller scale and different basis than in the heyday of eugenics.⁴⁸

Hence, it is clear that the right to procreate derived from the sterilization cases has never been absolute. Moreover, the question remains whether the right to procreate encompasses the right to procreate by means of assisted reproduction. Scholars have vigorously debated the point.⁴⁹ Some would argue that we cannot equate the right to be free from forced sterilization with the right to access reproductive technology.⁵⁰ They would posit that coerced sterilization involves a physical invasion of the person that poses risks to the person’s health and requires affirmative acts that take away a capability the person already has.⁵¹ Limiting access to ART, by contrast, implicates neither of these concerns. The government would not be forcing any physical intrusion, and the restriction would arguably not constitute an act, since it would not disturb the procreative status quo of the individual. Under this view, the right to procreate rests on a right of privacy grounded in the protection of bodily integrity, and thus would not extend to ART.⁵²

However, to accept this argument is to ignore *Skinner’s* recognition of the right to procreate as fundamental. Numerous cases have since cited it for that proposition.⁵³ Surely the Court’s frequent acknowledgment of a “right to procreate” means more than a right to be free from unwanted medical procedures or treatment or to be left alone to one’s own ability to procreate. Nor should it turn on a false act/omission dichotomy.⁵⁴ Indeed our understanding of the nature of the right to procreate needs to adjust to the changed circumstances of procreation in the 21st century. The reconceptualization of the fundamental right to marry to encompass same-sex marriage provides an instructive example of this process. For example, in interpreting its state constitutional privacy provision, the California Supreme Court viewed the fundamental right to marry not in structural terms, that is, as protection for a defined entity of a man and a woman with a singular purpose of procreation. Rather, it viewed the right in terms of the values underlying it—the significance of marriage to the happiness and fulfillment of the individuals involved.⁵⁵ Thus the right to marry deserved special protection because of its integral role in

⁴⁸ Lombardo, *supra* note 46, at 267-68; *See e.g.*, DEL. CODE ANN. tit. 16, § 5701; *Cf. Wirsing v. Mich. Protection and Advocacy Serv. (In re Wirsing)*, 573 N.W.2d 51, 55 (Mich. 1998) (allowing sterilization of incompetent woman on evidence of her best interests, but declining to apply a “clear and convincing evidence” standard); *Estate of C.W.*, 640 A.2d 427, 428 (Pa.Super.1994) (applying a “clear and convincing evidence” standard for evaluating whether sterilization was in the patient’s best interest).

⁴⁹ John A. Robertson, *Procreative Liberty in the Era of Genomics*, 29 AM. J.L. & MED. 439 (2003); Rao, *supra* note 14, at 1459-67 (2008); Sonia M. Suter, *The “Repugnance” Lens of Gonzalez v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1517-19 (2008) [hereinafter Suter, *Repugnance*]; Rosato, *supra* note 14, at 95-98.

⁵⁰ Rao, *supra* note 14, at 1461.

⁵¹ *Id.* at 1465.

⁵² Suter, *Repugnance*, *supra* note 49, at 1518; Rosato, *supra* note 14, at 96.

⁵³ *See e.g.*, *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997); *Conservatorship of Valerie N.*, 707 P.2d 760, 772 (Cal. 1985); *Goodwin v. Turner*, 908 F.2d 1395, 1402 (Mo. 1990); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 834 (1992); *Thornburgh v. Amer. College of Obstetricians and Gynecologists*, 476 U.S. 747, 773 (1986); *Zablocki v. Redhail*, 434 U.S. 374, 383 (1978); *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 34 (1973); *Griswold v. Conn.*, 381 U.S. 479, 485 (1965).

⁵⁴ *See* Leslie Bender, *A Lawyer’s Primer on Feminist Theory and Tort*, 38 J. LEGAL EDUC. 3, 34 (1988) (critiquing notion of legally relevant distinctions between acts and omissions).

⁵⁵ *See, e.g., In re Marriage Cases*, 183 P.3d 384, 425 (Cal. 2008) (quoting Bruce C. Hafen, *The*

personal autonomy and liberty of the individual. Likewise, we could deepen our understanding of the right to procreate consistent with the possibilities assisted reproductive technology now offers us. If so, we can more easily make the case that the right to procreate is broad enough to encompass the right to access reproductive technology necessary to enable the infertile to procreate.⁵⁶

A look at the flip side of the right to procreate—the right *not* to procreate can provide support for this point. Consider the contraception cases. In *Griswold v. Connecticut*, the Supreme Court struck down a law prohibiting the use of contraception, finding that the law infringed the married couple's right of privacy under the due process clause.⁵⁷ A few years later, the Court considered another challenge to a contraceptive ban in *Eisenstadt v. Baird*.⁵⁸ In *Eisenstadt*, the Court invalidated a Massachusetts law banning the sale of contraceptives to unmarried persons.⁵⁹ In doing so, the Court made clear that the right of privacy encompassed the right of *individuals*, not just married couples, “to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the *decision* whether to bear or beget a child (emphasis added).”⁶⁰

The contraception cases thus advance the case for constitutional protection of ART in three ways. First, *Eisenstadt* establishes that the constitutional right to privacy protects the *decision* whether to procreate; the right does not merely protect against unwarranted physical intrusions on one's person, as we might have extrapolated from the sterilization cases.⁶¹ Second, the right applies to individuals, regardless of marital status. Third, and quite significantly, the right protects access to the means of achieving the desired result—avoiding procreation through

Constitutional Status of Marriage, Kinship, and Sexual Privacy; Balancing the Individual and Social Interests, 81 MICH. L. REV. 463, 482 (1983)) (“In light of the fundamental nature of the substantive rights embodied in the right to marry – and their central importance to an individual's opportunity to live a happy, meaningful, and satisfying life as a full member of society . . .”).

⁵⁶ There are additional layers of complexity to this issue that are not raised by proposed restrictions on embryo transfers. Some would argue that use of certain technologies does not fall within the rubric of procreation. For example, preimplantation genetic diagnosis (PGD) enables individuals to control the characteristics of their children, an opportunity not enjoyed by individuals who procreate naturally, so that procedure might not justify constitutional protection based on the right to procreate. Meyer, *supra* note 47, at 9-10. For a fuller analysis of this argument, see Robertson, *supra* note 49. IVF and embryo transfer, by contrast, truly operate as substitutes for procreation by natural means; instead of joining egg and sperm coitally, egg and sperm are joined in the lab and resulting embryos transferred to the uterus. Of course, some might claim that the right to procreate means solely the right to genetically reproduce, which would take IVF using donor gametes outside the ambit of the right to procreate. Others might respond that the right to procreate should encompass the right to assume parental status through creation of a child. The embryo transfer limits discussed here, though, would apply to all users. Moreover, although Nadya Suleman used sperm from a known donor, she could have inseminated herself or engaged in coital reproduction if she did not suffer from infertility. Hence, we need not determine here if all assisted reproduction falls within the category of procreation to assess the constitutionality of embryo transfer restrictions.

⁵⁷ 381 U.S. 479 (1965).

⁵⁸ 405 U.S. 438 (1972).

⁵⁹ *Id.* at 454-55.

⁶⁰ *Id.* at 453. See also *Carey v. Population Servs. Int'l.*, 431 U.S. 678, 686-88 (1977) (discussing the privacy rights established in *Eisenstadt* regarding contraceptives).

⁶¹ But see Suter, *Repugnance supra* note 49, at 1544-45 (positing that contraception cases protect bodily integrity by allowing individuals to prevent unwanted physical burdens).

technology, however rudimentary; the right does not simply prohibit the government from taking away some freedom or capability the person already possesses. I would argue that the right of individuals to access ART for the purposes of procreating is no different than the right of individuals to access a condom, diaphragm, or other method of birth control for the purpose of avoiding procreation.

A federal district court agreed with the analogy. In *Lifchez v. Hartigan*,⁶² the court considered a challenge to an abortion statute that contained a provision prohibiting experimentation on a fetus. The court ruled that the provision violated a woman's fundamental right of privacy because it could be interpreted to prohibit procedures related to the decision whether to bear or beget a child, such as embryo transfer and chorionic villi sampling. In the court's view, these procedures fell squarely within the woman's zone of privacy:

Embryo transfer is a procedure designed to enable an infertile woman to bear her own child. It takes no great leap of logic to see that within the cluster of constitutionally protected choices that includes the right to have access to contraceptives, there must be included within that cluster the right to submit to a medical procedure that may bring about, rather than prevent, pregnancy.⁶³

Moreover, in the ART context, a federal district court has held that the constitutional right to privacy encompasses a woman's right to become pregnant by artificial insemination.⁶⁴ Considering the Supreme Court cases "holistically," the court concluded that, "A woman has a constitutional privacy right to control her reproductive functions."⁶⁵

The notion that the fundamental right to privacy encompasses reproductive *choice* has been recognized in both Supreme Court and lower court opinions outside of the contraception and ART contexts as well. In upholding a woman's right to abortion, the Court in *Planned Parenthood v. Casey*, wrote that:

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these

⁶² 735 F. Supp. 1361 (N.D. Ill. 1990).

⁶³ See also *Abigail Alliance for Better Access to Developmental Drugs v. Eschenbach*, 495 F.3d 695, 728 (D.C. Cir. 2007) (en banc) (Rogers, J., dissenting) (deciding whether to have children establishes "right of access"); *J.R. v. Utah*, 261 F. Supp.2d 1268, 1279 (D. Utah 2002) (observing that statute at issue did not prohibit gestational surrogacy or deny access to that medical technology, so plaintiffs had "effectively exercised their right to procreate," though statute did unduly burden that right by declaring surrogate legal parent). But see Robertson, *supra* note 49, at 454 (expressing doubt that conservative Supreme Court would find "most specific uses of assisted reproduction . . . constitutionally protected" but predicting that Court would grant protection to some technologies). Cf. *Abigail Alliance*, 495 F. 3d at 711 n.19 (distinguishing "protecting individual *freedom* from life-saving, but forced, medical treatment" from "providing affirmative *access* to a potentially harmful, and even fatal, commercial good").

⁶⁴ *Cameron v. Bd. of Educ.*, 795 F. Supp. 228, 236-37 (S.D. Ohio 1991).

⁶⁵ *Id.* at 237.

matters could not define the attributes of personhood were they formed under compulsion of the State.⁶⁶

Casey thus reaffirms the vitality of the *Griswold* protection of decision-making liberty, as well as the liberty interest in autonomy and bodily integrity that protects individuals from government coerced medical treatment recognized in cases like *Cruzan*.⁶⁷ *Casey* thus supports the claim that ART and IVF, in particular, fall within the fundamental right to procreate.

2. Familial Privacy and Parental Rights

Embryo transfer restrictions also could run afoul of the constitutional protection afforded to decision-making about important family matters. Beyond any concerns about infringing women's right to procreate, legislative limits on the number of embryos transferred undercuts women's parental authority. The right to control the upbringing of one's children is a constitutional right enjoyed by parents.⁶⁸ Recognition of this right by the Supreme Court in fact predates the procreation cases.⁶⁹ While the Supreme Court cases that have addressed the fundamental rights of parents have focused on education, custody, and visitation,⁷⁰ in *Parham v. J.R.*, the Court addressed a procedural due process challenge to procedures for commitment of minors.⁷¹ The Court stated that "our precedents permit the parents to retain a substantial, if not the dominant, role in the decision [to voluntarily commit a minor for psychiatric treatment], absent a finding of neglect or abuse."⁷² Likewise, other cases have recognized a constitutional right for parents to make decisions regarding medical care for their children.⁷³

Embryo transfer limits and ART restrictions do not directly implicate the constitutional right to parent, however, because the woman undergoing IVF is making a decision about her own medical care, not the child's. At the time of the decision, there is no child, there are only potential children. Moreover, defining it as a parental right runs the risk of elevating the status of the embryos to that of children.⁷⁴ Thus, the constitutional right to parent does not present the

⁶⁶ *Planned Parenthood*, 505 U.S. at 851.

⁶⁷ *Id.* at 2810.

⁶⁸ *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

⁶⁹ *Pierce*, 268 U.S. 510; *Meyer*, 262 U.S. 390; *Troxel v. Granville*, 530 U.S. 57, 65 (2000) ("[T]he interest of parents in the care, custody, and control of their children – is perhaps the oldest of the fundamental liberty interests recognized by this Court.")

⁷⁰ *Pierce*, 268 U.S. 510 (education); *Meyer*, 262 U.S. 390 (education); *Stanley v. Illinois*, 405 U.S. 645 (1972) (custody); *Troxel*, 530 U.S. 57 (visitation). *Cf.* *Parham v. J.R.*, 442 U.S. 584, 604 (1979) (voluntary psychiatric commitment).

⁷¹ *Parham*, 442 U.S. at 604.

⁷² *Id.* The Court earlier stated that parents generally the right and a "high duty" to seek medical care for their children. *Id.* at 602.

⁷³ *See, e.g., Wallis v. Spencer*, 202 F.3d 1126, 1141 (9th Cir. 2000) ("The right to family association includes the right of parents to make important medical decisions for their children, and of children to have those decisions made by their parents rather than the state."); *Matter of Hofbauer*, 47 N.Y.2d 648, 393 N.E.2d 1009, 1013-14 (1979).

⁷⁴ On the danger of according fetuses legal rights, *see* Lisa McLennan Brown, *Feminist Theory and the Erosion of Women's Reproductive Rights: The Implications of Fetal Personhood Laws and In Vitro Fertilization*, 13 AM. U. J. GENDER SOC. POL'Y & L. 87 (2005); Joyce E. McConnell, *Relational and Liberal Feminism: the 'Ethic of Care,' Fetal Personhood and Autonomy*, 99 W. VA. L. REV. 291 (1996). This concern might be ameliorated by viewing the right

strongest basis for challenging embryo transfer limits. I will argue, though, that the law’s treatment of parental decision-making provides a useful frame of reference for evaluating the wisdom of the policy at issue here.⁷⁵

3. The Right to Autonomy in Medical Decision-Making

In *Cruzan v. Director, Mo. Dep’t of Health*, the Supreme Court acknowledged a constitutionally protected liberty interest in refusing unwanted medical treatment, and assumed that this right encompassed refusal of life-saving nutrition and hydration.⁷⁶ *Cruzan* could have stood for broader recognition of a fundamental right to make decisions regarding one’s health care, but a subsequent decision related to medical care in the right-to-die context rejected that interpretation. In *Washington v. Glucksberg*, the Supreme Court upheld a Washington law that criminalized assisted suicide.⁷⁷ The Court insisted on a “careful description” of the asserted fundamental right—to avoid expanding the category of fundamental rights—and thus found that there was no such right to assisted suicide.⁷⁸ The Court wrote, “That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected.”⁷⁹

If we apply *Glucksberg*’s “careful description” methodology to the embryo transfer limits, we may have difficulty showing IVF is “deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty, that [it] is protected by the Fourteenth Amendment.”⁸⁰ *Glucksberg* makes a potential constitutional challenge to the embryo transfer limits based on a fundamental right to medical autonomy unlikely. Obviously, we cannot claim any deeply rooted tradition regarding IVF specifically, since it is technology created within the last thirty years.⁸¹ Unlike the case of assisted suicide, however, there has been no historical prohibition of ART or IVF. However, lack of consistent regulation alone might not suffice to distinguish IVF. In *Abigail Alliance for Better Access to Developmental Drugs v. Eschenbach*, the Court of Appeals for the D.C. circuit applied the *Glucksberg* analysis in considering a challenge to FDA restrictions on access to experimental drugs that passed phase I clinical testing by terminally ill patients.⁸² The court defined it as a right to access experimental drugs, and then

as one of family, rather than parental, decision-making. See Caitlin E. Borgmann, *Abortion, the Undue Burden Standard, and the Evisceration of Women’s Privacy*, 16 WM. & MARY J. WOMEN & L. 291, 305 (2010) (arguing Court has acknowledged importance of privacy in decisions regarding family and intimate relationships and “protected space for family decision-making”).

⁷⁵ See *infra* at n. 237-39 and accompanying text.

⁷⁶ 497 U.S. 261, 279 (1990).

⁷⁷ 521 U.S. 702, 735-36 (1997).

⁷⁸ *Id.* at 721.

⁷⁹ *Id.* at 727.

⁸⁰ *Id.*

⁸¹ The first so-called “test-tube baby” was Louise Brown, born on July 25, 1978. See *Medicine: Test-Tube Baby: It’s a Girl*, TIME MAGAZINE ONLINE (Aug. 7, 1978), <http://www.time.com/time/magazine/article/0,9171,948239,00.html>.

⁸² *Abigail Alliance*, 795 F.3d 695, 701 (D.C. Cir. 2007).

held that the right was not “deeply rooted” in the nation’s history and traditions.⁸³ The court rejected the plaintiffs’ claim that the regulation was deeply rooted because the government did not regulate drugs for efficacy until 1962. In the court’s view, lack of prior government regulation “standing alone,” was insufficient to establish a right as a deeply rooted tradition.⁸⁴ The court also cited several cases finding no constitutional right to a specific kind of treatment or to medical care without any government interference.⁸⁵

However, unlike the rights claimed in *Abigail Alliance* or *Glucksberg* (as narrowly defined by those courts), the right at stake here links directly to rights that have received protection. We might make a case that fertility treatment has long been recognized as a private matter between doctor and patient, looping back to the procreation, abortion and contraception cases. As such, fertility treatment may be considered essential to “ordered liberty.” We might also fight against the hyper-specific articulation of the claimed right and seek a broader understanding of tradition.⁸⁶ Nonetheless, basing a constitutional challenge to embryo transfer restrictions solely on a constitutional right to medical autonomy would likely prove unsuccessful. As with a claim based on fundamental parental rights, though, long-standing common law doctrine surrounding medical treatment will play a key role in our policy analysis.⁸⁷

Admittedly the constitutional right to parent is not directly on point, and the Court has refrained from characterizing the right to medical autonomy as fundamental. Nonetheless, as discussed above, the well-established fundamental right to procreate should be broad enough to encompass a right to access necessary fertility treatments like IVF. Thus I would argue in favor of a theory of procreative liberty that protects choices surrounding reproduction, is grounded essentially in protection of autonomy and self-determination, and is bolstered by constitutional solicitude for medical and parental decision-making.⁸⁸

4. Standard of Review: Strict Scrutiny or Undue Burden?

Of course, even if the right to procreate is fundamental and subsumes the right to ART or IVF, these precedents merely establish protection from *unwarranted* government intrusion into the procreative decision. The question is whether the state has sufficient reason and appropriate

⁸³ *Id.* at 703. A dissenting opinion took issue with the majority’s narrow characterization of the right, asserting the “claimed fundamental right is to attempt to preserve one’s life.” *Id.* at 716 (Rogers, J., dissenting).

⁸⁴ *Id.* at 707.

⁸⁵ *Id.* at 710 & n.18.

⁸⁶ Suter, *Repugnance*, *supra* note 49, at 1542-43.

⁸⁷ See *infra* nn. 69 and 239 and accompanying text.

⁸⁸ Competing theories regarding the constitutional right to procreate and ART abound. I do not intend a thorough assessment of all such theories here. Suffice to say, that a good case can be made that the right to procreate in its most basic sense—creating a genetically related child, as discussed *supra* note 56, could be justified based on many of the theories proffered. Sonia Suter, for example, would find a right to IVF potentially supported by theories based on procreative liberty and autonomy, equality and family privacy. Suter, *Repugnance*, *supra* note 49, at 1524-25, 1550, 1561. Although a theory based on “history and tradition,” would make recognition difficult, Suter argues that even that theory might not foreclose the inclusion of IVF in a right to procreate, though a theory grounded in the protection of bodily integrity would. *Id.* at 1543, 1546. See also Radhika Rao, *Reconceiving Privacy: Relationships and Reproductive Technology*, 45 UCLA L. REV. 1077, 1083, 1123 (1998) (defining the right to privacy as a “relational right” and arguing that a married couple’s right to reproduce via IVF is protected under that right). Sonia Suter, for example, would find a right to IVF potentially supported by theories based on procreative liberty and autonomy, equality and family privacy.

methods for restricting access to ART or prohibiting certain procedures. Typically, restrictions on fundamental rights have been subject to strict scrutiny—requiring the state to provide a compelling reason for the infringement and to demonstrate that the means used by the statute to achieve its purpose were closely related or narrowly tailored to that end.⁸⁹ However, the Supreme Court’s jurisprudence in this area has at times deviated from this analytical framework. The most recent cases implicating procreation-related rights are the abortion cases, and in these, the Court has enunciated a different standard of analysis.⁹⁰

Roe v. Wade, the case that first acknowledged abortion as within the fundamental right of procreative privacy, did apply the standard “strict scrutiny” analysis, and, in doing so, developed the well-known trimester framework for balancing the rights of the woman against the state’s interest in protection of potential life, the latter becoming compelling and sufficient to ban abortion once the fetus has reached the point of viability, roughly during the third trimester of pregnancy.⁹¹ However, in *Planned Parenthood v. Casey*, the Court retreated from this approach and adopted a new standard—the undue burden standard.⁹² Under this standard, a state regulation of abortion violates due process only if it “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion.”⁹³

Assuming that proposed embryo transfer limits would infringe on a fundamental right, it is not entirely clear whether a court would analyze a constitutional challenge to ART restrictions using the more traditional “strict scrutiny” typically applied to sterilization questions, or whether the “undue burden” standard now operative in the abortion context would control.⁹⁴ In fact, the one federal case to consider a constitutional challenge to an ART-related statute applied both standards. In *J.R. v. State of Utah*,⁹⁵ a married couple that had entered into a gestational surrogacy contract challenged the refusal of the Office of Vital Records to list them as mother and father on the birth certificate. The Office had relied on a Utah statute declaring surrogacy contracts unenforceable and declaring the surrogate the mother for all legal purposes.⁹⁶ The court ultimately concluded that the law violated the intended genetic parents’ right to procreate under both a strict scrutiny and undue burden analysis, so I will likewise analyze the proposed embryo transfer restrictions under both approaches.

⁸⁹ See, e.g., *Zablocki v. Redhail*, 434 U.S. 374, 386, 388, 390-91 (1978) (holding that requiring certain individuals to obtain a court order granting permission to marry does not meet strict scrutiny); *Loving v. Virginia*, 388 U.S. 1, 11-12 (1967) (holding that the statutory scheme adopted by the state of Virginia to prevent marriages between persons based on racial classification does not survive strict scrutiny).

⁹⁰ *Planned Parenthood*, 505 U.S. at 874-76 (1992).

⁹¹ *Roe*, 410 U.S. at 164-65 (1973).

⁹² 505 U.S. 833 (1992).

⁹³ *Id.* at 877-78.

⁹⁴ *Rosato*, *supra* note 14, at 98. Cf. Note, *supra* note 14 (arguing that court would apply intermediate scrutiny).

⁹⁵ *J.R. v. Utah*, F.Supp.2d 1268, 1279 (D. Utah 2002).

⁹⁶ *Id.*

B. Analyzing the Embryo Transfer Limits

1. Strict Scrutiny

If we analyze the proposed restrictions under strict scrutiny, the state must establish a compelling interest in minimizing the number of higher order multiple births. The state would undoubtedly argue that it has a compelling interest in ensuring the welfare of mothers, of children and, of potential life as well. There is no doubt that the more embryos transferred, the greater the chance of multiple births and thus the greater the risk of adverse outcomes for the mother and any resulting children.⁹⁷ Common potentially serious complications of multiple order pregnancies for the mother include preterm labor and delivery, gestational diabetes and pre-eclampsia, and, for the children, increased morbidity and mortality, as well as higher incidences of cerebral palsy,⁹⁸ blindness,⁹⁹ and chronic respiratory problems¹⁰⁰ resulting primarily from the preterm birth.¹⁰¹ Multiple births can also lead to increased maternal depression and anxiety.¹⁰²

While the importance of these state goals would seem unassailable, the evaluation of the sufficiency of the state's interests is a bit more complicated than might appear at first glance, particularly if the legislation aims primarily to protect future children conceived and born through IVF. As far back as *Roe v. Wade*, the Supreme Court has recognized that the state has at least a legitimate interest in protecting potential life.¹⁰³ Although under *Roe*, that interest did not rise to the level of "compelling" until the fetus had reached the point of viability,¹⁰⁴ in *Casey*, the Court declared that the state had a compelling interest in potential life that it could promote *throughout* the pregnancy.¹⁰⁵ These cases thus support the state's interest in protecting potential life. However, the state's interest in potential life in the abortion cases protects beings already conceived and developing in the womb. A question still remains whether the state has a compelling interest in the protection of potential lives at the embryo stage.¹⁰⁶ In *Davis v. Davis*,

⁹⁷ The Practice Comm. of the Am. Soc'y for Reproductive Med., *Multiple Pregnancy Associated with Infertility Therapy*, FERTILITY & STERILITY, Vol. 86, Suppl. 4 (Nov. 2006), available at [http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Educational_Bulletins/multiple_pregnancy_associated\(1\).pdf](http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Educational_Bulletins/multiple_pregnancy_associated(1).pdf) (last accessed Apr. 24, 2010).

⁹⁸ Cerebral palsy is a disorder that affects the "brain and nervous system functions such as movement, learning, hearing, seeing, and thinking." *Cerebral Palsy*, U.S. NAT'L LIBRARY OF MED., NAT'L INSTS. OF HEALTH, <http://www.nlm.nih.gov/medlineplus/ency/article/000716.htm> (last visited Apr. 24, 2010).

⁹⁹ Retinopathy of prematurity is abnormal blood vessel development in the eye, which can occur in a premature infant. *Retinopathy of Prematurity*, U.S. NAT'L LIBRARY OF MED., NAT'L INSTS. OF HEALTH, <http://www.nlm.nih.gov/medlineplus/ency/article/001618.htm> (last visited Apr. 24, 2010).

¹⁰⁰ Bronchopulmonary dysplasia is a chronic lung condition that can affect newborn babies born prematurely. *Bronchopulmonary Dysplasia*, U.S. NAT'L LIBRARY OF MED., NAT'L INSTS. OF HEALTH, <http://www.nlm.nih.gov/medlineplus/ency/article/001088.htm> (last visited Apr. 24, 2010).

¹⁰¹ *Multiple Pregnancy Associated with Infertility Therapy*, *supra* note 97.

¹⁰² *Id.*

¹⁰³ *Roe*, 410 U.S. at 150. See, e.g., *Planned Parenthood*, 505 U.S. at 837; *Carey v. Population Services, Int'l.*, 431 U.S. 678, 686 (1977); *Harris v. McRae*, 448 U.S. 297, 299, 313 (1980); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 466 (1983) (citing *Harris v. McRae*).

¹⁰⁴ *Roe*, 410 U.S. at 163.

¹⁰⁵ *Planned Parenthood*, 505 U.S. at 876.

¹⁰⁶ Cf. LA. REV. STAT. §§ 9:123-9:133 (West 2000) (declaring embryos to be "persons" as a matter of state

the Tennessee Supreme Court found no such interest, but *Davis* was relying on *Roe v. Wade*, which found the state's interest in potential life compelling only at the point of viability.¹⁰⁷ It may be that after *Casey*, the state's interest in potential life could precede initiation of the pregnancy, but the question generates complications of logic and philosophy. If we recognize a state's general and undifferentiated "interest in potential life," even prior to implantation, analogous to the one put forth in the abortion context, we open the door to state efforts requiring donation or implantation of embryos, regardless of the parents' wishes.¹⁰⁸ Recognizing such a sweeping state interest brings to mind Orwellian science fiction and would pose a grave threat to individual and parental autonomy.

Yet to deny any possibility of state interest also seems wrong. Surely the state has an interest in maximizing the chance that embryos that parents choose to implant will develop into healthy children. However there is an irony and an ontological paradox here. For those who would promote the broader state view—an undifferentiated interest in protecting preimplantation life—desirable policy might require transfer of many embryos, in direct contravention of the embryo transfer restriction, and thereby increase the risk of harm to any resulting children.¹⁰⁹ By contrast, those who argue for a narrower state interest—preventing harm to future children—would actually be promoting the destruction of some embryos to increase the chance for others to thrive. Thus the state's claim of a compelling interest in preventing harm to future children from multiple births might result in them not being born at all.¹¹⁰ Admittedly, it might be possible, in some instances, to cryopreserve the non-transferred embryos, which would give them a chance to develop in a later cycle or through donation. But that possibility rests on numerous assumptions that are unlikely to prove valid in many cases, including that the embryos could be cryopreserved, that the creators would undergo another IVF cycle, or that they would agree to donate any unused embryos to someone else for implantation.

Feminists also face something of a dilemma on this point. Whenever we acknowledge a state interest in protecting potential life—whether fetal or embryonic—we run the risk of inviting state restrictions on women's reproductive freedom.¹¹¹ On the other hand, as mothers, feminists also see the value and need for protection of women (and their children) from exploitive forces.¹¹² We can reconcile these seemingly conflicting goals by distinguishing between harms done *by*

policy).

¹⁰⁷ 842 S.W. 2d 588, 602 (Tenn. 1992).

¹⁰⁸ The future may be now in this regard. *See infra* at nn. 30, 155 and accompanying text (discussing S.B. 169, Gen. Assem. (Ga. 2009)). *See also* Suter, *Repugnance*, *supra* note 49, at 1527 (questioning whether bans on embryo destruction or compelled embryo donation would implicate constitutional right to procreate). Colorado voters faced Amendment 62, which would have defined person as "every human being from the beginning of biological development of that human being," in the Fall 2010 election. COLORADO GEN. ASSEM., 2010 BALLOT INFO. BOOKLET, RESEARCH PUB. NO. 599-1 16-17 (2010).

¹⁰⁹ This paradoxical position appears in reverse where anti-abortion proponents would prohibit termination of pregnancies when the child will suffer severe genetic or congenital defects.

¹¹⁰ *See* M.A. Roberts, Independent Article, *Supernumerary Pregnancy, Collective Harm and Two Forms of the Nonidentity Problem*, 34 J.L. MED. & ETHICS 776 (2006) (detailing the legal and philosophical analysis of whether children born in this situation can be considered harmed).

¹¹¹ *See* Brown, *supra* note 74, at 103-04; Joyce E. McConnell, *Relational and Liberal Feminism: The "Ethic of Care," Fetal Personhood and Autonomy*, 99 W. VA. L. REV. 291, 306-07 (1996).

¹¹² Marjorie M. Schultz, *Abortion and Maternal-Fetal Conflict: Broadening Our Concerns*, 1 S. CAL. REV. L. & WOMEN'S STUD. 79, 81-82 (1992).

third parties to the children and to women's interests as mothers,¹¹³ from actions undertaken by the mother in the exercise of her reproductive freedom, which may negatively impact her future offspring.¹¹⁴ Protecting women as prospective mothers from harm caused by others differs from state interventions that pit prospective mothers against their future children.¹¹⁵

Despite the philosophical, logical, and political conundrum presented, I believe courts would ultimately accept without too much difficulty that the state has an interest, maybe even compelling one, in trying to prevent creation of children with significant health problems of disabilities.¹¹⁶ In fact, the interest may even be stronger than the state's interest in promoting potential life in the abortion context, given that these potential lives must be affirmatively created and their protection would not impose physical burdens on the mother. In addition, the state undeniably has a strong interest in protecting women's health,¹¹⁷ as well as in regulating the medical profession and in protecting its ethics and integrity.¹¹⁸

The constitutionality of proposed embryo transfer restrictions ultimately will turn then, under strict scrutiny, on whether the statutory limits are narrowly tailored to achieve those purposes. The ASRM has promulgated practice guidelines¹¹⁹ to reduce the risk of multiple births, which under the Missouri bill,¹²⁰ would presumably have taken on the force of law. However, these guidelines, revised since the octuplets' birth, do not support a bright line rule regarding embryo transfer, as the Georgia bill sets forth, and certainly not one that would limit transfer to 1 or 2 embryos. The ASRM recommends a sliding scale based on age of the mother (or egg provider). For example, a woman under age 35 would be limited to 2 embryos transferred, while a woman age 38 could receive as many as 4, depending on certain parameters.¹²¹ Moreover, the Guidelines expressly instruct physicians to take into account individual circumstances and allow for upward adjustment for women under certain circumstances, such as two previous failed IVF

¹¹³ See, e.g., *Bonbrest v. Kotz*, 65 F. Supp. 138 (D.D.C. 1946) (recognizing a prenatal tort cause of action for children later born alive).

¹¹⁴ See, e.g., Carolyn B. Ramsey, *Restructuring The Debate Over Fetal Homicide Laws*, 67 OHIO ST. L.J. 721, 744 (2006) (distinguishing termination of pregnancy by abortion from termination by "third party killers" addressed in fetal homicide statutes).

¹¹⁵ See generally Reva Siegel, *Reasoning From The Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261 (1992).

¹¹⁶ See Garrison, *infra* note 208, at 1640 (arguing that once embryo has been "selected for birth," state has interest in protecting future child against health risks "comparable to those that the state offers to current children" because burden of harm, vulnerability and inability to consent apply equally for prebirth children); Noah, *supra* note 15, at 661-63 (analogizing to accepted FDA regulation of severely teratogenic agents, such as DES); Rao, *supra* note 14, at 1479 (supporting ban on cloning to further state interest in advancing welfare of children); Note, *supra* note 14, at 2810 (predicting that reasonable regulations of IVF aimed at protecting mothers and children would be upheld).

¹¹⁷ Cf. *Roe v. Wade* 410 U.S. 116 (recognizing state's interest in protecting woman's health as sufficient justification for regulation of abortion pre-viability).

¹¹⁸ *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007).

¹¹⁹ *Multiple Pregnancy Associated with Infertility Therapy*, *supra* note 97.

¹²⁰ See *supra* note 31 and accompanying text.

¹²¹ The Practice Comm. of the Am. Soc'y for Reproductive Med. & The Practice Comm. of the Soc'y for Assisted Reproductive Tech., *Guidelines on Number of Embryos Transferred*, 92 FERTILITY & STERILITY, no. 5, Nov. 2009, at 1518-19, available at [http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/Guidelines_on_number_of_embryos\(1\).pdf](http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/Guidelines_on_number_of_embryos(1).pdf).

attempts or other indicia of a less favorable prognosis.¹²²

Moreover, multiple births result from a variety of causes. Significantly, ovarian induction and super-ovulation, two kinds of fertility drug treatments, are actually responsible for a greater percentage of high-order multiple gestations than ART.¹²³ Yet calls for legislative restrictions on use of fertility drugs have been rare.¹²⁴ Moreover, the number of twin births resulting from causes other than ART far exceeds the number resulting from ART, though ART certainly has contributed to an increase.¹²⁵ Indeed, the rise in multiple births in recent decades can likely be attributed in significant part to delays in childbearing, as multiple births increase as the mother's age increases, even for children conceived naturally.¹²⁶ These facts suggest that if the asserted justification is protecting mother and future child health, the regulation is significantly under-inclusive. The regulation is over-inclusive, as well, because not every transfer in excess of the stated limit will result in multiple pregnancies or in serious complications for the mother or children. The most recent data from the CDC reveals that even when three or more embryos are transferred, of the cycles resulting in live births, most are of singletons, with the proportion of higher order multiples a relatively small percentage (under 5%).¹²⁷

Inevitably, medical procedures involve some risks. How much justifies state infringement when fundamental rights are at stake? Any use of IVF may increase risks for mothers and children, even when children are born as singletons.¹²⁸ For example, IVF appears to pose an increased risk of placenta previa, a pregnancy complication in which the placenta grows

¹²² *Id.*

¹²³ *Id.*; *Fertility Drugs Contribute Heavily to Multiple Births*, SCIENCE DAILY (Jan. 24, 2010), <http://www.sciencedaily.com/releases/2010/01/100120104002.htm> (stating more than one in five multiple births resulted from fertility drugs alone).

¹²⁴ See Noah, *supra* note 15 (arguing in favor of FDA bans or restrictions on ovulation-inducing drugs). Cf. Rosato, *supra* note 14, at 86, 88 (arguing for legal limitations to the number of pre-embryos implanted and licensing sanctions against physicians with excessive rate of super-multiples); Strong, *infra* note 144, at 278-79 (2003) (noting suggestion that physicians performing ovarian stimulation be licensed).

¹²⁵ Joyce A. Martin et al., *National Vital Statistics Reports, Births: Final Data for 2005*, available at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_06.pdf (accessed Apr. 24, 2010) (showing ART therapies alone accounting for only 17 percent of twin births).

¹²⁶ Victoria Clay Wright et al., *Assisted Reproductive Technology Surveillance 2001, United States*, CTR. FOR DISEASE CONTROL (April 30, 2009), <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5301a1.htm>; MULTIPLE PREGNANCY OVERVIEW, NEW YORK PRESBYTERIAN HOSPITAL, <http://nyp.org/health/pregnant-mpover.html> (last visited July 25, 2010). Feminists need to be wary of policies that directly or indirectly penalize women who delay childbearing. For an insightful exploration on the relationship between ART and workplace pressures that lead women to delay childbearing at the expense of their fertility, see Michelle Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 J. GEN. RACE & JUSTICE 1 (2005) [hereinafter Goodwin, *Double Bind*].

¹²⁷ ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS, CTRS. FOR DISEASE CONTROL AND PREVENTION Table 35, 49 (Dec. 2010). Recent data from Canada show a similar pattern. Of the cycles transferring three or more embryos, the triplet birth rate was 4.3%. Joanne Gunby et al., *Assisted Reproductive Technologies (ART) in Canada: 2006 Results from the Canadian ART Register*, 93 FERTILITY & STERILITY 2189, 2196 (May 2010). Moreover, for all cycles resulting in live birth, overall almost 30% resulted in multiples, but only 1.2% were triplets and only one was a quadruplet birth. *Id.* at 2191.

¹²⁸ Diana B. Welmerink et al., *Infertility Treatment Use in Relation to Selected Adverse Birth Outcomes*, 94 FERTILITY & STERILITY 2580 (2010). See also Suter, *Repugnance*, *supra* note 49, at 1523, n.57; Rosato, *supra* note 14, at 77-78.

over the cervix.¹²⁹ Placenta previa can lead to bleeding, premature delivery and major complications, including death, for mother and baby.¹³⁰ However, the actual percentage of women developing placenta previa after infertility treatment (including, but not limited to IVF) was still only 2.0, compared to 0.6 for women conceiving spontaneously.¹³¹ Thus although the percentage of increased risk was high (more than double), 98% of infertile women did not experience this complication, and, without treatment, would not have been able to conceive and carry a child to term. Moreover, the authors could not conclusively determine whether the increased risk of placenta previa (and other conditions observed) resulted from the treatment itself or some characteristic inherent in the conceiving couple.¹³² Would the increased risk of placenta previa warrant a prohibition on all IVF? It seems highly unlikely.¹³³ Similarly, a prenatal diagnostic test, chorionic villi sampling (CVS) poses a nearly two percent risk of miscarriage, yet no one has suggested legislatively banning the procedure, and it is a commonly used screening method.¹³⁴

Ultimately, no bright-line rule tells us when a given procedure or treatment poses too great a risk of harm to justify its use. Rather, physicians operating under principles of ethics and tort law, as well as regulatory agencies, rely on cost-benefit analysis, as do courts.¹³⁵ As a frame of reference, one commentator argued against mandatory anti-retroviral treatment for HIV positive pregnant women, stating: “Because the risk of HIV infection to the child, absent antiviral treatment is approximately one in four, a decision by a mother to “play the odds” cannot clearly be characterized as not in the child’s best interest.”¹³⁶ By contrast, in *Pemberton v. Tallahassee Mem. Reg. Med. Cen., Inc.*,¹³⁷ a federal district court found that a risk of uterine rupture estimated from 2 to 10 percent (depending on the expert testifying), which would have created a 50 percent chance of fetal death, was sufficient to compel a cesarean section without the woman’s consent.

In advocating for embryo transfer restrictions, a state would have difficulty establishing that the risk of serious health problems for the mother and child is sufficient to limit legislatively the number of embryos transferred, given that such a limit could effectively preclude the birth of a

¹²⁹ Welmerink, *supra* note 128.

¹³⁰ *Placenta Previa*, GOOGLE HEALTH, <https://health.google.com/health/ref/Placenta+previa> (last visited June 28, 2010).

¹³¹ Welmerink, *supra* note 128, at Table 2.

¹³² *Id.*

¹³³ *But cf.* Noah, *supra* note 15, at 652 (suggesting that the FDA might prevent the use of intracytoplasmic sperm injection (ICSI) if it causes increases in birth defects following IVF).

¹³⁴ *Antenatal Testing*, ENCYCLOPEDIA OF CHILDREN’S HEALTH, <http://www.healthofchildren.com/A/Antenatal-Testing.html> (last visited June 28, 2010).

¹³⁵ The use of cost-benefit analysis, rather than specific standards, remains a cornerstone of tort law. *See* DAN B. DOBBS, *THE LAW OF TORTS*, 277, 340 (2000). Judge Learned Hand expressed this idea algebraically in the famous case *United States v. Carroll Towing*, 159 F.2d 169 (2d Cir. 1947). Similarly, the FDA weighs risks and benefits in deciding whether to approve drugs. Lars Noah & Barbara A. Noah, *A Drug By Any Other Name . . . ? : Paradoxes In Dietary Supplement Risk Regulation*, 17 STAN. L. & POL’Y REV. 165, 187 (2006) (“Thus, balancing of risks and benefits is fundamental to the process of evaluating a new drug, and the agency may opt to tolerate very serious risks if the product offers a novel and important benefit.”).

¹³⁶ Michael A. Grizzi, *Recent Developments: Compelled Antiviral Treatment of HIV Positive Pregnant Women*, 5 UCLA WOMEN’S L.J. 473, 489-490 (1995).

¹³⁷ 66 F. Supp. 2d 1247, 1253 (N.D. Fla. 1999).

child altogether and given that the prevailing medical consensus in the United States underlines the need for individualized determination in each case.¹³⁸ Even reproductive endocrinologists seeking to promote single embryo transfer note the difficulty of determining when it is appropriate.¹³⁹ These authors note that optimal treatment may involve a “heavy load transfer”—transfer of a high number of embryos—for certain groups of women who may need it to initiate and sustain pregnancies of any kind.¹⁴⁰

There are also alternative ways of achieving the state’s goals, including improved education of patients and enhanced informed consent regarding the risks of transferring multiple embryos, as well as policing by state medical boards and professional societies. In fact, some evidence suggests that self-regulatory efforts have had some impact in stabilizing the rate of twin births and reducing the incidence of higher order multiples resulting from ART.¹⁴¹ Multifetal reduction is also an option that leaves the decision in the hands of the woman and her doctor.¹⁴² Multifetal reduction involves the termination by injection of one or more of the developing fetuses in order to reduce the pregnancy to a safer size.¹⁴³ However, some view multifetal reduction as a negative by-product of excessive embryo transfer, rather than as a desirable alternative to carrying a multifetal pregnancy to term. It can pose risks to the remaining fetuses, and some women object to the procedure for religious, philosophical, emotional, or other reasons.¹⁴⁴

Supporters of a transfer limit can also argue that the dramatic increase in serious complications for mother and child once the number of embryos transferred exceeds two justifies the restrictions. The fact that other causes of multiple births remain does not mean the restriction

¹³⁸ See ASRM guidelines discussed *supra* note 121 and accompanying text.

¹³⁹ Gerris & De Sutter, *supra* note 34, at 62-63.

¹⁴⁰ *Id.* at 62.

¹⁴¹ See Joyce A. Martin, et al., Center for Disease Control, *Births: Final Data for 2006*, 57 NAT’L VITAL STATISTICS REPS., NO. 7, JAN. 7, 2009. (reporting stabilization in the rate of twin births and continued decline in the rate of higher order multiple births and noting the effect of ASRM guidelines on declines in embryo transfers), available at http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf; *Multiple Pregnancy Associated with Infertility Therapy*, *supra* note 97 (noting that the rate of twin pregnancies remained stable while the “number of triplet or greater pregnancies resulting from ART cycles has decreased from 7.0% in 1996 to 3.8% in 2002, and to 3.2% in 2003”). See also Ulla Britt Wennerholm, *The Risks Associated with Multiple Pregnancy*, in SINGLE EMBRYO TRANSFER (Gerris et al., eds., 2009). *But see* Gunby, *supra* note 127 at 2198 (noting the “lack of progress in reducing multiple births” from 2005 to 2006, despite practitioners being “close” to meeting recommendations similar to ASRM guidelines for the number of embryos transferred).

¹⁴² Noah, *supra* note 15, at 654-55 (2003); Mark I. Evans & David W. Britt, *Multifetal Pregnancy Reduction*, GLOBAL LIBRARY OF WOMEN’S MED., http://www.glowm.com/index.html?p=glowm.com/l/section_view&articleid=214 (last visited June 22, 2010).

¹⁴³ Stacey Pinchuk, *A Difficult Choice in a Different Voice: Multiple Births, Selective Reduction and Abortion*, 7 DUKE J. GENDER L. & POL’Y 29, 30 (2000).

¹⁴⁴ See *Multiple Pregnancy Associated with Infertility Therapy*, *supra* note 97; Adamson, *supra* note 14, at 253; Carson Strong, *Too Many Twins, Triplets, Quadruplets, And So On: A Call For New Priorities*, 31 J. L. MED. & ETHICS 272, 275 (2003); Sivinski, *supra* note 34, at 906; Liza Mundy, *Too Much to Carry?* WASH. POST, May 20, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/05/15/AR2007051501730.html>.

Undoubtedly because of its resemblance to abortion, it is almost impossible to imagine the enactment of legislation compelling multifetal reduction or that a court would sustain it as a constitutional matter, yet many have little difficulty calling for embryo transfer restrictions that effectively foreclose procreation for some women.

on this particular cause is not narrowly tailored. Certainly when it comes to pharmaceutical agents affecting reproduction, we know the state has the power to restrict or prohibit access altogether for agents deemed to pose unacceptable health risks.¹⁴⁵ Thus even if strict scrutiny applied, a court might uphold an embryo transfer restriction statute.

2. The Undue Burden Standard

How does the analysis change under the undue burden approach? The Supreme Court has defined an undue burden as one that places “. . . a substantial obstacle in the path of a woman seeking an abortion . . .,”¹⁴⁶ or, in this case, seeking to procreate. In other words, how burdensome is the restriction? The proper method of quantifying that burden has generated controversy and confusion.¹⁴⁷ In evaluating a provision requiring spousal notification before a woman could obtain an abortion *Casey* stated, “The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.”¹⁴⁸ *Casey* defined the target group as those directly affected by the legislation: married women who wish to have an abortion without notifying their husbands, and who do not fit into one of the statutory exceptions. For a “large fraction” of those cases, the spousal notice requirement operated as a substantial obstacle and was thus unconstitutional.¹⁴⁹ By analogy then, the question in the present analysis would be whether the embryo transfer restriction would pose a substantial obstacle for those women who want to exceed the statutory limit.

For a woman who is unlikely to get pregnant and successfully carry a child to term if limited to transfer of the specified number of embryos, the burden would indeed be substantial. Options might include undergoing additional cycles of fresh IVF, with the attendant risks of ovarian stimulation and retrieval¹⁵⁰ and which might not provide eggs or embryos of sufficient

¹⁴⁵ See *What Does FDA Regulate?*, U.S. FOOD AND DRUG ADMIN., <http://www.fda.gov/AboutFDA/Basics/ucm194879.htm> (last visited June 30, 2010); *FDA Fundamentals*, U.S. FOOD AND DRUG ADMIN., <http://www.fda.gov/AboutFDA/Basics/ucm192695.htm> (last visited June 30, 2010).

¹⁴⁶ *Planned Parenthood*, 505 U.S. at 878.

¹⁴⁷ See *id.* at 886-87 (“We . . . disagree with the District Court’s conclusion that the ‘particularly burdensome’ effects of the waiting period on some women require its invalidation. A particular burden is not of necessity a substantial obstacle. Whether a burden falls on a particular group is a distinct inquiry from whether it is a substantial obstacle even as to the women in that group.”); *Gonzales v. Carhart*, 550 U.S. 124, 188 (2007) (Ginsburg, J., dissenting) (rejecting majority’s use of “large fraction” analysis of undue burden when judging lack of health exception to partial-birth abortion ban). For additional discussion, see generally Beth A. Burskstrand-Reid, *The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence*, 81 U. COLO. L. REV. 97 (2010); Caitlin E. Borgmann, *Abortion, the Undue Burden Standard, and the Evisceration of Women’s Privacy*, 16 WM. & MARY J. WOMEN & L. 291 (2010); Helena Silverstein, *In the Matter of Anonymous, A Minor: Fetal Representation in Hearings to Waive Parental Consent for Abortion* 11 CORNELL J.L. & PUB. POL’Y 69, 73-76 (2001) (discussing whether a parental consent requirement for minors seeking abortion amounts to a substantial obstacle); Hannah Stahle, *Fetal Pain Legislation: An Undue Burden*, 10 QUINNIPIAC HEALTH L.J. 251 (2007) (discussing fetal pain statutes and the obstacles they put on a physician’s ability to perform an abortion, and whether this amounts to a substantial obstacle for woman); Sarah E. Weber, *An Attempt to Legislate Morality: Forced Ultrasounds as the Newest Tactic in Anti-Abortion Legislation*, 45 TULSA L. REV. 359 (2009) (discussing forced ultrasounds).

¹⁴⁸ *Planned Parenthood*, 505 U.S. at 894.

¹⁴⁹ *Planned Parenthood*, 505 U.S. at 894-95.

¹⁵⁰ Some women who take fertility medicine to stimulate egg production develop ovarian hyperstimulation

quality,¹⁵¹ using frozen embryos, if any are available;¹⁵² and in either case, considerable additional expense,¹⁵³ which may well be prohibitive. Moreover, in some cases the restriction would effectively prevent procreation, similar to the women for whom a spousal notice requirement would essentially block their right to an abortion. Women older than 40 or with a history of poor ovarian response or previous failed IVF attempts would fall into this category.¹⁵⁴

This problem is particularly acute under the Georgia bill. In addition to limiting the number of embryos transferred to three for women older than 40, it prohibits physicians from creating more than that number of embryos in a given IVF cycle (to avoid the possibility of destroying the excess embryos).¹⁵⁵ This provision would further increase the burden on affected women, as the quality of the embryo plays a key role in assessing how many embryos to transfer in order to optimize the chance of a successful pregnancy.¹⁵⁶ Quality can only be determined by allowing the embryo to develop after fertilization.¹⁵⁷ Thus, a woman who fertilizes the maximum number allowed for transfer might well end up with fewer embryos of sufficient quality for transfer, further impairing her chance of initiating a successful pregnancy.

syndrome (OHSS). OHSS can cause significant weight gain in a short period of time, reduced urination, severe pain or swelling in the abdomen, and, in rare cases, life threatening complications. Nat'l Insts. of Health, *Ovarian Hyperstimulation Syndrome*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/007294.htm> (last visited Apr. 24, 2010); Mayo Clinic staff, *Ovarian Hyperstimulation Syndrome*, MAYOCLINIC.COM, <http://www.mayoclinic.com/health/ovarian-hyperstimulation-syndrome-ohss/DS01097/METHOD=print> (last visited Aug. 16, 2010).

¹⁵¹ Jonathan Van Blerkom, *An Overview of Determinants of Oocyte and Embryo Developmental Competence: Specificity, Accuracy and Applicability in Clinical IVF*, in SINGLE EMBRYO TRANSFER 17 (Gerris, et al., eds., 2009).

¹⁵² The availability of extra embryos for freezing decreases sharply with age. Saswati Sunderam et al., *Assisted Reproductive Technology Surveillance – United States, 2006*, 58 Center for Disease Control Surveillance Summaries, no. SS–5, June 12, 2009, at 1, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5805a1.htm?s_cid=ss5805a1_x [hereinafter Sunderam, *Assisted Reproductive Technology Surveillance*], (transfers with frozen embryos have a lower success rate than with fresh). See 2005 *Assisted Reproductive Technology Report: Section 3—ART Cycles Using Frozen, Nondonor Embryos*, CTR. FOR DISEASE CONTROL, http://www.cdc.gov/ART/ART2005/sect3_fig42-43.htm#f42 (last visited Apr. 24, 2010) (showing use of transfers of thawed embryos results in live births only 28% of the time compared to transfers using fresh results in live births 34.3% of the time). In addition, some embryos may not survive the thawing process. See Aila Tiitinen, *Cryo-Augmentation After Single Embryo Transfer: The European Experience*, in SINGLE EMBRYO TRANSFER 121, 124 (Jan Gerris, et al., eds. 2009).

¹⁵³ See, e.g., Jim Hawkins, *Financing Fertility*, 47 HARV. J. ON LEGIS. 115, 115 (2010) (noting that one treatment of IVF costs over \$12,000 for a single cycle); Mary Shedden, *The Financial Challenge of Overcoming Infertility*, WRBL NEWS, http://www2.wrbl.com/rbl/news/local/article/the_financial_challenge_of_overcoming_infertility/145053/ (last visited Apr. 24, 2010).

¹⁵⁴ Gerris & De Sutter, *supra* note 34, at 62.

¹⁵⁵ S.B. 169, Gen. Assem. (Ga. 2009) (as introduced). See *supra* note 30 and accompanying text.

¹⁵⁶ Mark Henderson, *Embryo 'Quality Check' Could Double IVF Success Rate*, THE TIMES, Nov. 10, 2008, <http://www.timesonline.co.uk/tol/news/science/article5119721.ece>; John M. Norian et al., *An American Perspective on Single Embryo Transfer*, in SINGLE EMBRYO TRANSFER 272 (Jan Gerris, et al., eds., 2009).

¹⁵⁷ Lynette Scott, *Sequential Embryo Selection for Single Embryo Transfer*, in SINGLE EMBRYO TRANSFER 109-16 (Jan Gerris, et al., eds., 2009). Transfer of blastocysts on day 5 or 6 after fertilization has a higher implantation rate than embryos transferred at day 2 or 3 after fertilization, though not all embryos will survive to the blastocyst stage and blastocyst transfer carries its own risks. See Adamson, *supra* note 14, at 252.

However, *Carhart v. Gonzales*¹⁵⁸ casts considerable doubt on the persuasiveness of this argument. In *Carhart*, the Court upheld a federal law that prohibited a specific medical procedure—dilation and evacuation (“D & E”), also known as partial-birth abortion—using the undue burden standard.¹⁵⁹ The *Carhart* Court seemed to veer away from the *Casey* mode of analysis, suggesting that the proper method was to evaluate the percentage of women negatively affected by the restriction compared to the total number of women undergoing the procedure.¹⁶⁰ If so, it is possible that out of the entire population of women undergoing IVF, relatively few women will be affected by the restriction. Under this analysis, the statute might not impose an undue burden.

The Court upheld the law in *Carhart* even though it admitted that there is uncertainty about whether the prohibition of the D & E procedure would put women’s health at risk.¹⁶¹ The Court also took pains to emphasize that abortion doctors were subject to the same treatment as other physicians; in other words, like other doctors, they were not entitled to “unfettered choice in the course of their medical practice.”¹⁶² *Carhart* makes clear that the state interest in protecting potential life and the integrity of the medical profession can justify prohibitions on specific medical procedures, despite their potential efficacy in effectuating women’s reproductive choices and even if the available alternatives might pose additional risks to a woman’s health. Neither the prospect of additional expense, inconvenience, or even additional risks to mother’s health sufficed to establish an undue burden.¹⁶³

Given the availability of cryopreservation of excess embryos as an alternative, *Carhart* provides considerable support for a court to uphold embryo transfer restrictions. However, even *Carhart* acknowledged that the ban on partial-birth abortion might be unconstitutional as applied to a woman whose health would be seriously compromised by use of another late-term procedure.¹⁶⁴ Hence an “as applied” challenge to an embryo transfer restriction might succeed where a facial attack would not. However, the difficulty of actually finding plaintiffs to pursue such a challenge, given the long timeframe of litigation, would render this option more illusory than real.¹⁶⁵ The chance of a woman achieving a live birth through IVF decreases dramatically as she ages, at least when she is using her own eggs.¹⁶⁶ Moreover, decisions about how many embryos to transfer typically depend on how many of them successfully fertilize and develop and

¹⁵⁸ 550 U.S. 124 (2007).

¹⁵⁹ *Id.* at 156.

¹⁶⁰ *Id.* at 140 (examining the percentage certain abortion procedures used in second-trimester abortions). Justice Ginsburg attacked the majority for misapplying the *Casey* test. *Gonzales v. Carhart*, 550 U.S. 124, 188 (2007) (Ginsburg, J., dissenting) (rejecting majority’s use of the “large fraction” analysis of undue burden when judging lack of a health exception to the partial-birth abortion ban).

¹⁶¹ *Id.* at 162.

¹⁶² *Id.* at 163.

¹⁶³ *Carhart*, 550 U.S. at 164, 166.

¹⁶⁴ *Id.* at 167.

¹⁶⁵ See Suter, *Repugnance*, *supra* note 49, at 1575 (noting the difficulty of mounting an as applied challenge to the partial birth abortion statute) and at n.345 (discussing the controversy about the standards for facial constitutional challenges in abortion cases); *Carhart*, 550 U.S. at 89-90 (Ginsburg, J., dissenting) (discussing inadvisability of relying on as applied challenge).

¹⁶⁶ SUNDERAM, *supra* note 152. The chance of a live birth for a woman as she ages may decrease even for women using donor eggs in certain circumstances, though the decline is slight. *Id.*

on the quality of the embryos.¹⁶⁷ Hence the need to transfer more than some statutory limit might not be apparent until the day of the scheduled embryo transfer. Any delay would render the problem moot, as careful timing is essential to the procedure. The only alternative would be to cryopreserve any excess embryos, again requiring the additional expense and physical burdens of another cycle of IVF.¹⁶⁸

Thus, although I believe there are strong arguments in favor of a constitutional challenge to transfer restrictions, jurisprudence in this area is far from coherent and the ultimate resolution is clearly open to debate. The question then becomes whether, even if restrictions could pass constitutional muster, they constitute good policy.

III. "BAD" MOTHERS LEAD TO BAD POLICY

The strongest argument in favor of an embryo transfer restriction is that it has the potential to further reduce the risk of multiple births and their attendant problems. While I argue that physicians and patients can exercise appropriate medical judgment without legislative interference and should be left to do so, I am aware that for reasons both financial and emotional, patients may exert pressure on physicians to pursue more aggressive treatment than they would otherwise recommend.¹⁶⁹ The widespread dearth of insurance coverage coupled with the high cost of fertility treatment may lead patients to seek to maximize their chances in any given cycle, even at the risk of increasing the odds of a multiple birth.¹⁷⁰ Indeed, some patients, especially those using surrogate carriers, may actively seek twins as a cost and stress saving measure.¹⁷¹

¹⁶⁷ *Guidelines on Number of Embryos Transferred*, 92 FERTILITY & STERILITY 1518 (2009); John M. Norian, et al., *An American Perspective on Single Embryo Transfer*, in SINGLE EMBRYO TRANSFER 274 (Jan Gerris et al., eds., 2009) (discussing the need to determine number of embryos for transfer based on embryo quality and age); Michelle Brandt, *Stanford Researchers Find Way to Predict IVF Success*, STANFORD SCHOOL OF MED. (July 1, 2008), http://med.stanford.edu/news_releases/2008/july/IVF.html. R. Dale McClure, *Birth of Octuplets Raises Questions*, WASH. TIMES, Mar. 8, 2009, at M13 ("When making a recommendation, the physician takes into account the diagnosis of the patient, her age, her prior experiences with medical treatment and the quality and quantity of embryos available").

¹⁶⁸ Of course, physicians might bring the challenge instead and could avoid the mootness problem, as they would likely repeatedly encounter women patients needing to exceed the statutory limit without time to litigate the question. See *Federal Election Commission v. Wis. Right to Life, Inc.*, 551 U.S. 449, 462 (2007) (discussing "established exception to mootness for disputes capable of repetition, yet evading review"). However, even this option would not protect women in all cases. The reasons why a patient might need to transfer more than the legislative limit vary widely. Capturing the range of situations would likely require multiple lawsuits, which still might not account for all situations. As Justice Ginsburg noted in *Carhart*, relying on an "'as-applied challenge in a discrete case' . . . jeopardizes women's health and places doctors in an untenable position. Even if courts were able to carve out exceptions through piecemeal litigation for 'discrete and well-defined instances,' women whose circumstances have not been anticipated by prior litigation could well be left unprotected." *Carhart*, 550 U.S. at 190 (Ginsburg, J., dissenting).

¹⁶⁹ Sivinski, *supra* note 34, at 901-05 (2010); Strong, *supra* note 144, at 275; MAKING THE RIGHT CHOICES WHEN IT COMES TO MULTIPLES, YALE FERTILITY CTR. (Apr. 24, 2010), http://medicine.yale.edu/ysminfo/top_story/2009/03/06032009.html.

¹⁷⁰ Hawkins, *supra* note 153, at 157.

¹⁷¹ Mundy, EVERYTHING CONCEIVABLE, *supra* note 33, at 214. See also Mary D'Alton, *Infertility and the Desire for Multiple Births*, 81 FERTILITY & STERILITY 523 (2004) (noting that 20% of women surveyed in study by Ginny L. Ryan et al., preferred multiple birth; 94% seeking twins); Guido Pennings, *Philosophical and Ethical Considerations on Single Embryo Transfer*, in SINGLE EMBRYO TRANSFER 200 (Jan Gerris et al., eds., 2009).

Age and notions of ideal family configuration may also play a role in patient preferences.¹⁷² Physicians are also under pressure to post high success rates, which may influence their decisions about the number of embryos to transfer.¹⁷³ These legitimate concerns, though, are far outweighed by the context in which the debate about this issue is taking place.

A. Putting the Restrictions into Context: Another Salvo in the War on Women's Reproductive Freedom and Medical Autonomy

We cannot view legislative responses to the Suleman case in isolation. Efforts to limit access to and regulate the practice of ART have been driven, at least in part, by pro-life advocates whose goal is to further erode women's reproductive freedom. They have had considerable success in recent years in the courts and legislatively in chipping away at a woman's right to choose.¹⁷⁴ The Supreme Court's most recent abortion decision in *Carhart* boldly undermined women's right to choose by upholding a ban on a late-term abortion procedure, despite ample evidence of the risk to women's health in doing so.¹⁷⁵

The same forces are at work here, and their influence sets the United States apart from other countries that regulate the number of embryos transferred.¹⁷⁶ The Missouri bill, which would establish American Society of Reproductive Medicine guidelines as legal limits on transfer,¹⁷⁷ was introduced by Robert Schaaf,¹⁷⁸ a self-identified anti-abortion and anti-stem cell research Christian physician, and Gayle Kingery,¹⁷⁹ also a pro-life Republican and sponsor of a 2007 bill that would prohibit minors from consenting to prescription contraception without a court order.¹⁸⁰ As for the Georgia bill, it goes significantly beyond restricting the number of embryos for transfer. Titled the "Ethical Treatment of Human Embryos Act," it would, among other things, prohibit stem cell research, declare that a human embryo is a "biological human being who is not the property of any person or entity," nullify any contract that describes the embryo in such terms, prohibit intentional destruction of any embryo and resolve disputes over embryos

¹⁷² Pennings, *supra* note 171 at 202.

¹⁷³ See, e.g., Strong, *supra* note 144, at 275; Sivinski, *supra* note 34, at 905; Rosato, *supra* note 14, at 72; Pinchuk, *supra* note 143, at 50-52. This concern appears to be overblown.

¹⁷⁴ See generally *State Policies in Brief, An Overview of Abortion Laws*, THE GUTTMACHER INST., http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf; *State Policies in Brief, Counseling and Waiting Periods for Abortion*, THE GUTTMACHER INST., http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf; Rachel Benson Gold, *All That's Old is New Again: The Long Campaign to Persuade Women to Forego Abortion*, GUTTMACHER POL. REV. 19 (Spring 2009), available at <http://www.guttmacher.org/pubs/gpr/12/2/gpr120219.html>.

¹⁷⁵ *Gonzales v. Carhart*, 550 U.S. 124, 164, 166 (2007).

¹⁷⁶ See Strong, *supra* note 144, at 279 (noting difference between strength of anti-abortion groups in U.S. and in Great Britain and observing relative lack of "excessive politicization" in embryo transfer regulation in Britain).

¹⁷⁷ H. B. 810, 95th Gen. Assemb., 1st Reg. Sess. (Mo. 2009).

¹⁷⁸ *Rep. Robert Schaaf, Dist. 028, Republican*, MISSOURI HOUSE OF REPS., <http://house.mo.gov/bio.aspx?year=2010&district=028> (last visited Nov. 8, 2010); *Issues*, ROBERT SCHAAF FOR STATE SENATE, <http://www.schaafforsenate.com/issues> (last visited Nov. 8, 2010).

¹⁷⁹ *Representative Gayle Kingery, District 154, Republican*, MISSOURI HOUSE OF REPRESENTATIVES, <http://house.mo.gov/bio.aspx?year=2010&district=154> (last visited Nov. 7, 2010).

¹⁸⁰ H.B. 617, 94th Gen. Assemb. (Mo. 2007) (prohibiting a minor from self-consenting for a prescription for a contraceptive drug or device unless a petition is granted by a juvenile court).

according to the “best interest” of the embryo, thus largely stripping the creators of the embryos—the intended parents—of control over the embryos’ fate.¹⁸¹

Moreover, I am deeply skeptical of the state’s effort to micromanage the doctor-patient relationship in this arena, given its track record involving other aspects of women’s medical care related to reproduction—namely abortion and state interference with pregnant women’s conduct. The devolution of informed consent doctrine in the area of women’s reproduction provides a telling case in point. For at least a half century, courts have recognized the importance of patient autonomy and the critical role informed consent plays in safeguarding the exercise of that autonomy.¹⁸² Informed consent aims to ensure that patients make the ultimate decisions about their health care by requiring that physicians provide sufficient information for them to do so.¹⁸³ Doctors who fail to disclose adequate information about the proposed treatment face civil liability.¹⁸⁴ Modern informed consent doctrine rejects the paternalistic model of “doctor knows best” that previously dominated. Current models of informed consent envision collaboration between patient and doctor to facilitate the patient’s exercise of her autonomy.¹⁸⁵

Yet recent cases and statutes have severely undercut that autonomy for women while at times imposing onerous obligations on physicians. *Carhart* asserted that by prohibiting the D & E medical procedure, it was merely treating abortion doctors like any other physicians. However, looking at regulation of medical procedures generally, legislators have subjected doctors involved with women’s reproductive health to unprecedented regulation and most often in a patronizing way that particularly burdens the woman’s exercise of reproductive freedom.¹⁸⁶ A Westlaw survey of statutes dealing with informed consent reveals three primary areas of regulation: mental health treatment, medical treatment of minors, and treatment related to women’s reproduction.¹⁸⁷ Once again, we see women classified with children and the mentally ill.¹⁸⁸

More than half the states have enacted abortion statutes that impose waiting periods

¹⁸¹ S.B. 169, Gen. Assemb. (Ga. 2009) (as introduced). The Georgia bill avoids the paradox identified earlier of elevating the interests of the embryo in life while limiting the number allowed for implantation, by prohibiting physicians from creating more embryos than permitted for transfer. See *supra* note 155 and accompanying text.

¹⁸² See generally *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (holding that doctors have a duty to disclose); *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261 (1990).

¹⁸³ Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 924 (1994).

¹⁸⁴ *Id.* at 927.

¹⁸⁵ Andrew E. Taslitz, *A Feminist Fourth Amendment?: Consent, Care, Privacy, and Social Meaning in Ferguson v. City of Charleston*, 9 DUKE J. GENDER L. & POL’Y 1, 48 (2002). See also Sharon N. Covington, *Counseling Patients for Single Embryo Transfer in SINGLE EMBRYO TRANSFER* 154 (Jan Gerris et al., eds., 2009) (describing shared decision making as “model of choice for complex medical decisions involving more than one reasonable treatment option”); Tracy Dobson, *Medical Malpractice in the Birthplace: Resolving the Physician-Patient Conflict Through Informed Consent, Standard of Care, and Assumption of Risk*, 65 NEB. L. REV. 655, 684 (1986) (advocating for shared decision-making and patient self-determination in birth related decisions).

¹⁸⁶ See B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 549 (2009) (observing the “uniquely onerous regulation of abortion” and noting that “many of the legal restrictions that apply to abortion providers would probably strike other physicians as outrageous if applied to them”).

¹⁸⁷ The following search was run on July 14, 2010 in the “all state statutes” and “50 state survey” databases: Informed written /s consent /p physician doctor /p treat!.

¹⁸⁸ Dan L. Burk, *DNA Rules: Legal and Conceptual Implications of Biological “Lock-Out” Systems*, 92 CAL. L. REV. 1553, 1580 (2004) (noting “historical inclusion of women together with children and mentally handicapped individuals as legal incompetents”).

and/or highly detailed informed consent requirements.¹⁸⁹ Legislation recently passed in Oklahoma over a gubernatorial veto presents one of the more egregious examples of this kind of regulation. Oklahoma already had a 24-hour waiting period and a requirement that detailed “informed consent” materials, including gestational photos, be provided to a woman seeking an abortion.¹⁹⁰ Oklahoma House Bill 2780, enacted in April 2010, now mandates that a physician perform an ultrasound on a woman seeking an abortion prior to obtaining informed consent for the procedure.¹⁹¹ Of course, by doing so, the law actually compels the woman to submit to the ultrasound procedure regardless of her consent. The law further requires that the physician simultaneously explain what the ultrasound is depicting, display the ultrasound so the woman can see the images and give a medical description of the images, including the dimensions of any fetus or embryo and the presence of any organs.¹⁹² Lest one think the law is unduly coercive, rest assured that it contains language expressly allowing the woman not to look:

Nothing in this section shall be construed to prevent a pregnant woman from averting her eyes from the ultrasound images required to be provided to and reviewed with her. Neither the physician, nor the pregnant woman shall be subject to any penalty if she refuses to look at the presented ultrasound images.¹⁹³

The law is silent as to whether the woman can choose to block out the narrative by wearing an I-Pod or other similar device during the procedure. Although the Center for Reproductive Rights quickly challenged the law and the Oklahoma attorney general has temporarily blocked enforcement, the ultimate outcome remains uncertain.¹⁹⁴ Nor is the Oklahoma law unique: in 2010, the Florida legislature passed a similar law, subsequently vetoed by the governor, and mandatory ultrasound bills have been introduced in Kentucky, Rhode Island, Montana, and Louisiana.¹⁹⁵

Moreover, a recently-enacted Nebraska anti-abortion statute takes the coercion to a new level.¹⁹⁶ Abortion providers under this statute must now engage in an extremely detailed risk

¹⁸⁹ WHO DECIDES? THE STATUS OF WOMEN’S REPRODUCTIVE RIGHTS IN THE UNITED STATES, NARAL PRO-CHOICE AMERICA 12 (JAN. 2011), available at <http://www.prochoiceamerica.org/government-and-you/who-decides/who-decides-2011.pdf>. See also *Planned Parenthood v. Casey*, 505 U.S. 833,881-87.

¹⁹⁰ OKLA. STAT. ANN. tit. 63 §§ 1-738.2-1-738.3. Similar requirements in a Kentucky statute, KY. REV. STAT. ANN. § 311.725 (West 2009), were largely upheld by a Kentucky court, although a Kentucky requirement of “in person” delivery of the materials was ruled unenforceable. *Eubanks v. Schmidt*, 126 F.Supp.2d 451 (W.D. Ky. 2000).

¹⁹¹ Act of April 27, 2010, 2010 OKLA. SESS. LAW SERV. 173 (West) (mandating that physicians perform ultrasounds on women seeking abortions).

¹⁹² *Id.* § 2 (A) (2)-(4).

¹⁹³ *Id.* § 2 (C).

¹⁹⁴ *Legal Challenge Blocks Oklahoma Law Requiring Ultrasound Before Abortion*, CATH. NEWS AGENCY, May 5, 2010, http://www.catholicnewsagency.com/news/legal_challenge_blocks_oklahoma_law_requiring_ultrasound_before_abortion/. A federal district court in Oklahoma struck down a prior bill containing a similar provision without reaching the merits of the ultrasound provision. *Oklahoma Abortion Law Overturned*, L.A. TIMES, Aug. 19, 2009, <http://articles.latimes.com/2009/aug/19/nation/na-abortion19>.

¹⁹⁵ H.B. 373, 10th Reg. Sess. (Ky. 2010); H.B. 7489, Gen. Assem. (R.I. 2010); H.B. 280, 62nd Legis. (Mt. 2011). S.B. 528, Reg. Sess. (La. 2010).

¹⁹⁶ 2010 Nebraska Laws L.B. 594.

assessment of women seeking abortions prior to performing the procedure. The risk assessment requires the physician to determine whether the “risks” of bearing the child outweigh the “risks” of the abortion, all ostensibly to protect the woman’s mental health. The statute explicitly defines these risks to include “physical, psychological, emotional, demographic, or situational factor[s]” as well as “familial” risks.¹⁹⁷ How a physician is to evaluate and weigh the extent of the “situational” and “familial” risks to the patient is anybody’s guess. And, of course, the statute fails to note the irony of insisting that a woman’s consent to abortion is only “voluntary and informed”¹⁹⁸ by imposing a requirement that destroys the bedrock of the doctrine of “informed consent”—the patient’s right to weigh the risks for herself.

Some may call foul at the equation of statutes restricting the number of embryos transferred and these abortion statutes. But I believe the connection is real and meaningful. While the abortion statutes aim predominantly to curtail abortion as much as possible in order to preserve fetal life, a goal openly sanctioned by the *Casey* Court,¹⁹⁹ some who support statutorily mandated informed consent for abortion may do so based on genuine concern that women do not fully understand the implications and future impact on their well-being that the choice to abort may have. Indeed the *Carhart* opinion gives credence to this notion, writing that:

While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained . . . In a decision so fraught with emotional consequence some doctors may prefer not to disclose precise details of the means that will be used²⁰⁰

But rather than simply require informed consent, the Court ultimately “deprives women of the right to make an autonomous choice, even at the expense of their safety.”²⁰¹ The Court thus leaves the state free ostensibly to protect a woman from her own poor decision-making. Indeed, *Casey* and, even more so, *Carhart*, have turned the common law doctrine of informed consent on its head in a way that, at best, demeans women as autonomous decision-makers, and at worse actively coerces them.²⁰² The abortion cases reveal a disturbing trajectory that began with rejection of statutorily-mandated informed consent, recognizing that the common law already required it.²⁰³ *Casey* moved the trajectory sharply in another direction when it disapproved those

¹⁹⁷ 2010 Nebraska Laws L.B. 594 (§28-326(11) and §28-327(6)(a)).

¹⁹⁸ 2010 Nebraska Laws L.B. 594 (§28-327).

¹⁹⁹ *Casey*, 505 U.S. at 883.

²⁰⁰ *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007). Interestingly, the Court ignores extensive factual findings by the District Courts regarding the harm women will suffer from a ban on D & E, *id.* at 178-79 (Ginsburg, J., dissenting), but draws this conclusion about women’s anticipated regrets without any evidence at all. *Id.* at 159.

²⁰¹ *Id.* at 184 (Ginsburg, J., dissenting).

²⁰² Indeed, the very notion, approved by the Court in *Casey*, that the state can express its interest in discouraging abortion through informed consent requirements inherently undermines the foundation of informed consent: free, voluntary and knowledgeable decision-making. Moreover, states have packed their informed consent materials with patently false and misleading information. Maya Manian, *The Irrational Woman: Informed Consent an Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL’Y 223, 251-54 (2009).

²⁰³ *Id.* at 244-47 (discussing *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983) and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986)).

earlier precedents and allowed a state to mandate so-called “informed consent” that the state could use to try to persuade a woman not to have an abortion.²⁰⁴ It culminated in *Carhart*, which allowed a state to ban a procedure entirely, at least partly because of concerns that physicians would not provide adequate information—thereby completely eliminating the option of any kind of “consent.”²⁰⁵

Mandatory ultrasound statutes like Oklahoma’s pervert the notion of informed consent in an even more dramatic fashion. They actually subject a woman to an invasive medical procedure *without* her consent, in the name of enhancing “informed” consent.²⁰⁶ Likewise, Nebraska’s “risk assessment” statute requires a physician to weigh a host of factors having nothing to do with any potential health risks to the woman, rather than allow the woman to exercise that judgment independently. These cases and statutes send a very clear message: women are simply incapable of making a decision whether to have an abortion and doctors cannot be trusted to give them the appropriate information to do so without extreme measures imposed by the state.

Proposed embryo transfer limits operate the same way as the partial birth abortion ban upheld in *Casey*: they completely bypass the possibility of achieving the desired result through true informed consent. Instead, they prohibit the option altogether. In doing so, they inject the state into the doctor-patient relationship and presume that the woman, left unrestrained, will choose an undue risk to herself and the children she desperately seeks. Indeed, my choice of the word “desperate” is intentional, for infertile women are frequently described as being both desperate and irrational—and physicians unable or unwilling to resist them, a perception that the Suleman case reinforces. This perception appears in the scholarly literature, as well as in the popular press.²⁰⁷ For example, Professor Marsha Garrison has written that “Regulation aimed at protecting future children seems particularly important when the treatment in question is aimed at achieving a sought-after pregnancy. Infertile would-be parents are much less likely than actual parents, or even pregnant women who have decided to carry a pregnancy to term, to act in the best

²⁰⁴ *Id.* at 252.

²⁰⁵ *Carhart*, 550 U.S. at 159. In a 2006 article, Samuel Bagenstos anticipated this type of analysis. He argued that the reliance of the abortion cases on an autonomy rationale left open the option of governmental regulation to protect actors from threats to their exercise of free choice—be they social, financial or otherwise. In his view, such an argument could be used to justify banning abortion altogether, a prospect that seems paradoxical, to say the least, but was nonetheless the path followed in *Carhart*. Samuel R. Bagenstos, *Disability, Life, Death and Choice*, 29 HARV. J. L. & GENDER 425, 449-51 (2006). Others too have noted the irony. See, e.g., Suter, *Repugnance*, *supra* note 49, at 1578 (Justice Kennedy “condones state efforts to prevent uninformed choice by prohibiting choice altogether. Ronald Dworkin highlights the irony of this analysis . . .”).

²⁰⁶ Some may argue that ultrasound is only minimally invasive because it requires no bodily incision. However, it does require the woman to lie on a table and submit to the application of gel and movement of the wand over her abdominal area. Moreover, transvaginal ultrasound, increasingly performed in the early stages of pregnancy, requires insertion of the ultrasound wand into the woman’s vagina—a procedure that would hardly qualify as minimally invasive. Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 391-92 (2008).

²⁰⁷ See, e.g., Strong, *supra* note 144, at 275; Anna Mulrine, *Making Babies It’s an Expensive Gamble, but Childless Couples are Trying Reproductive Therapy in Record Numbers*, U.S. NEWS & WORLD REP., Sept. 9, 2004, <http://health.usnews.com/usnews/health/articles/040927/27babies.htm>. Cf. Mundy, EVERYTHING CONCEIVABLE, *supra* note 33, at 214 (“Doctors are often eager to shift responsibility onto patients, against whose demands they portray themselves as helpless.”).

interests of their future children.”²⁰⁸ Professor Jennifer Rosato has expressed similar sentiments: “Infertile women will often opt for any treatment option presented, regardless of the physical, psychological, or financial price,” including depleting savings and risking foreclosure.²⁰⁹ She describes parents using ART as “categorically conflicted,” and caught in an “emotional vortex” that “causes them to obsess about conceiving, rather than carefully considering the quality of life of the children. The power of wishful thinking obscures rational deliberation.”²¹⁰ By characterizing infertile women as “categorically conflicted” because of their obsession with becoming parents, Rosato can justify intrusive state regulation of ART patients “in ways not otherwise tolerated.”²¹¹

No one could credibly deny the emotional and financial stress felt by many of those who undergo fertility treatment. But to denigrate a whole category of women as irrational and incapable of acting in their (future) children’s best interests feeds directly into societal stereotypes used to deny women autonomy in reproduction, medical decision-making and parenting. Indeed, our common acceptance of the term “Octomom,” is itself revealing—we have reduced her to a grotesque caricature of motherhood; she’s a creature, barely human and certainly not one that in any way resembles our vision of a good mother.

B. Beyond Abortion: Using “Irrational” Women To Justify State Intervention

This perception of Suleman, and infertile women generally, as irrational undoubtedly fueled the rapid-fire introduction of embryo transfer legislation—a response that seems disproportionate given the many causes of pre-term birth and low birth weight. Rather than focus on ensuring adherence to appropriate medical standards, educating patients about the risks of multiple births, obtaining true informed consent, and providing insurance coverage or financing that reduces the incentive for excessively aggressive treatment, we seek a partial solution, which begins with interfering with the doctor-patient relationship, devaluing the decision-making capacity of women, and furthering a right-wing agenda that seeks ultimately to control women’s reproductive decision-making power.

We have seen this kind of effort before in response to the problem of drug-exposed infants. Rather than provide adequate treatment, support and prenatal care, which might have systemic impact, but requires spending money on a demonized segment of the population, states began criminally prosecuting women for exposing their fetuses to drugs in utero.²¹² In Charleston, South Carolina, a public hospital instituted a program compelling drug testing and other measures of pregnant women who were suspected of drug use and came to the hospital to deliver their babies.²¹³ Positive results were forwarded to law enforcement, which used the results to prosecute the women. The U.S. Supreme Court ultimately ruled the practice a violation of the Fourth Amendment. The Court rejected the city’s attempt to justify the search as a means of protecting women and children’s health, as the policy clearly emphasized the goal of prosecuting

²⁰⁸ Marsha Garrison, *Regulating Reproduction*, 76 GEO. WASH. L. REV. 1623, 1642 (2008).

²⁰⁹ Rosato, *supra* note 14, at 72 (quoting Ellen A. Waldman, *Disputing Over Embryos: Of Contracts and Consents*, 32 ARIZ. ST. L.J. 897, 923 (2000)).

²¹⁰ *Id.* at 105-06.

²¹¹ *Id.* at 106.

²¹² *Ferguson v. City of Charleston*, 532 U.S. 67, 70 (2001).

²¹³ *Id.*

the women and provided no special medical care related to the substance abuse, beyond referral for treatment.²¹⁴ While the Court invalidated the Charleston searches and other criminal prosecutions of pregnant women have been overturned, some have been upheld.²¹⁵ Moreover, subjecting women to prosecution, regardless of the ultimate outcome, subjects them to grievous harm.²¹⁶ The racist and classist aspects of such prosecutions and other state interventions in conduct during pregnancy and child-bearing compound the damage and have been well-documented.²¹⁷

Unlike the criminal prosecutions of pregnant drug addicts, proposed restrictions on embryo transfer limits are not, generally speaking, directed at a similarly maligned group—substance abusers and poor women of color. In fact, most users of ART are affluent whites.²¹⁸ It is all the more telling, then, that the visceral public response and the embryo transfer legislation at issue here erupted in response to a woman who does not fit the norm. Suleman's choice to pursue repeated courses of IVF as a single, unemployed mother (not to mention a woman of color)²¹⁹ makes her look, if not criminal like the pregnant drug abusers, at best lacking in judgment and at worst, downright crazy and a danger to all her children. This depiction of irrational near-criminality is especially pernicious when applied to women in this context who are actively seeking to become mothers, because it violates societal norms defining what "good" mothers should be. As Andrew Taslitz argued in considering the (mal)treatment of pregnant drug abusers at issue in *Ferguson*, the "stigmatizing rage" felt toward these women reflected the violation of societal norms about motherhood:

To be a mother in our culture is to take upon oneself the obligations of "preservative love, nurturance, and training" of one's children as a substantial life responsibility. Preservation of the child's physical health and security is historically the preeminent of these demands. "A mother who callously endangers her child's well-being is simply not doing maternal work." Indeed, when such endangerment is intentional or extreme, the mother becomes a "monster," a hideous creature whose very survival endangers all that holds society together. Children, hearth, and home collapse when a mother fails to fit her assigned role.²²⁰

²¹⁴ *Id.* at 82.

²¹⁵ See, e.g., *Whitner v. State*, 328 S.C. 1 (1997) (child abuse conviction against mother based on ingesting crack cocaine during the third trimester of pregnancy upheld); Jim McBride, *Newborn Twins on Drugs at Birth*, AMARILLO GLOBE NEWS (June 12, 2004), http://www.amarillo.com/stories/061204/new_twindrugs.shtml (describing the first woman prosecuted on charges of delivery of marijuana to a minor for smoking marijuana while pregnant).

²¹⁶ See Meghan Horn, *Mothers Versus Babies: Constitutional and Policy Problems With Prosecutions for Prenatal Maternal Substance Abuse*, 14 WM. & MARY J. WOMEN & L. 635, 638 (2008) (discussing cases where mothers spent time in jail awaiting appeal for convictions relating to prenatal drug use).

²¹⁷ *Id.* at 648-49; Andrea Marsh, *Testing Pregnant Women and Newborns for HIV: Legal and Ethical Responses to Public Health Efforts to Prevent Pediatric AIDS*, 13 YALE J.L. & FEMINISM 195, 207-09; 211-12 (2001).

²¹⁸ Rao, *supra* note 14, at 1478 (2008).

²¹⁹ Suleman is of middle-eastern descent. Her father is Iraqi. *Octuplets' Family Filed For Bankruptcy*, CBS NEWS (Jan. 30, 2009), <http://www.cbsnews.com/stories/2009/01/30/earlyshow/health/main4764432.shtml>.

²²⁰ Taslitz, *supra* note 185, at 75 (quoting Sara Ruddick, *MATERNAL THINKING: TOWARD A POLITICS OF PEACE* 17-18 (1995)).

Nor can we ignore the racist and classist aspects of the societal response to Suleman. Public reaction to her stands in dramatic contrast to the reaction to the birth of the McCaughey septuplets a dozen years earlier to a white, religious married couple. The media greeted the McCaughey birth with amazement, kudos and virtually no criticism of the family and very little of the physician.²²¹ Granted there were differences aside from race/ethnicity and marital and employment status that set Suleman apart: She used IVF (as opposed to fertility drugs) and she had six previous children conceived through IVF. By contrast, the McCaugheys had one previous child, conceived with the help of a fertility drug.²²² Nonetheless, the response to another high order multiple birth, around the same time as the McCaughey birth, gives us cause for concern. Grace Ochukwu, an African-American, gave birth to octuplets one year after the McCaughey's. The media response, although not approaching the vitriol spewed at Suleman, was nonetheless markedly different from that enjoyed by the McCaugheys, prompting at least one commentator to posit racism as the only possible explanation.²²³

These contemptuous attitudes evoke another line of cases that questioned women's ability to make choices about their reproduction and saw heavy-handed response by the state. In the 1980s and 90s, courts decided several cases involving blood transfusions and C-sections performed on pregnant women without their consent.²²⁴ These cases, like the restrictions here, were justified by the need to protect the health of future born children and, in some cases, the woman herself. While some appellate courts ruled that these actions violated the woman's statutory, common law or constitutional rights,²²⁵ others upheld the coercive action.²²⁶ In one such case, *Pemberton v. Tallahassee Reg. Med. Ctr.*,²²⁷ a federal district court in Florida ruled that a hospital had not violated a woman's constitutional rights when it performed a caesarean section on her against her will after obtaining an order from the state court. Enforcement of the court order entailed sending a police officer to her home and forcibly transporting her back to the hospital by ambulance.²²⁸

²²¹ Goodwin, *Double Bind*, *supra* note 126, at 40-42.

²²² Michael D. Lemonick, *It's a Miracle*, TIME, Dec. 1, 1997, at 34, 38, available at <http://www.time.com/time/magazine/article/0,9171,987455-3,00.html> (accessed Aug. 15, 2010).

²²³ Pinchuk, *supra* note 143, at n.6 (quoting Robert Scheer, *Iowa Seven, Houston Eight: A Difference-Only Racism Explains Some Reactions to the Year-Apart Multiple Births*, L.A. TIMES, Dec. 29, 1998, at B7). See also Goodwin, *supra* note 126, at 40-42.

²²⁴ See, e.g., *Jefferson v. Griffin Spalding Cty. Hosp. Authority*, 274 S.E.2d 457 (Ga. 1981); *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994).

²²⁵ See, e.g., *In re Brown*, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997) (holding the state may not override a pregnant woman's competent treatment decision to forego a blood transfusion for religious reasons); *In re Baby Boy Doe*, 632 N.E.2d at 330 (holding the common law protects the right of a competent individual to refuse medical treatment and thus, a caesarean section, even when the fetus' health is at risk); *In re A.C.*, 573 A.2d 1235 (D.C. 1990) (holding trial court should not have ordered c-section without patient's consent or use of substituted judgment).

²²⁶ *Jefferson v. Griffin Spalding Cty. Hosp. Authority*, 274 S.E.2d 457 (Ga. 1981). In *Jefferson*, the court ordered the c-section, but it never took place, as the mother did not return to the hospital. She subsequently delivered a healthy baby vaginally, despite testimony by a physician that the probability of death to her was 50% and death to the fetus was 99% if delivered vaginally. *Jefferson*, 274 S. E.2d at 458. See also *In re Jamaica Hosp.*, 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (blood transfusion); *Crouse Irving Mem. Hosp. v. Paddock*, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985) (blood transfusion).

²²⁷ 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

²²⁸ *Pemberton*, 66 F. Supp. 2d at 1250.

In addition to coercing women's choices about procreation, legislative limits on the number of embryos transferred undercuts women's authority as prospective parents. While the restriction on embryo transfers, as already discussed, does not directly implicate the constitutional right to parent, the law's treatment of and deference to parental decision-making provide a useful frame for viewing analogous decisions by women undergoing IVF to create a family. We know that parents make decisions that subject their children to avoidable risks all the time, and unless those risks rise to the level of abuse or neglect, the government, consistent with the Constitution, typically may not intervene.²²⁹ For example, increasing numbers of parents have refused to vaccinate their children based in significant part on unfounded concerns of a link between certain vaccinations and autism.²³⁰ Despite a strong consensus among medical professionals about the overall safety of vaccines,²³¹ no effort has been made to compel vaccination over parental objection,²³² despite the undeniable benefits, not just to individual children, but also to the public health.²³³ Diseases such as measles and whooping cough (pertussis), once thought to be nearly eradicated in the U.S., are now reemerging in significant numbers.²³⁴ Although the Supreme Court ruled long ago that the state can compel vaccination over parental objection,²³⁵ in 48 states parents may opt out for religious reasons and in nearly half, based solely on personal objections.²³⁶ In the context of medical treatment of children, courts have likewise adhered to the principle of deference to parental choice unless the parental decision involves rejection of life-saving treatment²³⁷ or, in a few cases, of treatment that would dramatically improve the child's

²²⁹ Richard F. Storrow, *The Bioethics of Prospective Parenthood: In Pursuit of the Proper Standard for Gatekeeping in Infertility Clinics*, 28 CARDOZO L. REV. 2283, 2302 (2007); *In re Steed*, No. 03-08-00235-CV, 2008 WL 2132014 (Tex. Ct. App. May 22, 2008) (stating that the Department of Family and Protective Services must show danger to physical health or safety of children before removing from home).

²³⁰ *Browning v. Sec. of Health and Human Servs.*, No. 02-0928V, 2010 WL 1407212 (Fed. Cl. Mar. 19, 2010); *Immunization*, AM. ACAD. OF PEDIATRICS (Sept. 20, 2010), <http://www.aap.org/immunization/multimedia/news.html>; *An Interview with Dr. Geri Dawson*, AUTISM SPEAKS (July 30, 2009), http://www.autismspeaks.org/science/science_news/geri_dawson_vaccines_autism_interview.php.

²³¹ VACCINE STUDIES: EXAMINE THE EVIDENCE, AM. ACAD. OF PEDIATRICS, <http://www.aap.org/immunization/families/faq/VaccineStudies.pdf> (last accessed Apr. 25, 2010).

²³² James G. Hodge & Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal Perspectives*, 90 KY. L.J. 831, 833 (2002) (noting that each state has mandatory vaccination laws that are subject to medical, religious, and philosophical objections).

²³³ *Immunization Safety*, WORLD HEALTH ORGANIZATION (Apr. 6, 2009), http://www.who.int/immunization_safety/en/.

²³⁴ See Serena Gordon, *Measles Outbreak Triggered by Unvaccinated Child*, BLOOMBERG BUS. WEEK (Mar. 22, 2010), <http://www.businessweek.com/lifestyle/content/healthday/637218.html>; Christine S. Moyer, *Pertussis Epidemic in California Linked to Vaccination Gaps*, AM. MED. NEWS (July 26, 2010), <http://www.ama-assn.org/amednews/2010/07/26/pr110726.htm>; *Whooping Cough Epidemic May Be Worst In 50 Years*, CAL. DEP'T. PUB. HEALTH, (June 23, 2010), <http://www.cdph.ca.gov/Pages/NR10-041.aspx>.

²³⁵ *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

²³⁶ *States with Religious and Philosophical Exemptions from School Immunization Requirements*, NATL. CONF. OF STATE LEGIS. (Oct. 2010), <http://www.ncsl.org/issuesresearch/health/schoolimmunizationexemptionlaws/tabid/14376/default.aspx>. See, e.g., *Conscientious Objection to Public Health*, *Interim News*, HOUSE RESEARCH ORG., TEXAS H. R. (Dec. 3, 2003), available at <http://www.hro.house.state.tx.us/interim/int78-1.pdf> (describing Texas exemption).

²³⁷ Alicia R. Ouellette, *Growth Attenuation, Parental Choice, and the Rights of Disabled Children: Lessons from the Ashley X Case*, 8 HOUS. J. HEALTH L. POL'Y 207, 208 (2008) ("Only the exceptional parental choice, such as a

quality of life.²³⁸ Indeed, more than forty states allow parents to reject even life-saving treatment for their children if they are relying on spiritual care.²³⁹

The case for impinging on a parent's decision-making authority regarding the relative risks of IVF is arguably even weaker, since we must acknowledge once again the ontological problem embedded in the claim: Women undergoing IVF may expose their future children to risks in order to give them life. With IVF, the choice may not be between a risk of harm to a child and a healthy child; it may be between a risk of harm to a child or no child being born at all.

Finally, our willingness to consider limiting the options for the infertile stands in sharp contrast to our treatment of the fertile. Many people carry risks of serious genetic diseases, which they chance passing on to their children. Yet no legislation requires even genetic testing of the parents or preimplantation genetic diagnosis (PGD), which would allow the parents to screen out embryos carrying the diseases, let alone attempts to prohibit these individuals from procreating.²⁴⁰ Nor have scholars advocated for mandatory genetic testing.²⁴¹

IV. REDUCING MULTIPLE BIRTHS WITHOUT UNDERMINING WOMEN'S AUTONOMY: CONSIDERING THE OPTIONS

The goal of reducing multiple births is a worthy one, and legislative limits are not without some merit. They doubtless would reduce the number of multiple births resulting from IVF, and they might give "cover" to physicians who have trouble resisting patient entreaties to exceed the appropriate number of embryos. A bill like Missouri H.B. 810, which would give ASRM guidelines the force of law, would presumably still allow physicians to take into account

decision to forgo potentially life-saving treatment for a child, may be deemed so risky to the child's future well-being that it triggers court intervention."); *In re Green*, 292 A.2d 387 (Pa. 1972) (finding state has insufficient interest in overruling parent's religious objection to treatment when child's life not in immediate danger).

²³⁸ See, e.g., *In re Cabrera* 552 A.2d 1114 (Pa. Super. 1989) (affirming court order for transfusion of child with sickle-cell disease to avoid 80% probability of future strokes likely to cause mental retardation, paralysis, loss of speech or death); *In re Sampson*, 323 N.Y.S.2d 253 (N.Y. Sup. Ct. 1971) (upholding order of treatment over parental religious objection for surgery to correct condition causing massive disfigurement).

²³⁹ Adam Lamparello, *Taking God Out of the Hospital: Requiring Parents to Seek Medical Care for Their Children Regardless of Religious Belief*, 6 TEX. F. ON C.L. & C.R. 47, 48 (2001).

²⁴⁰ Mary Louise Hayes, *Experts Debate the Use of Some Genetic Testing*, WORCESTER TELEGRAM & GAZETTE, May 4, 1989 at Life/Style Section (examining the consequences of genetic testing and inheriting Huntington's, bipolar disorder, schizophrenia, Alzheimer's, and Tay-Sachs); Genetic Information Nondiscrimination Act of 2008, Pub.L. No. 110-233 (prohibiting insurance companies and employers from discriminating on the basis of information from genetic tests); Mayo Clinic Staff, *Huntington's Disease*, MAYO CLINIC (May 8, 2009), <http://www.mayoclinic.com/health/huntingtonsdisease/DS00401/DSECTION=prevention> (recommending genetic counseling or in vitro fertilization with pre-implantation screening); *Sen. Brown, Rep. Arcuri Introduce Bill to Raise Awareness of Tay-Sachs Disease*, US FED NEWS SERV., Aug. 1, 2009, available at <http://www.highbeam.com/doc/1P3-1812791251.html> (describing a bill to designate September as National Tay-Sachs Awareness Month).

²⁴¹ Some have suggested voluntary screening. See Suriya E.P. Jayanti, *Guarantors of Our Genes: Are Egg Donors Liable For Latent Genetic Disease?* 58 AM. U. L. REV. 405, 411, 456-57 (2008) (arguing that egg donors should not be held to a duty to warn of known genetic disorder but fertility clinic doctors and egg donation agencies should properly screen egg donors); RUTH SCHWARTZ COWAN, *HEREDITY AND HOPE: THE CASE FOR GENETIC SCREENING* (2008); Sonia M. Suter, *Whose Genes are These Anyway? Familial Conflicts Over Access to Genetic Information* 91 MICH. L. REV. 1854, 1905 (1993) (examining the state interest in protecting people from preventable or curable disease using genetic testing).

the needs of particular patients.

Nonetheless, legislating restrictions on embryo transfer at this point would be a grave mistake for a host of reasons. First, as we have seen, mandated embryo transfer limits raise serious constitutional questions.²⁴² Women affected by the limits can mount a strong case that such legislation violates their fundamental right to procreate, although the outcome remains uncertain. Beyond these constitutional concerns, the circumstances surrounding the introduction of these bills do not inspire confidence that they were carefully considered. Rather, they mark a visceral reaction to an extreme case. While we may desire to reduce the number of multiple births from IVF, using the cudgel of legislation to achieve that goal seems premature at this point.²⁴³ Multiple births appear to be holding steady or on the decline,²⁴⁴ and publicity regarding the octuplets may hasten that trend. One reproductive endocrinologist commented that her patients were showing an increased concern with the number of embryos transferred as “no one wants to be the Octomom.”²⁴⁵ In addition, the profession seems more ready to police itself, which should deter physicians from overly aggressive transfers. Compliance with ASRM and SART requirements has clearly contributed to a decline in the rate of multiple births.²⁴⁶ Although membership in SART is voluntary, the Fertility Clinic Success Rate and Certification Act of 1992²⁴⁷ requires reporting of success rates to SART, and more than 90% of all clinics report more than 95% of all cycles.²⁴⁸ Clinics that do not report are identified. Members of SART have increasingly followed SART guidelines, including those regarding embryo transfers. Member clinics that have results outside these guidelines must “explain the reasons to SART, develop a plan for corrective action and demonstrate improved results in the future, or else lose their SART membership.”²⁴⁹ Moreover, improved ART techniques may lead to significant changes in the guidelines and may obviate the need for regulatory limits. For example, researchers at Stanford Medical School have developed a computer model that can predict the live birth success of an IVF cycle with 1000 times more accuracy than current age-based guidelines for patients who have undergone a previous IVF cycle.²⁵⁰

Perhaps even more importantly, we should continue to oppose legislative restrictions on embryo transfer because they undermine women’s reproductive, medical, and parental autonomy and self-determination. As we have seen, these restrictions fall in line with other efforts by the state to regulate women’s reproduction in a way that furthers sex inequality and oppresses women as patients and mothers. Such legislative restrictions interpose the state in a relationship between women and their physicians that should be one of mutual trust. Nor does Missouri’s deference to

²⁴² See *supra* Part II.

²⁴³ For a discussion of the problems of legislating new technologies, specifically IVF, see generally Lyria Bennett Moses, *Understanding Legal Responses to Technological Change: The Example of In Vitro Fertilization*, 6 MINN. J.L. SCI. & TECH. 505, 606-07 (2005); John M. Norian, et al., *An American Perspective on Single Embryo Transfer*, in SINGLE EMBRYO TRANSFER 276 (Jan Gerris et al., eds., 2009); Pinchuk, *supra* note 143, at 54.

²⁴⁴ See *supra* note 141 and accompanying text.

²⁴⁵ Author’s conversation with Dr. Lori Arnold, California Ctr. for Reproductive Med., Mar. 11, 2010.

²⁴⁶ Adamson, *supra* note 14, at 257.

²⁴⁷ 42 U.S.C. § 263a-7; Pub. L. 102-493.

²⁴⁸ Adamson, *supra* note 14, at 256.

²⁴⁹ Adamson, *supra* note 14, at 257.

²⁵⁰ Michelle L. Brandt, *New Test to Predict Success of IVF Treatment Developed at Stanford*, INSIDE STANFORD MEDICINE (July 19, 2010), <http://med.stanford.edu/ism/2010/july/ivf.html> (last accessed August 10, 2010).

the medical profession constitute a panacea. By giving medical guidelines the force of law, they transfer ultimate responsibility for the decision from the woman, where it should reside, to her physician. This result is especially troubling when we consider that physicians have at times contributed to the oppression of women's reproductive freedom, as in the forced c-section cases, and the medical establishment has exhibited its own sexist bias across a variety of issues.²⁵¹ Legislative embryo transfer restrictions will extend what Michelle Oberman has identified as a flawed paradigm of "maternal-fetal conflicts"²⁵² to maternal-embryo conflicts. Oberman recognized that cases of so-called maternal-fetal conflict really involve conflict between the woman and her physician. By structuring the conflict as one between mother and fetus, the doctor appears neutral, even though he or she has decided what is in the fetus' best interests and may, in fact, actively pressure or coerce the woman to acquiesce.²⁵³ In similar fashion, by legislating the permissible number of embryos transferred, a seemingly neutral act, the state erects itself as the future children's protector against the desperate mother.

There is nothing unique about the fertility industry that requires this kind of regulation. True, the woman's actions impact her future child, but so does every decision a parent makes regarding medical care for a child (along with an endless plethora of other decisions). The potential effect on the future child only justifies regulation if we think children need to be protected from their prospective mothers and that mothers cannot make a sound decision. Likewise, instances of economic incentives for risky medical treatment abound, yet we rely on medical ethics and the tort system, as imperfect as they are, to counter physician's self-interest, rather than attempt to dictate by statute specific medical procedures.²⁵⁴ For example, treatment of prostate cancer depends very much on which type of physician the patient consults. A patient who consults a radiation oncologist will likely undergo radiation treatment, while one who consults a urologist will likely end up having surgery, and one consulting a primary care physician may be advised to wait and see. As the author of one study noted,

Part of the reason for the emphasis on treatment . . . is the large capital investments surgeons make for robotically assisted surgery and that radiation therapists make for proton beam therapy or newer techniques of radiation therapy. Moreover, current reimbursement rules do not allow physicians

²⁵¹ See Ellen Waldman & Marybeth Herald, *Eyes Wide Shut: Erasing Women's Experiences from the Clinic to the Courtroom*, 28 HARV. J. L. & GENDER 285, 285-88 (2005); See also *North Coast Women's Care Medical Group, Inc. v. San Diego Co. Sup. Ct. 189 P.3d 959* (Cal. 2008) (holding physician's refusal to perform artificial insemination on unmarried lesbian could violate California anti-discrimination law).

²⁵² Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 Nw. U. L. Rev. 451, 453-54 (2000).

²⁵³ *Id.*

²⁵⁴ On the limitations of the tort system as a deterrent to sub-par medical practice, see Eleanor D. Kinney, *Administrative Law Approaches to Medical Malpractice Reform*, 49 ST. LOUIS U. L.J. 45, 47-49 (2004); See generally Kyle Miller *Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law*, 59 VAND. L. REV. 1457 (2006); Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 14 OHIO ST. J. ON DISP. RESOL. 907, 907-08 (1999). But see Moses, *supra* note 243, at 590 (discussing limited effectiveness of tort law for redressing problem of multiple births from IVF).

adequate time to educate patients about the pros and cons of the various procedures.²⁵⁵

Indeed, robotic prostate surgery, which now dominates the surgical treatment options, may in fact be riskier than traditional open prostatectomy, but “a lot of community hospitals felt the need to be competitive . . . and they acquired these robots and marketed them before there has been diffusion of experience among surgeons.”²⁵⁶ Indeed, the notion that physicians may order unnecessary tests or promote expensive, but risky, procedures because of concerns with competition and compensation is so obvious as to barely warrant mention. Much more salient, though, is the lack of empirical data to support this hypothesis in the IVF context. Indeed, several studies demonstrate the opposite: that increased competition actually *decreases* high order multiple births.²⁵⁷ Hence this concern cannot suffice to justify regulation of ART unless we ignore the empirical data and regulate medical treatment in similar fashion across the board.

A better approach would look for solutions that enhance women’s reproductive and parental power rather than undermine it. Common sense suggests that increased insurance coverage would reduce the patient’s financial incentive for excessive embryo transfers, though the empirical evidence on this point is not conclusive.²⁵⁸ Other ways to reduce financial pressure on patients include refund programs offered by some fertility clinics, tax breaks, and expanded credit access for fertility patients.²⁵⁹

²⁵⁵ Thomas H. Maugh II, *With Prostate Cancer Treatment, Who You See Is Often What You Get*, L.A. TIMES, Mar. 8, 2010, available at http://latimesblogs.latimes.com/booster_shots/2010/03/for-prostate-cancer-treatment-who-you-see-is-often-what-you-get.html (last accessed Aug. 11, 2010).

²⁵⁶ Shari Roan, *Minimally Invasive Prostate Surgery Carries Risk, Study Suggests*, L.A. TIMES, Oct. 14, 2009, <http://articles.latimes.com/2009/oct/14/science/sci-prostate14>).

²⁵⁷ See Melinda B. Henne & M. Kate Bundorf, *The Effects of Competition on Assisted Reproductive Technology Outcomes*, 93 FERTILITY & STERILITY 1820, 1820, 1828 (2010) (finding that competition among clinics did not lead to more aggressive embryo transfers); Anne Z. Steiner et al., *Effects of Competition Among Fertility Centers on Pregnancy and High-Order Multiple Gestation Rates*, 83 FERTILITY & STERILITY 1429, 1432 (2005) (finding increased competition associated with decrease in high order multiple births per clinic); Barton H. Hamilton & Brian McManus, *Infertility Treatment Markets: The Effects of Competition and Policy* 4-6, 24 (2007), available at <http://www.unc.edu/~mcmansub/IVFJuly2007.pdf> (finding that increased competition in fertility markets does not increase rate of higher order multiple births). See also Robertson, *supra* note 49 at 482 (doubting that infertility practitioners are more prone to promoting dangerous practices and exploiting consumers than other types of medical practitioners).

²⁵⁸ A recent study found that clinics in states with comprehensive insurance mandates did tend to transfer fewer embryos per cycle, but this difference did not automatically translate to reduced multiple birth rates. The authors postulated that other factors were at work—particularly a change in the mix of patients: expanded insurance coverage attracted more patients, including some with better prognosis and others with poorer prognosis. Nicole K. Banks et al., *Insurance Mandates, Embryo Transfer, Outcomes – The Link Is Tenuous*, 94 FERTILITY & STERILITY 2776, 2778 (2010) (confirming earlier studies showing decreased embryo transfer numbers in states with comprehensive insurance mandates, but variable impact on multiple birth rates).

Countries with state-imposed embryo transfer limits typically provide coverage or financial assistance for fertility treatment. See, e.g., John Collins, *Cost-Effectiveness of Single Embryo Transfer in Assisted Reproductive Technology Cycles*, in SINGLE EMBRYO TRANSFER 228 (Jan Gerris et al., eds., 2009) (discussing Belgium and Sweden); Adamson, *supra* note 14, at 251 (countries with statutory regulation had “much better insurance coverage” than countries with guidelines or no regulation; six countries have national health plans that provide complete coverage).

²⁵⁹ Hawkins, *supra* note 153, at 158.

Enhanced education and emphasis on effective informed consent can also make a difference. Certainly there have been cogent critiques of the limits of informed consent. Feminists have criticized the existing model of informed consent in general as an ineffective means of ensuring women's autonomy, given the patriarchal domination of the medical profession, as well as societal pressures constraining women's self determination.²⁶⁰ Much of the critique in the ART context centers on deficiencies in informed consent in collaborative reproduction, which raises somewhat different concerns (e.g. financial coercion of donors, unknown psychological risks) than the risk of multiples.²⁶¹ But some of the potential problems would apply to the risk of multiple births as well. In particular, the weakness of informed consent may lie not in lack of knowledge, but in lack of appreciation of the risks and psychological barriers to that appreciation.²⁶² Some evidence suggests that fertility patients are very well-versed in the risks of higher order multiples and, to a somewhat lesser degree, of twins.²⁶³ But cognitive dissonance may lead some to discount known risks, as they do not fit with their pre-existing view of multiples, particularly twins. Patients may have trouble making sense of the statistical data and dealing with the complexities of the decision as well.²⁶⁴

While these factors may make achieving effective informed consent more difficult, they do not justify depriving women of the right to make choices regarding their infertility treatment, including the number of embryos to transfer.²⁶⁵ Recognizing these potential barriers to

²⁶⁰ See, e.g., Melanie Latham, *The Shape of Things to Come: Feminism, Regulation and Cosmetic Surgery*, 16 MED. L. REV. 437, 441 (2008).

²⁶¹ See, e.g., Sonia M. Suter, *Giving in to Baby Markets: Regulation without Prohibition*, 16 MICH. J. GENDER & L. 217, 242-48 (2009) (arguing for bolstering of informed consent protections in context of collaborative reproduction); Elizabeth S. Scott, *Surrogacy and the Politics of Commodification*, 72 LAW & CONTEMP. PROBS. 109, 122-23 (2009) (noting feminist critique of surrogacy contracts as lacking informed consent because of difficulty anticipating future emotional reactions). Some go even farther, arguing that true informed consent for ART is an impossibility because patriarchal society has socially constructed the desire for motherhood. See Rachel Anne Fenton, *Catholic Doctrine Versus Women's Rights: The New Italian Law on Assisted Reproduction*, 14 MED. L. REV. 73, 92 (2006) (discussing views of some feminists).

Concerns about physician pressure on patients considering multifetal reduction have also emerged. Pinchuk, *supra* note 143, at 42-43 (describing "one-sided" nature of informed consent between doctor and patient considering multifetal reduction). *But see* Mundy, *EVERYTHING CONCEIVABLE supra* note 33, at 253-72 (describing thoughtful process between physicians and patients considering multifetal reduction).

On the limits of informed consent generally, see Schuck, *supra* note 183.

²⁶² Pennings, *supra* note 171, at 202-03.

²⁶³ D'Alton, *supra* note 171, at 523 (discussing study by Ryan, et al., showing that for triplets, 93% of patients surveyed knew of increased maternal risks, 77% of cerebral palsy and 56% of infant mortality; for twins, 76% knew of maternal risks, 49% of cerebral palsy and 30% of increased risk of infant death, though 95% understood increased risk of premature delivery).

²⁶⁴ Nicole Hope & Luk Rombauts, *Can an Educational DVD Improve the Acceptability of Elective Single Embryo Transfer? A Randomized Controlled Study*, 94 FERTILITY & STERILITY 489, 493 (2010); Pennings, *supra* note 171, at 203.

²⁶⁵ These phenomena are not unique to patients making ART decisions. For example, parents of children with cancer have been shown to be overoptimistic of chances of a cure, though physicians may have contributed to the parents' unrealistic expectations. Hope & Rombauts, *supra* note 265, at 494-95 (discussing J.W. Mack, et al, *Understanding of Prognosis Among Parents of Children with Cancer: Parental Optimism and the Parent-Physician Interaction*, 25 J. Clinical Oncology 1357 (2007)). Cf. *Arato v. Avedon*, 5 Cal.4th 1172, 858 P.2d 598, 607 (Cal. 1993) (observing difficulty of applying general life expectancy statistics for cancer patients into meaningful data regarding

understanding, though, can help physicians present the information in ways that patients can comprehend and absorb. Research into how to accomplish this goal is ongoing and showing promise. One recent study suggests that decisional aids, such as brochures and DVDs, can be effective in translating increased knowledge into changed preferences for transfer of fewer embryos. The study found that the desirability of twins decreased in both the group receiving the brochure and the group viewing the DVD, but the DVD group reported a significantly greater preference for single embryo transfer than the brochure group. The researchers postulate that part of the enhanced impact of the DVD stemmed from the emotional impact of hearing from mothers of twins. Using such a DVD could provide a cost-effective means of educating patients and changing attitudes. In addition, room still exists for improvements in physician education. Some physicians lack sufficient knowledge of certain risks associated with multiples.²⁶⁶ Improving knowledge and changing attitudes among physicians can facilitate changes in patient understanding and preferences.²⁶⁷ So too might providing more comprehensive counseling about psychosocial as well as medical risks of multiples.²⁶⁸

V. CONCLUSION

Outliers like Nadya Suleman and Dr. Kamrava will always exist, even in a regime of legislative prohibition. Neither public condemnation of Suleman, influenced by societal norms about motherhood, nor the anti-abortion movement, should drive legislative policy. While the goal of avoiding multiple births for the sake of women and their future children is one we should embrace, we should not do so at the cost of women's reproductive freedom and autonomy. Legislative embryo transfer restrictions would infringe women's constitutional right to procreate, undercut women's familial authority, perpetuate harmful and degrading stereotypes of infertile women as "irrational" and render women adversaries against their future children and physicians. No compelling reasons exist to subject infertile women and their physicians to such pernicious and heavy-handed regulation at this time. Rather, we should focus on enhancing physician self-regulation, patient education, and informed consent. These efforts can lead to reductions in multiple births while preserving and promoting women's right to reproductive and medical autonomy.

individual prognosis).

²⁶⁶ D'Alton, *supra* note 171, at 524.

²⁶⁷ *Id.*; Covington, *supra* note 185, at 157.

²⁶⁸ Covington, *supra* note 185, at 153-57 (identifying counseling and education [sic] as "the single most important variable in patient decision-making regarding the number of embryos to transfer").