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The Injury of Birth: Minnesota's Statutory Prohibition of Postconception Negligence Actions

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THE INJURY OF BIRTH: MINNESOTA'S STATUTORY PROHIBITION OF POSTCONCEPTION NEGLIGENCE ACTIONS

Negligence that interferes with a person's decision to reproduce may result in the somewhat unpalatable "damage" of a child being born. An injury of birth action can arise from negligence that induced a couple to conceive or a woman to bear an unwanted child. In either case the plaintiff must assert that but for the negligence, the child would not have been born. Recent legislation passed in Minnesota may be interpreted as allowing recovery for the costs of rearing an unwanted child born due to negligence that occurred prior to its conception. Conversely, actions that involve postconception negligence, in which birth only could have been prevented by abortion, are precluded by the legislation.

INTRODUCTION

> I fail to see how a decision on child bearing becomes *less* important the day after conception than the day before. Indeed, if one decision is more "fundamental" to the individual's freedom than the other, surely it is the post conception decision that is the more serious.[1]

There is no joy watching a child suffer with genetic or congenital anomalies.[2] If the birth of a child could have been prevented but for a doctor's failure to properly counsel a couple on their reproductive options or carry out their decisions, many states allow recovery for the injury of birth in a tort action.[3] Minnesota became a leader in recognizing these actions over fifty years ago.[4] The state continued

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1. Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 776 (1986) (Stevens, J., concurring) (emphasis in original).

2. *See* Schroeder v. Perkel, 87 N.J. 53, 63, 432 A.2d 834, 842 (1981) (holding that the pleasures of raising a child do not offset the extraordinary medical expenses of raising a child with cystic fibrosis). Some of the birth defects that may result in injury of birth lawsuits are: *albinism*, which causes a total lack of pigment in the body coupled with various eye defects, *see* THE MOSBY MEDICAL ENCYCLOPEDIA 23 (1985); *cri du chat syndrome*, a rare disease which causes larynx defects, low birth weight, a small head and wide set eyes that do not work together, *id.* at 134; *cystic fibrosis*, which causes glands to produce thick releases of mucus resulting in absorption problems and chronic lung infections, *id.* at 208; *Down's Syndrome*, which causes mental retardation and numerous physical defects including bowel defects, heart disease, respiratory infections and vision problems, *id.* at 237; *erythroblastosis fetalis*, a form of anemia in newborns who have Rh positive blood, but whose mothers are Rh negative, *id.* at 268; *fetal hydantion syndrome*, a complex of defects including lack of nails on the digits, mental retardation, slowed growth and heart defects, *id.* at 288; *hemophilia*, a bleeding disorder in which there is a lack of one of the blood clotting factors, *id.* at 335; *neurofibromatosis*, which causes fiberlike growths, brown spots on the skin and defects in the muscles, bones and abdominal organs, *id.* at 500; *polycystic kidney disease*, a fatal disease which causes enlarged kidneys with many cysts, *id.* at 583; *Spina Bifida*, which causes a gap in the bone surrounding the spinal cord sometimes resulting in paralysis and loss of bowel and bladder function, *id.* at 681; *rubella-related syndrome*, which causes birth defects including heart disorders, cataracts, deafness and mental retardation, *id.* at 650; *Tay Sachs disease*, a nerve breakdown disorder which causes progressive mental and physical retardation, spasticity, dementia, paralysis and early death, *id.* at 708; and *Thalassemia major*, which causes anemia and iron deposits in major organs necessitating blood transfusions, *id.* at 717. For additional information relating to birth defects that may result in injury of birth lawsuits, see Fryns, *Chromosomal Anomalies and Autosomal Syndromes*, 23 BIRTH DEFECTS 7-32 (1987) (discussing clinical recognition of genetic and congenital disorders); Opitz & Herrmann, *The Study of Genetic Diseases and Malformations*, 13 BIRTH DEFECTS 45, 49-66 (1977) (same); Note, *Father and Mother Know Best: Defining the Liability of Physicians for Inadequate Genetic Counseling*, 87 YALE L. J. 1488, 1491 nn.15-16 (1978) (same).

3. *See infra* notes 73, 161, 165-66, 170 and accompanying text.

4. *See* Christensen v. Thornby, 192 Minn. 123, 126, 255 N.W. 620, 622 (1934) (recognizing that a fraud action for misrepresentation of guaranteed sterility could be brought against a doctor who performed a vasectomy).

to expand this area of law as recently as a decade ago.[5] More recently, the state passed legislation prohibiting tort actions for postconception negligence that interfered with a woman's abortion decision.[6] The interests of health care providers and women making procreative decisions have been affected by the statute and two Minnesota Supreme Court decisions.[7]

This Note will examine the constitutionality and providence of Minnesota's prohibition of postconception injury of birth actions. The Note will also outline the circumstances under which a cause of action sounding in tort for the injury of birth may be maintained under the present law. Part I of the Note provides background on the exploding technologies of genetic counseling and prenatal diagnosis, including who uses these services and the affect these services have on reproductive decisionmaking. Part II briefly traces the development of the right of individuals to make procreative decisions free from interference from the state. Part III of the Note attempts to clarify injury of birth terminology by providing clear definitions of the various claims based on the premise that these cases, although somewhat revolutionary in tort law, fit within the traditional confines of negligence. Part IV analyzes Minnesota's early experience with injury of birth cases. Part V discusses Minnesota's statutory prohibition of postconception injury of birth actions and the constitutional challenge to the statute. Part VI examines the remaining liability in Minnesota for causing the injury of birth. Part VII suggests that the statute is improvident in light of policy considerations and provides a model for improving the statute. The Note concludes that even though Minnesota's statute has been held to be constitutional, prudential and policy considerations warrant revision to allow actions arising from negligence prior to the third trimester of pregnancy.

I. GENETIC COUNSELING: USE OF AN EXPLODING TECHNOLOGY

Amniocentesis, genetic counseling and the legalization of abortion have allowed prospective parents some measure of control in

5. *See* Sherlock v. Stillwater Clinic, 260 N.W.2d 169 (Minn. 1977); Martineau v. Nelson, 311 Minn. 92, 247 N.W.2d 409 (1976).

6. *See* MINN. STAT. § 145.424 (1986). Minnesota has joined four other states in enacting legislation prohibiting postconception injury of birth suits. *See* IDAHO CODE § 5-334 (Supp. 1986); MO. ANN. STAT. § 188.130 (Vernon 1987); S.D. CODIFIED LAWS ANN. § 21-55-2 (1987); UTAH CODE ANN. § 78-11-24 (1986). Similar legislation has been introduced in 21 others states. *See* Note, *Wrongful Birth Actions: The Case Against Legislative Curtailment*, 100 HARVARD L. REV. 2017, 2019 n.7 (1987). A California statute prohibits only suits by a child against its parents. *See* CAL. CIV. CODE § 43.6 (West 1982). A Maine statute specifically recognizes injury of birth actions. *See* ME. REV. STAT. ANN. tit. 24, § 2931(2) (1986).

7. *See* Pratt v. University of Minn. Affiliated Hosps. and Clinics, 414 N.W.2d 399 (Minn. 1987); Hickman v. Group Health Plan, Inc., 396 N.W.2d 10 (Minn. 1986).

preventing the birth of handicapped offspring. In the last thirty years, prenatal and preconception diagnosis and counseling have become highly sophisticated and accessible to the public.[8] Paralleling the growth of these new technologies and the various reproductive options they make available are decisions by the United States Supreme Court that protect the exclusive right of individuals to make their own decisions about conceiving and bearing children.[9] As a result, potential liability for interfering with procreative decisions may cohere to many members of the health profession who are involved in genetic counseling.[10]

Although genetic counseling and prenatal diagnosis are appropriate in many situations, women who have a substantial risk of bearing affected children because of illness,[11] advanced maternal age[12] or

8. The first American genetic counseling center was founded by Charles B. Davenport in 1915. From its association with the eugenics movement, which advocated regulated marriages, sterilization, immigration restrictions and permanent confinement of certain individuals, genetic counseling fell from favor as contrary to the nation's protection of the basic civil liberties. Wariness over the early misuse of genetic information slowed the growth of the field until the late 1950's. Since then, great strides have been made in understanding human genetics. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, A REPORT ON THE ETHICAL, SOCIAL, AND LEGAL IMPLICATIONS OF GENETIC SCREENING, COUNSELING, AND EDUCATION PROGRAMS 10 (U.S. Gov't Printing Office, Wash., D.C. 1983) [hereinafter REPORT].

9. *See infra* notes 28-51 and accompanying text.

10. Liability is not limited to genetic specialists or physicians. Nurses too must be concerned, due to the great amount of time they spend with patients in all aspects of care. *See, e.g.*, Tammelleo, *R.N. Sued for "Wrongful Birth & Life": Dilemma*, 26 REGAN REP. NURS. LAW 1, 1 (Feb. 1986) (discussing Azzolino v. Dingfelder, 337 S.E.2d 528 (N.C. 1985), where a family nurse practitioner was sued for negligently failing to advise a woman of the availability of amniocentesis); Thomson, *The Role of the Occupational Health Nurse in the Prevention of Birth Defects and Genetic Disorders*, 31 OCCUPATIONAL HEALTH NURS. 28, 28-31 (1983) (role of the nurse in genetic counseling includes risk assessment, referral, identification of environmental hazards and education); Williams, *Understanding Genetic and Birth Defects — An Essential Skill for the Occupational Health Nurse*, 31 OCCUPATIONAL HEALTH NURS. 24, 24-27 (1983) (because nurses are regarded as a source of health information, knowledge about birth defects is essential).

11. *See, e.g.*, Dyer, *Elevated Maternal Serum Alpha-Fetoprotein Levels and Oligohydramnios: Poor Prognosis for Pregnancy Outcome*, 157 AM. J. OBSTETRICS & GYNECOLOGY 336, 336-39 (1987); Robertson & Shulman, *Pregnancy and Prenatal Harm to Offspring: The Case of Mothers with PKU*, 17 HASTINGS CENTER REP. 23, 23-33 (1987); Sachs, *Acquired Immunodeficiency Syndrome: Suggested Protocol for Counseling and Screening in Pregnancy*, 70 OBSTETRICS & GYNECOLOGY 408, 408-11 (1987).

12. Roghmann, *Reassurance Through Prenatal Diagnosis and Willingness to Bear Children After Age 35*, 73 AM. J. PUBLIC HEALTH 760, 760-62 (1983).

> Survey of 2,209 women age 25-45 asked about their reproductive plans and whether prenatal reassurance might influence their reproductive intentions. 25 percent of 35-39 year olds and 12.8 percent of 40-45 year olds indicated an increased willingness to have children if they were reassured that their baby had none of the birth defects detectable by amniocentesis.

the prior birth of affected children[13] are particularly likely to seek these services. Several factors may influence a couple's decision to have more children after the birth of a genetically handicapped child, including the desire for children, past reproductive experiences and maternal age.[14] Regardless of the degree of recurrent risk and the availability of prenatal diagnosis, couples are more likely to reproduce again when the affected child was their first rather than later born.[15]

A. Prenatal Diagnosis

Although availability of prenatal diagnosis[16] (most commonly through amniocentesis[17] and ultrasound[18]) is not alone determina-

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Id. Another study, based on 10,000 amniocenteses, suggests that because women age 30-35 have more children, maternal age indicators should be reduced to age 30 by the year 2000. This would result in a substantial increase in the number of Down's Syndrome pregnancies identified. The study recommends lowering the maternal age indicator to 34 immediately. Crandell, Lebherz & Tabsh, *Maternal Age and Amniocentesis: Should This be Lowered to 30 Years?* 6 PRENATAL DIAGNOSIS 237, 241 (1986). *See* Goodwin & Huether, *Revised Estimates and Projections of Down Syndrome Births in the United States, and the Effects of Prenatal Diagnosis Utilization, 1970-2002*, 7 PRENATAL DIAGNOSIS 261, 261 (1987) (total estimated cases of Down's Syndrome to peak at 5,100 in 1990 — increased use of amniocentesis by women over 30 could reduce this by one-third). *See also infra* notes 108-51 (discussing Hickman v. Group Health Plan, Inc., 396 N.W.2d 10 (Minn. 1986), where a 34-year old woman gave birth to a child with Down's Syndrome).

13. Steele, *Effect of Sibship on Reproductive Behavior of Couples After the Birth of a Genetically Handicapped Child*, 30 CLINICAL GENETICS 328, 328-34 (1986). *See also infra* notes 177-97 (discussing Pratt v. University of Minn. Affiliated Hosps. and Clinics, 414 N.W.2d 399 (Minn. 1987), where a woman gave birth to a second child with congenital defects despite genetic counseling).

14. Steele, *supra* note 13, at 328-34.

15. *Id.*

16. The first type of prenatal diagnosis is diagnosis of the pregnancy itself. Negligence in diagnosing a pregnancy is actionable in many states, but Minnesota's wrongful birth statute may be interpreted to preclude such actions. *See infra* notes 165-69.

17. Amniocentesis involves inserting a needle into the mother's womb and withdrawing amniotic fluid containing fetal cells. Laboratory testing of fetal cells can detect all known chromosomal defects and the majority of metabolic defects. Recent Development, *Washington Recognizes Wrongful Birth and Wrongful Life — A Critical Analysis*, 58 WASH. L. REV. 649, 655 n.39 (1983); *see* Chemke, *Prenatal Diagnosis of Genetic Diseases*, 22 ISRAEL J. MEDICAL SCIENCES 207, 207-09 (1986) (over 100 metabolic diseases are detectable).

Amniocentesis may, however, involve some risk of spontaneous abortion, although the extent of that risk is not clear. In a study of 691 pregnancies after amniocentesis, the rate of spontaneous abortion was found to be much higher in women who had one or more previous spontaneous abortions. This study was careful to point out that the high rate might have been due to the age and previous pregnancy history of the women, rather than the amniocentesis procedure. *See* Esrig

tive of a couple's decision to have another child,[19] many couples at risk seek early prenatal diagnosis to help them have an unaffected child.[20] In one study of forty women who had borne children after giving birth to a child with Down's Syndrome, half had amniocentesis in subsequent pregnancies.[21] As noted earlier, ultrasound scans are also very effective in determining recurrence of a particular affliction.[22] The use of ultrasound and amniocentesis together provides couples at risk with the maximum amount of information about their unborn children. Today, prenatal diagnosis is widely used to detect a wide variety of afflictions.

B. Preconception Diagnosis and Counseling

Preconception diagnosis and counseling may be distinguished

& Leonardi, *Spontaneous Abortion After Amniocentesis in Women with a History of Spontaneous Abortion*, 5 PRENATAL DIAGNOSIS 321, 327 (1985).

18. Ultrasound measures the reflection or transmission of ultrasonic waves to detect anatomical abnormalities. It is often used in combination with amniocentesis and presents no discernible risks to the woman or the fetus. *See* Note, *supra* note 2, at 1493 n.22.

The results of ultrasound testing in cases of suspected fetal anomalies are accurate 99% of the time when specific anomalies are suspected. The ability of ultrasound to detect additional defects, however, is questionable. *See* Manchester, *Accuracy of Ultrasound Diagnoses in Pregnancies Complicated by Suspected Fetal Anomalies*, 8 PRENATAL DIAGNOSIS 109, 112 (1988).

19. *See* Alper, *Genetic Counseling*, 5 DERMATOLOGIC CLINICS 43, 47-48 (1987). "[T]he burden of a disease is something to which every couple can relate. They know how the disease has affected the living situation of their family, and that is very meaningful." *Id.* at 48.

20. Super, Schwartz, Elles, Irvinson, Giles & Read, *Clinic Experience of Prenatal Diagnosis of Cystic Fibrosis by Use of Linked DNA Probes*, 3 LANCET 782, 782 (1987). This article discusses study of 96 families at risk of having a child with cystic fibrosis who were counseled about prenatal diagnosis. All women with a prenatal prediction of cystic fibrosis decided to terminate their pregnancy. One pregnancy was terminated because of a 50/50 chance of a child afflicted with cystic fibrosis. *Id.* In addition to risking an affected child, not having children, or adopting, amniocentesis provides couples at risk with another option. Now they can "have as many unaffected children as they desire . . . through prenatal diagnosis and elective abortion of affected fetuses." Rimoin, *The Delivery of Genetic Services*, 13 BIRTH DEFECTS 105, 109 (1977).

21. Elkins, Stovall, Wilroy & Dacus, *Attitudes of Mothers of Children With Down Syndrome Concerning Amniocentesis, Abortion, and Prenatal Genetic Counseling Techniques*, 68 OBSTETRICS & GYNECOLOGY 181, 181 (1986) (half of these said they would seek abortion if Down's Syndrome was confirmed). Sixty-six percent of the women polled received genetic counseling prior to conception of further children. *Id. See also infra* notes 23-27 (discussion of preconception diagnosis and counseling).

22. *See supra* note 18. *But see* Tolmie, Melby, Stephenson, Doyle & Connor, *Microencephaly : Genetic Counselling and Antenatal Diagnosis After the Birth of an Affected Child*, 27 AM. J. MEDICAL GENETICS 583, 588 (1987). A study was conducted of 15 families with one microcephalic child, using ultrasound scans in 21 subsequent pregnancies. The study found diagnosis difficult before the last trimester because head growth did not slow until then. *See id.* at 588-90.

from prenatal diagnosis in that it occurs prior to conception of further children. The techniques used are family history[23] and chromosome analysis of the parents and any affected children.[24] Preconception counseling is often recommended for the parents of affected children to inform them of the recurrence risk and the option of prenatal diagnosis.[25] Such counseling may have a profound influence on a couple's decision to attempt to conceive other children.[26]

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23. A genetic history involves "constructing a pedigree and listing the patient's near relatives by sex, age, and state of health, with particular reference to the occurrence of relevant diseases in the family." FINEBERG & PETERS, GENETIC COUNSELING AND SCREENING: STANDARDS OF CARE, CUSTOMARY PRACTICE, AND LEGAL LIABILITY, PERSONAL INJURY DESKBOOK 173, 176 (1985). The family history provides useful information to the health care provider that allows the practice of preventive medicine. *See* Gelehrter, *The Family History and Genetic Counseling: Tools for Preventing and Managing Inherited Disorders*, 73 POSTGRADUATE MEDICINE 119, 126 (1983). Genetic counselors convey information regarding the probability that a couple will have an affected child, the severity of the child's affliction and its effect on the family and the possibility of treating or preventing the affliction. *See id.* at 123.

24. Many diseases have been classified as genetic based on specific patterns which enable experts to estimate the risk of inheriting the disease. In order for some traits or diseases to appear, two recessive genes are necessary. When both parents contribute genetic material containing the same variation, the gentic disorder is termed autosomal recessive. Examples of autosomal recessive conditions are cystic fibrosis, phenylketonuria (PKU), Tay-Sachs disease and sickle-cell anemia. If two carriers mate, each child they have has a 25% chance of having the condition, a 50% chance of becoming an unaffected carrier, and a 25% chance of not having the abnormal gene in question. *See* REPORT, *supra* note 8, at 11-13.

Carriers of autosomal dominant genes can pass on the disorder even if their mates do not carry the variant gene. A couple in which one person is a carrier and the other is not has a 50% chance of having a child with the disorder with each pregnancy. Examples of autosomal dominant disorders include Huntington's disease, achonodroplastic dwarfism and polycystic kidney disease. *Id.*

25. Sadovnick, Baird, Hall & Keena, *Use of Genetic Counselling Services for Neural Tube Defects*, 26 AM. J. MEDICAL GENETICS 811, 811 (1987). This study indicated that use of genetic counseling services is influenced by the type of handicap and whether the child was born alive or stillborn. Genetic counseling was most often sought after the birth of a live infant with handicaps. *See id.* at 816.

26. Swerts, *Impact of Genetic Counseling and Prenatal Diagnosis for Down Syndrome and Neural Tube Defects*, 23 BIRTH DEFECTS 61 (1987). Two studies evaluated the impact of genetic counseling and prenatal diagnosis on family planning decisions of parents of a child with Down's Syndrome or neural tube defects. *Id.* Each study compared parents who received genetic counseling to parents who already had amniocentesis performed and parents who had received neither genetic counseling nor amniocentesis. *Id.*

> The information given during the counseling session(s) influenced more than half of the parents of a child with Down syndrome, to decide in favor of further pregnancies. In the group of parents having a child with a neural tube defect the information received at the genetic counseling session(s) even had a more important effect: 80 percent decided to plan another pregnancy. Results of both studies clearly indicate that for more than half of the families the availability of prenatal diagnosis was of crucial importance in the decision to plan future pregnancies.

Id. at 61-62.

Thus, preconception counseling can be essential in helping couples make informed reproductive decisions.[27]

II. Preserving Choice in Procreative Decisionmaking

Technology has afforded individuals a large measure of control over their reproductive options, improving the ability of couples to conceive and bear children[28] as well as avoid conception and birth.[29] The strength of these options often becomes the subject of controversy and litigation. This controversy often pits the consumer or distributor of these new technologies against the state or groups advocating the interests of large sectors of society.

Voluntary sterilization[30] of men[31] and women[32] is widely accepted as a method of birth control. Voluntary sterilization has been accepted fairly recently[33] and remains controversial even today.[34]

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27. Care should be taken to distinguish the term "informed decisionmaking" from "informed consent," a legal term of art that implies rights and duties in the physician/patient relationship that may not be applicable to pure counseling situations. *See infra* notes 177-90 and accompanying text.

28. In vitro fertilization, fertility drugs and surrogate parentage are just a few of the techniques that afford couples previously unable to have children the opportunity to reproduce. *See generally* Fletcher, *Moral Problems and Ethical Issues in Prospective Human Gene Therapy*, 69 Va. L. Rev. 515, 530-31 (1983); Note, *Surrogate Parenthood — An Analysis of the Problems and a Solution: Representation for the Child*, 12 Wm. Mitchell L. Rev. 143, 145-48 (1986).

29. Sterilization, contraception and abortion are all methods of birth control. They differ in degree of acceptance, however. Sterilization has been a widely approved method of birth control since the 1940's. *See infra* note 33. Today almost everyone would agree that a person should be free to choose to be sterilized. *But see infra* note 34. Many other contraceptive techniques have also gained wide approval. These techniques range from abstinence and withdrawal (which might not even be considered "birth control" by some individuals) to IUD's and morning after pills (which are considered abortion by some individuals). Abortion is not considered an acceptable method of routine birth control. It remains, however, the final method of preventing birth and as such must be considered birth control. *See* Holt, *Wrongful Pregnancy*, 33 S.C. L. Rev. 759 n.1 (1982). Abortion is the most controversial method of birth control because it allows women to choose to prevent birth after conception.

30. Involuntary sterilization has been performed on the mentally defective and prisoners. *See, e.g.*, Skinner v. Oklahoma, 316 U.S. 535, 538 (1942) (Court invalidated statute calling for sterilization of persons convicted of three felonies involving moral turpitude); Buck v. Bell, 274 U.S. 200, 207 (1927) (Court upheld statute allowing involuntary sterilization of institutionalized mental patients). It is extremely doubtful that the decision in *Buck* would be upheld today.

31. Sterilization of a man is accomplished by vasectomy, an operation involving removal of a section of the vas deferens under local anesthesia. The Mosby Medical Encyclopedia 773 (1985).

32. Women are sterilized by tubal ligation, a procedure slightly more complicated than vasectomy that involves tying off the fallopian tubes. *Id.* at 754.

33. Doctors have been performing sterilizations since the turn of the century. *See Vasectomy: The V Word*, St. Paul Pioneer Press, Feb. 1, 1988, at B1, col. 3, B2, col. 2. It used to be much more difficult, however, to obtain a sterilization.

Although no statute attempting to prevent voluntary sterilization has been challenged in the United States Supreme Court, it is doubtful that such a statute could survive substantive due process challenges today.

The Supreme Court has struck down statutes interfering with the dissemination of contraceptive information and devices[35] or restricting the sale of contraceptives[36] to unmarried people.[37] Today no person may be prohibited from buying, selling or using contraceptives.[38] Thus, the protection of reproductive autonomy extends beyond the "marital bedroom" of *Griswold* "to the doctor's office, the hospital, the hotel room or as otherwise required to safeguard the right to intimacy involved."[39]

The right to privacy first found in *Griswold* and its progeny was significantly expanded to the abortion context in 1973. The abortion decision is made by the woman with advice from her physician.[40]

For women, the "Rule of 120" prevailed. This meant that if the woman's age times the number of children she had did not equal 120 or more, she could be considered for sterilization.

For men, it was more up to the whim of the doctor whether he thought it was proper to sterilize a particular patient. For example, a urologist might only consider sterilizing a man 40 years old with five children because he himself was 40 years old with five children.

Id. at B2, col. 2. The Association for Voluntary Sterilization was formed in 1943 to make sterilization available to those who wanted it. *Id.* The association is still in existence today as the Association for Voluntary Surgical Contraception with headquarters in New York. *Id.*

34. For example, the Couple-to-Couple League believes that deliberate sterilization is incompatible with a positive view of life and promotes natural family planning. *Id.* at B2, col. 1. The group also has physical and moral objections to sterilization, believing that antibodies built up against sperm could cause a breakdown in the immunological defense system and that God made our bodies perfect so surgery should only be performed when necessary. *Id.*

35. Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (Connecticut statute which forbade the use of contraceptives and forbade aiding others in contraceptive use held unconstitutional).

36. Carey v. Population Servs. Int'l, 431 U.S. 678, 689-91 (1977) (statute which attempted to limit sales of contraceptives by forbidding all but licensed pharmacists from selling contraceptives held unconstitutional).

37. Eisenstadt v. Baird, 405 U.S. 438, 440-42 (1972) (Massachusetts statute which permitted physicians and pharmacists to distribute contraceptives to married persons only held unconstitutional).

38. *See Carey*, 431 U.S. at 687 (*Griswold* protects individual decisions regarding childbearing from unjustified intrusion by the state).

39. Paris Adult Theatre I v. Slaton, 413 U.S. 49, 66 n.13 (1973).

40. Several attempts have been made to require the consent of third persons before an abortion may be performed. The Supreme Court has held that neither the father of an unborn child nor the parents of an unemancipated minor have an absolute veto over the abortion decision. *See* Planned Parenthood Ass'n of Kansas City v. Ashcroft, 462 U.S. 476 (1983); Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983); Belotti v. Baird, 443 U.S. 622 (1979); Planned Parenthood Ass'n of Kansas City v. Danforth, 428 U.S. 52 (1976). More recently parental notification stat-

Although the states are not required to fund abortions,[41] they may not interfere with the abortion decision by imposing regulations that discourage abortions.[42] The Court in *Roe v. Wade*[43] held that regulations protecting the fetus prior to the third trimester of pregnancy are impermissible.[44] A companion case, *Doe v. Bolton*,[45] permitted a physician to consider all emotional, psychological and familial factors in deciding whether or not to perform an abortion.[46]

Regulations that act as a substantial impediment to making abortion decisions and that are not necessary to achieve a compelling state objective have been invalidated by the courts.[47] Statutes purporting to gain a woman's informed consent through provisions that discourage abortion, rather than providing information, are not relevant to informed consent and thus advance no legitimate state interest.[48] Thus, provisions requiring doctors to distribute materials relating to the "anatomical and physiological characteristics" of a fetus, the "serious complications" of the abortion procedure or the alternatives to abortion have been struck down as "poorly disguised elements of discouragement for the abortion decision."[49]

Popular opinion clearly has some effect on judicial and legislative bodies. It is fairly clear that the majority of Americans believe in retaining the abortion right in some form.[50] Under what circumstances abortion is favored is less clear.[51] Although public support

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utes have been challenged. *See* Note, *Parental Notification Prior to Abortion: Is Minnesota's Statute Consistent With Current Standards*, 14 WM. MITCHELL L. REV. 653 (1988).

41. *See* Maher v. Roe, 432 U.S. 464, 469 (1977). More troubling was a later decision that the state need not even fund medically necessary abortions. Harris v. McRae, 448 U.S. 297, 326 (1980).

42. *See* Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 759 (1986); *Akron*, 462 U.S. at 444-45 (1983).

43. 410 U.S. 113 (1973).

44. *Id.* at 162-64.

45. 410 U.S. 179 (1973). The *Bolton* case struck down a Georgia statute which placed numerous procedural burdens on a woman seeking an abortion including allowing abortions to be performed only at accredited hospitals and requiring the consent of additional doctors. *Id.* at 192-200. One of the factors a physician was allowed to consider under the statute was the risk of fetal defects. *Id.*

46. *Id.* at 192.

47. *See Thornburgh*, 476 U.S. at 759.

48. *Akron*, 462 U.S. at 44-45.

49. *Thornburgh*, 476 U.S. at 763.

50. On the 15th anniversary of *Roe*, a nonpartisan study was released by the National Abortion Rights Action League showing that 88% of those polled favored retaining the abortion right in some form. *Abortion Support High, But Doubts Remain, Poll Says*, St. Paul Pioneer Press, Jan. 21, 1988, at 1A, col. 1. Only 10% of those polled said they opposed abortion under all circumstances. *Id.* at 6A, col. 3.

51. Although 39% of those who believed the abortion right should be retained thought abortions should be permitted for "any woman who wants one," 49% believed abortions should be allowed only in certain circumstances. *Id.* at 6A, col. 3. The two situations offered by the poll were abortions to terminate pregnancies re-

of the abortion right remains high despite eight years of an administration with a strong anti-abortion platform, that public sentiment may not be reflected in legislation prohibiting actions for the injury of birth.

III. About Confusing Terminology: A New Framework

This Note refers to several terms that have been confusing[52] practitioners and the courts for years and introduces new terms that, it is hoped, will end the confusion.[53] By the term "injury of birth," this Note refers to two broad categories of negligence actions involving

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sulting from rape or when a woman's health was seriously endangered. *Id.* While the poll did not ask whether or not abortion should be allowed when the fetus is afflicted with a serious genetic disorder, one might suppose that the support of the abortion right in that circumstance would be something higher than 39% and lower than 88% of those polled.

Several state legislatures have found the physical or mental health of the fetus to be a factor that should be considered. *See* Idaho Code § 18-608(1) (1987) (one factor doctors should consider in determining whether to perform an abortion is whether the child would be born with physical or mental defects); N.M. Stat. Ann. § 30-5-1(C)(2) (1984) (medical termination of pregnancy "justified" if child would probably have grave physical or mental defects). *See also* Roe v. Wade, 410 U.S. 113, 142 (1973) (American Medical Association Committee on Human Reproduction would allow abortion when child would be born with incapacitating deformity); Note, *supra* note 6, at 2027 n.59 (prior to *Roe*, Uniform Abortion Act permitted abortions when child would be born with grave defects).

52. The confusion stems from two separate sources. First, the courts have been unable to agree on the meaning of the "seemingly oxymoronic" terms wrongful birth, wrongful life, wrongful conception and wrongful pregnancy. Gallagher v. Duke Univ., 638 F. Supp. 979, 981 (M.D.N.C. 1986). Second, many people outside the medical profession have trouble understanding the complex terminology and concepts inherent in reproductive sciences. *See generally* Knott, *Considerations in Communicating Genetics to the Uninformed*, 13 Birth Defects 147, 147-53 (1977).

53. The Minnesota wrongful birth statute specifically defines causes of action for wrongful birth and wrongful life differently than most recent courts and commentaries. The Minnesota Supreme Court has accepted the legislature's terminology distinguishing injury of birth actions arising from negligence prior to conception from those arising after conception. While it is not the intention of this Note to further confuse accepted terminology, a new framework is necessary in light of Minnesota's approach.

Most recent courts and commentators have adopted the terminology of the federal district court in Phillips v. United States, 508 F. Supp. 544 (D.S.C. 1981), to refer to the various negligence claims involving newborns. The *Phillips* court defined "wrongful pregnancy" as an action against a physician for negligence in performing an abortion resulting in the birth of an unwanted child. *Id.* at 545 n.1. Also included in the *Phillips* "wrongful pregnancy" definition were cases that the Minnesota Supreme Court has termed "wrongful conception," referring to claims involving the birth of unwanted children due to failed contraception methods or unsuccessful sterilization procedures. *See id.* The above actions are distinguished from a "wrongful birth" claim brought by the parents of an unwanted child born with birth defects, or a "wrongful life" claim brought by the unwanted child suffering from such birth defects. *See id.* Because the *Phillips* court did not distinguish between the merits of

injuries to parents and their children: negligence prior to conception, *preconception negligence*, and negligence after conception, *postconception negligence*.[54]

Preconception negligence claims arise from the birth of children,

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claims based on whether they arose prior to or after conception, as the Minnesota statute and courts have, this Note abandons the *Phillips* terminology.

Injury of birth actions were originally distinguished in part on the basis of whether the child was born healthy (wrongful pregnancy/conception) or unhealthy (wrongful birth/life). While wrongful birth and wrongful life actions *always* involve children born with birth defects (with the exception of the "illegitimacy cases," which have never been accepted by any court, *see, e.g.*, Aronoff v. Snider, 292 So. 2d 418 (Fla. App. 1974); Zepeda v. Zepeda, 41 Ill. App. 2d 240, 190 N.E.2d 849 (1963); Williams v. State, 18 N.Y.2d 481, 223 N.E.2d 343, 276 N.Y.S.2d 885 (1966)), wrongful pregnancy/conception actions *may also* involve children born with birth defects. *See, e.g.*, LaPoint v. Shirley, 409 F. Supp. 118 (W.D. Tex. 1976); Elliot v. Brown, 361 So. 2d 546 (Ala. 1978); Fassoulas v. Ramey, 450 So. 2d 822 (Fla. 1984); Fulton-DeKalb Hosp. Auth. v. Graves, 252 Ga. 441, 314 S.E.2d 653 (1984); Comras v. Lewin, 183 N.J. Super. 42, 443 A.2d 229 (1982); Speck v. Finegold, 497 Pa. 77, 439 A.2d 110 (1981); Stribling v. deQuevedo, 288 Pa. Super. 436, 432 A.2d 239 (1980). Thus, that distinction is no longer particularly meaningful.

A second distinction made in these actions involves whether the child was unplanned (wrongful pregnancy/conception) or planned (wrongful birth/life). This distinction, however, lacks contemporary significance and places the focus on the victim's culpability, rather than the tortfeasor's. For example, a couple who underwent sterilization or practiced some other form of contraception could be said to have an "unplanned child" if, due to negligence, a child was born despite their precautions (wrongful conception). Similarly, a woman seeking diagnosis of the fact of pregnancy could be said to have an "unplanned" child, if she is pregnant and chooses to give birth (wrongful pregnancy). A woman who undergoes an abortion procedure and nevertheless gives birth due to a physician's negligence, could be said to have an "unplanned" child (wrongful pregnancy). Following this reasoning, a woman who does not wish to become pregnant and gives birth to a child with Down's Syndrome that, but for a health care provider's negligence in failing to diagnose the anomaly, she would have aborted could be said to have an "unplanned" child (wrongful birth/life). The possibilities, while not infinite, are so variant as to prevent any meaningful distinction based on whether the child is "planned" or "unplanned."

54. Procreative decisions made prior to conception are commonly distinguished from those made after conception in medical literature:

> At the outset, one can differentiate between decisions involving genetic risk which are taken *during* the planning stage of a pregnancy and decisions taken *after* the pregnancy has been confirmed. In the former case, we are dealing with prospective parents who have to face the possibility that their offspring may be subjected to a genetic risk. In the latter case, the prospective parents may or may not have known that there existed such a possibility prior to conception, and would have found out about it only as a result of the routine medical investigations carried out after the woman was diagnosed as pregnant.

Humphreys & Berkley, *Representing Risks: Supporting Genetic Counseling*, 23 BIRTH DEFECTS 227, 229 (1987) (emphasis in original). Parents who know the risk prior to conception gamble that they will have to abort an affected child. When parents become aware of the risk during pregnancy, the only risk they take is that the diagnostic test will be false positive, thus inducing them to abort a healthy child. *See id.*; *see also* APPENDIX: THE DECISION TO REPRODUCE.

who, but for another's negligence would not have been conceived. This term captures actions involving children conceived due to negligent sterilization procedures, failure of birth control devices and negligent genetic diagnosis and counseling prior to conception that induced the parents to conceive a child with severe congenital anomalies.[55]

Postconception negligence claims, on the other hand, arise from the birth of children, who, although already conceived, would not have been born but for another's negligence. These cases involve children born due to negligently diagnosed pregnancies, negligently performed abortions,[56] or negligent diagnosis and counseling after conception that induces a woman to carry a child with severe congenital anomalies to term.

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55. *See, e.g., Gallagher*, 638 F. Supp. at 980. In *Gallagher*, despite the North Carolina Supreme Court's refusal to recognize a cause of action for wrongful birth, a federal district court allowed the parents' cause of action for preconception negligence which induced them to conceive an affected child. *Id.* at 982. The plaintiffs gave birth to a child who died 20 days later from multiple birth defects. *Id.* at 980. Doctors at Duke University found no chromosomal deficiencies in the child and did not test the parents. When the plaintiffs conceived again the doctors did not use amniocentesis and a second child was born with multiple birth defects. Later, it was determined that the two children suffered from similar chromosomal abnormalities and that the father carried the suspect gene. *Id.* The federal court, distinguishing the case from Azzolino v. Dingfelder, 315 N.C. 103, 337 S.E.2d 528 (1985), reasoned:

> The issue of genetic counseling makes this case unique. It appears to the court that two types of genetic counseling currently [exist] to serve couples in their right to plan their families. The first is pre-conception genetic counseling. This type of counseling provides patients with information pertaining to whether they could or should conceive. Typically, such information relates to fertility and to the relative potential for conceiving a child with genetic or congential defects. Post-conception genetic counseling usually relates to tests conducted while the child is *in utero*, to determine if the fetus suffers from genetic defects. . . . Post-conception genetic counseling is employed so that a mother may make an informed decision on whether to have a eugenic abortion of a deformed or otherwise genetically defective fetus.

Gallagher, 638 F. Supp. at 981-82. Since *Azzolino* was distinguishable because it involved postconception genetic counseling, the court was free to conclude that a cause of action for the birth of an affected child due to preconception negligence was not precluded in North Carolina. *Id.* at 982. The court relied, in part, on Jackson v. Bumgardner, 71 N.C. App. 107, 321 S.E.2d 541 (1984), a preconception negligence case involving the failure to replace an IUD which resulted in the birth of a healthy child.

56. Most courts have not distinguished between postconception claims involving misdiagnosed pregnancies or negligently performed abortions, and preconception claims involving failed sterilization procedures or contraception methods. Courts have refused to recognize such a distinction because in both instances the child is "unplanned." *See supra* note 53 (criticizing this distinction). The Minnesota statute appears, however, to prohibit a cause of action for the birth of a child due to the failure of an abortion procedure or a misdiagnosed pregnancy because these claims necessarily involve the assertion that the child would have been aborted. *See infra* notes 165-69 and accompanying text.

Injury of birth does not refer to claims that a person negligently failed to treat or caused injury to a fetus *in utero*.[57] The "injury" in injury of birth cases is the birth itself, that results in unwanted financial, emotional and physical damages to the plaintiffs. Necessary to any injury of birth claim, therefore, is the assertion by the plaintiff (in some cases the child itself) that the child was unwanted.[58]

Injury of birth cases divide neatly based on whether or not the child was conceived at the time the negligence occurred. Nonetheless, a few cases still escape these divisions. Extraordinary cases have involved both preconception and postconception negligence.[59] These cases should be treated as two separate instances of negligence, combining the suits of the injured parties without permitting double recovery for the same injury. In addition the child's claim that its parents, rather than the health care provider, were negligent in allowing conception or birth logically follows from the other

57. Claims that a person affirmatively injured an unborn fetus have been well accepted for over 40 years. *See* D. DOBBS, R. KEETON AND R. OWEN, PROSSER AND KEETON ON TORTS § 55, 367-70 (5th ed. 1984). Recently, claims have arisen from fetal injuries caused by amniocentesis. *See, e.g.*, McBride v. Brookdale Hosp. Medical Center, 130 Misc.2d 999, 498 N.Y.S.2d 256 (1986); Wheeldon v. Madison, 374 N.W.2d 367 (S.D. 1985).

58. Although it may stigmatize the child, basing the distinction on whether the child is "wanted" or "unwanted" is a way to distinguish between injury of birth claims in terms of their merits. In any injury of birth case, the parents must allege that the child was unwanted to plead sufficient damages. This is true regardless of whether the procreative choice was interfered with prior to or after conception and regardless of whether the child was born healthy or unhealthy. Parents who undergo sterilization procedures or take contraceptives do not "want" to conceive children. Yet if a child is conceived, they may "want" the child and cannot be forced to mitigate damages by aborting the fetus or by putting the child up for adoption once born. Still, a cause of action should lie as long as the child was unwanted prior to the point of injury (in this case prior to its conception) and the health care provider's negligence has prevented the parents from exercising their fundamental right to carry out procreative decisions preventing the conception or birth of the child.

The stigma of having to say a child is unwanted is inherent in the claim itself. As such, it serves to prevent frivolous claims by making parents of children (especially those born healthy) carefully consider the effect that the lawsuit will have on their child. This soul searching might lead some potential claimants to reach the conclusion that their child was always wanted — for it is the parents bringing the action, and not the courts, who stigmatize the child. *See* Custodio v. Bauer, 251 Cal. App. 2d 303, 324, 59 Cal. Rptr. 463, 477 (1967) (unplanned child who learned of parents' suit should not be protected from "emotional bastardry" by court because stigma is no greater than for other unplanned children).

59. *See, e.g.*, Speck v. Finegold, 268 Pa. Super. 342, 408 A.2d 496 (1979). After fathering two children with neurofibromatosis, Mr. Speck underwent a vasectomy. His wife became pregnant, indicating that the vasectomy was unsucessful (failed sterilization/preconception negligence). Mrs. Speck then underwent an abortion that failed and was told that she was no longer pregnant, despite her protests to the contrary (failed abortion and misdiagnosed pregnancy/postconception negligence). Mrs. Speck then gave birth to a third child with neurofibromatosis.

claims, but strong public policy arguments have universally precluded such claims.[60]

Courts vary widely on the application of damage principles in injury of birth cases. This variance is perhaps due to confusion over the various titles given these actions. For example, many courts do not award the costs associated with pregnancy and childbirth in cases involving postconception negligence inducing a woman to carry a child with congenital anomalies to term. Courts have reasoned that because the woman wanted to give birth when she conceived, she was not damaged in that manner.[61] This kind of reasoning may reflect outdated notions of birth control, as the woman must claim that but for the physician's negligence she would have aborted the fetus in any postconception negligence case. Therefore, she should be entitled to the costs associated with pregnancy and childbirth minus the cost of the foregone abortion. Similarly, no court has awarded an affected child damages for pain and suffering or loss of earnings, although these children surely suffer and may never be able to work. Several commentators have provided detailed analysis of the perplexing topic of injury of birth damages, which is not a major focus of this Note.[62]

IV. Recovery for the Injury of Birth: Minnesota's Early Experience

Aside from a constitutional challenge to Minnesota's statute prohibiting actions for postconception negligence,[63] and a case attempting to avoid the statute by grounding its claim in negligent nondisclosure,[64] Minnesota's case law regarding the injury of birth has been limited to preconception negligence cases involving failed sterilization procedures. A careful examination of these cases reveals some of the policy considerations important in examining the providence of Minnesota's prohibition of postconception injury of birth claims.

60. *See infra* notes 106-107. *But see infra* notes 162-64 (Minnesota statute does not reach child's claim that but for parents' negligence he or she would not have been conceived).

61. The pregnancy and delivery associated with an affected child are generally no more difficult than if the child had been normal. Moores v. Lucas, 405 So. 2d 1022, 1026 (Fla. Dist. Ct. App. 1981). The *Moores* court held that the plaintiff's claim for pain and suffering was properly stricken, "since Linda Moores wanted to become pregnant and bear a child." *Id.*

62. *See, e.g.*, Note, *Wrongful Birth Damages: Mandate and Mishandling by Judicial Fiat*, 13 Val. U.L. Rev. 127 (1978).

63. Hickman v. Group Health Plan, Inc., 396 N.W.2d 10 (Minn. 1986) (discussed *infra* notes 108-51).

64. Pratt v. University of Minn. Affiliated Hosps. and Clinics, 414 N.W.2d 399 (Minn. 1987) (discussed *infra* notes 177-97).

Preconception negligence claims may arise in three ways: (1) failure of a sterilization procedure; (2) failure of a contraceptive method; and (3) negligent preconception genetic diagnosis and counseling that induces the parents to conceive a child with severe congenital anomalies. Minnesota courts have recognized the first type of claim explicitly and the second type by implication. The Minnesota Supreme Court refers to these claims as "wrongful conception."[65]

The Minnesota Supreme Court heard what has generally been recognized as the first injury of birth case in 1934. In *Christensen v. Thornby*,[66] the plaintiff underwent a vasectomy operation upon the advice of his physician because it was thought further pregnancies would be dangerous to his wife's health.[67] When Mr. Christensen resumed sexual relations with his wife, she became pregnant. Mr. Christensen alleged that his doctor had assured him the operation was successful and guaranteed sterility, and that his wife's pregnancy had caused him great anxiety as well as considerable expense.[68] The supreme court rejected the defendant's argument that a contract to sterilize was void as illegal and against public policy.[69]

The court showed reluctance to find damages,[70] however, since Mrs. Christensen gave birth, without complications, to a healthy child. The supreme court, in prophetic dicta, stated:

> The purpose of the operation was to save the wife from hazards to her life which were incident to childbirth. It was not the alleged purpose to save the expense incident to pregnancy and delivery. The wife has survived. Instead of losing his wife, the plaintiff has been blessed with the fatherhood of another child. The expenses alleged are incident to the bearing of a child, and their avoidance is remote from the avowed purpose of the operation. *As well might the plaintiff charge defendant with the cost of nurture and education of the child*

65. Sherlock v. Stillwater Clinic, 206 N.W.2d 169, 174-75 (Minn. 1977).

66. 192 Minn. 123, 255 N.W. 620 (1934).

67. Mrs. Christensen had experienced great difficulties in the birth of the couple's first child. The Christensens were advised that the birth of a second child would put Mrs. Christensen's life in danger. *Id.* at 123, 255 N.W.2d at 621.

68. Although the plaintiff's allegations would appear to have supported recovery for breach of contract or malpractice, Mr. Christensen insisted his complaint was grounded on deceit. *Id.* at 126, 255 N.W. at 622. The court, finding no allegation of fraudulent intent on the defendant's part, affirmed the district court's order sustaining a demurrer to the complaint. *Id.*

69. The court found no legal difference between the sterilization of men and women, but noted that the operation was much simpler and did not require hospitalization if performed on a man. *Id.* at 125, 255 N.W.2d at 621. The court also found that the operation had no affect on the health and vigor of the patient either mentally or physically. Thus, the contract to perform a sterilization was neither illegal, nor void as against public policy. *Id.* at 126, 255 N.W.2d at 622.

70. The plaintiffs had sought $5,000 for anxiety and expenses relating to the pregnancy and birth. *Id.* at 124, 255 N.W.2d at 621.

during its minority.[71]

Much of the dicta of the *Christensen* court has been discarded[72] since the late 1960's.[73] The dicta was instrumental, however, in establish-

71. *Id.* at 126, 255 N.W.2d at 622 (emphasis added).

72. It is doubtful, for example, that a modern court would make a legal distinction based on whether the *purpose* of the operation was to protect the mother from injury or to save the expenses incident to childbirth. One court believed that "[t]o say, as in *Christensen*, that the expenses of bearing a child are remote from the avowed purpose of an operation undertaken for the purpose of avoiding child bearing is a non sequitur." Custodio v. Bauer, 251 Cal. App. 2d 303, 324, 59 Cal. Rptr. 463, 476 (1967). Similarly, the birth of an unwanted child might be something less than a blessed event in circumstances where the parents are extremely poor, already have a large family or the child is born with an affliction. The effects of an unwanted pregnancy on a woman were noted by the United States Supreme Court in Roe v. Wade, 410 U.S. 113 (1973):

> Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved.

Id. at 153.

73. Since the late 1960's no jurisdiction that has heard a wrongful conception claim involving a failed sterilization procedure or contraceptive method has failed to recognize the cause of action. *See, e.g.*, Hartke v. Mckelway, 707 F.2d 1544 (D.C. Ct. App. 1983) (laproscopic cauterization); White v. U.S., 510 F. Supp. 146 (D. Kan. 1981) (tubal ligation); LaPoint v. Shirley, 409 F. Supp. 118 (D. Tex. 1976) (tubal ligation); Bishop v. Byrne, 265 F. Supp. 460 (S.D.W.Va. 1967) (tubal ligation); Elliot v. Brown, 361 So. 2d 546 (Ala. 1978) (vasectomy); University of Ariz. Health Sciences Cent. v. Superior Court, 136 Ariz. 579, 667 P.2d 1294 (1983) (vasectomy); Wilbur v. Kerr, 275 Ark. 239, 628 S.W.2d 568 (1982) (vasectomy); Custodio v. Bauer, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (1967) (tubal ligation); Anonymous v. Hospital, 33 Conn. Supp. 126, 366 A.2d 204 (1976) (tubal ligation); Flowers v. District of Columbia, 478 A.2d 1073 (D.C. App. 1984) (tubal cauterization); Fassoulas v. Ramey, 450 So. 2d 822 (Fla. 1984) (vasectomy); Fulton-DeKalb Hosp. Auth. v. Graves, 252 Ga. 441, 314 S.E.2d 653 (1984) (tubal ligation); Clay v. Brodsky, 148 Ill. App. 3d 63, 499 N.E.2d 68 (1986) (tubal ligation); Garrison v. Foy, 486 N.E.2d 5 (Ind. Ct. App. 1985) (vasectomy); Johnston v. Elkins, 241 Kan. 407, 736 P.2d 935 (1987) (vasectomy); Maggard v. McKelvey, 627 S.W.2d 44 (Ky. Ct. App. 1981) (vasectomy); Pitre v. Opelousas Gen. Hosp., 517 So. 2d 1019 (La. Ct. App. 1987) (tubal ligation); Macomber v. Dillman, 505 A.2d 810 (Me. 1986) (tubal ligation); Jones v. Malinowski, 299 Md. 257, 473 A.2d 429 (1984) (tubal laproscopy); Zeller v. Greater Baltimore Med. Cent., 67 Md. App. 75, 506 A.2d 646 (Md. Ct. Spec. App. 1986) (spermicide); Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971) (birth control pills); Bushman v. Burns Clinic Med. Cent., 83 Mich. App. 453, 268 N.W.2d 683 (1978) (vasectomy); Sherlock v. Stillwater Clinic, 260 N.W.2d 169 (Minn. 1977) (vasectomy); Hershley v. Brown, 655 S.W.2d 671 (Mo. Ct. App. 1983) (insertion of tubal ring instead of agreed upon cauterization); Szekeres v. Robinson, 715 P.2d 1076 (Nev. 1986) (contract recovery only for failed sterilization); Kingsbury v. Smith, 122 N.H. 237, 422 A.2d 1003 (1982) (tubal ligation); J.P.M. v. Schmid Laboratories, Inc., 178 N.J. Super. 122, 428 A.2d 515 (N.J. Super. Ct. App. Div. 1981) (condom); Betancourt v. Gaylor, 136 N.J. Super. 69, 344 A.2d 336 (N.J. Super. Ct. Law Div. 1975) (tubal ligation); O'Toole v. Green-

ing the "overriding benefits rule," which requires that the benefit of a healthy, but unwanted child be weighed against any damage suffered incident to the child's birth.[74] The "benefit rule" has been inconsistently applied by the courts to prevent unjust enrichment in injury of birth cases.[75]

In *Martineau v. Nelson*,[76] the Minnesota Supreme Court faced a collateral issue in the injury of birth arena without reaching the issue of damages. In *Martineau*, a negligently performed tubal ligation resulted in an unwanted child. The defendants in *Martineau* claimed that the husband's failure to seek a vasectomy constituted contributory negligence and the jury agreed. On appeal, the supreme court held that because the physicians had superior knowledge, giving conflicting advice on the necessity of the husband undergoing a vasectomy breached their obligation to give clear information and advice.[77] Thus, the jury's findings that the husband was fifty percent negligent for failing to obtain sterilization was not justifed.[78]

The supreme court squarely addressed the issue of what damages could be recovered in a wrongful conception action in *Sherlock v. Stillwater Clinic*.[79] In *Sherlock*, the plaintiffs sought sterilization to prevent further pregnancies after the birth of their seventh child in August 1970.[80] A vasectomy was performed and the Sherlocks were advised to take additional contraceptive measures until postoperative testing determined that Mr. Sherlock's semen was free from sperm.[81] About one month after the operation the doctor informed Mr. Sherlock that

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berg, 64 N.Y.2d 427, 477 N.E.2d 445, 488 N.Y.S.2d 143 (1985) (tubal ligation); Jackson v. Bumgardner, 318 N.C. 172, 347 S.E.2d 743 (1986) (failure to replace IUD); Bowman v. Davis, 48 Ohio St.2d 41, 356 N.E.2d 496 (1976) (tubal ligation); Morris v. Sanchez, 746 P.2d 184 (Okla. 1987) (tubal ligation and fallopian ring); Speck v. Finegold, 497 Pa. 77, 439 A.2d 110 (1981) (vasectomy); Smith v. Gore, 728 S.W.2d 738 (Tenn. 1987) (tubal ligation); Ball v. Mudge, 64 Wash. 2d 248, 391 P.2d 201 (1964) (vasectomy); Beardsly v. Wierdsman, 650 P.2d 288 (Wyo. 1982) (tubal ligation). The courts differ, however, on whether the costs of rearing a healthy child is an acceptable element of damages. *See* Holt, *supra* note 29, at 761.

74. *See* Holt, *supra* note 29, at 780. Early courts could not accept the concept that the birth of a normal child could be harmful. The *Christensen* dicta gave rise to the overriding benefits rule, which declared as a matter of law that the benefit of a healthy child outweighs any damage suffered incident to the child's birth. The overriding benefits rule has been replaced by a rule which uses the benefit of the child to offset or mitigate damages, rather than prevent liability. *Id.* at 780-82.

75. *See* Note, *supra* note 62, at 132.

76. 311 Minn. 92, 247 N.W.2d 409 (1976).

77. *Id.* at 105, 247 N.W.2d at 417.

78. *Id.* at 104-05, 247 N.W.2d at 416-17.

79. 260 N.W.2d 169 (Minn. 1977).

80. *Id.* at 171. *Sherlock* makes it clear that the purpose of the sterilization operation is irrelevant to liability. *See id.* at 174-75.

81. *Id.* at 171.

the results of his semen test were negative.[82] The Sherlocks resumed sexual relations without contraceptives and Mrs. Sherlock became pregnant.

The complaint alleged that the Sherlock's physician negligently performed the operation and was also negligent in his postoperative care.[83] The supreme court allowed damages for prenatal and postnatal medical expenses, the mother's pain and suffering during pregnancy and delivery, the father's loss of consortium and the reasonable cost of raising the child, offset by the value of the child's aid, comfort, and society.[84] In rejecting the *Chistensen* dicta,[85] the court reasoned that "public policy considerations" were not persuasive arguments for denying recovery to the parents of an unwanted, healthy child conceived as a result of a negligently performed sterilization operation.[86]

> Analytically, such an action is indistinguishable from an ordinary medical negligence action where a plaintiff alleges that a physician has breached a duty of care owed to him with resulting injurious consequences. Where the purpose of the physician's actions is to prevent conception *or birth*, elementary justice requires that he be held legally responsible for the consequences which have in fact

82. *Id.* In fact, the test revealed a sperm density of 5 to 10 sperm cells per microscope field and that 50% of those were motile. *Id.*

83. *See id.* A claim that a vasectomy was negligently performed involves difficult issues of proof. The area operated on is fully concealed and, in a small percentage of cases, the operation will be unsuccessful even if performed non-negligently due to the tendency of the severed vas to "recanalize" or rejoin. *Id.* at 171 n.1 (citing Lombard, *Vasectomy*, 10 SUFFOLK U. L. REV. 25 (1975)).

84. *Sherlock*, 260 N.W.2d at 170-71. The jury awarded $19,500. The case was remanded for a new trial limited to the consideration of an offset in damages for the benefit of the child to its parents. *Id.* at 176.

85. *See supra* text accompanying note 71.

86. *See Sherlock*, 260 N.W.2d at 173-74. The *Sherlock* court considered, and rejected, arguments that awarding damages would be antithetical to the historical purpose of marriage, that such claims would have the effect of reducing the child to an "emotional bastard," that it would be unjust for the health care provider to pay all the costs of raising the child while the parents derived all the joy of raising the child, and that any damages caused to the parents was more than offset by the intangible benefits gained by the birth of the child. *Id.* at 173-74. These arguments have been persuasive in other jurisdictions. *See, e.g.*, Terrell v. Garcia, 496 S.W.2d 124, 128 (Tex. Civ. App. 1973) *cert. denied*, 415 U.S. 927 (1974); Reick v. Medical Protective Co., 64 Wis.2d 514, 517-18, 219 N.W.2d 242, 245 (1974).

The *Sherlock* court was particularly concerned for the well-being of the child. The court concluded its opinion by warning the parents of the psychological consequences which could result from litigating such a claim and imploring that future parents and attorneys seriously reflect on the "silent interests of the child and . . . the parent-child relationships that must be sustained long after the legal controversies have been laid to rest." *Sherlock*, 260 N.W.2d at 176-77; *see also id.* at 177 (Sheran, J., dissenting).

occurred.[87]

The *Sherlock* court allowed recovery for the costs of rearing a normal, healthy child, recognizing that such costs were "a direct financial injury to the parents."[88] The court rejected the overriding benefits rule, reasoning that "it would seem myopic to declare today that [the benefits of parenthood] exceed the costs as a matter of law."[89] The court permitted the plaintiffs to recover the reasonably foreseeable costs of rearing an unwanted child[90] offset by the value of the benefits enuring to the parents from the child.[91]

Important in the *Sherlock* court's reasoning were policy considerations that the court has recently questioned in light of Minnesota's legislation prohibiting wrongful birth and wrongful life claims. First, the court found the use of contraceptives by millions of Americans demonstrative of the acceptance of family planning as an integral

87. *Id.* at 174 (emphasis added). The emphasized language indicates possible judicial acceptance of postconception injury of birth claims prior to the Minnesota legislation prohibiting such actions.

88. *Id.* at 175.

89. *Id.*

90. *Id.* These costs include foreseeable expenses incurred to maintain, support and educate the child — costs which were considered preposterous by the *Christensen* court. *See id.* at 177 (Sheran, J., dissenting). The "rearing liability" would not extend beyond the child's majority, unless the child was born with genetic or congenital anomalies. *Sherlock*, 260 N.W.2d at 176 n.11.

91. *Id.* at 176. The total costs of rearing the child must then be reduced by "the value of the child's aid, comfort and society which will benefit the parents *for the duration of their lives*." *Id.* (emphasis added). The court valued these benefits against the parents' life expectancy because pecuniary benefit would be minimal during the child's minority. *Id.* at n.12.

The court explicitly rejected any duty of the parents to mitigate damages by abortion or adoption. *Id.* That sentiment became part of Minnesota's wrongful birth statute. *See* MINN. STAT. § 145.424, subd. 3 (1986) (failure or refusal to have an abortion not a defense in any action and cannot be considered in awarding damages). The doctrine of avoidable consequences would not allow recovery for damages the parents could reasonably mitigate by aborting their unborn child or putting their child up for adoption. *See* RESTATEMENT (SECOND) OF TORTS § 918(1) (1974). These restrictions on recovery are designed to prevent the plaintiff from being unjustly enriched and the defendant from being unjustly burdened. *See* Note, *supra* note 62, at 164-70. Generally, one who suffers injury as the result of a tort is required to exercise reasonable care and diligence to minimize the resulting damages. *See id.* The doctrine of avoidable consequences applies after the legal wrong has occurred, but while damages may still be averted, and denies recovery for such damages. *See id.* In the injury of birth context, it has been held that the parents of an unwanted healthy child born due to a health care provider's negligence do not have to mitigate their damages by putting the child up for adoption. *See, e.g.*, Stills v. Gratton, 55 Cal. App. 3d 698, 709, 127 Cal. Rptr. 652, 658 (1976); Troppi v. Scarf, 31 Mich. App.2d 240, 259, 187 N.W.2d 511, 519 (1971). "Indeed, parents have been known to keep children that many think should be institutionalized, e.g., mentally retarded children, not because of any anticipated joy or happiness that the child will bring them but out of a sense of obligation." *Troppi*, 31 Mich. App.2d at 259, 187 N.W.2d at 520.

part of the modern marital relationship.[92] Second, it acknowledged that "the time-honored command to 'be fruitful and multiply' has not only lost contemporary significance to a growing number of potential parents but is contrary to the public policies embodied in the statutes encouraging family planning."[93] Third, the court recognized that decisions of the United States Supreme Court "suggest that the right to limit procreation is of constitutional dimension."[94] Finally, the court noted the useful deterrent effect of allowing compensatory damages for the cost of rearing a child in reinforcing the physician's duty of care from the outset of the physician-patient relationship and in preventing negligence.[95] The court was not untroubled by the deep, painful ethical problems that injury of birth cases pose for the courts and litigants, observing that "[t]he result we reach today is at best a mortal attempt to do justice in an imperfect world."[96]

The discussion above has been confined to the preconception negligence claims involving sterilization procedures. By implication, the supreme court would also recognize actions based on the failure of contraceptive methods. Although no action of this type has been heard in Minnesota, the legislature has codified an action based on the failure of a contraceptive method.[97] More significantly, the supreme court has also suggested a willingness to recognize the third type of preconception negligence: negligent preconception genetic diagnosis and counseling that induces the parents to conceive a child with severe congenital anomalies. A case that adequately pleads the facts necessary to maintain such an action, however, has not yet been heard.[98]

Preconception injury of birth actions while different from postconception suits, involve many of the same ethical problems and policy considerations of their kin. Because the children in preconception negligence actions are often born healthy, two jurisdictions continue to apply the overriding benefits doctrine to deny damages, but allow actions when a child is born with congenital deformities.[99] Accepting that the birth of a healthy child can be a great expense, these states ignore the compensatory nature of tort law. Minnesota, on the

92. *Sherlock*, 260 N.W.2d at 175.
93. *Id.*
94. *Id.*
95. *Id.* at 175-76.
96. *Id.* at 176.
97. *See* MINN. STAT. § 145.424, subd. 3 (1986).
98. *See* Pratt v. University of Minn. Affiliated Hosps. and Clinics, 414 N.W.2d 399, 402 (Minn. 1987). "If the Doctors' diagnosis was negligently made or if the tests were negligently done, then the proper claim would have been for malpractice. There is no such claim before this court." *Id.*
99. *See supra* note 86.

other hand, has been placed in the awkward position of recognizing actions that usually involve the unwanted birth of healthy children, while disallowing actions that usually involve the birth of children afflicted with anomalies.

V. Statutory Prohibition of Postconception Injury of Birth Claims

> [W]rongful birth statutes do not rationally further the goals the proponents of the legislation offer. The justifications offered in support of wrongful birth legislation are thin cover for an unremitting protest against abortion. Wrongful birth statutes are motivated by private biases and moral condemnation of abortion. Such private prejudices do not constitute permissible bases for classification. Because the true aim of the wrongful birth statutes is to discourage women from exercising their constitutional right to make informed procreative decisions, the statutes serve an illegitimate purpose and thus violate the equal protection clause.[100]

A. Minnesota Statute Section 145.424

Minnesota Statute section 145.424[101] severely limits tort actions for postconception negligence.[102] Specifically, the statute bars all claims of an infant alleging that, but for a doctor's negligence, the

100. Note, *supra* note 6, at 2034 (footnote omitted).

101. The entire text of the statute reads:

> **Prohibition of tort actions**
>
> **Subdivision 1. Wrongful life action prohibited.** No person shall maintain a cause of action or receive an award of damages on behalf of that person based on the claim that but for the negligent conduct of another, the person would have been aborted.
>
> **Subd. 2. Wrongful birth action prohibited.** No person shall maintain a cause of action or receive an award of damages on the claim that but for the negligent conduct of another, a child would have been aborted.
>
> **Subd. 3. Failure or refusal to prevent a live birth.** Nothing in this section shall be construed to preclude a cause of action for intentional or negligent malpractice or any other action arising in tort based on the failure of a contraceptive method or sterilization procedure or on a claim that, but for the negligent conduct of another, tests or treatment would have been provided or would have been provided properly which would have made possible the prevention, cure, or amelioration or any disease, defect, deficiency or handicap; provided, however, that abortion shall not have been deemed to prevent, cure, or ameliorate any disease, defect, deficiency, or handicap. The failure or refusal of any person to perform or have an abortion shall not be a defense in any action, nor shall that failure or refusal be considered in awarding damages or in imposing a penalty on any action.

MINN. STAT. § 145.424 (1986).

102. The statute does not preclude postconception negligence actions for failure to treat a child *in utero* or affirmatively injuring a fetus. These actions, however, do not involve the claim that a child would have been aborted and thus, are not postconception injury of birth actions. *See supra* notes 53-58 and accompanying text.

infant would have been aborted.[103] Similarly, the statute bars all claims of parents alleging that, but for a doctor's negligence, they would have aborted a child.[104] Curiously, the statute does not expressly prohibit claims for preconception negligence.[105] Based on the legislative history, it appears that the statute was enacted more out of concern for an anti-abortion sentiment,[106] than out of concern

103. MINN. STAT. § 145.424, subd. 1 (1986).

104. *Id.* subd. 2 (1986).

105. *See id.* subd. 3 (1986).

106. The bill was initiated by the anti-abortion group, Minnesota Citizens Concerned for Life (MCCL). The testimony of Maurice Rosenbloom at the Senate Subcommittee Hearings is indicative of the purpose of the MCCL in proposing the legislation.

> Whether we agree on legalized abortion or not, we should recognize the right of a woman not to have an abortion as well as the right of medical personnel and institutions not to participate in this procedure. This piece of legislation would allow a freedom of conscience for all of society. Free to choose and not to be placed in the position of pushing abortion on demand for those who are handicapped in some way or less fortunate.

Testimony of Maurice Rosenbloom at Senate Subcommittee on the Judiciary, Senate File 1461, Feb. 1, 1982 (transcript of tape available at William Mitchell Law Review office). Further testimony in favor of the bill was provided by Anna Lawler of the Human Life Alliance of Minnesota (HLAM) stating the purpose of the bill was, "to establish in the state of Minnesota that 1) being alive is better than not being alive; and 2) that the choice of medical care and treatment can be based on this premise." *Id.*

As the bill moved through both houses it was often apparent that its purpose and ramifications were unclear to many of the legislators and those offering testimony. The sponsor of the bill in the House suggested that the bill would not preclude actions for postconception claims against the health care provider.

> We're concerned about the cases where children, where obviously none of us are born perfect, can bring suit at will against their parents for any imperfection. Any child who is born less than perfect with this dictum now being brought forth can maintain an action against their parents. We don't believe this is right. *The bill doesn't go any further than that, it doesn't preclude any other types of actions. . . . This bill doesn't preclude actions for malpractice, for intentional or negligent malpractice. It does not preclude actions for products liability, nor does it preclude actions which can be brought against doctors for failure of abortions or for failure of contraceptive devices.*

Testimony of Representative O'Connor before House Judiciary Committee, House File 1532, Feb. 11, 1982 (emphasis added) (transcript of tape available at William Mitchell Law Review office).

There was confusion over whether or not the bill was an "abortion bill." "The Abortion Rights Council does not look upon 1461 as an abortion bill, but we do feel that this bill is an attack on health care for both men and women." Testimony of Kay Taylor before Senate Judiciary Committee, Senate File 1461, Feb. 11, 1982.

> *Representative Hokenson*: [I]t appears to me that this is going to be one of those votes that's some sort of litmus test on the abortion issue. And you know what — I actually wanted to find out something about this bill. You know, what it was about and what it could do. If you can't do that and if that dilutes the subcommittee process — take the vote.
>
> *Representative O'Connor*: Mr. Chairman, members of the committee. I personally don't believe this is a litmus test type bill. I think this is, should be common ground. All we're saying is we're trying to preclude kids from su-

about the recovery of tort damages.[107] While the providence of curtailing such actions in light of exploding genetic technologies is

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ing their parents and in the future trying to keep any action for, like I said, less than perfection in a child that's born from coming into court. I don't view this necessarily as a pro-life or pro-choice bill and that's not my intentions. I am certainly not out here to try to make anybody turn from blue to pink, I guess, when they're tested.

Id. In sum, both the Senate and House judiciary committee tapes are evidence of a confused approach to some very complicated issues including delineating between various claims, interference with procreative decisionmaking, and compensation for injury in fact. *See id.*; Subcommittee on the Judiciary, Senate File 1461, Feb. 1, 1982.

107. The skyrocketing awards for damages in injury of birth cases might at first blush suggest a reform oriented purpose. The fact that only two cases of this type have reached the Minnesota appellate courts would seem to dispel that notion. Minnesota's two postconception negligence cases arose after the statute, although three preconception cases preceeded it.

Another suggestion of the purpose of the statute is that the legislature "decided [that] the already perplexing problems of *Sherlock* would have been compounded and exacerbated and that a further tort remedy was not warranted." *Hickman*, 396 N.W.2d at 18 (Simonett, J., concurring). Although the Minnesota legislature generally does not include purpose sections in statutes, such a suggestion ignores the effect the bill has of punishing parents who would have chosen to abort their child, but for the negligent conduct of their health care provider. *See* Note, *supra* note 6, at 2017-19. Prevention of abortion was clearly the intent behind the legislation. In fact, representatives of Minnesota Conference of Catholic Health Facilities, Minnesota Catholic Conference, Catholic Health Association of the United States, Rutherford Institute, Americans United for Life, Catholic League for Religious and Civil Rights, and National Right to Life Committee represented their interests in this, the first constitutional challenge to such a statute. *Hickman*, 396 N.W.2d at 10-11.

At both the Senate and House subcommittee hearings, the bill was described as a response to *dicta* from Curlender v. Bio-Science Laboratories, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980), which approved of a cause of action by an afflicted child against its parents for "the pain, suffering and misery which they have wrought upon their offspring" by not having an abortion. *Id.* at 829, 165 Cal. Rptr. 488. *See* Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 DUKE L.J. 1401, 1457 (suggesting possibility of child's suit against parents for wrongful life). The effect of this *dicta* was quickly mooted, however, by the California legislature, which prohibited a cause of action by a child against its parents and provided that the failure to have an abortion could not be a defense in any action.

(a) No cause of action arises against a parent of a child based upon a claim that the child should not have been conceived or, if conceived, should not have been allowed to have been born alive.

(b) The failure or refusal of a parent to prevent the live birth of his or her child shall not be a defense in any action against a third party, nor shall the failure or refusal be considered in awarding damages in any such action.

(c) As used in this section "conceived" means the fertilization of a human ovum by a human sperm.

CAL. CIV. CODE § 43.6 (West 1982). This legislation, though much narrower than the Minnesota statute, was also drafted in response to the *Curlender* dicta. *Turpin*, 31 Cal.3d at 229, 643 P.2d at 959, 182 Cal. Rptr. at 342. *See* Comment, *Wrongful Life: A Legislative Solution to Negligent Genetic Counseling*, 18 U.S.F. L. REV. 77, 90 (1983) (discussing the California statute). *See also* Capron, *Tort Liability in Genetic Counseling*, 79

questionable, the statute has also been challenged as a violation of equal protection and due process.

B. Hickman: *The Constitutional Challenge*

> We are fully aware of the situation that existed a mere quarter of a century ago when physicians' actions were scarcely ever challenged and there was very little or any accountability to anyone for the decisions that they made. Those times have changed. The pendulum has now swung to the opposite extreme. Simply put, doctors must be returned some leeway in exercising judgement affecting the treatment of their patients without fear of legal sanction.[108]

The Minnesota Supreme Court held the legislative prohibition of postconception injury of birth actions constitutional in *Hickman v. Group Health Plan, Inc.*[109] In *Hickman*, the plaintiff gave birth to a

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COLUM. L. REV. 618, 661-66 (1979) (concluding that parental liability to child for wrongful life is unacceptable).

Thus, Minnesota's wrongful birth statute appears to serve a prophylactic function by easing the fear that allowing wrongful birth actions will create a legal duty for health care providers to recommend prenatal tests and nontherapeutic abortions and encourage parents to abort children more often in fear of suits brought against them by their affected children. *See* Note, *Wrongful Birth and Wrongful Life: Analysis of the Causes of Action and the Impact of Utah's Statutory Breakwater*, 1984 UTAH L. REV. 833, 857-58.

108. Hickman v. Group Health Plan, Inc., 396 N.W.2d 10, 14 (Minn. 1986). Justice Yetka's comment seems to disregard the fact that genetic counseling is in its infancy, as are tort actions arising from its negligent execution. *See supra* note 8. The comment may also be criticized because "returning leeway" to health care providers in exercising judgement affecting procreative choice involves issues of constitutional dimension. *See infra* notes 114-51. Thus, in Minnesota's genetic counseling arena, physicians are in a position similar to what they were in a quarter of a century ago for traditional medical treatments, and their patients are, again, mostly in the dark.

The *Hickman* decision, with three justices concurring and three dissenting, has been met with criticism as Minnesota clings to its statutory prohibition on postconception injury of birth actions involving claims that, but for the health care provider's negligence, the fetus would have been aborted. The *Hickman* case represents the first hearing of the constitutionality of the statutes, which have been introduced in 21 states at the urging of anti-abortion groups. *See* Note, *supra* note 6, at 2018-19. Two cases have been heard in states with wrongful birth statutes based on claims that arose prior to the effective dates of the statutes. *See* Wilson v. Kuenzi, 751 S.W.2d 741 (1988); Payne v. Myers, 743 P.2d 186 (Utah 1987). The Utah court denied the parent's and child's preconception injury of birth actions based on a state employee immunity statute. *Payne*, 743 P.2d at 190. The Missouri court judicially denied both the parent's and child's actions in a postconception case, without considering the constitutionality of the statute. *Wilson* at 751 S.W.2d at 745. *See also* Rolf v. Youngblood, — S.W.2d — (Mo. Ct. App. 1988) (following the decision in *Wilson*). Thus in Missouri, postconception injury of birth actions are precluded both legislatively and judicially.

109. 396 N.W.2d 10 (Minn. 1986).

child with Down's Syndrome. Because of her age,[110] the chances of bearing an abnormal child were significantly increased.[111] Although the facts were disputed, the claim was that but for the doctor's negligence in failing to offer or advise amniocentesis, the child would have been aborted.[112] Upon cross motions for partial summary judgment, the district court struck down the statute as unconstitutional and certified the case for immediate appeal to the Minnesota Supreme Court.[113]

1. State Action

State interference with the abortion decision is a prerequisite to finding a violation of the fourteenth amendment. The *Hickman* court held that the statute did not violate the due process and equal protection provisions of the fourteenth amendment because there was no state action or involvement.[114] Relying on *Blum v. Yaretsky*,[115] the

110. At the time the plaintiff became pregnant, she was 34 years of age. *Id.* at 11.

111. The risk of Down's Syndrome increases with maternal age. *Id. See also infra* note 170.

112. 396 N.W.2d at 11-12.

113. *Id.* at 11.

114. *Id.* at 13.

115. 457 U.S. 991 (1982) (due process does not require that the state adopt regulations prohibiting purely private conduct). *Blum* may be distinguished because the *Hickman* statute affirmatively shields private actors from liability for interference with a fundamental right, rather than involving mere legislative refusal to prohibit the private conduct. In *Blum*, the Court required that the state be responsible for "the specific conduct of which the plaintiff complains" for state action to exist. *Id.* at 1004. In *Blum* the specific conduct by the staff was based on their medical judgment, not the state regulations identifying conditions meriting the various levels of nursing care. *Id.* at 1008. *Blum* cannot be read as involving regulations designed to immunize defendants for their negligent medical judgements. In injury of birth cases, the specific conduct complained of is based on a health care provider's negligent or intentional medical judgement that interferes with reproductive decisionmaking, which may or may not be a result of the statute prohibiting such actions. Thus, these are not cases "in which the states have merely abstained from action, leaving private individuals free to impose such discriminations as they see fit." Shelley v. Kraemer, 334 U.S. 1, 19 (1948) (state action met by court grant of injunction enforcing racially restrictive covenants). *Cf.* Barrows v. Jackson, 346 U.S. 249, 254-56 (1953) (state action met by court grant of money damages to plaintiffs).

Further, the action of the state courts themselves in denying injury of birth suits may be state action. The *Shelly* court held that judicial enforcement of a racially restrictive covenant would constitute state action. "[B]ut for the active intervention of the state courts, supported by the full panopoly of state power, [the defendants] would have been free to occupy the properties in question. . . ." *Shelly*, 334 U.S. at 19. While the plaintiff in an injury of birth case could never retrieve the lost right even in the absence of judicial intervention, the state has prevented her from recouping damages which, in an abstract sense, equal that right. So as a court may not award money damages that effectively enforce racially restrictive covenants, neither should they refuse to award damages intended to make whole those whose rights have been infringed upon. *Cf. Barrows*, 346 U.S. at 255-56.

court found no infringement by the state that "directly touch[ed] on the expectant mother's right to choose an abortion."[116] This is because the obstacle placed in the path of the woman's ability to make an informed abortion decision is placed there by the doctor's negligence, not the state's prohibition of postconception injury of birth actions.[117] The relationship is strictly between the doctor and the patient. The statute does not forbid the doctor from informing the patient of prenatal tests or risks of pregnancy.[118]

Griswold v. Connecticut established that a person's decision to use contraceptives is constitutionally protected.[119] *Roe v. Wade* extended this protection to a woman's abortion decision.[120] These cases establish the fundamental legal right of persons to make decisions regarding childbearing. Since the state cannot infringe on such rights, it follows that the state cannot completely denigrate the right by denying protection provided to similar rights.[121] If fundamental rights are to be protected, the state must allow actions to be brought when there has been interference with such rights.[122] For the state to allow a person, through negligent conduct, to frustrate the realization of a married couple's desire to limit the size of their family or a woman's desire to choose abortion denigrates the right itself.[123] Thus, the removal of the deterrent effect of a lawsuit is state action.[124]

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116. *Hickman*, 396 N.W.2d at 13.

117. *Id.* at 17 (Simonett, J., concurring).

118. *Id.* at 13.

119. *See supra* notes 35-39 and accompanying text.

120. *See supra* notes 40-49 and accompanying text.

121. Troppi v. Scarf, 31 Mich. App. 240, 253-54, 187 N.W.2d 511, 517 (1971).

122. The primary reason for the almost universal acceptance of injury of birth actions since the early 1970's may be attributed to the decision in *Roe*. Several courts have noted *Roe*'s significance in this context. *See, e.g.*, Robak v. United States, 658 F.2d 471, 475-76 (7th Cir. 1981); Phillips v. United States, 508 F. Supp. 544, 550 (D.S.C. 1981); Berman v. Allan, 80 N.J. 421, 431-32, 404 A.2d 8, 13 (1979); Ziemba v. Sternberg, 45 A.D.2d 230, 232-33, 357 N.Y.S.2d 265, 269 (1973).

123. Justice Candena, dissenting from the majority decision in *Terrell*, stated:

> It is, therefore, impermissible to say that social policy requires that a husband and wife be denied the right to limit the number of children which they will bring into the world, or that a person shall be allowed, by his negligent conduct, to frustrate the realization of the married couple's aim to limit the size of their family.

Terrell v. Garcia, 496 S.W.2d 124, 128 (Tex. Civ. App. 1973), *cert. denied*, 415 U.S. 927 (1974).

124. Two surveys show that the threat of malpractice liability causes obstetricians and gynecologists to modify their behavior to reduce the risk of injuries to their patients. *See* Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939, 966-70 (1984) (citing PORTER, NOVELLI & ASSOC., PROFESSIONAL LIABILITY INSURANCE AND ITS EFFECTS: REPORT OF A SURVEY OF ACOG'S MEMBERSHIP (Aug. 31, 1983) [hereinafter ACOG SURVEY]; P.M. HARTNETT, AN ANALYSIS OF THE IMPACT OF WRONGFUL BIRTH AND WRONGFUL LIFE ON THE OBSTETRICIANS AND GYNECOLOGISTS IN NEW YORK (Jan.

The Minnesota statute also possesses characteristics forbidden by the equal protection clause.[125] Because only women can give birth, the statute discriminates against them precisely because they are women. The statute allows actions brought by men and women based on claims that negligent or intentional conduct caused them to conceive an unwanted child, while prohibiting only the claims of women that negligent conduct induced them to give birth, rather than have an abortion.[126] That such a classification was drawn by the Minnesota statute suffices for state action.[127]

2. *Violation of the Fourteenth Amendment*

Even though the plurality in *Hickman* found no state action, they went on to analyze the case for a possible violation of the fourteenth amendment.[128] Once a finding has been made that the state has interfered with the fundamental right protected by *Roe*, it must be determined whether or not a compelling state interest for interference exists.[129] Neither the interest in protecting the health of the woman, nor the interest in protecting the potential for human life is sufficient prior to the third trimester of pregnancy.[130] Thus, the statute

1984) [hereinafter HARTNETT SURVEY]). Over 70% of the physicians in both the ACOG SURVEY and the HARTNETT SURVEY indicated that they had increased the use of amniocentesis in women at risk due to the rising number of malpractice suits. *See* Bell, *supra* at 967. The use of amniocentesis and ultrasound was also substantially increased in all pregnancies. *Id.* at 968. The studies also pointed out less formal evidence of the deterrent effect of liability including: higher premiums; increased use of lab tests, X-rays and consultations; decreased amount of high risk obstetric care offered; refusal to practice obstetrics at all; relocation due to high premiums; and increased lobbying. *Id.* at 968-69. *See generally* Capron, *supra* note 107, at 666-71 (discussing increased use of defensive medicine in genetic counseling and its effect in health care).

125. *See* TRIBE, AMERICAN CONSTITUTIONAL LAW 1698-1700 (2d ed. 1988).

126. Men and children of both sexes who suffer pecuniary loss are also precluded from postconception negligence suits involving claims that but for a physician's negligence, a child would have been aborted. Neither the child nor, less obviously, the man has absolute veto power over a woman's decision to terminate her pregnancy. *See* Planned Parenthood v. Danforth, 428 U.S. 52, 67-72 (1976). Since their actions for pecuniary loss are uniquely dependent on the woman's fundamental right, men and children are not considered in the excluded class for equal protection analysis. *See supra* note 122 (*Roe* was a primary factor in allowing postconception injury of birth lawsuits); Geduldig v. Aiello, 417 U.S. 484 (1974) (although precluding women from disability benefits would also affect men's and children's pecuniary interests, they were excluded from the class for equal protection analysis).

127. *See Geduldig*, 417 U.S. 484 (1974) (state action was not even an issue in a challenge to a statute which treated pregnant women differently than other claimants under state disability program).

128. Thus, it might be argued that much of the *Hickman* plurality opinion should be treated as non-binding dicta, with the exception of the state action analysis.

129. *Hickman*, 396 N.W.2d at 19 (Amdahl, C.J., dissenting).

130. *Id.* at 19-20 (Amdahl, C.J., dissenting); *Roe*, 410 U.S. at 163-64.

should be found unconstitutional as it relates to negligence prior to the third trimester of pregnancy.[131]

The statute was also challenged as a violation of equal protection, because preconception injury of birth actions are allowed in Minnesota, while postconception injury of birth actions are prohibited. *Roe* makes it clear that the Supreme Court views abortion as a method of birth control.[132] A statute which allowed the *practice* of preconception methods of birth control (sterilization, contraception), but not postconception methods (abortion) should fail constitutional scrutiny under *Roe*. Wrongful birth statutes preclude *causes of action* on this very same basis. Only women who give birth due to postconception negligence that prevented them from terminating a pregnancy are barred from suit.

Middle level scrutinty has been applied to classifications made by government based on gender.[133] These classifications "must serve important government objectives and must be substantially related to achievement of those objectives."[134] Two Supreme Court cases, *Geduldig v. Aiello*[135] and *General Electric Co. v. Gilbert*,[136] involved disability programs that classified men and women in a fashion similar to the wrongful birth statutes. In *Geduldig*, a California statute excluded pregnancy from coverage under a state disability insurance program. The Supreme Court found that the program divided potential recipients of insurance benefits into two groups: "pregnant women and nonpregnant persons."[137] Admitting that the denied group was exclusively female, the Court reasoned that because both men and women benefitted equally when the condition of pregnancy was excluded,[138] the program did not violate equal protection. The *Geduldig* opinion has been met with criticism for not applying middle level scrutiny to a gender-based classification[139] in order to reach an

131. *Hickman*, 396 N.W.2d at 20 (Amdahl, C.J., dissenting).

132. *See Roe*, 410 U.S. at 162-64.

133. Craig v. Boren, 429 U.S. 190, 204 (1976). The Supreme Court first invalidated gender discrimination under the traditional "rational relationship" test. Reed v. Reed, 404 U.S. 71, 76 (1971). Shortly after *Reed*, the Court redefined the standard in gender discrimination cases as one of strict scrutiny. Frontiero v. Richardson, 411 U.S. 677, 691 (1973) (plurality opinion). The Court seems to have settled on middle level scrutiny since *Craig*. *See* Mississippi University for Women v. Hogan, 458 U.S. 718 (1982); Michael M. v. Superior Court, 450 U.S. 464 (1981).

134. *Craig*, 429 U.S. at 204.

135. 417 U.S. 484 (1974).

136. 429 U.S. 125 (1976).

137. *Geduldig*, 417 U.S. at 496-97 n.20.

138. Even this was not as clear as the Court made it appear. Men were allowed to receive benefits for other sex-specific kinds of disability such as prostectomy and circumcision. *Id.* at 501 (Brennan, J., dissenting).

139. "Did the Court mean to suggest that *anyone* who becomes pregnant, whether male or female, is equally ineligible?" TRIBE, AMERICAN CONSTITUTIONAL LAW 1071

arguably defensible result.[140] The *Geduldig* reasoning was followed, however, by the Court in *Gilbert* when a group of women challenged a similar private disability program under Title VII.[141] The *Gilbert* Court recognized that only women become pregnant, but because pregnancy is "often a voluntarily undertaken and desired condition" it differed significantly from the other disabilities covered.[142]

The pregnancies involved in postconception injury of birth claims are neither voluntary nor desired. These pregnancies continue only as a result of failed abortion procedures, misdiagnosed pregnancies, or negligence that induces the woman to carry a child with anomalies to term. Although wrongful birth statutes classify men and women similarly to the *Geduldig* and *Gilbert* disability programs, they do not involve the exclusion of women from benefits received from either the state or an employer. Rather, wrongful birth statutes exclude women from their common law right to redress in a tort action against a tortfeasor. Thus, even though the classifications are similiarly drawn, the criticism of *Geduldig*, the fact that *Gilbert* was effectively overruled by Congress,[143] and the important differences between wrongful birth statutes and disability programs compel a different result.

While the continuing validity of *Geduldig* is suspect,[144] the fact that

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n.5 (1978) (emphasis in original). Professor Tribe also noted the similarity of pregnancy classifications to burdens placed on women by government restrictions on abortion. *Id.* at 1071 n.6. *See also* LOCKHART, KAMISAR AND CHOPER, CONSTITUTIONAL LAW— CASES, COMMENTS, QUESTIONS 1410 n.a (5th ed. 1980) (suggesting that a disability program excluding only sickle cell anemia or a statute forbidding blacks from unaccredited law schools from becoming lawyers might also survive if the *Geduldig* reasoning was followed); Dowd, *Maternity Leave: Taking Sex Differences into Account*, 54 FORDHAM L.J. 699, 741 (1986) (tautological reasoning of *Geduldig* rests on Court's inability to conceptualize discrimination based on sex differences); Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 983-85 (1984) (listing "cottage industry" of *Geduldig* criticism, including over two dozen law review articles and suggesting that discrimination against pregnant women is as sex-based as creating obstacles to abortion).

140. California's disability program, which largely benefited workers who did not have insurance and were not covered by workers compensation, would certainly have been bankrupt under its original scheme if pregnancy was included as a disability. *See Geduldig*, 417 U.S. at 492-96. This is not to say that the program could not have been restructured to allow benefits to pregnant women. *Id.* at 504 (Brennan, J., dissenting).

141. 429 U.S. at 127-28.

142. *Id.* at 136.

143. Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k) (1978). *See* California Savings and Loan Assoc. v. Guerra, 107 S. Ct. 683, 692 (1987) (Congress intended PDA to end discrimination against pregnant women).

144. *See* City of Los Angeles, Dept. of Water and Power v. Manhart, 435 U.S. 702, 725 (1978) (Blackmun, J., concurring).

> [T]oday's decision cuts back on *General Electric* and inferentially on *Geduldig*, the reasoning of which was adopted there, and, indeed, makes the recogni-

it stands alone as equal protection analysis, and apart from the line of Title VII decisions,[145] makes it important in analyzing the wrongful birth statutes. Even without applying middle level scrutiny, *Geduldig* left open the possibility that a statute would violate equal protection if the "distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against members of one sex or the other."[146] The aim of the wrongful birth statutes is to discriminate against those causes of action that necessarily involve the claim that a child would have been aborted. Since that claim is inextricably linked to a woman's decision to terminate her pregnancy, the statutes discriminate against women.

The *Hickman* majority rejected the equal protection argument without considering *Geduldig*. The court suggested that precluding claims for preconception negligence would remedy the problem of unequal treatment.[147] The concurring opinion tried to distinguish wrongful birth from wrongful conception plaintiffs based on the in-

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tion of those cases as continuing precedent somewhat questionable. I do not say that this is necessarily bad. I feel, however, that we should meet the posture of the earlier cases head on and not by thin rationalization that seeks to distinguish but fails in its quest.

Id. *See also* Law, *supra* note 139, at 984 n.110 (*Geduldig* limited to questions of insurance by Turner v. Department of Employment Sec., 423 U.S. 44, 45 (1975)).

145. There was some question as to whether the *Geduldig* equal protection analysis, as followed in *Gilbert*, should apply to Title VII cases.

> The dissenters in *Gilbert* took issue with the majority's assumption 'that the Fourteenth Amendment standard of discrimination is coterminous with that applicable to Title VII.' As a matter of statutory interpretation, the dissenters rejected the Court's holding that the plan's exclusion of disabilities caused by pregnancy did not constitute discrimination based on sex . . . . [T]he appropriate classification was 'between persons who face a risk of pregnancy and those who do not.'
>
> When Congress amended Title VII in 1978, it unambiguously expressed its disapproval of both the holding and the reasoning of the Court in the *Gilbert* decision.

Newport News Shipbuilder and Dry Dock Co. v. EEOC, 462 U.S. 669, 677-78 (1983). Justice Rehnquist, who wrote the majority opinion in *Gilbert*, disagreed with the result and the reasoning of *Newport*. "For a different result to obtain, *Gilbert* would have to be judicially overruled by this Court or Congress would have to legislatively overrule our decision in its entirety by amending Title VII. Today the Court purports to find the latter by relying on the Pregnancy Discrimination Act. . . ." *Id.* at 686. (Rehnquist, J., dissenting).

146. 417 U.S. at 496-97 n.20.

147. *See Hickman*, 396 N.W.2d at 15.

> [I]f the plaintiff has the right to invoke equal protection, does it follow that, if a statute has three sections, two of which specifically deny a cause of action and the third merely codifies the existence of an earlier decision of this court made prior to the express will of the legislature, this court must hold the two sections invalid on the basis of section three? We think not. The legislative intent is clear and if any section of the statute is open to question, it would most likely be section three rather than the previous two sections.

Id.

terests sought to be compensated,[148] an analysis that breaks down both in negligent inducement of conception cases[149] and postconception negligence cases involving misdiagnosed pregnancies or failed abortion procedures.[150] The opinion of the court, like the Minnesota legislature, evidenced a reluctance to accept that a woman's choice to not have a child is the same whether made before or after conception.[151]

VI. Remaining Liability Under Section 145.424

The Minnesota statute precludes nearly all liability for postconception negligence. Postconception negligence will be actionable only in the rare situation where prenatal treatment of some kind was available. Negligent nondisclosure appears to offer little escape from the statute's prohibition. It should be noted, however, that the statutory language applies to a doctor's *negligent* conduct only; thus, a woman's postconception injury of birth action, and a child's, would not be precluded if a health care provider *intentionally* withheld information crucial to a reproductive decision. In addition, all claims for preconception negligence appear to be actionable.

A. Preconception Negligence

The statute does not preclude actions based on a failure of a contraceptive method or a sterilization procedure.[152] The *Hickman* court suggested, however, that the reasoning, and perhaps the decision, of *Sherlock v. Stillwater Clinic*[153] might be erroneous in light of

148. *Id.* at 17 (Simonett, J., concurring).

149. *See infra* notes 157-64 and accompanying text.

150. *See infra* notes 165-76 and accompanying text. For a different view of why wrongful birth statutes deny equal protection of the law, see Note, *supra* note 6, at 2027-034.

151. *Cf.* Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 776 (1986) (Stevens, J., concurring) (the decision on child-bearing is no less important the day after conception than the day before); Gallagher v. Duke Univ., 638 F. Supp. 979, 982-83 (M.D.N.C. 1986) (allowing action for preconception negligence that induced a couple to conceive a child even in a state which bars suits for postconception negligence).

152. Minn. Stat. § 145.424, subd. 3 (1986). Thus, actions for preconception negligence are still permissible under the statute. *Accord* Sherlock v. Stillwater Clinic, 260 N.W.2d 169 (Minn. 1977). The *Hickman* court noted that the legislature did not "create" a wrongful conception cause of action, but rather "simply recognized the existing common law under *Sherlock*." *Hickman*, 396 N.W.2d at 17 (Simonett, J., concurring). It might be argued, however, that the legislation creates a cause of action based on the failure of a contraceptive device, as no Minnesota case has addressed the issue. *See* Minn. Stat. § 145.424, subd. 3 (1986).

153. 260 N.W.2d 169 (Minn. 1977). The Minnesota Supreme Court has been cited for its well-reasoned approach to preconception negligence in the *Sherlock* case,

the legislative intent expressed in the wrongful birth statute.[154] The likelihood that *Sherlock* would be overruled is remote in light of the fact that a preconception negligence claim arises from negligence that induces *conception* and, thus, would not seem to interfere with the state's goal of favoring child birth over *abortion*.[155] Further, the statute itself codifies the common law under *Sherlock*.[156]

An action for negligent counseling is possible if the negligence occurred prior to conception. If, for example, a doctor negligently failed to diagnose an autosomal dominant carrier who later had a child born with a disorder, liability would be appropriate for the extraordinary medical expenses of the child. The preconception claim would be a hybrid of the wrongful birth and wrongful conception claims.

> In both cases, the plaintiff would not have had the child but for the negligence of the doctor, but the interests sought to be compensated are different. In [wrongful conception] there is the right not to conceive; in [wrongful birth] there is the right not to give birth. In [wrongful conception] it is the right not to have an unplanned child, while in [wrongful birth] it is the right not to have an unwanted child. In [wrongful conception] there is no hypothetical exercise of choice of treatment, while in [wrongful birth] there is.[157]

The parents' claim is that but for the physician's preconception neg-

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decided just ten years ago. *See* D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS § 55, at 372 n.54 (5th ed. 1984).

154. *Hickman*, 396 N.W.2d at 14 n.5, 15.

155. *See* MINN. STAT. § 256B.011 (1986). The statute, while referring specifically to abortion funding, is evidence of the state's policy regarding abortion:

> Between normal childbirth and abortion it is the policy of the state of Minnesota that *normal childbirth* is to be given preference, encouragement and support by law and by state action, it being in the best interests of the well being and common good of Minnesota citizens.

Id. (emphasis added); *see also* Brief for Intervenor State of Minnesota at 13-14, Hickman v. Group Health Plan, Inc., 396 N.W.2d 10 (Minn. 1986) (No. C2-95-2013). The birth of an affected infant is usually no different than the birth of a healthy child. *See supra* note 61.

One commentator believed that legislation overturning the *Sherlock* decision would be unconstitutional.

> Legislation immunizing physicians from civil liability for the consequences of their negligence in performing sterilizations appears to be as constitutionally objectionable as is legislation prohibiting the procedure altogether. Legislation that draws a distinction between the types of medical malpractice for which a remedy would be provided also may be unconstitutional as a denial of equal protection. The *Sherlock* court's suggestion that legislation could be drafted to immunize physicians from liability in the wrongful conception context therefore can be discounted because such legislation probably would be unconstitutional.

Comment, *Wrongful Conception*, 5 WM. MITCHELL L. REV. 464, 473 (1979).

156. *See* MINN. STAT. § 145.424, subd. 3 (1986).

157. *Hickman*, 396 N.W.2d at 17 (Simonett, J., concurring) (discussing the differences between wrongful birth and wrongful conception).

ligence, the child would not have been conceived, which fits the wrongful conception cause of action.[158] However, the claim also involves a planned, but unwanted child, which fits the wrongful birth model.[159] Finally, the claim would not involve an exercise of choice of treatment, unless the decision not to bear children is considered such a choice, again following the wrongful conception model.[160] There have been several cases that fit the hypothetical tort that have been decided as wrongful birth cases.[161]

If the parents' action for preconception negligence exists, it follows that the child's corresponding action may lie as well.[162] This

158. *Id.* at 11-12. Theoretically, it would be irrelevant whether or not the parents would have chosen to abort the child, as their claim rests on preconception negligence, rather than on postconception negligence. Further, the fact that the parents knew the child was affected in time to abort it could not be used to mitigate damages due to public policy favoring childbirth over abortion. *See supra* note 155 and accompanying text; *see also* Stills v. Gratton, 55 Cal. App. 3d 698, 708-09, 127 Cal. Rptr. 652, 658 (1976); Troppi v. Scarf, 31 Mich. App. 240, 259-60, 187 N.W.2d 511, 519 (1971).

159. There are also wrongful conception cases involving children with congenital defects. *See, e.g.*, cases cited *supra* note 53.

160. This would seem unlikely in that the plaintiffs in other preconception negligence cases make a similar "choice" not to bear children by their decision to be sterilized or use other birth control methods. The parents in the hypothetical preconception case were simply denied the opportunity to make an informed decision regarding conception.

161. *See, e.g.*, Gallagher v. Duke Univ., 638 F. Supp. 979 (M.D.N.C. 1986) (multiple genetic defects); Gildner v. Thomas Jefferson Univ. Hosp., 451 F. Supp. 692 (E.D. Pa. 1978) (Tay Sachs); Turpin v. Sortini, 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982) (hereditary hearing defect); Curlender v. Bio-Science Laboratories, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980) (Tay Sachs); Continental Casualty Co. v. Empire Casualty Co., 713 P.2d 384 (Colo. Ct. App. 1986) (erythroblastosis fetalis); Moores v. Lucas, 405 So. 2d 1022 (Fla. Dist. Ct. App. 1981) (Larsen's syndrome); Goldberg v. Ruskin, 128 Ill. App. 3d 1029, 471 N.E.2d 530 (1984) (Tay Sachs), *aff'd*, 113 Ill. 2d 482, 499 N.E.2d 406 (1986); Bruggeman v. Schimke, 239 Kan. 245, 718 P.2d 635 (multiple genetic defects); Schroeder v. Perkel, 87 N.J. 53, 432 A.2d 834 (1981) (cystic fibrosis); Park v. Chessin, 60 A.D.2d 80, 400 N.Y.S.2d 110 (N.Y. App. Div. 1977) (polycystic kidney disease), *modified*, Becker v. Schwartz, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); Rubin v. Hamot Medical Cent., 329 Pa. Super. 439, 478 A.2d 869 (1984) (neurofibromatosis); Nelson v. Krusen, 678 S.W.2d 918 (Tex. 1984) (neuromuscular disease); Naccash v. Burger, 223 Va. 406, 290 S.E.2d 825 (1982) (Tay Sachs); Harbeson v. Parke-Davis, Inc., 98 Wash. 2d 460, 656 P.2d 483 (1983) (fetal hydantoin syndrome). In these cases, the injury arose at the time of conception, because had the parents known of the consequences of pregnancy, they would not have conceived. The fact that the parents could have prevented birth at a later time had they known of the child's affliction is indistinguishable from the "no duty to mitigate" by abortion rule in a sterilization/contraceptive claim involving a healthy child. In effect, the parents' claim is for wrongful conception, though these courts refer to it as wrongful birth. Literally, the claim is for preconception negligence, "for it is at the point of conception that the injury claimed by the parents originates." *Sherlock*, 260 N.W.2d at 175.

162. The district court in *Hickman* denied the postconception negligence claim of

action would seek to recover damages not available in the parent's cause of action, such as the child's pain and suffering and loss of earnings.[163] Additionally, a cause of action may lie for the child to sue its parents for negligently conceiving. It is ironic that such a claim remains possible after legislation has been passed that was at least in part a response to fears that dicta from *Curlender v. Bio-Science Laboratories*[164] would lead to more abortions as a result of parents fearing suit from their offspring.

B. Postconception Negligence

Minnesota's wrongful birth statute might be read to preclude postconception negligence actions involving failed abortion procedures[165] or misdiagnosed pregnancies.[166] In the first situation, a

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Jessica Hickman, upholding MINN. STAT. § 145.424, subd. 1 (1986) as constitutional. The constitutionality of that section was not challenged on appeal. *See Hickman*, 396 N.W.2d at 12 n.2. Because preconception negligence would involve a claim that *but for the negligence of the health care provider the plaintiff child would not have been conceived*, the action is not barred by the Minnesota statute. The statute only precludes claims that "*but for the negligent conduct of another the person would have been aborted.*" MINN. STAT. § 145.424, subd. 1 (1986) (emphasis added). It is the position of this Note that the Minnesota Legislature or appellate courts will not soon recognize a child's cause of action for negligence that induced its parents to conceive. The indifference of the statute toward children's preconception claims, however, again reveals its goal of preventing claims based on negligently interfered with abortions. This inconsistency, as well as the inconsistency of allowing claims for negligence involving sterilization or contraceptives, but precluding those for negligence involving the diagnosis of pregnancies or the performance of abortions, illuminates the anti-abortion character of the statute and its real purpose of discouraging the abortion decision.

163. The Minnesota Supreme Court may find sufficient reason to dismiss such a cause of action by the fact that only four jurisdictions have recognized children's injury of birth actions. *See infra* note 218 and accompanying text. It is the position of this Note that a child's injury of birth claim should be recognized. Other commentators have also taken this position. *See, e.g.*, Capron, *Informed Decisionmaking in Genetic Counseling: A Dissent to the 'Wrongful Life' Debate*, 48 IND. L.J. 581, 603-04 (1973); Capron, *supra* note 107, at 647-60; Rogers, *Wrongful Life and Wrongful Birth: Medical Malpractice in Genetic Counseling and Prenatal Testing*, 33 S.C. L. REV. 713, 756-57 (1982); Note, *supra* note 6, at 2034; Note, *supra* note 2, at 1500-02; Note, *supra* note 107, at 848-49; Note, *A Cause of Action for 'Wrongful Life'*, 55 MINN. L. REV. 58, 80-81 (1970); Comment, *supra* note 107, at 91-97.

164. 106 Cal. App. 3d 811, 829, 165 Cal. Rptr. 477, 488 (1980). The *Curlender* dicta was quickly and effectively mooted by the California Legislature. *See supra* note 107. The Minnesota Legislature, concerned that such an action could exist, did not eliminate it entirely.

165. Postconception injury of birth actions have been brought as the result of failed abortion procedures. *See, e.g.*, Stills v. Gratton, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976); Ladies Cent. of Clearwater, Inc. v. Reno, 341 So. 2d 543 (Fla. Dist. Ct. App. 1977); Wilczynski v. Goodman, 73 Ill. App. 3d 51, 391 N.E.2d 479 (1979); Nanke v. Napier, 346 N.W.2d 520 (Iowa 1984); Jean-Charles v. Planned Parenthood Ass'n of Mohawk Valley, Inc., 99 A.D.2d 542, 471 N.Y.S.2d 622 (N.Y. App. Div. 1984); Mears v. Alhadeff, 88 A.D.2d 827, 451 N.Y.S.2d 133 (N.Y. App. Div. 1982);

woman who makes a choice to terminate her pregnancy goes to a doctor willing to perform an abortion. The doctor performs the abortion procedure negligently, and the woman gives birth to an unwanted child.[167] The second situation involves a doctor who negligently misdiagnoses a pregnancy that prevents the woman from seeking an abortion within the lawful time period. The plain language of subdivision 2 precludes a cause of action or damages on the claim that but for the negligent conduct of another, a child would have been aborted.[168]

In the past, these types of actions may have been governed by the *Sherlock* decision, which clearly allows recovery of the costs of rearing

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Speck v. Finegold, 268 Pa. Super. 342, 408 A.2d 496 (1979); Miller v. Johnson, 231 Va. 177, 343 S.E.2d 301 (1986).

166. For examples of postconception injury of birth actions involving misdiagnosed pregnancies, see, e.g., Clapham v. Yanga, 102 Mich. App. 47, 300 N.W.2d 727 (1980); Comras v. Lewin, 183 N.J. Super. 42, 443 A.2d 229 (N.J. Super. Ct. App. Div. 1982); Ziemba v. Sternberg, 45 A.D.2d 230, 357 N.Y.S.2d 265 (N.Y. App. Div. 1974); Rieck v. Medical Protective Co., 64 Wis. 2d 514, 219 N.W.2d 242 (1974). Part of the reason for the acceptance of such actions is that the risk to the woman from an abortion increases as her pregnancy continues. *See* Roe v. Wade, 410 U.S. 113, 149-50 (1973).

167. In Minnesota, the victim of medical malpractice is not required to mitigate damages by seeking a second treatment to remedy the first doctor's negligence. *See* Martineau v. Nelson, 311 Minn. 92, 102-03, 247 N.W.2d 409, 415-16 (1976). Similarly, the Minnesota wrongful birth statute provides that "the failure or refusal of any person to . . . have an abortion shall not be a defense in any action." MINN. STAT. § 145.424, subd. 3 (1986). Thus, even if the woman, after an abortion was negligently performed, decided she wanted the unexpected child during a time when a legal abortion was still possible, she could still state a claim for postconception negligence damages in the absence of a wrongful birth statute.

168. MINN. STAT. § 145.424, subd. 2 (1986). Because of the preclusion of a cause of action, it is possible that even recovery of damages for the pain and suffering associated with the unwanted childbirth, costs of hospitalization, loss of earnings and loss of consortium would be precluded in these actions. Abortion is not considered a contraception method, since it does not prevent fertilization of the ovum. Thus, the language of subdivision 3, which saves a cause of action "arising in tort based on the failure of a contraceptive method" would not allow these types of actions. *Id.* § 145.424, subd. 3. Abortion, while not acceptable as a method of routine birth control, should be considered a birth control method because it is the last alternative when other birth control methods fail. *See* Holt, *supra* note 29, at 759 n.1. Minnesota courts are put in the awkward position of allowing actions resulting from the failure of some forms of birth control (i.e., failed sterilization procedures and contraception methods), but not others (failed abortion procedures and misdiagnosis preventing abortions). This inconsistency may reflect outdated beliefs of the Minnesota Legislature. *But see supra* note 106 (testimony of Representative O'Connor that bill would not preclude these actions).

A better approach in these situations would be to allow damages for the pain and suffering associated with the unwanted pregnancy, loss of earnings, hospital costs and loss of consortium, while denying damages for the costs of rearing the unwanted, but healthy child to the age of majority. The best approach would be to allow all damages reasonably flowing from the defendant's tortious act, as in *Sherlock*.

a child born due to negligence involving a birth control method. These claims and the cost of rearing damages could not be precluded without facing strong constitutional challenges.[169] Thus, the distinction between negligence in failing to suggest an abortion and negligence in performing an abortion or failing to diagnose a pregnancy in time for the patient to obtain a legal abortion remains important in Minnesota.

Postconception negligent counseling and diagnosis is unactionable under the statute if the counseling and diagnosis could only prevent the damage by allowing the parents to choose abortion.[170] The

169. A constitutional challenge to the preclusion of actions involving misdiagnosed pregnancies or negligently performed abortions may provide a stronger argument than the *Hickman* wrongful birth challenge. The language of the statute precludes such claims as "wrongful birth" causes of action because they necessarily involve the assertion that a child would have been aborted. These are not "wrongful birth" claims, according to popular definition. *See supra* notes 53-56 and accompanying text. The Minnesota Supreme Court calls failed sterilization actions "wrongful conception" actions, but has yet to hear a case involving a misdiagnosed pregnancy or failed abortion procedure.

Assuming that the state action requirement could be met, the possibility of the statute surviving an equal protection challenge on this basis is doubtful. The concurrence in *Hickman* found, in effect, that failed sterilization plaintiffs and plaintiffs who were induced to carry an affected child to term were not similarly situated, given the differences between the interests served by the two actions. *See Hickman*, 396 N.W.2d at 15-18. The statute shows its discriminatory effect more clearly when preconception negligence claims involving failed sterilization procedures or the failure of certain contraceptive methods are compared with postconception negligence claims involving negligent abortions or misdiagnosed pregnancies. The interests sought to be compensated by the claims are identical: to compensate the mother of an unwanted child born due to a health care provider's negligence. The Minnesota statute favors women and men whose claims are based on the failure of preconception birth control methods over women who give birth to children as the result of misdiagnosed pregnancies or failed abortions (postconception birth control).

170. The claim would be that the physician's negligence induced the woman to carry an affected child to term, rather than seeking an abortion. These postconception claims usually arise when a woman has an illness or is of advanced age. For example, a woman who contracts german measles (rubella) in the first three months of pregnancy risks bearing a child with defects. *See* THE MOSBY MEDICAL ENCYCLOPEDIA 650 (1985). In addition to the birth defects, the child may carry the virus for up to 30 months after birth. *See id.*; *see also supra* note 2 (discussion of rubella-related syndrome). Advanced maternal age may lead to birth defects, the most prevalent being Down's Syndrome. Down's Syndrome occurs in approximately 1 in 600 live births. *See* THE MOSBY MEDICAL ENCYCLOPEDIA 237. The incidence may be as high as 1 in 80 for women over 40. *See id.* For a discussion of Down's Syndrome defects, see *supra* note 2.

Many courts have heard postconception injury of birth claims based on negligent diagnosis and counseling which prevented a woman from terminating the pregnancy of an affected fetus. For examples of these cases, see, e.g., Scales v. United States, 685 F.2d 970 (5th Cir. 1982) (rubella-related syndrome); Robak v. United States, 658 F.2d 472 (7th Cir. 1981) (rubella-related syndrome); Phillips v. United States, 508 F. Supp. 544 (D.S.C. 1981) (Down's Syndrome); Andalon v. Superior Court (Plowman),

statute, however, leaves open the possibility of a cause of action that:

> but for the negligent conduct of another, tests or treatment would have been provided or would have been provided properly which would have made possible the prevention, cure, or amelioration of any disease, defect, deficiency, or handicap; provided, however, that abortion shall not have been deemed to prevent, cure, or ameliorate any disease, defect, deficiency, or handicap.[171]

Unfortunately, the only "treatment" for many of the afflictions post-conception negligence actions seek to compensate is abortion.[172] There are very few conditions that medicine can prevent, cure, or ameliorate prenatally.[173] Thus, at least for the present, the statute offers a very small concession in return for the outright preclusion of postconception injury of birth actions.

Assuming that a condition existed that could be treated prenatally, would the failure of a health care provider to suggest amniocentesis in appropriate circumstances result in liability? If the failure to sug-

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162 Cal. App. 3d 600, 208 Cal. Rptr. 899 (1984) (Down's Syndrome); Haymon v. Wilkerson, 535 A.2d 880 (D.C. 1987) (Down's Syndrome); DiNatale v. Lieberman, 409 So. 2d 512 (Fla. Dist. Ct. App. 1982); Blake v. Cruz, 108 Idaho 253, 698 P.2d 315 (1985) (rubella-related syndrome); Siemieniec v. Lutheran Gen. Hosp., 117 Ill. 2d 230, 512 N.E.2d 691 (1987) (hemophilia); Proffitt v. Bartolo, 162 Mich. App. 35, 412 N.W.2d 232 (Mich. Ct. App. 1987) (rubella-related syndrome); Smith v. Cote, 128 N.H. 231, 513 A.2d 341 (1986) (rubella-related syndrome); Procanik v. Cillo, 97 N.J. 339, 478 A.2d 755 (1984) (rubella-related syndrome); Berman v. Allen, 80 N.J. 421, 404 A.2d 8 (1979) (Down's Syndrome); Bani-Esraili v. Lerman, 69 N.Y.2d 807, 505 N.E.2d 947, 513 N.Y.S.2d 807 (1987) (Thalassemia major); Alquijay v. St. Luke's-Roosevelt Hosp. Cent., 63 N.Y.2d 978, 473 N.E.2d 244, 483 N.Y.S.2d 994 (1984) (Down's Syndrome); Jacobs v. Theimer, 519 S.W.2d 846 (Tex. 1975) (rubella-related syndrome); James G. v. Caserta, 332 S.E.2d 872 (W. Va. 1985) (Down's Syndrome); Dumer v. St. Michael's Hosp., 69 Wis. 2d 766, 233 N.W.2d 372 (1975) (rubella-related syndrome).

171. MINN. STAT. § 145.424, subd. 3 (1986).

172. *See* Note, *supra* note 2, at 1497.

173. Scientific and technological advances may change this result. *See Phillips*, 508 F. Supp. at 543. The *Phillips* court hypothesized of:

> a technological breakthrough in genetic engineering, focusing perhaps on the transduction or transformation of chromosomal material through recombinant DNA ("gene-splicing") techniques, controlled mutagenesis, or microsurgery, or in euphrenics, which would allow a particular genetic defect to be treated *in utero* during the early stages of pregnancy.

Id. at 543 n.12 (citing M. STRICKBERGER, GENETICS 822 (1968); Diamond v. Chakrabarty, 447 U.S. 303 (1980)). The *Phillips* court felt these advances would cause a child's action for postconception negligence to be viewed more like torts *en ventre sa mere*, thus making them more like the DES cases involving drug-induced carcinoma. *Phillips*, 508 F. Supp. at 543-44 n.12. One situation where the failure to diagnose a woman's condition prenatally may prevent treatment *in utero* involves a pregnant woman who, as a child, had PKU. "The mother can prevent harm to her baby by returning to the admittedly unpleasant diet that prevented her from being retarded." Robertson & Shulman, *supra* note 11, at 23-33. The diet is expensive and offensive to the taste and smell. *See* Note, *supra* note 2, at 1496-97 n.35.

gest prenatal diagnosis prevented the parents from pursuing fetal treatment, an action would appear to lie for the parents and the child.[174] This result might lead the court to accept the value of a chance doctrine,[175] with recovery based on the percentage chance of the foregone treatment being successful.[176]

C. *Informed Consent*

> To say that the Doctors had a duty to disclose something more would, in effect, require them to inform the [patient] that their diagnosis might be incorrect. There is no logical stopping point to such a requirement. Such a rule could conceivably force physicians to inform patients of all risks associated with all conditions that were not diagnosed. To require physicians to list such a parade of horribles under those circumstances is not countenanced under either law or policy.[177]

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174. Since the claim would not involve abortion, it might best lie in the child for pain and suffering, loss of earnings and extraordinary medical expenses. *But see* Andalon v. Superior Court, 162 Cal. App. 3d 600, 208 Cal. Rptr. 899 (1984) (no damages for loss of earnings in wrongful life action). However, since the parents are required to raise the child to the age of majority, they might also have a claim for extraordinary medical expenses.

175. The value of a chance doctrine is derived from section 323 of the RESTATEMENT (SECOND) OF TORTS which provides:

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking, if
>
> (a) his failure to exercise such care increases the risk of such harm. . . .

RESTATEMENT (SECOND) OF TORTS § 323 (1965).

The value of a chance doctrine has been accepted in the majority of jurisdictions that have considered the issue. *See* Bradt & Guthmann, *Recovery for the Value of a Chance in Medical Negligence Cases: Bringing Minnesota's Standard of Causation Up to Date*, 12 WM. MITCHELL L. REV. 459, 494-504 (1986). The value of a chance doctrine has been mentioned, but not followed, in the Minnesota appellate courts. *See* Cornfeldt v. Tongen, 295 N.W.2d 638, 641 n.4 (Minn. 1980); Kalsbeck v. Westview Clinic, 375 N.W.2d 861, 870 (Minn. Ct. App. 1985).

176. Thus, a court could permit recovery in a medical negligence case even where the plaintiff had less than a 50% chance of recovery. *See, e.g.*, Jeanes v. Milner, 428 F.2d 598 (8th Cir. 1970). In *Jeanes*, a young boy died of throat cancer after his condition was misdiagnosed. Expert testimony established that the boy would have had a 35% chance of recovery had the condition been properly diagnosed. Because of the delay in treatment, his chance of recovery fell to 24%. The case was remanded for the jury to determine whether the delayed diagnosis was the proximate cause of the boy's death, thus avoiding the "more probable than not" standard. *See id.* at 606.

177. Pratt v. University of Minn. Affiliated Hosp. and Clinics, 414 N.W.2d 399, 402 (Minn. 1987). In a thinly veiled attempt to avoid the prohibition against wrongful birth actions in Minnesota, the Pratts' attorney brought their action in negligent nondisclosure (informed consent). Although treatment should be defined broadly for the purposes of the doctrine, the Minnesota Supreme Court held that "mere diag-

In *Pratt v. University of Minnesota Affiliated Hospitals and Clinics*,[178] a couple gave birth to a second child with birth defects after genetic counselors were unable to determine the specific cause of their previous child's defects.[179] While the counselors could not rule out autosomal recessive causes for the first child's defects, they told the Pratts it was most likely a " 'sporadic event without genetic implications.' "[180] The Minnesota Supreme Court found that the doctrine of negligent nondisclosure did not apply to this case involving preconception genetic diagnosis.[181]

Since the doctrine of negligent nondisclosure has roots in the battery cause of action,[182] liability without some kind of "treatment" has generally been thought to be inappropriate.[183] The *Pratt* court believed that "treatment" should be given a broad definition.[184]

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nosis, *without more*, does not give rise to a duty to disclose risks concerning conditions not diagnosed." *Id.* (emphasis added).

178. 414 N.W.2d 399 (Minn. 1987).

179. *Id.* at 400.

180. *Id.* The record was unclear as to whether both boys suffered from the same disorder, although both disorders were genetically related. *Id.* at 401 n.1.

181. While the Minnesota Supreme Court stated the issue as "whether the doctrine of negligent nondisclosure . . . applies to cases involving genetic diagnosis," *id.* at 401, the holding does not appear to totally foreclose the possibility of such an action. *See infra* notes 191-97 and accompanying text.

182. The battery doctrine protects the patient against unconsented touchings. *See, e.g.*, Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905). In *Mohr*, the patient consented to surgery on her right ear. In surgery, the physician operated on the patient's left ear. *Id.* at 265, 104 N.W. at 13. The patient sued on a battery action, claiming that the physician touched her left ear without her consent. *Id.*

Negligent nondisclosure protects the patient against touchings where consent to treatment was given without knowledge of some risk. *See, e.g.*, Kohoutek v. Hafner, 383 N.W.2d 295 (Minn. 1986); Reinhardt v. Colton, 337 N.W.2d 88 (Minn. 1983); Plutshack v. University of Minn. Hosps., 316 N.W.2d 1 (Minn. 1982); Cornfeldt v. Tongen, 295 N.W.2d 638 (Minn. 1980). The battery action was not concerned with how informed the consent was about risks or alternative treatments, but only with whether there was consent at all. *See generally*, Note, *Consent to Medical Treatment: Informed or Misinformed*, 12 WM. MITCHELL L. REV. 541 (1986).

183. *But see Pratt*, 414 N.W.2d at 402 (the court believed "there may be some non-treatment situations where the doctrine could be applicable").

184. *Id.* Apparently "treatment" can include diagnosis in some situations. In genetic counseling situations, reasonable prudence may dictate a higher standard of care where testing is inconclusive and the risk of having an affected child is high due to the woman's condition, age or the birth of prior affected children. *Cf.* Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974) (en banc) (standard of care held to be higher than normal despite low risk of presence of eye disease). For example, it has been held that the failure to inform a patient of further diagnostic procedures that could be undertaken to determine the significance of an abnormality or shed light on previous inconclusive diagnostic procedures results in liability under the doctrine of informed consent. *See* Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919, 924 (1979). In genetic counseling cases, the further diagnostic procedures would include informing the patient of ultrasound and amniocentesis testing. Whether the failure to suggest further or additional diagnostic procedures would invoke the doctrine of

Treatment does not have to involve a touching in the traditional medical sense, i.e., by a surgical procedure or ingestion of drugs, but must be something more than "mere diagnosis" for the doctrine of negligent nondisclosure to apply.[185] If recovery in preconception diagnosis situations is allowed, the counselor has to inform the patient of the risks of an incorrect diagnosis without knowledge of the incorrect diagnosis.[186]

Negligent nondisclosure involves failure to disclose a risk of treatment that the patient should have been informed of prior to giving consent to treatment.[187] Negligent nondisclosure applies when the

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negligent nondisclosure has not been decided by the Minnesota Supreme Court. *But see* Kalsbeck v. Westview Clinic, P.A., 375 N.W.2d 861, 869 (Minn. Ct. App. 1985) (negligent nondisclosure does not apply to decisions concerning additional, rather than alternative treatment).

The effect of the two Washington cases has been closely followed by health care providers and attorneys. *See* Bell, *supra* note 124, at 970; Wiley, *The Impact of Judicial Decisions on Professional Conduct: An Empirical Study*, 55 S. CAL. L. REV. 345, 384 nn.132-33 (1981) (list of legal and medical articles on these decisions). A survey conducted following the decision in *Helling* indicated that a substantial number of opthalmologists had not changed their testing procedures for glaucoma for those under the age of 40 due to the decision. *See* Bell, *supra* note 124, at 970; Wiley, *supra* at 384. While the *Helling* court did not articulate any policy reason for imposing a higher standard, economic efficiency, strict liability and equal protection were cited by the survey takers. *See* Wiley, *supra* at 385-87.

185. Thus, the *Pratt* court believed the rule in Karlsons v. Guerinot, 57 A.D.2d 73, 394 N.Y.S.2d 933 (N.Y. App. Div. 1977), went too far by requiring "affirmative treatment" which was a violation of the woman's "physical integrity." *See id.* at 82, 394 N.Y.S.2d at 939. The *Pratt* court refused to draw any bright boundaries. Instead it merely postulated that there may be non-treatment cases where the doctrine could be applicable. *Pratt*, 414 N.W.2d at 402. The court cited with approval reasoning from *Gates*

> The patient's right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed. Important decisions must frequently be made in many non-treatment situations in which medical care is given, including procedures leading to a diagnosis, as in this case.

92 Wash. 2d at 250-51, 595 P.2d at 922-23. The court found *Gates* distinguishable from *Pratt*, however, because in *Pratt* the doctors used all available tests and information to reach their diagnosis and then proceeded in a manner consistent with the diagnosis. *Pratt*, 414 N.W.2d at 402. It is unclear whether the failure to suggest amniocentesis if indicated in a case with facts similar to *Hickman*, where the mother claimed the physician failed to suggest amniocentesis as indicated by her advanced maternal age, would invoke the *Gates* reasoning.

186. *Pratt*, 414 N.W.2d at 402. But in high risk situations, health care providers may be put on notice by a red flag of warning raised by some abnormality or even inconclusive diagnostic procedures.

187. In Minnesota, the doctrine was first enunciated in Cornfeldt v. Tongen, 262 N.W.2d 684 (Minn. 1977):

> [A]n action for *negligent nondisclosure* will lie if the patient was not properly informed of a risk inhering in the treatment, the undisclosed risk materialized in harm, and consent to the treatment would not have been secured if the risk were disclosed.

patient must choose between the recommended treatment and no treatment at all, or when the patient must choose between two or more medically accepted alternative treatments.[188] In preconception genetic counseling, the counselor does not purport to make decisions, but only to help an individual to make the best decision for him or herself through non-directive counseling.[189] Holding a genetic counselor liable for lack of informed consent in a situation similar to *Pratt* would stretch the doctrine beyond any rational limits.[190]

The *Pratt* court implied that informed consent might be applicable

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Id. at 699 (emphasis in original). The rationale behind the doctrine is that disclosure to the patient is necessary to provide free choice in treatment. *Id.*

188. *Pratt*, 414 N.W.2d at 401 (citing Kalsbeck v. Westview Clinic, 375 N.W.2d 861, 869 (Minn. Ct. App. 1985)).

189. A good example of directive treatment is the phrase "doctor's orders." With directive treatment, the doctor tells the patient what to do; with nondirective treatment, the doctor suggests alternatives from which the patient may choose. A debate over whether genetic counseling should be directive or nondirective has arisen in recent years. *See* A. Capron, *Genetic Counseling: Facts, Values and Norms*, 15 BIRTH DEFECTS 169, 169-201 (1979) (a collection of essays on paradigmatic models for genetic counselors to follow). In the case of Huntington's Chorea, for example, it is argued that counselors should strongly advise carriers of the gene not to reproduce, since inheritance from the parent, rather than new mutations, accounts for 95% of the cases and the symptoms (i.e., progressive, fatal neurological deterioration) do not manifest themselves until after the childbearing years. *See* Perry, *Some Ethical Problems in Huntington's Chorea*, 125 CAN. MED. ASSOC. J. 1098 (1981); *see also* Evers-Kiebooms, *Decision Making in Huntington's Disease and Cystic Fibrosis*, 23 BIRTH DEFECTS 115, 115-18 (1987).

190. It has been suggested that genetic counselors could be held liable for erroneous advice given prior to conception under the informed consent doctrine. *See* Capron, *supra* note 107, at 626-30. Such a suggestion confuses negligence with informed consent.

> [T]he adequacy of genetic counseling methods could be measured under the doctrine of informed consent. Although no further physical treatment of a counselee may occur after the genetic diagnosis is conveyed, the basic aim of the informed consent cases — to render the patient an informed decisionmaker able to participate in his or her own care — is nonetheless applicable to the counseling context.

Id. at 629. What this approach fails to recognize is that if the counselor's duty is to make a reasonable diagnosis and give it to the parents, breach of that duty is negligence and nothing more. The confusion stems, at least in part, from the use of the terms "informed decisionmaker" in the counseling context. *See* Note, *supra* 2, at 1506-07 n.77.

> Although doctors in the context of both informed consent and genetic counseling are not to make the ultimate choice among various courses of action, they possess information that deciders often cannot otherwise easily obtain. Indeed, it is usually only through physician disclosure that prospective parents will be given the opportunity to avert the birth of children with genetic defects. Thus doctors should be required to inform prospective parents of all the genetic risks and reproductive options that a reasonable person would want to know in deciding whether to procreate.

Id. at 1507-08. Part of the reason the authors advocate such a standard is out of fear that some health care providers would intentionally fail to disclose information which would lead to abortion. *See* Capron, *supra* note 107, at 626-30. Because that rationale

to some situations involving additional, rather than alternative treatment.[191] The court quoted *Gates v. Jensen*,[192] which allowed an informed consent suit based on a failure to inform a patient of additional tests for glaucoma. In the genetic counseling arena, liability might arise from failure to inform a woman of additional tests, such as amniocentesis or ultrasound, that could determine after conception if her child suffered from genetic or congenital anomalies.[193] Where the failure to obtain such tests would involve risks that the physician should be aware of and that a reasonable patient would consider significant in making a procreative decision, the physician should be liable if a reasonable person who knew the risk would have undergone the additional tests and avoided the injury of the resulting birth of an affected child.[194]

While the use of informed consent may be inappropriate in preconception counseling cases, the doctrine should apply to protect postconception reproductive decisionmaking. A postconception informed consent claim would be brought by a pregnant woman who

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is inapplicable to preconception cases, it supports the notion that informed consent, as a basis for liability, applies in postconception cases only.

Instead, when the very nature of the "treatment" is to disclose risks material to the couple's decision to have a future pregnancy, the failure to disclose such risks would give rise to a cause of action in negligence or possibly deceit. Application of the informed consent doctrine would require the preconception counselor to disclose the risks material to the couple's decision to seek counseling or diagnosis ("treatment") not their decision to have future pregnancies. Thus, counselors would have to disclose that their diagnosis could be wrong. *Pratt*, 414 N.W.2d at 402. Professor Capron has recognized this concept:

> The doctrine of "informed consent," is a hybrid; its parentage includes both battery and negligence actions. In analyzing genetic counseling, negligence provides the most relevant precedent because the issue is the failure to convey the diagnosis rather than the lack of permission for any "touchings" involved in making the diagnosis.

Capron, *supra* note 163, at 588 n.23.

191. *See Pratt*, 414 N.W.2d at 402.

192. 92 Wash. 2d 246, 595 P.2d 919 (1979).

193. *See supra* notes 16-22 and accompanying text.

194. *Cf.* Madsen v. Park Nicollet Medical Cent., 419 N.W.2d 511 (Minn. Ct. App. 1988). The preclusion of injury of birth claims and the informed consent doctrine's limited expert testimony requirement have spawned other suits using the doctrine in this area of law. *See* Public Health Trust of Dade Co. v. Valcin, 507 So. 2d 596 (Fla. 1987) (ruptured tubal pregnancy after tubal ligation); Phillips v. Hull, 516 So. 2d 488 (Miss. 1987) (birth after tubal ligation); Iafelice v. Zarafu, 221 N.J. Super. 278, 534 A.2d 417 (N.J. Super. Ct. App. Div. 1987) (physicians who successfully performed operation to save child with severe brain damage not liable under informed consent to parents who alleged they would have allowed child to die if informed of child's poor prospects of regaining intellectual and neurological functioning); Duffey v. Fear, 121 A.D.2d 928, 505 N.Y.S.2d 136 (N.Y. App. Div. 1986) (failure to remove IUD from pregnant woman); Spencer v. Seikel, 742 P.2d 1126 (Okla. 1987) (no duty to inform woman with affected 24 month old fetus that 3rd trimester abortion permissible in other states).

was prevented from making an informed decision on whether to abort her fetus because she was not informed of the availability of prenatal diagnosis techniques or of the risks of her pregnancy. The treatment is prenatal care, and because the woman is actually pregnant it can be argued that the treatment is directive.[195] While the court in *Hickman* suggested that the woman "assumes certain well-known risks in childbearing,"[196] this suggestion should not relieve health care providers from the responsibility of informing women of these risks or of informing women of sophisticated diagnostic techniques that, although known by many, may not be known or understood by some. Since a pregnant woman has a fundamental right to make an abortion decision with advice from her physician, a pregnant woman who is prevented from making that decision because information has been withheld from her should have a cause of action under the doctrine of informed consent.[197]

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195. Since the woman becomes a patient of the physician with a condition, i.e. pregnancy, it can be argued that the health care provider's advice regarding prenatal care would be directive. For example, the health care provider might advise the woman on nutrition, exercise and the hazards of drinking and smoking. This advice is directive. Similarly, if the health care provider advises the woman that her baby will be born healthy, or remains silent on prenatal diagnosis, it should be interpreted as directive counseling. Prenatal counseling and diagnosis may have a profound effect on the decisionmaking of couples at risk. *See supra* notes 16-22 and accompanying text. Because of the severe implications of the birth of an affected child, postconception counseling of couples at risk that does not include information about the risks of pregnancy and availability of prenatal diagnosis and eugenic abortion should result in liability under the informed consent doctrine.

196. *Hickman*, 396 N.W.2d at 14. Justice Yetka added, "[m]ost adults are fully aware of the risks of childbearing when the mother is over 30 years old." *Id.*

197. Many states have used "informed consent" provisions in abortion statutes to discourage the decision to abort. *See supra* notes 40-49 and accompanying text. The Supreme Court in *Bolton*, *Akron* and *Thornburgh* made it clear that provisions that discourage abortion, rather than informing, advance no legitimate state interest. The existence of these provisions suggests that the doctrine of informed consent is applicable to postconception treatment situations. Thus, a woman at risk should be informed of all information relevant to her choice of prenatal care, including the risks involved in her pregnancy and the options of prenatal diagnosis and eugenic abortion. Since the claim is based on a violation of the woman's autonomous decisionmaking, rather than a health care provider's negligence as in *Hickman*, the plurality opinion of *Hickman* may be seriously challenged when faced with a postconception informed consent case. A postconception informed consent claim consists of the following four elements: (1) the pregnant woman was not properly informed of the risk that her unborn child could suffer from genetic or congenital anomalies; (2) the risk could have been reduced or eliminated by prenatal diagnosis and, if indicated, eugenic abortion; (3) her child was born with genetic or congenital anomalies; and (4) her consent to prenatal care without prenatal diagnosis would not have been secured had the risk been disclosed. *See Cornfeldt*, 262 N.W.2d at 684. Although there are subtle differences between the postconception informed consent claim and the postconception negligence claim precluded by Minnesota's statute, the damages

D. *Duty to Refer to a Specialist*

One of the most disturbing aspects of the Minnesota wrongful birth statute is that it frustrates the duty of health care personnel to refer to a genetic specialist when such a referral is required.[198] There are a variety of less specialized health care providers who practice genetic counseling in one form or another.[199] Many general practitioners, obstetricians and nurses provide some genetic counseling, even when not responding to a specific inquiry.[200] Under the statute, these less specialized practitioners cannot be held liable for even clearly negligent counseling if correct counseling would only have lead to the parents' decision to abort the fetus. Such insulation of less-skilled health care providers can not be countenanced under law or public policy.

E. *Intentional Withholding of Information*

Minnesota's statute does not shield health care providers from liability for intentionally withholding information that would affect the decision to abort.[201] The language only applies to negligence situa-

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sought are identical, and thus the informed consent claim may be precluded by the statute.

198. In Minnesota, if a person involved in the delivery of medical services knows or should know that a patient's ailment is beyond his or her knowledge, there is a duty to refer the patient to a specialist. A failure to refer will result in the person being held to a standard of the specialist. Larsen v. Yelle, 310 Minn. 521, 526, 246 N.W.2d 841, 845 (1976).

199. *See* Capron, *supra* note 107, at 622. "In the absence of any form of licensure or certification, people with diverse backgrounds and orientations toward patient care can legitimately hold themselves out as genetic counselors." *Id.* (footnotes omitted). These health care providers include nurses, social workers and physicians in the fields of pediatrics, obstetrics, psychiatry and internal medicine. *Id.* Even among those specifically trained in genetics, there is great variation in the amount of training. *See* Rimoin, *The Delivery of Genetic Services*, 13 BIRTH DEFECTS 105, 119-21 (1977) (medically trained geneticists (M.D.), Ph. D. human geneticists and M.A. genetic associates may all deliver genetic services).

200. Health care providers who do not describe themselves as genetic counselors may find themselves viewed as such by patients needing genetic counseling. *Capron*, *supra* note 107, at 622.

> Of course, someone who seeks genetic counseling from a nonspecialist — for example, a general practitioner — cannot complain if that person does not measure up to the knowledge and skills of a genetic counseling specialist, provided, of course, that the person doing the counseling was not negligent in failing to refer the patient to a specialist because the problem was one that he or she should have known was beyond his or her competence.

Id. at 623 n.17. This is especially true of prospective parents who rely on general practitioners as their "first, and often sole, source of [genetic information]." Note, *supra* note 2, at 1494.

201. *See Hickman*, 396 N.W.2d at 16 (Simonett, J., concurring); *id.* at 20 (Amdahl, C.J., dissenting).

tions.[202] Some doctors, for moral or religious reasons, may not reveal information or recommend abortion even if they know a woman has a high chance of having an affected child.[203] An action for such intentional conduct, however, entails difficult problems of proof that the postconception negligence action largely avoids.[204] In a postconception negligence action the patient need only show that but for the doctor's *negligence*, the affected fetus would have been aborted. It

202. The purposeful withholding of information important to a patient by a health care provider is unethical. *See* Note, *supra* note 6, at 2025 n.44 (citing THE AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, STANDARDS FOR OBSTETRIC-GYNECOLOGIC SERVICES 98-99 (6th ed. 1985)). In certain circumstances, however, such as life-threatening situations, doctors may be privileged in withholding information. Such situations are arising with less and less frequency. *See* Note, *supra* note 182, at 559-63.

While the Minnesota statute was interpreted by the concurrence and dissent in *Hickman* as only preventing a cause of action for a health care provider's negligence, the Idaho, South Dakota and Utah statutes fail to distinguish between negligence and intentional conduct on the part of health care providers. *See* IDAHO CODE § 5-334 (Supp. 1987); S.D. CODIFIED LAWS ANN. § 21-55-2 (1987); UTAH CODE ANN. § 78-11-24 (1987). As an example, the text of the Utah statute reads:

> A cause of action shall not arise, and damages shall not be awarded, on behalf of any person, based on the claim that *but for the act or omission of another*, a person would not have been permitted to have been born alive but would have been aborted.

UTAH CODE ANN. § 78-11-24 (1987) (emphasis added). The Utah statute broadly precludes actions, based on acts or omissions and, thus can be read to preclude actions based on intentional conduct. None of these statutes has yet faced a constitutional challenge.

203. In Minnesota and many other jurisdictions there is no liability for refusing to participate in an abortion procedure. *See* MINN. STAT. § 145.414 (1986) (no person shall be coerced, held liable or discriminated against for failure to perform an abortion); MINN. STAT. § 145.42, subd. 1 (1986) (no person shall be held liable for failure to perform an abortion). *See also* ALASKA STAT. § 18.16.010(b) (1986); ARIZ. REV. STAT. ANN. § 36-2151 (1986); FLA. STAT. ANN. § 390.001, subd. 8 (West 1986); IDAHO CODE § 18-612 (1987); KY. REV. STAT. ANN. § 311.800, subds. 3, 4, 5 (Michie/Bobbs-Merrill 1983); LA. REV. STAT. ANN. §§ 40:1299.31-32 (West 1977); ME. REV. STAT. ANN. tit. 22, § 1591 (1980); MASS. GEN. LAWS ANN. ch. 112, § 12I (West 1983); MO. ANN. STAT. § 188.105 (Vernon Supp. 1988); NEB. REV. STAT. ANN. §§ 28-337 to -341 (1985); N.M. STAT. ANN. § 30-5-2 (1984); PA. CONS. STAT. ANN. § 18-3213(d) (Purdon 1983); S.C. CODE ANN. §§ 41-44-40 to -50 (Law. Co-op. 1985); TENN. CODE ANN. §§ 39-4-204 to -205 (1982); UTAH CODE ANN. § 76-7-306 (1978). Where a health care provider undertakes to perform an abortion or give genetic counseling, however, liability for negligent or intentional conduct should follow.

204. One commentator has likened the medical malpractice action to a criminal trial:

> In many respects, malpractice litigation, like a criminal trial, is a public degradation ceremony, in which other members of the profession contribute to the public challenge to a doctor's performance of his vocation. The malpractice lawsuit creates a situation in which lawyers, judges, juries, and other doctors figuratively look over the shoulder of the defendant doctor to evaluate his work. That is likely to be especially onerous for persons, like doctors, to whom independence in work is expected and very important.

Bell, *supra* note 124, at 984-85.

is, therefore, the bonus of the postconception negligence action that prevents the purposeful withholding of information by imposing liability for negligent withholding of such information.[205] While courts should remain free to refuse to impose liability based on factual distinctions or some perceived public policy, legislation preventing postconception injury of birth claims based on intentional conduct encourages private interference with the right to abortion by taking away the deterrence of the fact finding process of the courts.[206]

Intentional conduct is, of course, difficult to prove. The plaintiffs in *Christensen v. Thornby* unsuccessfully tried to base their wrongful conception claim on deceit.[207] The court held that in such an action the plaintiff must prove both that the representation made was false, and that it was made with fraudulent intent.[208] In at least one injury of birth decision, a court has held that the plaintiff stated a cause of action for fraudulent representation.[209] That case, however, decided

205. Chief Justice Amdahl stated the proposition more eloquently.

> The possibility that a doctor will be held responsible for negligent conduct stands as a safeguard that the woman will be fully informed. The legislature's removal of the negligence action safeguard, while not preventing a woman from actually obtaining an abortion, does harm the complete exercise of a woman's rights under *Roe*.

Hickman, 396 N.W.2d at 19 (Amdahl, C.J., dissenting). In certain postconception negligence cases the removal of the "negligence action safeguard" inches nearer to actual prevention of abortion. If a health care provider misdiagnoses a woman's pregnancy, for example, and the woman does not have time to seek a legal abortion when she realizes she is pregnant, the only semblance left of her right to choose is her action against the health care provider, if she is to avoid illegal conduct. A similar situation arises when a health care provider performs an abortion negligently, and the fetus remains intact. *See supra* notes 165-66 and accompanying text (discussing cases in other jurisdictions based on these scenarios).

206. Although Minnesota's statute does not shield health care providers from intentionally withholding information from a woman, it "constitutes a subtle entry into that relationship and interference with the informed decisionmaking process." *Hickman*, 396 N.W.2d at 19 (Amdahl, C.J., dissenting).

The concurring opinion in *Hickman* suggests that this argument is disingenuous because the statute does not allow the health care provider to withhold information. This duty is imposed by standards of medical ethics and enforced by intraprofessional sanctions. *See id.* at 16 (Simonett, J., concurring). *But see* Bell, *supra* note 124, at 988-89 (disciplinary boards have little effect on physician conduct). The "but for" causation standard is also criticized as allowing "a woman who delivers a handicapped baby to choose, hypothetically, post facto, whether or not to have an abortion." *Id.* This is the general criticism of informed consent cases, where the patients may also choose post facto whether or not they would have undertaken a particular treatment route. Further, the concurrence's approach grossly favors the health care provider's judgment in the abortion decision over the woman's judgment. While *Roe* suggests that the woman consult with her doctor in making a decision to abort, the right to make the decision clearly vests in the woman.

207. *Christensen*, 192 Minn. 123, 126, 255 N.W. 620 622 (1939).

208. *Id.*

209. Custodio v. Bauer, 251 Cal. App. 2d 303, 313-14, 59 Cal. Rptr. 463, 470 (1967).

only the sufficiency of the pleadings and not the proof.[210] These actions are difficult to maintain because of the requirement of knowledge on the part of the defendant that his statements are false. While it is not impossible to prove this element, the difficulty of proving what is in a person's mind led early courts to disallow such actions, reasoning that "[t]he thought of a man shall not be tried, for the devil himself knoweth not the thought of man."[211]

F. Allowing the Child's Cause of Action

The common justifications for allowing the parents' injury of birth claims include recognition of a person's right to practice contraception and a woman's right to terminate a pregnancy,[212] the availability of preconception diagnosis and counseling and postconception testing that allows health care providers to determine whether a fetus is affected,[213] and the compensatory and deterrent nature of tort damages.[214] The claims of children born with severe genetic or congenital anomalies are analytically indistinguishable from claims of their parents. The infant sues a health care provider for damages resulting from being conceived or born with anomalies. Yet in nearly every state that has decided the issue, it has been held that no cause of action lies for an infant with such injuries. The states that allow a child's action, California, Colorado, New Jersey and Washington,[215]

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210. *See id.*

211. *See* D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON TORTS § 4, at 21 (5th ed. 1984) (quoting Y.B. 7 Edw. IV, f. 2, pl. 2).

212. *See supra* notes 28-51 and accompanying text.

213. *See supra* notes 8-27 and accompanying text.

214. It has been argued that holding physicians liable for the injury of birth will cause them to refuse to perform prenatal diagnosis procedures or increase the cost of these procedures substantially. Thus, liability might have the unintended effect of increasing the number of unwanted pregnancies. University of Ariz. v. Superior Court, 136 Ariz. 579, 588, 667 P.2d 1294, 1302 (1983) (Gordon, V.C.J., dissenting). Injury of birth cases do not arise with great frequency, however, due to the infrequency with which birth defects themselves occur.

It is also argued that the costs seemingly imposed on the defendant will actually be borne by those using the service because of malpractice insurance, so the deterrent effect on health care providers will be minimal. *Procanik*, 97 N.J. at 358, 478 A.2d at 773. It is a common principle of tort law that the injury be shifted from the blameless to society at large through insurance. *See* D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON TORTS § 4, at 24-25 (5th ed. 1984). Since many hospitals are self-insured, they have strong financial incentives to reduce the number of malpractice claims brought against their staff. *See* Bell, *supra* note 124, at 989-90. This has been accomplished largely through the use of "risk management" systems, which identify problem areas and introduce procedures that reduce the risk of recurrence. *Id.*

215. *See* Turpin v. Sortini, 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982) (hereditary hearing defect, preconception negligence); Continental Casualty Co. v. Empire Casualty Co., 713 P.2d 384 (Colo. Ct. App. 1986) (erythroblastosis fatalis, preconception negligence); Procanik v. Cillo, 97 N.J. 339, 478 A.2d 755 (1984) (con-

do so only under severely restricted circumstances. These courts hold that a child may recover the extraordinary expenses incurred in its lifetime as a result of its congenital defect, so long as the parents did not recover those same costs.[216] No other damages for the child's cause of action have been allowed by any court.

Although many courts disallow actions of the child based on the sanctity of human life,[217] including the logical difficulty of holding that a person is harmed by coming into existence and the difficulty of ascertaining damages, a suit for wrongful life can be construed in such a way as to rebut these arguments.[218] First, it must be accepted that a person has a right not to be born into a world of pain and suffering, without the prospect of pursuing the most basic interests.[219] The sanctity of human life is denigrated if the basic interests

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genital rubella syndrome, postconception negligence); Harbeson v. Parke-Davis, Inc., 98 Wash. 2d 460, 656 P.2d 483 (1983) (fetal hydantoin syndrome, preconception negligence). Viewing the postconception negligence recovery in *Procanik* as an aberration, all the remaining cases allow the child's action where preconception negligence is involved. Distinguishing between affected children's claims based on whether the negligence occurred prior to or after conception seems logical. In the postconception cases, the anomaly is not suspected prior to conception, and is, of course, undetectable prior to its existence. Thus, the child is already affected prior to any negligence on the part of the health care provider. Allowing postconception recovery by the child for its existence may be unsound because the child, or at least the embryo, existed prior to the negligence. In preconception negligence cases, however, the injury to the child is not birth, but rather conception. In that case, the health care provider's negligence does indeed cause the child to exist with anomalies by inducing the parents to conceive. *See* Curlender v. Bio-Science Laboratories, 106 Cal.App.3d 811, 165 Cal. Rptr. 477 (1980) (holding that genetic counselors owe a duty to unconceived child as well as parents). *But see* Gallagher v. Duke Univ. 638 F. Supp. 979, 982-83 (1986) (holding that physician owed no duty to child who did not exist at time of negligence).

216. *Turpin*, 31 Cal. 3d at 238, 643 P.2d at 965, 182 Cal. Rptr. at 348; *Procanik*, 97 N.J. at 353, 478 A.2d at 766; *Harbeson*, 98 Wash. 2d at 474, 656 P.2d at 495.

217. The *Phillips* court summed up the various arguments against recognizing a cause of action for wrongful life before focusing on the preciousness and sanctity of human life as the overriding reason for denying these claims.

> Although these arguments are phrased in varying terminology—the 'impossibility' of determining damages based on a comparison of defective existence with non-existence, . . . the metaphysical, theological, or philosophical nature of the issues, . . . the lack of a 'justiciable' issue, . . . or the absence of a legally 'cognizable' cause of action, . . . they essentially focus on the 'preciousness of human life.'

Phillips, 508 F. Supp. at 543 (citations omitted).

218. "[T]he grounds for charging that a wrongdoer has violated another's right not to be born do not include reference to a strange never-never land from which phantom beings are dragged struggling and kicking into their mothers' wombs and thence into existence as persons in the real world." J. FEINBERG, *Is There a Right to be Born?* in RIGHTS, JUSTICE AND THE BOUNDS OF LIBERTY 207, 219 (1980).

219. As Feinberg pointed out:

> Talk of a "right not to be born" is a compendious way of referring to the plausible moral requirement that no child be brought into the world unless

of living are doomed in advance.[220] Life as protected by the Constitution includes "all personal rights and their enjoyment of the faculties, acquiring useful knowledge, the right to marry, establish a home, and bring up children, freedom of worship, conscience, contract, occupation, speech, assembly and press."[221] The child born into the world with serious anomalies can hardly be said to take advantage of life in this legalistic sense. Children born with the most severe anomalies might not even be able to "take in food, get energy from it, grow, adapt themselves to their surroundings, and reproduce their kind." [222] Children brought into existence without these minimal assurances of well-being have been wronged.[223]

Second, it should be accepted that a child deprived of many, but not all, of the basic interests of life has also been wronged.[224] Many

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certain very minimal conditions of well-being are assured. . . . When a child is brought into existence even though those requirements have not been observed, *he has been wronged* thereby; and that is not to say that any metaphysical interpretation, or any sense at all, can be given to the statement that he would have been better off had he never been born.

Id. (emphasis in original).

220. *See* Steinbock, *The Logical Case for "Wrongful Life,"* HASTINGS CENT. REP. 15, 8-19 (Apr. 1986).

221. BLACK'S LAW DICTIONARY 833 (5th ed. 1979).

222. WEBSTER'S NEW UNIVERSAL UNABRIDGED DICTIONARY 1044 (2d ed. 1979). It might be argued that these children were never "viable" in the strictest sense of the word. *See id.* at 2035; *see also* MOSBY MEDICAL ENCYCLOPEDIA 778 (1st ed. 1985). The courts have adopted a much broader definition of the term, defining viability as "when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life support systems." Planned Parenthood of Mo. v. Danforth, 428 U.S. 52, 63-65 (1976).

223. The impact of christianity and the "suffering-based" philosophies of western cultures has certainly had an effect on the reasoning of some jurists denying the affected child's cause of action. As one author concluded, this impact may not be as strong in the future:

> One of the recent changes in western society is that reproduction has been quantitatively regulated even to the extent that there is no replacement at the present time, but also that there is a very big concern about the quality of the children that are born.
>
> Here we observe that a centuries-long impact of christianity has been lost in recent years: Man in this society of to-day can no longer find any sense in suffering, especially when it hits him, on a genetic basis, in his existential prolongation which is the child.

Van den Berghe, *Impact of Genetics on Society*, 23 BIRTH DEFECTS 1, 3 (1987) (emphasis omitted).

224. *See* Steinbock, *supra* note 223, at 19. The author argues that it is not necessary for the child to have such an impaired condition that nonexistence is preferrable to life with the handicap.

> Either we have to maintain, implausibly, that a rational person would prefer nonexistence to, say, being born deaf, or we must dismiss the suits of less seriously impaired children. . . .
>
> The escape from this dilemma is to see that it is not necessary to maintain that the child would be better off never having been born in order to claim that he or she has been wronged by birth. Instead, we can say that it is

children suffering from severe handicaps may lead productive lives if their expensive medical and educational needs are met.[225] It is not necessary to compare their lives against nonexistence, because the compensation they seek is for their handicap, not for their existence.[226] While it is often said that the tortfeasor did not cause the child's handicap, the antithesis of this argument also has merit: but for the negligent conduct of the tortfeasor, the child, and thus the handicap, would not exist.

Third, allowing the child to recover in an injury of birth action assures more certain justice than allowing the parents to recover. In the strictest sense, it is the child who will suffer enormous damages as a result of being born with severe anomalies.[227] If damages are awarded solely on the parents' cause of action, no award based on the child's pain and suffering is possible.[228] In the event that the child is given up for adoption, institutionalized or the parents are unavailable to sue, will states preclude the infant plaintiff from the

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> a wrong to the child to be born with such serious handicaps that many very basic interests are doomed in advance, preventing the child from having the minimally decent existence to which all citizens are entitled. While this is something less than a right to be born a whole functional human being, it is not dependent on the implausible view that a life with serious impairments is always worse than no life at all.

Id.

225. *See id.*

226. "The harm complained of is not life, but suffering by a living person, flowing from negligent conduct. . . ." Payton v. Abbott Labs, 386 Mass. 540, 437 N.E.2d 171, 192 (1982) (Hennessey, C.J., dissenting) (DES case).

227. Although the parents take the risk that a health care provider's negligence will cause them to conceive or carry an affected child to term, it is the child's interest that is ultimately harmed.

> Genetic risk taking, unlike other personal decisions involving risk, is taken under the knowledge that an undesirable outcome of one's own decision will primarily affect another person. While, if the feared outcome of a pregnancy were to [materialize], one would have to live with the consequences of such a decision, one's offspring is the person who would be primarily affected.

Humphreys & Berkley, *supra* note 54, at 227.

228. Although no injury of birth case has allowed damages for the child's pain and suffering, there can be little doubt that these damages exist.

> Admittedly these terms refer to subjective states, representing a detriment which can be translated into monetary loss only with great difficulty. . . . But the detriment, nevertheless, is a genuine one that requires compensation . . . and the issue generally must be resolved by the "impartial conscience and judgement of jurors who may be expected to act reasonably, intelligently and in harmony with the evidence."

Capelouto v. Kaiser Found. Hosp., 7 Cal. 3d 889, 893, 500 P.2d 880, 883, 103 Cal. Rptr. 856, 859 (1972) (quoting Beagle v. Vasold, 65 Cal. 2d 166, 181, 417 P.2d 673, 681, 53 Cal. Rptr. 129, 137 (1966)). *But cf.* Salin v. Kloempken, 322 N.W.2d 736, 740 (Minn. 1982) (preventing child's recovery for loss of parental consortium because "[t]he intangible nature of the child's loss makes it difficult to assess damages").

very same damages that they allow parents to recover?[229] Further, the child's special costs will often continue beyond the age of majority, placing the eventual burden on the parents or the state.[230] Finally, the statute of limitations protects the interests of children by tolling until the age of majority or sound mind.[231]

VII. The Providence of Prohibiting Tort Actions: Policy Considerations

Scientific advances can produce new problems that are thrust upon the courts and legislatures.[232] In 1963, an Illinois court predicted new causes of action arising as man's knowledge increases and he wields "ever greater control over the functions of nature."[233] In holding that the sweeping results of creating a new tort for wrongful life would be more properly addressed by the legislature, the court noted that while the legal questions presented are new, "the social conditions producing the problem have existed since the advent of man."[234]

A. Respective Judicial and Legislative Roles

The question of recognition of a cause of action for the injury of birth has sometimes been considered a matter for legislative, rather than judicial, decisionmaking:

> The establishment of a cause of action based on the matter of wrongful conception, wrongful life or wrongful birth is clearly within the purview of the legislature only. The enunciation of public policy is the domain of the General Assembly. We do not propose to invade their jurisdiction in any respect. The courts interpret the law. They do not enact legislation.[235]

Upon closer examination, however, it appears that courts are at least as well-equipped as legislatures to recognize new tort actions. In circumstances where liability and damages may vary greatly from case to case, courts may be in a better position to decide because that system has the unique advantage of being able to hear the specific facts of each case.

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229. Procanik v. Cillo, 97 N.J. 339, 352, 478 A.2d 755, 762 (1984).

230. In some states, the damages recoverable in injury of birth actions involving affected children are only based on raising the child to the age of majority. *See, e.g.*, Bani-Esraili v. Lerman, 69 N.Y.2d 807, 808, 505 N.E.2d 947, 948, 513 N.Y.S.2d 382, 383 (1987). If Minnesota were to recognize such an action, however, the court would probably follow dicta from the *Sherlock* decision allowing damages for support of an affected child to extend beyond majority. *Sherlock*, 260 N.W.2d 176 n.11.

231. *See* Minn. Stat. § 541.15 (1986).

232. Zepeda v. Zepeda, 41 Ill. App. 2d 240, 253, 190 N.E.2d 849, 859 (1963).

233. *Id.*

234. *Id.*

235. Schork v. Huber, 648 S.W.2d 861, 863 (Ky. 1983).

It is often argued that since legislatures allowed actions for wrongful death, they should also decide whether to recognize actions for the injury of birth.[236] Yet the differences between legislative acceptance of wrongful death suits and legislative prohibition of injury of birth suits are striking. First, the legislature is prohibiting, rather than allowing, a cause of action for a person injured by another's negligence.[237] Second, wrongful death statutes allow the decedent's estate (a third party) to recover, while injury of birth statutes prohibit recovery to the injured parties themselves.[238] Although both types of actions invoke public policy considerations, the resolution of these considerations in favor of wrongful death plaintiffs actually supports recognition of injury of birth suits.[239] In sum, a comparison between legislative acceptance of wrongful death and legislative prohibition of injury of birth actions provides an indication that a legislative solution to the complex issues involved in the latter is neither warranted nor prudent.[240]

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236. *See, e.g.*, Hickman v. Group Health Plan, Inc., 396 N.W.2d 10, 11 (1986).

237. The Minnesota Legislature has prohibited other actions based on contract, under the statute of frauds. *See* MINN. STAT. § 513.01 (1986) (prohibiting actions for breach of contract to marry between cohabitants without a written contract). *See also Hickman*, 396 N.W.2d at 16 n.1 (Simonett, J., concurring) (list of situations in which breach of duty owed to another does not result in tort damages).

238. There are principles of law, such as the third party beneficiary rule in contract and emotional distress and loss of consortium rules in tort, which allow persons indirectly injured by a defendant's conduct some measure of recovery. Legislation that prevents redress to the injured party for ordinary negligence *in toto* are not commonplace, with the exception of principles of comparative fault (provided the plaintiff's fault is greater than the defendant's). Similar principles have not been persuasive in injury of birth decisions. *See* Rogers, *supra* note 163, at 750 (attempts by defendants to construe parents' sexual intercourse as intervening cause have not been persuasive).

239. These public policy arguments include the difficulty of ascertaining damages, increased litigation and determining the respective judicial and legislative roles. *Hickman*, 396 N.W.2d at 13. The arguments have not been persuasive in precluding claims by parents for the injury of birth. *See supra* note 122 and accompanying text (nearly every post-*Roe* court reaching the merits of such a case has allowed the action). Further, such policy arguments would seem equally applicable to suits involving failed sterilization procedures or contraception methods, which have gained both legislative and judicial approval in Minnesota.

240. About the only similarity that can be found between wrongful death claims and injury of birth claims is that both may involve injuries arising from negligent or intentional conduct or strict liability. *Cf. Hickman*, 396 N.W.2d at 13. Injury of birth suits may arise from a health care provider's intentional conduct, *see supra* notes 201-13 and accompanying text, from a products liability suit against a manufacturer involving a contraceptive device, *see* Troppi v. Scarf, 31 Mich. App. 240, 187 N.W.2d 511 (1971), or from negligent conduct.

One final criticism of any legislation preventing a common law cause of action based on some perceived public policy is that the legislature is in effect interpreting common law, an inherently judicial function. There were no postconception negligence suits before Minnesota courts prior to this legislation. As a result, the legisla-

In contrast, the judiciary first recognized injury of birth actions in Minnesota.[241] Because of the fact specific nature of injury of birth actions, it is more provident for the courts to accept or reject such actions on a case-by-case basis than to continue with the legislature's outright prohibition. The *Sherlock* decision demonstrated the court's ability to struggle with these difficult issues to reach a fair and just result. The language of the legislation itself recognizes that ability and shows confidence in the court's decision.[242]

B. A Proposal to Redraft Section 145.424

At the outset, it should be noted that "improvement" of Minnesota Statute section 145.424 is unlikely. A statute with perceived beneficial effects of curbing abortions that has recently been held constitutional by the Minnesota Supreme Court is not likely to be a candidate for change in the eyes of the legislators.[243] Thus, the following revision is proposed in the event that a further challenge to the statute's validity is successful or the cultural lag between genetic counseling technology and morality resolves itself.[244] In any event, the proposal is useful as a way of recapping the major themes of this Note and demonstrating that careful legislation may arrest some of the problems inherent in the injury of birth arena without precluding all recovery.

A legislative solution to the problems with Minnesota's statute would require repeal of subdivision 2 as well as significant revision of the other subdivisions. The statute should prohibit any claim by a child against its parents. It should allow other actions by the child only in cases of severe physical or mental impairment, thus prohibiting cases for impairment of status (illegitimacy). The statute should allow claims where negligence induced a woman to carry a severely handicapped child to term. Finally, the statute should protect defendants from multiple liability for identical damages claimed by both the parents and the child. This approach would allow the courts to determine, on a case-by-case basis, when the child's impair-

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tors had no idea how the court would react to such a situation in terms of liability or damages. Nor did they have the benefit of the court's reasoning and guidance in an extremely complicated and controversial area of tort law. Instead, the legislature forged ahead, throwing out the baby with the bathwater.

241. *See supra* notes 79-96 and accompanying text (discussing *Sherlock*).

242. *See* MINN. STAT. § 145.424, subd. 3 (1986) (codifying the result in the *Sherlock* decision).

243. The final vote on the bill was 100 to 20 on February 26, 1982. This is approximately the same vote breakdown as on other abortion-related bills. Interview with Representative Linda Scheid (January 10, 1988).

244. *See* Rogers, *supra* note 162, at 757. It is a depressing observation that genetic counseling is increasing at a tremendous rate, but society is not prepared to receive this information. *See* Van Den Berghe, *supra* note 225, at 3.

ment was severe enough and when the parents' right to procreative choice was interfered with in such a way as to make liability appropriate.[245]

The titles of all subdivisions have been deleted because labelling these actions tends to confuse and mislead.[246] The changes to subdivision 1 would effectively prevent any lawsuit by a child against its parents as well as any lawsuit by a child based on impaired status. The repeal of subdivision 2 would allow actions by women against health care providers who negligently induced them to carry a child with severe handicaps to term and actions by women against health care providers who negligently diagnosed pregnancies or negligently performed abortions.[247] The long first sentence of subdivision 3 is

245. A suggested revision of MINN. STAT. § 145.424 follows:

Prohibition of tort actions

Subdivision 1. ~~Wrongful life action prohibited~~. No ~~person~~ *child* shall maintain a cause of action or receive an award of damages ~~on behalf of that person~~ based on the claim that but for the negligent conduct of ~~another~~ *the parents*, the ~~person~~ *child* would have been aborted. *No child shall maintain a cause of action or receive an award of damages on the claim that but for the negligent conduct of another, the child would have been aborted unless the child suffers from severe physical or mental defects.*

Subd. 2. ~~Wrongful birth action prohibited. No person shall maintain a cause of action or receive an award of damages on the claim that but for the negligent conduct of another, a child would have been aborted~~. *[Repealed]*

Subd. 3. ~~Failure or refusal to prevent a live birth. Nothing in this section shall be construed to preclude a cause of action for intentional or negligent malpractice or any other action arising in tort based on the failure of a contraceptive method or sterilization procedure or on a claim that, but for the negligent conduct of another, tests or treatment would have been provided or would have been provided properly which would have made possible the prevention, cure or amelioration of any disease, defect, deficiency, or handicap; provided, however, that abortion shall not have been deemed to prevent, cure, or ameliorate any disease, defect, deficiency, or handicap.~~ The failure or refusal of ~~any person to perform or~~ *a parent to* have an abortion, *put a child up for adoption, or institutionalize a child* shall not be a defense in any action *against a third party*, nor shall that failure or refusal be considered in awarding damages or in imposing a penalty in any *such action*.

Subd. 4. In the event that both the child and the parents seek damages against a third party in any action under subdivisions 1 or 2, any damages awarded shall be offset to prevent multiple recovery for the same injury.

246. In the case of subdivision 2, the statutory title, "Wrongful Birth Action Prohibited," is particularly misleading because, according to popular definitions, the language can be inaccurately interpreted to prohibit both wrongful birth and wrongful pregnancy actions.

247. At first blush it might seem that adding the words "unless the child suffers from severe physical or mental defects" to the end of subdivision 2 would improve the statute. Unfortunately this would effectively bar suits by women who had negligently misdiagnosed pregnancies or negligently performed abortions, resulting in the birth of unwanted healthy children (commonly referred to as "wrongful pregnancy").

This Note maintains that the prohibition of such actions is likely to fail constitutional challenges. In such a case, the woman would face a nearly insurmountable burden of proof to maintain an action for misrepresentation. *See supra* notes 208-13.

deleted as unnecessary because nothing in this revision would preclude actions based on intentional conduct, wrongful conception or torts *in utero*.[248] The remaining additions in subdivision 3 protect the parents from any duty to mitigate damages by aborting their child, putting their child up for adoption or institutionalizing their child.[249] The protection for a health care provider who refuses to perform an abortion is deleted as redundant in light of Minnesota Statutes sections 145.42, subdivision 1 and 145.414. Finally, the addition of subdivision 4 protects a defendant from multiple liability to the parents and the child for the same injury.[250]

CONCLUSION

The ability of the medical profession to prevent birth, screen prospective parents for inheritable conditions, and diagnose these and other conditions early in pregnancy has brought with it a duty of care. Minnesota's statute has removed the deterrent effect of liability from health care practitioners for negligence in situations where women would opt for abortion. Although the Minnesota Supreme Court has found the statute constitutional, it is clear that the statute places the financial, physical and emotional burden of raising an unwanted child on the family rather than on the tortfeasor, who negli-

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This result can hardly be reconciled with the intention or spirit of *Roe*. Thus, limiting postconception negligence suits to suits involving infants with severe handicaps is better left to the courts.

248. By couching the terms of the statute in negligence, it can be inferred that no cause of action based on intentional conduct is prohibited. Similarly, the result in the *Sherlock* decision would not be affected because the statute does not purport to preclude actions based on negligence prior to conception. *See supra* notes 152-64 and accompanying text. Finally, claims based on negligence that result in injury to a fetus or a failure to treat a fetus *in utero* have traditionally been treated differently than claims based on negligence preventing abortion. *See, e.g., Phillips*, 508 F. Supp. at 542-43.

249. This "no duty to mitigate" was first discussed in *Sherlock*. *See supra* note 91 and accompanying text.

250. Damage issues in injury of birth cases have been beyond the general scope of this Note. It is suggested, however, that legislation precluding recovery of *certain damages*, rather than *entire causes of action*, might be more provident. The preclusion of the parents' damages associated with the pregnancy itself might be unconstitutional under *Griswold* and *Roe* and seems offensive to notions of the reparational, deterrent and compensatory aspects of tort law.

Legislation may be able to preclude damages for the costs of rearing a healthy child to the age of majority. These damages, although they flow from the negligent conduct, seem offensive to the basic notions of family, which the state should foster and protect. They also seem offensive to concepts of benefits and harm. In addition, when a healthy child is born, the cost of rearing damages may be further removed from the actual guarantees of *Roe* and *Griswold*. In Minnesota, the preclusion of cost of rearing damages would effectively overrule a portion of the *Sherlock* decision and reinstate the overriding benefits doctrine of *Christensen* when healthy children are born.

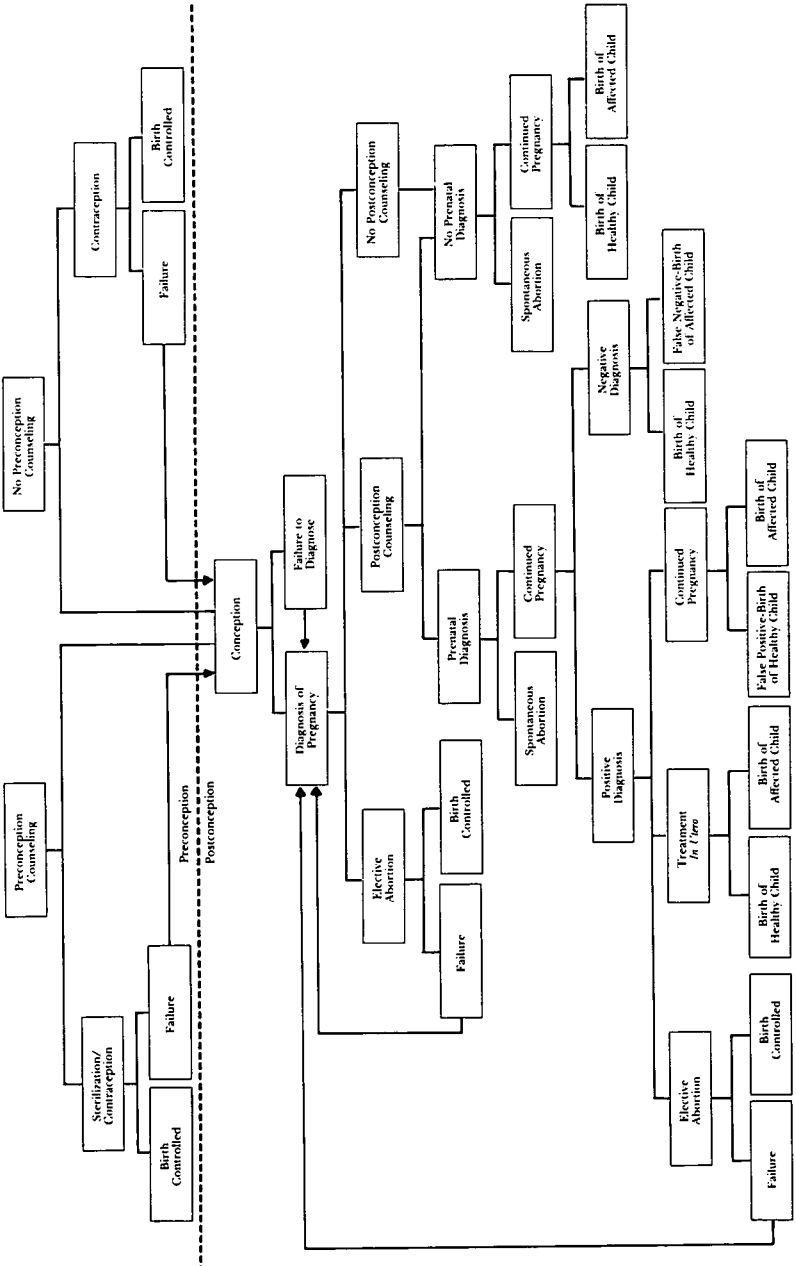
gently prevented the woman from making an informed procreative decision and, in some cases, negligently caused a human being to be brought into a world of pain and suffering. Thus, the statute may not only be criticized for its failure to deter negligent conduct, but also for its failure to provide reparation and vindication for the victims of the tort: the reluctant parents and, in some cases, a handicapped child.

The statute specifically prohibits causes of action brought by a child or a woman based on the claim that but for the negligence of another, the child would have been aborted. While the statute proports to prohibit "wrongful birth" and "wrongful life" actions, it does not completely eliminate these actions and prohibits other actions that have commonly been referred to as "wrongful pregnancy." The plain intent of the statute is to prevent causes of action based on abortions, either because a woman's pregnancy was misdiagnosed, an abortion procedure was performed negligently or because a woman was denied information that would have led her to terminate the pregnancy of a severely handicapped child. The statute prefers to protect the health care provider's negligence over the woman's right to procreative choice. This preference disregards the balancing of interests between the unborn fetus, the woman and the state as set forth by the United States Supreme Court in *Roe*.

Thus, in states with wrongful birth statutes, the focus of tort actions for the injury of birth has been shifted from whether a couple's constitutional right to make procreative decisions has been interfered with to whether there was negligence prior to conception or postconception negligence that prevented proper treatment of the fetus *in utero*. The *Hickman* court's finding of no state action interfering with the abortion decision has led to attempts by lawyers to expand the informed consent doctrine in ways that recover compensation for the lost rights of women prevented from making informed procreative decisions. Future injury of birth actions in states with wrongful birth statutes will require claims that creatively avoid the abortion issue as well as alternative claims that the statutes are unconstitutional.

Phillip A. McAfee

APPENDIX: THE DECISION TO REPRODUCE*



* *See* S. Pauker, *The Amniocentesis Decision: Ten Years of Decision Analytic Experience*, 23 BIRTH DEFECTS 151, 154 (1987).