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Selective Reduction of Multiple Pregnancy: Lifeboat Ethics in the Womb

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INTRODUCTION

On May 21, 1985, amidst a mass-media stampede and a forty-person medical team, Patti Frustaci gave birth to the first septuplets born in the United States.[1] While touted as an American medical record, the multiple birth quickly took on its predicted outcome: one infant was stillborn and three others died within weeks of birth from respiratory failure.[2] The three surviving infants remained hospitalized for four months, generating a hospital bill of over one million dollars.[3] Seven years after their birth, the three children continue to suffer severe physical and developmental impairment, including cerebral palsy and serious eye problems.[4]

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[1] Judith Cummings, *Six Babies Born to Californian; 7th is Stillborn*, N.Y. TIMES, May 22, 1985, at A1 [hereafter *Six Babies*]. The birth of septuplets to Mrs. Frustaci, a 30-year-old high school teacher from Riverside, California, made headlines around the world. The *Los Angeles Times*, quoting from *The Guiness Book of World Records*, reported the largest multiple birth was nine babies in Sydney, Australia, in 1971. None survived more than six days. Marcida Dodson, *Septuplets Born, 6 Survive in Critical Condition, 1 Dies; All Weigh Less Than 2 Pounds*, L.A. TIMES, May 21, 1985, Part 1, at 1. Three cases of septuplets have been reported to survive—in Cape Town, South Africa in 1974; in Florence, Italy in 1980; and in Liverpool, England in 1983. *Id.*

[2] Dina L. Heredia, *Last Frustaci Baby Joins Family at Home*, L.A. TIMES, Oct. 5, 1985, Part 2, at 4. Of the six infants born alive, one died 64 hours after birth, a second died after 16 days, and a third died after 19 days. *Id.* The infants were born at 28 weeks of gestation, 12 weeks premature. *Six Babies*, *supra* note 1.

[3] Gary Jarlson, *Septuplet Parents Name Doctor, Clinic; Frustacis Sue, Charge Malpractice*, L.A. TIMES, Oct. 9, 1985, Part 2, at 1 [hereafter *Septuplet Parents Name Doctor*]. It was earlier reported that the Frustacis' medical insurance plans were expected to cover most of the hospital costs. *See* Dave Palermo, *Insurance Expected to Pay for Most of Babies' Hospital Care; Frustacis' Medical Bills Could Top $1 Million*, L.A. TIMES, May 25, 1985, Part 1, at 31.

[4] *Ask the Globe*, BOSTON GLOBE, Mar. 11, 1992, at 42. Shortly after their third surviving child was discharged from the hospital, the Frustacis filed a malpractice and wrongful death lawsuit against the fertility specialist and the fertility medical center involved in Mrs. Frustaci's treatment. *Septuplet Parents Name Doctor*, *supra* note 3. The plaintiffs alleged Mrs. Frustaci was not properly monitored with ultrasound screening following treatment with the fertility drug Pergonal. *Id.; see infra* note 5 and accompanying text (discussing Pergonal). The lawsuit was settled almost six years later for a reported sum of $6.2 million. *$6 Million for Septuplets: Infertility Clinic Will Pay Family*, L.A. TIMES, July 10, 1990, at P1. At the time of the settlement, Mrs. Frustaci announced that she was pregnant with twins conceived following treatment with Pergonal. *Id.* She gave birth to the twins on December 21, 1990. Of her new babies, Patti Frustaci is reported as saying, "This

The Frustaci septuplets were not naturally conceived. For three months beginning in September 1984, Mrs. Frustaci was treated with Pergonal,[5] a fertility drug reported to cause a multiple pregnancy in one out of every five pregnancies produced by the drug.[6] This twenty percent multiple pregnancy rate is in contrast to the naturally occurring twin pregnancy rate of one to two percent of pregnancies.[7] The spontaneous occurrence of multiple pregnancy with three or more fetuses is even more rare: current figures estimate the rate as 1 in 8100 births for triplets and 1 in 729,000 births for quadruplets.[8]

Following treatment with Pergonal, Mrs. Frustaci became pregnant in November 1984. She underwent her first ultrasound examination[9] on January 14, 1985. It was then that her obstetrician discovered the presence of seven fetuses.[10] Knowing that the chances for a healthy septuplet delivery were virtually nonexistent, Mrs. Frustaci's physician offered her three options: 1) abort

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completes it. The twins are healthy and everything's fine." *Ask the Globe, supra*, at 42.

5 *See* PHYSICIANS DESK REFERENCE 2184 (46th ed. 1992) [hereafter PDR]. Pergonal is a trade name for human menopausal gonadotropin (hMG), a substance extracted from the urine of postmenopausal women. *Id.* Administered by intramuscular injection daily for seven to twelve days, Pergonal hyperstimulates a woman's ovaries to produce multiple oocytes (eggs), increasing the chances for fertilization. *Id.* For a general discussion of the use of Pergonal to treat female infertility, see Zev Rosenwaks & Owen K. Davis, *Fertilization and Related Techniques, in* DAVID N. DANFORTH, OBSTETRICS AND GYNECOLOGY 824-27 (James R. Scott et al. eds., 6th ed. 1990). For further discussion of various infertility treatments, see *infra* notes 69-81 and accompanying text.

6 *See* PDR, *supra* note 5, at 2185. The manufacturer of Pergonal, Serono Laboratories, reports that data from clinical trials revealed the following results regarding multiple births: Of the pregnancies following therapy with Pergonal, 80% were single births, 15% were twins, and 5% were births of three or more children. *See id.* Serono recommends that physicians prescribing Pergonal advise "the patient and her husband . . . of the frequency and potential hazards of multiple gestation before starting treatment." *Id.*

7 *See* Mary R. Osborn, *Selective Reduction in Multiple Gestation*, 3 PERINATAL & NEONATAL NURSING 14 (1989).

8 *See* Mark I. Evans et al., *Selective Termination: Clinical Experience and Residual Risks*, 162 AM. J. OBSTET. & GYNECOL. 1568 (1990) [hereafter Evans I].

9 See *infra* note 58 for a description of ultrasonography.

10 Marcia Chambers, *$3.2 Million Suit By Parents of Septuplets Focusing on Ultrasound*, N.Y. TIMES, Dec. 4, 1985, at A20 [hereafter *$3.2 Million Suit By Parents*].

the entire pregnancy, 2) proceed with the pregnancy to delivery, or 3) selectively reduce the number of fetuses she was carrying to maximize the chances that all the remaining fetuses would be born healthy.[11] This final option involves a surgical procedure known as selective reduction of multiple pregnancy, which is the subject of this Article.[12]

For Mrs. Frustaci, each of the three options inescapably involved harm. First, elective abortion was unacceptable to Mrs. Frustaci for two reasons. To begin, her religious background steered her away from abortion both in principle and in practice.[13] Also, like most women who face a high order multiple pregnancy,[14] the Frustaci pregnancy was achieved at a substantial cost, measured in terms of financial, social, emotional, and psychological expenditures. For many women undergoing fertility treatment, a pregnancy may be finally achieved only after many years of therapy, and the thought of voluntarily terminating this long awaited status may be utterly unacceptable.[15] Indeed, many women facing multiple pregnancy following years of treatment for infertility reject abortion because they feel their current pregnancy might be their last opportunity to have a child.[16]

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[11] *Id.*

[12] See *infra* text accompanying notes 26-34 for a description of the surgical technique used in selective reduction.

[13] *See $3.2 Million Suit By Parents*, *supra* note 10. In the *New York Times* interview, Mrs. Frustaci said that she rejected the option to abort the fetuses because of her Mormon religious background and "all [she] had gone through to have kids." *Id.*

[14] The term "high order multiple pregnancy" is used in the medical literature to refer to pregnancies of three of more fetuses. *See, e.g.*, Boris M. Petrikovsky & Anthony M. Vintzileos, *Management and Outcome of Multiple Pregnancy of High Fetal Order: Literature Review*, 44 OBSTET. & GYNECOL. SURV. 578 (1989). Throughout this Article, I will use the term multiple pregnancy to refer to a pregnancy with two or more fetuses, making no distinction between high order multiple pregnancy and twin pregnancy. As I hope will become clear as my analysis progresses, I make no distinction between the terms because I argue that the same principles should apply to a woman's choices regardless of the number of fetuses she is carrying.

[15] For a discussion of the success rates of various infertility treatment modalities, see *infra* note 80.

[16] *See* Mark I. Evans et al., *Selective First-Trimester Termination in Octuplet and Quadruplet Pregnancies: Clinical and Ethical Issues*, 71 OBSTET. & GYNECOL. 289, 290-91 (1988) [hereafter Evans II] (reporting on four couples facing multiple pregnancy after years of infertility treatment; each disfavored abortion because they viewed current pregnancy as last opportunity to conceive).

The second option available to Mrs. Frustaci was to attempt to carry all the fetuses to term. This option carried a significant risk of harm to the fetuses and to Mrs. Frustaci. Multiple gestation is associated with a high incidence of perinatal morbidity[17] and mortality and maternal morbidity.[18] And as the number of fetuses in a pregnancy increases, the likelihood of an improved obstetric outcome decreases. Commonly occurring maternal complications include preterm labor, premature delivery, severe anemia, preeclampsia, pregnancy-induced hypertension, polyhydramnios, hemorrhage, and post-partum blood transfusions.[19] In addition to these serious complications, the mother of multiple fetuses must endure months of discomfort from uterine overdistention plus the boredom of long-term bed rest, often in a hospital, recommended beginning in the second trimester of pregnancy.[20]

Multiple gestation also presents serious risk of harm and even death to the fetuses. Neonatal[21] complications arise primarily from prematurity, causing low birth weight and respiratory distress syndrome.[22] Moreover, as the number of fetuses increases, the rate of neonatal and infant death also rises. Studies estimate

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[17] Perinatal morbidity, as used in this Article, refers to diseases or medical disorders that occur in the fetus or infant during periods before, during, or after the time of birth: that is, from the 28th week of gestation through the first 7 days after delivery. *See* STEDMAN'S MEDICAL DICTIONARY, 888, 1055 (5th unabridged lawyers ed. 1982) [hereafter STEDMAN'S]; *see also infra* note 21-22 and accompanying text (describing neonatal complications).

[18] Maternal morbidity, as used in this Article, refers to diseases or medical disorders that occur in a pregnant woman. *See* STEDMAN'S, *supra* note 17, at 839, 888; *see also infra* note 19 and accompanying text (describing maternal complications).

[19] *See* Evans II, *supra* note 16, at 292. Preeclampsia is the development of hypertension (high blood pressure) with proteinuria (excess protein in the urine) and/or edema (swelling) after the 20th week of pregnancy. *See* STEDMAN'S, *supra* note 17, at 443, 676, 1133, 1153. Polyhydramnios is an excess in the amount of amniotic fluid. *Id.* at 1118.

[20] *See* John C. Hobbins, *Selective Reduction—A Perinatal Necessity?*, 318 NEW ENG. J. MED. 1062, 1062 (1988).

[21] Neonatal refers to the period immediately succeeding birth and continuing through the first 28 days of life. *See* STEDMAN'S, *supra* note 17, at 931.

[22] *See* C. H. Syrop & M. W. Varner, *Triplet Gestation: Maternal and Neonatal Implications*, 34 ACTA. GENET. MED. GEMELLOL. 81, 81 (1985) (abstract). For a general discussion of the maternal and fetal medical complications surrounding multiple pregnancy, see Evans I, *supra* note 8; Lauren Lynch et

that among triplets, sixteen percent of the fetuses die during the perinatal period and another fifteen percent do not survive infancy.[23] Among quadruplets and quintuplets, perinatal mortality is twenty-one percent and infant mortality is twenty-two percent; among sextuplets, the perinatal mortality rate is forty-one percent and the infant death rate is fifty percent.[24] In the case of septuplets, the chance of even one infant surviving is extremely low.[25] In addition to these grim statistics, a couple facing a multiple pregnancy must consider the impact on their own lives from caring for one or several handicapped children and the financial burden they may incur from medical expenses arising from long-term neonatal intensive care.

Mrs. Frustaci's final option was to reduce the number of fetuses she was carrying through a relatively new surgical procedure known as selective reduction of multiple pregnancy.[26] Performed

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al., *First-Trimester Transabdominal Multifetal Pregnancy Reduction: A Report of 85 Cases*, 75 OBSTET. & GYNECOL. 735 (1990).

[23] *See* Hobbins, *supra* note 20, at 1062 & n.3 (quoting a study from Oxford's National Perinatal Epidemiology Unit conducted between 1975 and 1983); *but see infra* note 213 (citing reports showing improving outcomes with triplet and quadruplet pregnancies).

[24] *Id.* at 1062.

[25] *See* Evans I, *supra* note 8, at 1568-69.

[26] In this Article, I will refer to the termination of one or more fetuses in a multifetal pregnancy as "selective reduction." Throughout its brief existence, this surgical procedure has been referred to variously as selective birth, selective termination, selective abortion, and selective continuation. *See* Richard L. Berkowitz & Lauren Lynch, *Selective Reduction: An Unfortunate Misnomer*, 75 OBSTET. & GYNECOL. 873, 873 (1990). In their article, Berkowitz and Lynch argue that the term "selective reduction" is both inaccurate and potentially psychologically damaging to patients because it suggests that certain fetuses are deliberately selected for termination, requiring either the doctor or the patient to make a kind of "Sophie's choice." *See id.* at 874. Because the decision about which fetus(es) to terminate is based strictly on accessibility, *see infra* text accompanying notes 32-33, no deliberate selection occurs. A preferred term, the authors suggest, is "multifetal pregnancy reduction," which more accurately describes the procedure. *See* Berkowitz & Lynch, *supra*, at 873. A slightly different approach to the name of the procedure was taken in Fred Rosner, *Pregnancy Reduction in Jewish Law*, 1 J. CLINICAL ETHICS 181 (1990). Rosner suggests we use the term "enhanced survival of multifetal pregnancies in the first trimester" to accentuate the positive goals of the procedure. *See id.* at 185.

While I agree that language shapes perception, I will use the term "selective reduction" because I believe it accurately reflects what is transpiring when a woman elects to undergo the procedure. First, a woman

during the first trimester of pregnancy,[27] selective reduction involves inserting a needle through the woman's abdomen into one of the gestational sacs. The needle is then maneuvered into the fetal chest, and if possible, into the fetal heart, where potassium chloride is injected.[28] Once cardiac asystole, or complete standstill of the heart, is achieved, the needle is removed.[29] The needle can be reinserted into one or more gestational sacs, depending on the number of fetuses to be reduced.[30] The terminated fetuses remain in the woman's uterus where they are

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can "select" or "choose" the option of reducing her multifetal pregnancy. *See* WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 397 (unabridged ed. 1986) [hereafter WEBSTER'S] (defining "choose" as "select"). Second, and perhaps more importantly, a woman, in consultation with her physician, should select the number of fetuses to be reduced. Calling the procedure "selective reduction" creates a perception of choice and control for the patient.

27 See *infra* note 63 for a reference to the cases of selective reduction performed to date in the United States. In virtually all of the cases in which selective reduction was used to reduce the number of fetuses, the procedure was performed between the ninth and thirteenth week of pregnancy. *See infra* note 63. Selective reduction is also used to terminate an anomalous fetus in a twin pregnancy. *See* Usha Chitkara et al., *Selective Second-Trimester Termination of the Anomalous Fetus in Twin Pregnancies*, 73 OBSTET. & GYNECOL. 690, 690 (1989). As the title of the foregoing article suggests, the procedure is done during the second trimester of pregnancy, following results from one of several prenatal diagnostic tests. *Id.* at 690-91.

28 *See* Khalil M. A. Tabsh, *Transabdominal Multifetal Pregnancy Reduction: Report of 40 Cases*, 75 OBSTET. & GYNECOL. 739 (1990).

29 This method of selective reduction, known as transabdominal selective reduction, seems to be the method currently utilized by all centers in the United States that report performing the procedure. *See infra* note 63 (discussing all reported cases of selective reduction performed in the United States); note 113 (defining transabdominally). Physicians from other countries have reported success using a new technique whereby injection of potassium chloride into the fetus is achieved by introducing the needle transvaginally, as opposed to transabdominally. *See* Yael Gonen et al., *Transvaginal Ultrasound in Selective Embryo Reduction For Multiple Pregnancy*, 75 OBSTET. & GYNECOL. 720, 720-21 (1990) (transvaginal approach used in Canada); Josef Shalev et al., *Selective Reduction in Multiple Gestations: Pregnancy Outcome After Transvaginal and Transabdominal Needle-Guided Procedures*, 52 FERTILITY & STERILITY 416, 417 (1989) (transvaginal technique used on 10 women in Israel); note 112 (defining transvaginally).

30 *See* Lynch et al., *supra* note 22, at 736. Dr. Lynch and her coauthors report reducing the desired number of fetuses during one procedure. *Id.* Dr. Tabsh reports he will reduce a maximum of two fetuses at one time. Tabsh, *supra* note 28, at 739. If more than two fetuses are to be reduced, a repeat procedure is scheduled for one week later. *Id.*

resorbed, allowing the remaining fetuses to grow normally.[31]

The operating physician observes the entire procedure through ultrasound. This allows the physician to observe the overall location of the fetuses as well as the location of the needle once the procedure is underway. The primary criterion for selecting a fetus for termination is its proximity to the maternal abdominal wall.[32] Only the sac above the cervix is avoided to minimize the risk of rupture of the membranes, which could result in loss of the entire pregnancy.[33] Thus, unless ultrasound shows a gross abnormality at the time of the procedure, selection is done with no knowledge of any fetal characteristics, including sex and genetic make-up.[34]

In the case of Mrs. Frustaci, by reducing the number of fetuses from seven to two or three, she could have optimized her chances of carrying and delivering healthy full-term infants. When presented with this third option of selective reduction, Mrs. Frustaci reportedly said it "wasn't a viable alternative" and elected to continue the pregnancy without intervention.[35]

Though not used by the Frustacis, selective reduction of multiple pregnancy has been the elected option over the past several years of hundreds of women facing multiple pregnancy.[36] In almost every reported case in which selective reduction was performed, the multiple pregnancy resulted from some form of infer-

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31 *See* Gonen et al., *supra* note 29, at 721.

32 Lynch et al., *supra* note 22, at 736.

33 *See* Tabsh, *supra* note 28, at 739-40. The only time that a particular fetus is selected for termination is in the case of an anomalous fetus detected by prenatal diagnostic techniques such as amniocentesis. *See* Berkowitz & Lynch, *supra* note 26, at 873. In the case of first-trimester selective reduction, prenatal diagnostic tests to detect fetal sex or congenital abnormalities are not performed prior to the procedure, thus nothing is known about the fetuses that are terminated at the time of the procedure. *See id.*

34 *See* Berkowitz & Lynch, *supra* note 26, at 873.

35 *See $3.2 Million Suit By Parents*, *supra* note 10. Mrs. Frustaci is not the only woman to reject selective reduction as an option for her multiple pregnancy. One woman who conceived four fetuses through the use of Pergonal rejected selective reduction, explaining, "There's a risk that you can lose the entire pregnancy. And if that happened, and we were never able to achieve a pregnancy again, I don't think we could ever forgive ourselves." Susan Christian, *Frustaci Fallout; Couples Fear $6-Million Settlement May Make Potent Fertility Drug Scarce*, L.A. TIMES, July 24, 1990, at E1 [hereafter *Frustaci Fallout*].

36 *See infra* note 63 (listing reported cases).

tility treatment.[37] Given the continuing development and increasing utilization of reproductive technologies,[38] many of which carry a significant risk of multiple gestation,[39] the ethics and legality of selective reduction will draw increasing attention and debate. Perhaps in an effort to generate that debate, this Article raises several of the legal and ethical issues that arise from the technology of selective reduction. Part I describes the short history and rapid development of selective reduction as a surgical procedure.[40] As physicians become more adept at reducing a multiple pregnancy without causing harm to the remaining fetuses, some may worry that the mere availability of the successful procedure will result in more risk taking in treating infertility. That is, if patients and physicians are aware of selective reduction as a viable option for successfully reducing a multiple pregnancy, they (patient, physician, or both) may opt for a treatment regimen that surpasses current recommendations for ovulation induction, embryo implantation, and the like, to maximize the chances of achieving a pregnancy.[41]

Examination of the medical literature, however, reveals that the availability and increasing success of selective reduction has not had an adverse impact on the standard of care used in infertility treatment. In fact, the concurrent development of other technologies, particularly cryopreservation of embryos,[42] has decreased

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[37] *See, e.g.*, Lynch et al., *supra* note 22, at 736 (reporting 85 cases in which a multiple gestation was reduced; 66 pregnancies resulted from ovulation induction, 12 from in vitro fertilization, and 7 from gamete intrafallopian transfer). For a discussion of these infertility therapies, see *infra* text accompanying notes 69-78. The only reports of selective reduction used in response to a naturally conceived pregnancy are those cases in which an anomalous twin pregnancy is reduced to a single fetus. See *infra* text accompanying notes 56-61 for a discussion of selective reduction of an anomalous twin.

[38] *See* U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, INFERTILITY: MEDICAL AND SOCIAL CHOICES 117-35 (1988) (outlining variety of infertility treatments currently available in United States).

[39] One physician researching in the area of selective reduction reports that the incidence of multiple gestation in induced ovulation, a technique used in most forms of female infertility therapy, ranges from 16 to 39%. *See* Hobbins, *supra* note 20, at 1062.

[40] *See infra* notes 54-99 and accompanying text.

[41] *See infra* note 88.

[42] *See generally* Linda R. Mohr et al., *Deep-Freezing and Transfer of Human Embryos*, J. IN VITRO FERTILIZATION EMBRYO TRANSFER, Mar. 1985, at 1 (discussing cryopreservation).

the number of embryos implanted following ovulation induction. Thus, it appears that physicians and patients do not view selective reduction as a "bail out" procedure for overly aggressive fertility treatment, but rather as yet another technology to take its place along the spectrum of available infertility treatments.

The technical aspects of the procedure described in Part I raise questions about the relationship between selective reduction and abortion. Part II explores this relationship, focusing on the surgical techniques used for both and on the intent of the parties participating in both procedures.[43] A woman undergoing a "traditional" abortion[44] intends that her entire pregnancy will be terminated: that following successful completion of the procedure she will no longer be pregnant. In contrast, a woman undergoing selective reduction intends that her pregnancy will not be terminated, but rather will be enhanced by creating a better environment for her fetus(es) to develop. The difference in intent so separates these two procedures as to render them wholly distinguishable. This distinction should be maintained in the policy-making and political arenas that swirl around the abortion issue. Given the predicted demise of *Roe v. Wade*[45] and the constitutional right to choose abortion,[46] it is important to keep selective reduction out of the abortion debate. Physicians practicing in the area of reproductive technologies must be permitted to offer this life-saving technology to their patients free from whatever restrictions their state governments may place on abortion.[47] Moreover, to allow selective reduction to be swallowed up in the

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[43] *See infra* notes 100-215 and accompanying text.

[44] I use the term "traditional" abortion here to refer to a situation where a woman is desirous of terminating her entire pregnancy. I am assuming that this scenario—as opposed to a scenario where a woman remains pregnant following the procedure—is what most people think of when they think of abortion.

[45] 410 U.S. 113 (1973).

[46] In a television interview, Nadine Strossen, President of the American Civil Liberties Union, and Robert Bork, former judge of the United States Court of Appeals for the District of Columbia Circuit, predicted that *Roe v. Wade* will be overturned by 1993. *See Roe v. Wade Foe, Backer See Reversal*, L.A. TIMES, June 24, 1991, at A18; *see also infra* notes 127-29 and accompanying text (discussing recently enacted state statutes that restrict a woman's right to choose abortion).

[47] *See infra* text accompanying notes 123-29 (discussing restrictive abortion legislation and United States Supreme Court's decision in Webster v. Reproductive Health Services, 492 U.S. 490 (1989), which grants states more power to restrict abortion).

abortion debate would be to bury it in the political process much the way other seemingly abortion-related technologies have been buried.[48]

Part III of this Article looks at the ethical and moral dilemmas raised by selective reduction.[49] At issue is a basic question pondered over time by moral philosophers and others: Is it ever right to do harm to one just to benefit another? American jurisprudence has often prided itself on protecting the individual from being invaded and hurt by another, reasoning that in a free society, every individual has a right to bodily security.[50] This principle comes sharply into focus when one person asks another to submit to an intrusion or extraction of her body for the sake of the other. Generally, our jurisprudence has denied requests from those in need of rescue, in the form of medical treatment or otherwise, from gaining forced access into another's bodily integrity. Do our hard-wrought concepts of jurisprudence, including the mandate against forced rescue and the duty to do no harm to others, make us bristle at the thought of selective reduction? While these areas of the law serve as relevant analogies, in the end selective reduction must be viewed as the unique scenario that it is—a lifeboat in the womb in which some must die for the others to live.

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[48] A striking example of the abortion debate stifling the advancement of scientific research and development is in the area of fetal tissue transplantation. Over the objections of two federal panels that said experiments with fetal tissue hold promise for treating diabetes and Parkinson's disease, the Bush Administration extended an existing ban on financing such research in 1989. Administration abortion opponents say that fetal tissue transplants are unethical because they encourage women to have abortions to provide a supply of the tissue. *See* Philip J. Hilts, *Abortion Debate Clouds Research on Fetal Tissue*, N.Y. TIMES, Oct. 16, 1989, at A19. For a discussion of existing laws regulating fetal tissue transplantation, see Jenn S. Bregman, Comment, *Conceiving to Abort and Donate Fetal Tissue: New Ethical Strains in the Transplantation Field—A Survey of Existing Law and a Proposal for Change*, 36 UCLA L. REV. 1167 (1989).

[49] *See infra* notes 216-68 and accompanying text.

[50] *See* Nancy K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951 (1986). As a prelude to her conclusion that courts should not force women to submit to Cesarean sections under any circumstances, Professor Rhoden argues that Anglo-American law imposes no duty to come to the assistance of a person in distress. *Id.* at 1976. Instead, the principles of privacy, autonomy, and bodily integrity compel courts to deny any request for involuntary sacrifice of one for the sake of another. *Id.* at 1978.

Finally, Part IV examines the doctrine of informed consent as applied to infertility treatment, asking what role selective reduction plays in a physician's pretreatment disclosure to patients.[51] Part IV concludes that the availability of the procedure should be disclosed to every patient undergoing fertility treatment which entails a risk of multiple pregnancy.[52] This disclosure must come early in the treatment process so that a woman who would reject the procedure, as did Patti Frustaci,[53] or a woman who would reject treatment out of fear of multiple pregnancy can make an informed decision about the course of her therapy.

I. SELECTIVE REDUCTION OF MULTIPLE PREGNANCY: THE TECHNOLOGY EMERGES

A. The First Reports

Law professors are reputed to remark each fall to incoming students that "the law is a seamless web,"[54] suggesting that independent principles of law are inextricably linked to seemingly unrelated legal doctrines, together forming a massive network that continually builds upon itself. This phenomenon of self-propellment is perhaps most apparent in the field of medical technology, where one discovery advances the field and at the same time creates a void that did not exist before the introduction of the new technology. In many ways, selective reduction is a technology that was developed to fill the void created by successful therapies for female infertility.[55] Initially, however, the procedure was used to solve a naturally occurring and long-standing dilemma—a twin pregnancy with one abnormal and one normal fetus.

The surgical reduction of a multiple pregnancy was first

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51 *See infra* notes 269-300 and accompanying text.

52 *See infra* notes 301-07 and accompanying text.

53 *See supra* note 35 and accompanying text.

54 *See, e.g.,* Transworld Airlines v. American Coupon Exch., 913 F.2d 676, 685 (9th Cir. 1990) (Reinhardt, J.) (discussing "law's oft-proclaimed seamless web").

55 While the focus of this Article is necessarily on therapies for female infertility (because of their tendencies to cause multiple gestation, *see infra* note 80), it is important to note that male infertility is believed to be causative in approximately 40% of infertile couples. *See* DANFORTH, *supra* note 5, at 822. Treatment for male infertility, by itself, does not correlate to multiple pregnancy. *See id.*

reported in the United States in 1981.[56] That first report in the American medical literature and those that followed for the next five years all involved reduction of a multiple pregnancy in which one or more of the fetuses was diagnosed with a congenital abnormality.[57] In those cases, the fetal abnormalities were detected by second-trimester diagnostic techniques that give physicians a glimpse of the anatomy and genetic make up of the developing fetus.[58] Although medical literature generally reveals little about the counseling that occurs between doctor and patient, the physicians who performed the first selective reduction on an abnormal twin pregnancy reported that without the availability of the procedure, the parents would have terminated the entire pregnancy.[59] In explaining their sentiments about the technique, the doctors wrote:

> [O]ur procedure was attempted for the sake of salvaging the life of the normal twin for parents in an extreme predicament, who desperately wanted a normal child but found themselves personally unable to cope with a lifelong responsibility for a retarded

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56 *See* Thomas D. Kerehyi & Usha Chitkara, *Selective Birth in Twin Pregnancy with Discordancy for Down's Syndrome*, 304 NEW ENG. J. MED. 1525, 1525 (1981) (first report of surgical reduction of multiple pregnancy in United States).

57 *See, e.g.*, C.H. Rodeck et al., *Selective Feticide of the Affected Twin by Fetoscopic Air Embolism*, 2 PRENATAL DIAGNOSIS 189 (1982); Aris Antsaklis et al., *Selective Survival of Only the Healthy Fetus Following Prenatal Diagnosis of Thalassemia Major in Binovular Twin Gestation*, 4 PRENATAL DIAGNOSIS 289 (1984).

58 JACK A. PRICHARD ET AL., WILLIAMS OBSTETRICS 267-93 (17th ed. 1985). Prenatal diagnostic techniques include amniocentesis and ultrasound. *See id.* Amniocentesis is performed after the first trimester. *See id.* at 268. It involves inserting a needle through the woman's abdominal wall and into the amniotic fluid surrounding the fetus. A small amount of fluid is withdrawn and used by a laboratory to test for hereditary diseases or fetal defects. *See id.* Ultrasonography is a system that uses high-frequency sound waves which pass through the soft tissue of the woman's abdominal wall until they reach material of a different density. *Id.* at 278. When the sound waves encounter structures of a different density (such as the fetal skeletal structure), some of the waves bounce back to the transducer. The system is then able to translate the various waves into a picture, which is displayed on a monitor. *Id.*

59 *See* Thomas D. Kerenyi & Usha Chitkara, *Correspondence to the Editor*, 305 NEW ENG. J. MED. 1219 (1981). In their letter, the doctors discuss more broadly the dilemma faced by parents who discover through amniocentesis that their fetus has a certain genetic defect—namely Down's Syndrome. *See id.* They report that "[p]arents of fetuses with trisomy 21 [Down's Syndrome] almost invariably choose termination of pregnancy." *Id.*; *see supra* note 56 (citing first report of selective reduction in United States).

> child and who were unwilling to shift the burden to society at large.[60]

To date, fewer than thirty cases of second-trimester selective reduction have been reported in the English language literature.[61]

B. Adapting the Technology to Reduce High Order Multiple Pregnancies

Though physicians have been aware of the existence of selective reduction since 1981, it was not until 1988 that they reported using the procedure to reduce multiple pregnancies (usually of three or more fetuses) when no abnormality was known to exist.[62]

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60 Kerenyi & Chitkara, *supra* note 59, at 1219.

61 The largest report of second-trimester procedures to date is Usha Chitkara et al., *Selective Second-Trimester Termination of the Anomalous Fetus in Twin Pregnancies*, 73 OBSTET. & GYNECOL. 690, 692 (1989) (reporting 17 cases in which 4 women lost entire pregnancy).

62 *See* Richard L. Berkowitz et al., *Selective Reduction of Multifetal Pregnancies in the First Trimester*, 318 NEW ENG. J. MED. 1043 (1988) (reporting publicly for first time use of selective reduction without abnormal fetus). In this Article, I generally make no distinction between selective reduction performed on an anomalous twin and on a seemingly healthy fetus in a high order multiple pregnancy. To me, any policies surrounding selective reduction should apply equally in both instances because such policies should be based on the woman's right to control the course of her pregnancy.

The American College of Obstetricians and Gynecologists (ACOG), in a promulgated ethics opinion, has taken the position that the issues involved in "multifetal pregnancy reduction" are different from those in "selective fetal termination". Committee on Ethics, *Multifetal Pregnancy Reduction and Selective Fetal Termination*, 94 ACOG COMMITTEE OPINION 1, 2 (1991). The ACOG defines multifetal pregnancy reduction as "a first-trimester procedure in a pregnancy usually with triplets or more, designed to increase the chances of survival of the remaining fetuses." *Id.* at 1. In contrast, the ACOG describes the procedure of selective termination of an anomalous fetus as a second-trimester procedure that is different from multifetal pregnancy reduction because "[m]ost of these patients do not have infertility problems, and most of these abnormalities are diagnosed in the second trimester. The later gestational age at which these procedures are usually performed may make termination more emotionally difficult." *Id.* at 2-3. In distinguishing the ethical considerations surrounding the two procedures, the AGOC states, "Insofar as selective termination offers an alternative to aborting the entire pregnancy, its rationale may parallel that of other reductions. But insofar as the intention of selective termination is . . . to avoid having a child with a known medical problem [its ethical rationale is importantly distinctive]." *Id.* at 3. For a discussion of the ethical

To date, well over 200 cases of selective reduction have been reported in the United States.[63] Even in the few years since the procedure has emerged, doctors are reporting increasing success, measured in terms of fewer complications to the woman and her remaining fetuses. For example, when doctors published the first major study of selective reduction in 1988, they reported that one-third of the pregnancies ended with the loss of all the fetuses.[64] Two years later those same physicians reported that in eighty-five cases of selective reduction, eight women lost all the fetuses.[65] These reports demonstrate a decrease in the fetal loss rate from 33.3 percent to 9.5 percent in a very short time. Another physician recently reported that not one of his forty patients lost the entire pregnancy after the procedure.[66] A fetal loss rate of 0 to 9.5 percent becomes more meaningful when compared to the fetal mortality rate of 16 to 41 percent that accompanies multiple pregnancy.[67] Because the goal of selective reduction is to produce a healthy birth by giving the remaining fetuses room to grow and develop, the neonatal morbidity following the procedure is significantly lower than that seen in

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rationales surrounding selective reduction, see *infra* text accompanying notes 245-47.

63 *See* Lynch et al., *supra* note 22 (reporting 85 cases performed from September 1986 through December 1989 in New York); R. J. Wapner et al., *Selective Reduction of Multifetal Pregnancies*, 335 THE LANCET 90 (1990) (reporting 46 cases performed from 1987 through 1990 in Philadelphia); Tabsh, *supra* note 28 (40 cases performed from February 1987 through October 1989 in Los Angeles); Evans I, *supra* note 8 (22 cases performed from January 1986 through April 1989 in Detroit); Berkowitz et al., *supra* note 62, (reporting 12 cases performed from January 1986 to October 1987 in New York).

Selective reduction is also practiced outside the United States. *See* Josef Shalev et al., *supra* note 29, at 416 (reporting 20 cases performed in Israel); Yael Gonen et al., *supra* note 29, at 720 (reporting 6 cases performed in Canada); Adolfo Uribarren et al., *Selective Embryo Reduction in a Sextuplet Pregnancy*, 53 FERTILITY AND STERILITY, 1102, 1102 (1990) (discussing 1 case performed in Spain).

64 *See* Berkowitz et al., *supra* note 62, at 1044.

65 *See* Lynch et al., *supra* note 22, at 737.

66 *See* Tabsh, *supra* note 28, at 739. Dr. Tabsh reports that of his 40 patients, 23 presented with triplets, 13 with quadruplets, and 4 with quintuplets. The number of fetuses was reduced to 2 in 38 of his 40 cases; one woman chose to reduce quintuplets to triplets, and another reduced triplets to twins and later to a singleton after one of the remaining fetuses was discovered to have a severe abnormality. *Id.* at 740.

67 *See supra* text accompanying notes 23-25.

nonreduced multiple pregnancies.[68]

In virtually all the reported cases of selective reduction, the women presenting with multiple pregnancy had undergone some form of infertility therapy involving induced ovulation, used alone or in conjunction with another procedure.[69] In fact, the basic medical approach underlying most female infertility therapy is ovulation induction through drug therapy.[70] Doctors administer certain drugs to stimulate the ovaries to produce numerous oocytes (eggs) in a single cycle.[71] Once the multiple eggs are produced, fertilization is attempted. Fertilization can be achieved in the body (in vivo) through natural or artificial insemination, or in the laboratory (in vitro). Where and when fertilization occurs can be manipulated according to whatever reproductive technology one selects.

The most publicized reproductive technological advance has been in vitro fertilization and embryo transfer (IVF-ET). It may be difficult to believe that the world's first "test-tube baby," Lou-

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68 For example, Dr. Tabsh reports a mean gestational age at delivery of 35 weeks for his patients who underwent selective reduction (normal gestational age is 40 weeks). Tabsh, *supra* note 28, at 740. This compares with an average gestational age for triplets of 33 weeks. *See* Syrop & Varner, *supra* note 22, at 84. In the case of quadruplets, the average gestational age at the time of delivery is 31 weeks; the gestational age then decreases as the number of fetuses increases. *See* Petrikovsky & Vintzileos, *supra* note 14, at 579-83.

69 In the largest study to date of selective reduction cases, the authors report that of the 85 multiple pregnancies presented, most occurred after induction of ovulation alone, i.e. drug therapy (66); the others followed in vitro fertilization (12) and gamete intrafallopian transfer (7). *See* Lynch et al., *supra* note 22, at 736. For a discussion of these reproductive techniques, see *infra* text accompanying notes 70-78.

70 *See* Jean Lien & Jeffrey B. Russell, *High-Tech Reproduction: Advances in Reproductive Technology*, 61 DEL. MED. J. 211, 215 (1989). The most widely used fertility drug is clomiphene citrate, trade name Clomid. *Id.* Clomid has been available for clinical use since 1968. *Id.* The drug is administered orally for five days during a woman's cycle. *See id.* One study concluded that of the pregnancies resulting from the use of Clomid, 8 to 12% are multiple pregnancies. *Id.* Pergonal is a second fertility drug, *see supra* note 5, used generally after Clomid therapy has failed. *See* Lien & Russell, *supra*, at 215. While induction with Pergonal is more effective than with Clomid, it is more expensive ($500-$1000 per cycle) and carries a higher rate of multiple pregnancy (20% for Pergonal versus 12% for Clomid). *Id.*

71 Normally a woman produces one egg per cycle. *See* DANFORTH, *supra* note 5, at 821.

ise Brown, was born fourteen years ago on July 25, 1978.[72] Since then, over 10,000 IVF infants have been delivered worldwide,[73] and more than 180 IVF programs are operating in the United States.[74] Briefly, IVF involves the following steps: First a doctor treats the woman with one or more fertility drugs to induce the production of multiple eggs. Next the eggs are retrieved from the ovaries[75] and inseminated in a culture dish (the "test tube") with sperm from the husband or donor. Approximately two days later, healthy embryos are transferred back to the woman's uterus.[76] Recently two new reproductive technologies have emerged: zygote intrafallopian transfer (ZIFT) and gamete intrafallopian transfer (GIFT). ZIFT is similar to IVF-ET except that the embryos are placed in the fallopian tube instead of in the uterus;[77] GIFT involves placing retrieved eggs and sperm into the fallopian tube.[78]

Despite their technical differences, IVF-ET, ZIFT, GIFT, and

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72 *See* NEWSWEEK, Sept. 4, 1978, at 81.

73 Lien & Russell, *supra* note 70, at 211.

74 *See* Medical Research International et al., *In Vitro Fertilization-Embryo Transfer (IVF-ET) in the United States: 1989 Results from the IVF-ET Registry*, 55 FERTILITY & STERILITY 14, 14 (1991) (fourth annual report of United States Registry of IVF-ET and related practices).

75 *See* DANFORTH, *supra* note 5, at 828. The eggs are retrieved by inserting a needle transabdominally, transurethrally, or transvaginally, under ultrasound guidance. *Id.* at 830. The patient is generally under local anesthesia for the retrieval process. *Id.*

76 *See id.* at 832 (defining healthy embryos as those that reach the four- to eight-cell stage).

77 *See* C. Staessen et al., *An 18-Month Survey of Infertility Treatment by In Vitro Fertilization, Gamete and Zygote Intrafallopian Transfer, and Replacement of Frozen-Thawed Embryos*, 6 J. IN VITRO FERTILIZATION & EMBRYO TRANSFER 22 (1989) (comparing ZIFT and GIFT with IVF-ET). Physicians believe placement in the tube is a more physiologic approach to pregnancy because fertilization normally occurs in the tube. *See id.* at 28.

78 *See* R.H. Asch et al., *Pregnancy After Translaparoscopic Gamete Intrafallopian Transfer*, THE LANCET, Nov. 3, 1984, at 1034, 1034 (describing 100 completed patient GIFT cycles producing 28 pregnancies). The first pregnancy using GIFT was reported in 1984. *Id.* In GIFT, induced oocytes are retrieved through laparoscopy. *See id.* The oocytes and sperm are then deposited into the fallopian tube with a catheter. *See id.* GIFT has several advantages over IVF-ET. *See* Stassen et al., *supra* note 77, at 28. First, GIFT involves in vivo fertilization, which is more physiologic than IVF. *Id.* Also, GIFT is usually less expensive because the need for highly trained embryologists and sophisticated laboratory facilities is reduced, and GIFT can be performed in one procedure, thus allowing shorter patient hospitalization. *See* DANFORTH, *supra* note 5, at 839.

even insemination following ovulation induction share the same common denominator for success—the more eggs that are produced, fertilized, and (in the case of IVF and ZIFT) transferred, the better a woman's chances of getting pregnant. For example, in IVF-ET, it has been shown that pregnancy rates improve with increasing numbers of embryos per transfer.[79] The pregnancy rate plateaus if more than three or four embryos are transferred, but multiple gestation rates rise sharply.[80] Despite these findings, infertility specialists have openly reported using more aggressive therapy. In one particular case, physicians using GIFT reported retrieving and transferring eight oocytes "with the intent to increase the likelihood of multiple pregnancy."[81]

Given the seeming medical certainty that three or four embryos or eggs maximize the opportunity for pregnancy while minimizing the likelihood of a dangerous multiple pregnancy, one would imagine that infertility specialists would be compelled, either by law or through the evolution of a generally held standard of care,[82] to adopt the practice of limiting the number of embryos or eggs transferred in any one cycle. To date, however, there are no federal regulations governing the clinical practice of infertility therapy.[83] In fact, the single entity that could guide infertility

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79 *See* DANFORTH, *supra* note 5, at 833. This text states that the pregnancy rate using IVF plateaus after four concepti are transferred. *Id.*

80 *Id.* In a recent study comparing IVF-ET and GIFT, researchers reported pregnancy rates of roughly 20% using IVF-ET and 31% using GIFT. *See* Stephen L. Corson et al., *Outcome in 242 In Vitro Fertilization-Embryo Replacement or Gamete Intrafallopian Transfer-Induced Pregnancies*, 51 FERTILITY & STERILITY 644, 644 (1989). The multiple pregnancy rate for the two procedures was reported as high as 26% for IVF-ET and 20% for GIFT. *See id.* at 647.

81 B. Brambati et al., *Selective Reduction of Quadruplet Pregnancy at Risk of B-Thalassaemia*, 336 THE LANCET 1325 (1990). As is obvious from the title of the article, a quadruplet pregnancy resulted from the treatment. *See id.* The pregnancy was reduced to twins and the patient delivered a healthy boy and girl at 37 weeks gestation. *Id.*

82 It is likely that a general national standard of care would be applied to fertility clinics because they are so highly specialized. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 188 (5th ed. 1984) [hereafter PROSSER] (discussing national standards of care for medical specialists).

83 *See* Shari Roan, *Pressure Growing to Regulate Infertility Clinics, Surrogates*, L.A. TIMES, Jan. 3, 1991, at A5. This article describes various bills introduced into Congress to regulate currently unregulated infertility clinics. For example, one bill would set minimum standards for quality assurance, record-keeping, and qualifications of lab personnel. *Id.* Our

centers in their clinical therapies, the American Fertility Society (AFS),[84] has expressly declined to make any definitive recommendations regarding the number of eggs or embryos transferred.[85] The AFS position is that decisions about the number of embryos to transfer should be made on a case-by-case basis.[86]

While patients and physicians should approach treatment decisions with some degree of flexibility, this total lack of concrete guidance could lead to widely different practices among fertility clinics. In the end, these different practice standards could result in a reduced standard of care in particular clinics. The next section in this Article explores whether the lack of an articulated standard of care, coupled with the option of selective reduction,

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country's lack of regulation is in sharp contrast to the express regulation of infertility care in England. In May 1987, the Voluntary Licensing Authority announced its intention to impose restrictions in IVF on the number of implants per cycle, with a view to curbing the frequency of multiple pregnancies and reducing the need for selective reduction. *See* Diana Brahams, *Assisted Reproduction and Selective Reduction of Pregnancy*, THE LANCET, Dec. 12, 1987, at 1409, 1409. The guidelines, issued in September 1987, provide that "if the IVF procedure is used no more than three pre-embryos should be transferred in any cycle, unless there are exceptional clinical reasons when up to four pre-embryos may be replaced per cycle. If the GIFT procedure is used no more than three or exceptionally four eggs should be introduced to the fallopian tubes." *Id.* at 1409.

84 The American Fertility Society is a national professional organization for those dealing with issues surrounding fertility and sterility.

85 In a 1990 report by the Ethics Committee of the AFS, the Committee addressed the "safe number" of embryos to be transferred in IVF as follows:

> Safety should be defined as the number of preembyros that give optimal pregnancy success on a per-cycle basis without significantly increasing the risk of triplet or quadruplet gestation. Therefore, the number of preembryos used per transfer cycle will vary according to the pregnancy success rate per treatment cycle and the incidence of multiple gestation.

Ethics Committee of the American Fertility Society, *Ethical Considerations of the New Reproductive Technologies*, 53 FERTILITY & STERILITY 58S (Supp. II 1990).

86 *See id.* An interesting question that arises regarding the standard of care in fertility treatment is does our society have a stake in trying to prevent multiple births, whenever possible, to reduce a possible fiscal drain? In other words, it may not be just individual physicians and patients (and their respective insurance companies) who care about the standard of care in fertility therapy and its association with multiple birth, but rather there may be a wider concern that focuses on the long-term impact of multiple births in our society. Though interesting, the question of societal influence on a medical standard of care is beyond the scope of this discussion.

has in fact had a negative effect on the standard of care in fertility treatment.

C. Selective Reduction and the Standard of Care in Fertility Treatment

Without specific government or self-government guidelines, infertility centers probably will most likely look internally or to each other to develop their standard of care in the field of reproductive technologies.[87] One might imagine that an infertility center, eager to attract new clientele, would market itself based on its pregnancy rate. What better way to increase its pregnancy rate than to aggressively treat its patients, downplaying the rising possibility of multiple pregnancy because the pregnancy can be successfully completed with the intervention of selective reduction?[88]

Fortunately, this hideous scenario does not appear to have come to pass, at least not according to the medical literature discussing the standard of care in individual fertility centers. Of the centers reporting their data, most employ the practice that maximizes the opportunity for pregnancy while minimizing the chance of multiple pregnancy: fertilizing or transferring three to four eggs per cycle.[89] This practice has remained fairly consistent across the country, in large part because of the advent of cryopreservation of human embryos. Since the first major report of human pregnancies after the freezing and thawing of embryos in 1985,[90] cryopreservation has added an important dimension to

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87 When the Frustacis first filed their lawsuit against the doctor and fertility clinic that treated Mrs. Frustaci, lawyers for both sides anticipated that the outcome of the suit would "decide for the first time the standard of care for California fertility clinics." *See $3.2 Million Suit By Parents*, *supra* note 10.

88 In an interview with *People Magazine*, Arthur Caplan, Director of the Center for Biomedical Ethics at the University of Minnesota, expressed concern that selective reduction "might be used as a remedy for incompetent practices at fertility clinics." *A Fear That Selective Termination May Be Abused*, PEOPLE, May 9, 1988, at 51.

89 *See* DANFORTH, *supra* note 5, at 833 (reporting that to avoid multiple gestation, IVF centers limit number of embryos transferred to three or four); *see also* Frances R. Batzer et al., *Multiple Pregnancies with Gamete Intrafallopian Transfer (GIFT): Complications of a New Technique*, 5 J. IN VITRO FERTILIZATION AND EMBRYO TRANSFER 35, 35 (1988) (reporting IVF procedure where eight eggs were obtained, seven embryos resulted, three were replaced, and the other four were cryopreserved).

90 *See* Mohr et al., *supra* note 42, at 3 (reporting transfer of 68 frozen and thawed 4- and 8-cell embryos into 45 patients resulting in 9 pregnancies).

the practice of IVF-ET and GIFT.[91] With this important technology, IVF programs can fertilize all retrieved eggs, thus maximizing the chances of transferring three or four healthy embryos; any remaining embryos can be frozen for eventual transfer in a future natural cycle. This practice increases the woman's cumulative pregnancy rate per egg-retrieval procedure while avoiding most of the risks of multiple pregnancy.

Perhaps cryopreservation can be used to effectively manage the risk of multiple pregnancy when eggs or embryos are manipulated through catheters inside the woman's body, but what of the risks when ovulation induction alone is used? This is an important question given that the vast majority of multiple pregnancies resulting from reproductive technologies follow drug therapy alone.[92] In a recent report on quadruplets, the authors discovered that a variety of drug therapies, including Pergonal, caused seventy-three percent of the quadruplets studied; GIFT and IVF accounted for eighteen and seven percent, respectively, of the quadruplets.[93]

While management of a patient using drug therapy may not be as precise as with interventionist therapies, physicians can and should monitor the number of oocytes that are present in the ovaries prior to insemination. Although it is not possible to predict the number of mature eggs that will ovulate or the number of eggs that will be fertilized and implant in the uterus, it is possible to monitor egg development in the ovary through the use of ultrasound.[94] If an undesirable number of mature follicles (which

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91 *See* DANFORTH, *supra* note 5, at 836 (discussing use of cryopreservation in IVF-ET); *see also* Batzer, *supra* note 89, at 37. Dr. Batzer explains that cryopreservation has helped avoid the problem of multiple pregnancy when GIFT is used because all the eggs can be retrieved while only four are replaced in the tubes. *See id.* The rest are frozen for later use. Before cryopreservation, the technique was to aspirate only as many eggs as were needed for replacement, i.e. two per tube. *Id.* This left open the possibility that the remaining eggs could be naturally fertilized in addition to those placed in the tubes. *See id.*

As to ZIFT, there are no studies indicating the use of cryopreservation in connection with this new technique, but the possibility seems highly likely given ZIFT's similarity to IVF-ET.

92 *See supra* note 37.

93 *See* Michael S. Collins & Janet A. Bleyl, *Seventy-One Quadruplet Pregnancies: Management and Outcome*, 162 AM. J. OBSTET. & GYNECOL. 1384, 1385 (1990).

94 *See* Sergio C. Stone et al., *Incidence of Multiple Gestations in the Presence of*

release the egg from the ovary) is detected by ultrasound prior to insemination, a woman can be counselled to refrain from attempting fertilization during that cycle.[95] While a patient may reject this advice and proceed with insemination, at least she is given the opportunity to reduce the risk of conceiving a multiple pregnancy.

Because it appears that the increasing success rate for selective reduction is not inversely related to the standard of care in infertility therapy, one may next begin to look for a direct relationship between these emerging technologies. Can our current and future reproductive technologies be perfected to the point where they no longer create dangerous multiple pregnancies? Will advances in ovulation induction, IVF-ET, GIFT, and ZIFT eliminate the void currently occupied by selective reduction? While answers to these questions remain well beyond the scope of this Article, at present there appears to be no danger of rendering selective reduction obsolete. As noted earlier, high order multiple pregnancies, though rare, do occur naturally.[96] More importantly, infertility experts seem to agree that given our current fertility therapies, some degree of multiple pregnancy is inevitable.[97] One expert summarized this sentiment as follows: "Even the most skilled reproductive endocrinologist using the best techniques will still produce multifetal pregnancies."[98] Thus, physicians should continue to perfect selective reduction and should make it more widely available than its current availability in but a few major metropolitan areas.[99]

Two or More Mature Follicles in the Conception Cycle, 48 FERTILITY & STERILITY 503, 503 (1987).

95 Likewise, if the insemination is to be performed by the physician, she then has the responsibility to advise the patient regarding the risks of proceeding with the insemination. At some point, it may be considered malpractice for a doctor to proceed with an insemination when, say, five or more eggs are visible on ultrasound. In fact, the Frustaci lawsuit focused on this very issue; the plaintiffs alleged that Mrs. Frustaci's treating physician failed to properly monitor her following injections with Pergonal, and thus failed to warn her that any attempt at fertilization could result in a multiple pregnancy. *See $3.2 Million Suit by Parents*, *supra* note 10.

96 *See supra* notes 7-8 and accompanying text.

97 *See* Stone et al., *supra* note 94, at 504.

98 Tabsh, *supra* note 28, at 740.

99 *See supra* note 63 (describing current centers for selective reduction as New York, Los Angeles, Detroit, and Philadelphia).

II. Selective Reduction and Abortion: Distinguishing Practices and Principles

Few would argue with the proposition that selective reduction bears some relation to abortion; both are surgical procedures performed on a pregnant woman for the purpose of terminating one or more fetuses. This similarity has provoked some to argue that selective reduction is essentially identical to abortion and should be regulated under the laws pertaining to abortion.[100] This argument focuses exclusively on the fact that fetal death occurs and does not consider the means or the end to which that death takes place. The following section argues that selective reduction is fundamentally different from abortion, warranting its exclusion from the increasingly strict regulations surrounding abortion.[101] These differences can be seen in the way that the two procedures are performed, in the way that they are defined, and most importantly, in the intent that motivates election of the procedures.

A. The Techniques of Abortion

Part I describes the technique currently used to selectively reduce a multiple pregnancy.[102] That technique differs signifi-

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100 *See, e.g.*, David P.T. Price, *Selective Reduction and Feticide: The Parameters of Abortion*, 1988 Crim. L. Rev. 199, 209 (arguing selective reduction is euphemism for selective abortion and should be regulated under Abortion Act of England).

101 Beginning after the Supreme Court's ruling in Webster v. Reproductive Health Servs., 492 U.S. 490 (1989), which gave greater power to individual states to restrict access to abortion, several state legislatures passed laws that significantly cut back on a woman's right and access to abortion. To date, four jurisdictions have passed restrictive abortion legislation. They are: 1) Pennsylvania, 18 Pa. Cons. Stat. Ann. §§ 3205, 3206, 3209, 3211 (Purdon 1983 & Supp. 1991) (imposing a 24-hour waiting period; providing for notice to spouse prior to abortion; requiring consent of one parent; prohibiting abortions based solely on sex of fetus; prohibiting certain abortions after 24 weeks gestation); 2) Guam, Pub. L. No. 20-134 (1990) (allowing abortion only when pregnancy poses grave risk to woman's health or endangers her life); 3) Utah, Utah Code Ann. §§ 76-7-301 to -302 (Supp. 1991) (as amended by Senate Bill 23, enacted January 25, 1991) (prohibiting abortion except when pregnancy poses grave damage to woman's health or life, or in cases of rape or incest, or to prevent birth of child with grave defects); 4) Louisiana, 1991 La. Sess. Law Serv. 74 (West) (prohibiting all abortions except those to save the life of the mother or when pregnancy is result of rape or incest promptly reported to authorities).

102 *See supra* text accompanying notes 26-34.

cantly from those used to terminate an entire pregnancy. Generally, a procedure used to intentionally terminate a pregnancy is called an induced abortion.[103] The method used to induce abortion depends primarily on the stage of the pregnancy; it also depends on the woman's and the physician's preferences, on the woman's other medical diagnoses, and perhaps on statutory requirements.[104]

Approximately ninety percent of the abortions in the United States are performed in the first trimester.[105] First-trimester abortions are usually performed by means of a dilation and curettage (D & C) or a dilation and evacuation (D & E).[106] Both methods involve removal of the contents of the uterus.[107] A doctor performs a D & C by dilating the cervix,[108] inserting a hollow tube connected to a vacuum, and scraping the endometrium,[109] which contains the implanted fetus.[110] A D & E also involves removal of the contents of the uterus, usually by suction.[111]

The technical differences between abortion and selective reduction are obvious; in one, the fetus is removed from the uterus transvaginally,[112] in the other, the fetuses are terminated transabdominally[113] and remain in the uterus to avoid disrupting the uterine environment for the remaining fetuses. One could argue that these two techniques represent a distinction without a difference. After all, in both instances one or more fetuses are killed. While fetal death is a fact in both instances, the technical differ-

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103 *See* STEDMAN'S, *supra* note 17, at 3 (defining an induced abortion as one "brought on purposefully by drugs or mechanical means").

104 *See* Hutton Brown et al., Special Project, *Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth*, 39 VAND. L. REV. 597, 624 (1986); *see also id.* at 625 nn.134-35 (discussing various statutes regulating method of abortion).

105 *See id.*

106 *Id.*

107 *Id.*

108 The cervix is the opening to the uterus. *Id.*

109 The endometrium is the inner lining of the uterus. STEDMAN'S, *supra* note 17, at 464.

110 *See* Brown et al., *supra* note 104, at 607.

111 *Id.* at 624.

112 In the medical field, "trans" is a prefix meaning across or through. Thus, transvaginally means across or through the vagina. *See* STEDMAN'S, *supra* note 17, at 1476 (defining "transvaginal" as "[a]cross or through the vagina").

113 Transabdominally means across or through the abdomen. *See id.* at 1, 1472.

ences and the intended outcomes do distinguish the procedures. A woman is no longer pregnant following an abortion; a woman remains pregnant, optimally for six months, following selective reduction. These opposite outcomes mean that the procedures could not be used interchangeably.[114] They are distinct in both practice and purpose.

B. Abortion Defined

Considering the intense public debate generated on the issue of abortion, one might guess that the only common ground in the acrimony would be a settled definition of this thing that so polarizes our society. If nothing else, we could at least agree on exactly what it is we are taking to the streets and lobbying about. But no. It seems there are nearly as many definitions of abortion as there are positions in the debate. Yet among the myriad of words used to formally describe abortion, none would embrace the practice of selective reduction. In fact in some cases, selective reduction would be expressly excluded from the definition of abortion.

1. The Plain Language

What does the word "abortion" mean to those who routinely perform the procedure? *Stedman's Medical Dictionary* defines abortion as "[g]iving birth to an embryo or fetus prior to the stage of viability at about 20 weeks of gestation."[115] This definition embraces the notion that the fetus is expelled from the womb prior to viability; it also implies that the woman is no longer pregnant, having "given birth" to the product of conception.[116] The notion that abortion empties the womb is also reflected in *Web-*

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114 *Cf.* Berkowitz et al., *supra* note 62, at 1045. Some of the first attempts at selective reduction of multifetal pregnancies were attempted using transvaginal aspiration of the gestational sac closest to the cervical os (bone). *See id.* In this method, a catheter and syringe are introduced into the lowest sac and hand suction is used to aspirate the fluid and fetus from the sac. *See id.* at 1043-44. This method was used in three patients and then abandoned after the third patient lost her entire pregnancy because of intractable hemorrhage. *Id.* at 1045. The physicians were concerned about the possibility of introducing vaginal bacteria by the transvaginal approach, thus they switched to the transabdominal approach thereafter. *Id.*

115 STEDMAN'S, *supra* note 17, at 3.

116 I borrow the term "product of conception" from Barbara Katz Rothman. *See* BARBARA K. ROTHMAN, THE TENTATIVE PREGNANCY: PRENATAL DIAGNOSIS AND THE FUTURE OF MOTHERHOOD 2 (1986).

ster's Dictionary, which defines abortion as "the expulsion of a nonviable fetus."[117] Again, this definition suggests that the plain meaning of abortion is the expulsion of the fetus from the uterus, either spontaneously or by induction.[118] As explained in Part I, selective reduction does not involve the expulsion or extraction of the fetus from the womb. Instead, the fetus is injected with a toxic substance while still inside the uterus. It is then resorbed and ultimately delivered with the placenta.[119] If selective reduction is successfully performed, the woman remains pregnant and delivers one or more healthy infants. Thus, the plain meaning of the medical and general definitions of abortion do not embrace selective reduction.

Given the basic agreement between members of the medical community and the general public as to the definition of abortion, it should come as no surprise that lawyers ascribe a somewhat different meaning to the term. *Black's Law Dictionary* defines abortion as "[t]he knowing destruction of the life of an unborn child or the intentional expulsion or removal of an unborn child from the womb other than for the principal purpose of producing a live birth or removing a dead fetus."[120]

The legal view of abortion differs from the medical and general views in several important respects. First, the legal definition expressly excludes from its scope a spontaneous abortion, com-

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117 WEBSTER'S, *supra* note 26, at 5.

118 Here I use the term "plain meaning" to suggest that the definitional words taken together are unambiguous in their meaning. The plain meaning doctrine is most often associated with statutory interpretation. *See* Hamilton v. Rathbone, 175 U.S. 414, 419 (1899) (Brown, J.) (stating that "where the act is clear upon its face, and when standing alone it is fairly susceptible of but one construction, that construction must be given to it"). I would argue that the language used to define abortion, definitional, statutory, and otherwise, is clear not necessarily in its own right, but insofar as it plainly does not encompass selective reduction. For a discussion of the plain meaning doctrine as applied to abortion statutes, see *infra* text accompanying notes 130-41.

119 *See supra* text accompanying note 31.

120 BLACK'S LAW DICTIONARY 7 (5th ed. 1979). In the sixth edition, *Black's Law Dictionary* changes the definition of abortion as follows: "The spontaneous or artificially induced expulsion of an embryo or fetus. As used in legal context, usually refers to induced abortion." BLACK'S LAW DICTIONARY 7 (6th ed. 1990). My analysis of the legal definition of abortion follows the earlier definition because, as is made clear in the text accompanying notes 130-31, a majority of the states have adopted the earlier definition in their abortion statutes.

monly referred to as a miscarriage.[121] Both the medical and general definitions provide for spontaneous abortion. The law's failure to recognize a miscarriage as an abortion most likely stems from its focus on state of mind. This focus, the second key distinguishing feature between the definitions, is unique to the legal view of abortion; the medical and general definitions are silent as to the state of mind surrounding an abortion. Conversely, the law views abortion as a "knowing" or "intentional" act of one or more persons (presumably the woman and her physician); thus, a miscarriage is not an abortion because it occurs naturally, devoid of any associated state of mind.

Like the nonlegal definitions, the law describes abortion as the expulsion of the fetus from the womb, but then goes on to qualify that the expulsion not be for the "principal purpose" of live birth or removing a dead fetus, presumably one that died naturally in utero and not as a result of induced death.[122] An argument can be made that the "principal purpose" portion of the definition modifies both the first part dealing with the destruction of the life of an unborn child and the second part pertaining to the expulsion of the fetus. If this is the case, then an abortion does not occur when the principal purpose of a knowing destruction of the life of an unborn child is to produce a live birth. Therein lies selective reduction. Plainly, the principal purpose of selective reduction is to produce one or more live births. Because the law seems to define abortion by one's motivation to avoid producing a live birth, the legal definition of abortion cannot also include selective reduction.

2. Statutory Schemes Defining Abortion

The political future of selective reduction lies not in academic legal or medical definitions of abortion, but rather in the meaning

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[121] *See* STEDMAN'S, *supra* note 17, at 881 (defining "miscarriage" as "spontaneous expulsion of the products of pregnancy before the middle of the second trimester"); *see also* WEBSTER'S, *supra* note 26, at 5 (defining "abortion" as "spontaneous expulsion of a human fetus during the first 12 weeks of gestation—compare MISCARRIAGE").

[122] During most abortions, the fetus does not die until after separation from the uterus, i.e. expulsion from the womb. The only exception is a saline abortion, performed during the second or third trimester of pregnancy in which a salt solution, toxic to the fetus, is injected into the amniotic fluid. *See* Brown et al., *supra* note 104, at 625. Fetal death usually occurs within a few hours. *Id.*

attributed to abortion by state legislatures. In 1989, the United States Supreme Court expressed willingness to have the question of abortion resolved on a state-by-state basis. In *Webster v. Reproductive Health Services*,[123] the Court upheld a Missouri statute which prohibits the use of public employees and facilities to perform or counsel on abortions that are not necessary to save a woman's life; the Missouri statute also requires physicians to test all fetuses believed to be twenty weeks or older to determine viability.[124] The Court acknowledged that its holding would "allow some governmental regulation of abortion that would have been prohibited under [earlier Supreme Court] cases."[125] This acknowledgement opened the door for the abortion issue to join the "legislative process, whereby the people through their elected representatives deal with matters of concern to them."[126]

Following the Court's invitation, several states passed restrictive abortion legislation,[127] the most restrictive of which prohibits abortion except when it is necessary to save the life of the mother or when the pregnancy results from rape or incest that is promptly reported to authorities.[128] While the constitutional validity of these restrictive statutes is currently being litigated,[129]

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123 492 U.S. 490 (1989).

124 MO. ANN. STAT. § 188.029 (Vernon Supp. 1992); *see Webster*, 492 U.S. at 501.

125 492 U.S. at 521.

126 *Id.*

127 See *supra* note 101 for a description of the four restrictive post-*Webster* abortion statutes.

128 *See* Louisiana House Bill 112 (enacted June 18, 1991), 1991 La. Sess. Law Serv. 74 (West).

129 *See* Planned Parenthood of Southeastern Pennsylvania v. Casey, 744 F. Supp. 1323 (E.D. Pa. 1990), *aff'd in part and rev'd in part*, 947 F.2d 682 (3d Cir. 1991), *cert. granted, in part*, 112 S. Ct. 932 (U.S. Jan. 21, 1992) (Nos. 91-744 & 91-902). In granting certiorari, the Court agreed to consider whether the Court of Appeal erred in ruling on the constitutionality of five provisions of the Pennsylvania abortion statute. A decision in this highly-watched case is expected in late June or July. *See* Linda Greenhouse, *High Court Takes Pennsylvania Case on Abortion Right*, N.Y. TIMES, Jan. 22, 1992, at A1. Likewise, in Guam a federal district court struck down that jurisdiction's new abortion law as violating the principles set out in *Roe v. Wade*. *See* Tamar Lewin, *High Court Has Several Options for New Look at Abortion Right*, N.Y. TIMES, June 20, 1991, at A1. In Louisiana, a federal district judge struck down the new abortion law on August 8, 1991, concluding that the statute must be held unconstitutional under the terms of *Roe v. Wade*. *See Louisiana Abortion Law Is Halted in U.S. Court*, N.Y. TIMES, Aug. 8, 1991, at A16. On August 31, 1991, the Fifth Circuit Court of Appeals denied a

they certainly raise the possibility that in the not-too-distant future, other state legislatures will mobilize to prohibit or severely restrict access to abortion in all cases. If this does happen, will selective reduction also be banned? The answer lies in the way abortion is defined in the laboratory of the states.

A majority of states define abortion as the termination of a human pregnancy.[130] An example of this definition is found in the Florida law that defines abortion as "the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus."[131] As is illustrated by this statute, most states view abortion from the perspective of the intention surrounding and the result obtained from the abortion procedure. An abortion is something that is intended to end the pregnancy. Selective reduction, on the other hand, is intended to continue the pregnancy. In my view, no canon of statutory construction[132] could produce an interpretation of these statutes that would include selective reduction within the definition of abortion. The underlying purpose of the procedure—the continua-

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request from State Attorney General William J. Guste, Jr. to hold an expedited hearing of the federal district court case or to send it directly to the United States Supreme Court. *See Louisiana's Abortion Curbs Won't Get a Quick Hearing*, N.Y. TIMES, Aug. 31, 1991, at A1.

130 *See* ALA. CODE § 26-21-2(3) (1991); ALASKA STAT. § 18.16.010(d) (1991); ARK. CODE. ANN. § 20-16-702(1) (Michie 1991); COLO. REV. STAT. ANN. § 18-6-101(1) (West 1990); FLA. STAT. ANN. § 390.011(1) (West 1986); HAW. REV. STAT. § 453-16(b) (1990) (stating "abortion shall mean an operation to intentionally terminate pregnancy of a nonviable fetus"); IDAHO CODE § 18-604(1) (1990); ILL. ANN. STAT. ch. 38, para. 81-22(6) (Smith-Hurd Supp. 1991); IND. CODE ANN. § 35-1-58.5-1(b) (West 1991); IOWA CODE ANN. § 146.1 (West 1989); KAN. STAT. ANN. § 21-3407(1) (1988); KY. REV. STAT. ANN. § 311.732(c) (Michie/Bobbs-Merrill 1990); LA. REV. STAT. ANN. § 1299.35.1(1) (West 1991); ME. REV. STAT. ANN. tit. 22, § 1598(2)(A) (West 1980); MICH. STAT. ANN. § 14.15 (2835)(1) (Callaghan 1988); MINN. STAT. ANN. § 145.411(5) (West 1989); MO. ANN. STAT. § 188.015(1) (Vernon 1992); MONT. CODE ANN. § 50-20-104(4) (1991); NEV. REV. STAT. § 442.240 (1985); N.M. STAT. ANN. § 30-5-3 (Michie 1984); N.D. CENT. CODE § 14-02.1-02(1) (1991); OHIO REV. CODE ANN. § 2919.11 (Anderson 1987); OKLA. STAT. ANN. tit. 63, § 1-730(1) (West 1984); PA. CONS. STAT. ANN. § 3203 (1983); R.I. GEN. LAWS § 23-4.7-1 (1989); S.C. CODE ANN. § 44-41-10(a) (Law. Co-op Supp. 1990); S.D. CODIFIED LAWS ANN. § 34-23A-1(1) (1986); UTAH CODE ANN. § 76-7-301(1) (Supp. 1990).

131 FLA. STAT. ANN. § 390.011(1) (West 1986).

132 See EDGAR BODENHEIMER ET AL., AN INTRODUCTION TO THE ANGLO-AMERICAN LEGAL SYSTEM 132-60 (2d ed. 1988) for a discussion of canons of construction used to interpret statutes.

tion of the pregnancy—is expressly excluded by the plain language of these abortion statutes.[133]

A smaller group of states, eleven in all, defines abortion as an intent to procure a miscarriage.[134] Because miscarriage involves the expulsion of the fetus from the uterus,[135] this statutory definition also excludes selective reduction. While an abortion necessarily requires that the fetus be expelled from the uterus, selective reduction requires that the fetuses remain in the womb during the entire pregnancy. Like the majority of states, this group of states views abortion as an act that could not be held to include selective reduction. State legislation is geared toward women and physicians who act to terminate a pregnancy, and not toward those who act to enhance a pregnancy.

The handful of states that do not adhere to the definition of abortion as either a termination of pregnancy or an intent to procure a miscarriage offers a variety of definitions for the term "abortion." One state adopts verbatim the *Black's Law Dictionary* definition,[136] while another defines abortion as "an intentional expulsion of a human fetus . . . for the purpose of causing the death of the fetus."[137] As argued earlier, these definitions do not encompass the practice of selective reduction because of the

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133 See *supra* note 118 for a discussion of the plain meaning rule in statutory construction. In essence, the plain meaning rule dictates that if the statutes are susceptible of one construction, that construction should be given to them. Applying the plain meaning rule to the statutes described in the text paragraph above, I would argue that abortion, defined in terms of the "termination of a human pregnancy," is susceptible to only one meaning, that is that following the procedure, a woman is no longer pregnant. "Pregnant" is defined as "containing unborn young." WEBSTER'S, *supra* note 26, at 1788. A woman who undergoes an abortion does so to remove all her unborn young; a woman who undergoes selective reduction retains her unborn young, even those that will not be born alive.

134 *See* ARIZ. REV. STAT. ANN. § 13-3603 (1989); CAL. PENAL CODE § 274 (West 1988); CONN. GEN. STAT. ANN. § 53-29 (West 1990); DEL. CODE ANN. tit. 11, § 654 (1979); D.C. CODE ANN. § 22-201 (1989); GA. CODE ANN. § 16-12-140 (Michie 1990); MISS. CODE ANN. § 97-3-3 (1973); N.H. REV. STAT. ANN. § 585:12 (1986); N.Y. PENAL LAW § 125.05(2) (McKinney 1987); VT. STAT. ANN. tit. 13, § 101 (1974); WASH. REV. CODE ANN. § 9.02.010 (West 1988).

135 *See supra* note 121.

136 *See* MASS. GEN. LAWS ANN. ch. 112, § 12K (West 1983); *supra* text accompanying note 120.

137 TEX. FAM. CODE ANN. § 15.022 (West 1986).

intent and the actions involved in the procedure.[138] Two states define abortion as "an act [done] with the intent of producing the premature expulsion, removal or termination of a human embryo or fetus, except . . . cases in which the viability of the embryo or fetus is threatened by continuation of the pregnancy."[139] Here an argument can be made that these statutory schemes could encompass selective reduction; selective reduction involves a termination of a fetus, and the statutes do not seem to require either a termination of the pregnancy or an expulsion of the fetus. But these statutes do except from their definition those acts done to terminate a fetus that is threatened by continuation of the pregnancy. Given the grim statistics surrounding the obstetric outcome for multiple gestations,[140] one could see how selective reduction, at least in certain cases, could be excepted from this definition of abortion. Particularly in cases of quintuplets or greater, the fetuses are in grave danger if the pregnancy is continued without intervention.

A final group of state statutes defines abortion broadly as an intent to destroy an unborn child.[141] In these states, the legislative focus is on fetal death, not on the status of the pregnancy. Plainly these broad definitions could encompass the procedure of selective reduction, which produces fetal death. The question then is whether selective reduction could be regulated or banned under these statutes in the same way as abortion.

To answer this question requires one to speculate about legislative intent and judicial statutory interpretation. One thing is clear about the possible applicability of every statutory abortion definition to selective reduction—none of the abortion statutes expressly refers to selective reduction. Moreover, it is highly unlikely, given the limited utilization of the procedure, that any legislature contemplated this specialized technique when debating the abortion issue.[142] But the lack of an expressed term does

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138 *See supra* text accompanying notes 112-14.

139 NEB. REV. STAT. § 28-326 (1989); WYO. STAT. § 35-6-101 (1988).

140 *See supra* notes 17-25 and accompanying text.

141 *See* N.C. GEN. STAT. § 14-44 (1986); TENN. CODE ANN. § 39-15-201(a)(1) (1991); VA. CODE ANN. § 18.2-71 (Michie 1988); W. VA. CODE § 61-2-8 (1989); WIS. STAT. ANN. § 940.04 (West 1982). Three states, Maryland, New Jersey, and Oregon, appear to have no specific statutory language defining abortion, although the Oregon abortion statute is entitled "Termination of Pregnancy." OR. REV. STAT. § 435.435 (1987).

142 This certainly appears to be the case in the newly enacted restrictive

not save it from being captured within the plain meaning of the statute.[143] If and when a state court or legislature faces the question, "Does our statutory scheme for abortion apply to selective reduction?", I would urge it to consider not only the plain meaning of the words, but also the intent behind the words that seeks to protect fetal life.

In fact, in the few state cases to interpret the abortion statutes that prohibit destruction of the unborn child, the courts have emphasized the importance of intent. For example, in *Anderson v. Commonwealth*,[144] the court reviewed the conviction of a physician who was prosecuted for performing an abortion, which was at that time illegal under Virginia law.[145] The doctor defended himself on the ground that the fetus was dead at the time he performed the abortion; thus, he could not be prosecuted for destroying an unborn child.[146] The court held that the offense did not require that the fetus be alive, reasoning that "the intent with which the means are used is the controlling factor."[147] Because the doctor intended that his actions produce an abortion (expulsion of the fetus), it made no difference whether the fetus was alive or dead.[148] What mattered to the court was whether the doctor intended his actions to destroy the fetus. Whether or not his actions actually did kill the fetus was irrelevant.[149]

Likewise, presumably in the case of selective reduction what would matter to this court (and perhaps other courts interpreting similar abortion statutes) would be the intent motivating a physician's actions. Under the reasoning set out in *Anderson*, if the phy-

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abortion statutes cited, *supra*, note 101. Pennsylvania, Utah, and Louisiana all define abortion in terms of termination of a pregnancy.

143 *See, e.g., In re* Baby M, 537 A.2d 1227 (N.J. Sup. Ct. 1988) (applying adoption laws to surrogate mother contract even though existing law made no mention of surrogacy).

144 58 S.E.2d 72 (Va. 1950).

145 *Id.* at 72. The operative words of the Virginia abortion statute at issue in the *Anderson* case are the same as those that appear in the statute today. The only difference is that the 1950 version of the statute contained an exemption for an "act . . . done in good faith, with intention of saving the life of such a woman or child." VA. CODE ANN. § 18.1-62.3 (Michie 1949).

146 58 S.E.2d at 74. The assignment of error was in fact procedural: the refusal of the trial court to instruct the jury that the commonwealth had the burden of establishing that the woman "was pregnant with a *living* fetus at the time" of the abortion. *Id.* (emphasis in original).

147 *Id.* at 75.

148 *Id.* at 76.

149 *Id.*

sician's primary intent was to save, and not destroy, fetal life, the physician would not fall under the state abortion statute. Even if the court views selective reduction as the intentional destruction of fetal life, it must at the same time see it as the intentional salvation of fetal life. Any statute that is aimed exclusively at avoiding fetal death cannot also be aimed at techniques that promote fetal life.

Because selective reduction presents these conflicting results, life-saving on the one hand, life-ending on the other, it has no real place in the abortion regulation quagmire. Selective reduction presents a unique and special set of circumstances and deserves individualized debate. To extend statutory definitions of abortion to cover selective reduction would be to foreclose debate and education about this important new technology.

C. Principles and Purposes Surrounding the Termination of Fetal Life

The preceding sections demonstrate that abortion and selective reduction are different by focusing on how they are performed, how they are defined, and how they may be viewed by lawmakers. These differences in technique, definition, and regulation, however, rest on one central theme—the intent of the woman who undergoes the procedure. A woman who undergoes an abortion intends to end her pregnancy, and her fetus must be killed to achieve that end. A woman who undergoes selective reduction intends to both continue and enhance the well-being of her pregnancy, but she must sacrifice one or more of her fetuses to achieve that end. Do these different states of mind justify excluding selective reduction from the abortion debate? If not, will one's attitude toward abortion mirror one's attitude toward selective reduction? After reviewing literature concerning the values and philosophies underlying the positions on abortion, I believe that the abortion debate will not swallow up the inevitable debate on selective reduction. Specifically, selective reduction will be more generally accepted in our society because it serves to save and promote fetal well-being. To understand the different positions on abortion, it is necessary to examine the concept of the trimester framework.

1. *Roe* and the Trimester Framework

In 1973 the Supreme Court handed down its landmark decision

in *Roe v. Wade*,[150] spelling out a trimester framework for analyzing abortion regulation. Stated briefly, the trimester framework provides that during the first trimester of pregnancy, a woman is free to determine, without interference by the state, that her pregnancy should be terminated;[151] after the first trimester, the state may regulate abortion in ways that are reasonably related to maternal health.[152] The Court cited as examples of permissible state regulation of maternal health the qualifications and licensing of persons performing abortions and of facilities in which abortions are performed.[153] In the third trimester when the fetus reaches viability (pegged by the Court at somewhere between twenty-four and twenty-eight weeks), the state may regulate and even proscribe abortion to promote its interest in the potentiality of human life.[154] The state may not, however, proscribe abortion when it is necessary to preserve the life or health of the woman.[155]

At first blush, it appears that selective reduction is totally compatible with the *Roe* trimester framework. Because selective reduction is performed only during the first and second trimesters of pregnancy, when the state may not proscribe abortion, women should be able to elect the procedure free of government

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150 410 U.S. 113 (1973).

151 *Id.* at 163. The language of the opinion suggests that it is the physician, and not the woman, who is free to determine that the pregnancy should be terminated. *See id.* The Court says, "[F]or the [first trimester], the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." *Id.* Despite this language, the abortion decision has been unequivocally attributed to the woman. The Court itself attributed this right to the woman when it later said "the right of privacy, grounded in the concept of personal liberty guaranteed by the Constitution, encompasses *a woman's right to decide whether to terminate her pregnancy*." City of Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 419 (1983) (Powell, J.) (emphasis added).

152 410 U.S. at 164.

153 *Id.* at 163. For example, in the ensuing years the Court has reviewed regulations requiring hospitalization for post-first-trimester abortions. *See, e.g.*, City of Akron v. Akron Ctr. of Reprod. Health, Inc., 462 U.S. 416 (1983) (holding unconstitutional a city ordinance requiring hospitalization for all second-trimester abortions). *But see* Simopoulos v. Virginia, 462 U.S. 506 (1983) (upholding hospitalization requirement by broadly reading statutory definition of "hospital" to include licensed outpatient clinics).

154 *Roe*, 410 U.S. at 160, 163-65.

155 *Id.* at 163-64.

interference. Moreover, even if the state were to regulate abortion after the first trimester to promote maternal health, selective reduction would be permitted because it is always performed in a hospital setting by highly trained, licensed physicians.[156] Additionally, one could even argue that should a woman choose to undergo selective reduction during her third trimester, she should be free to do so because the procedure would be necessary to preserve her health. After all, it is well-documented that maternal health in a multiple pregnancy deteriorates as the fetuses grow and crowd the uterus.[157]

But this simple application of the trimester framework to selective reduction is inadequate to analyze the legality of the procedure for two reasons. First, by drawing analogies between the scope of permissible abortions and the timing of selective reduction, one implicitly analogizes the two procedures. However, the two are inherently different techniques, calling into question different values and moral judgments. These different procedures deserve separate legal standards.

Second, by applying the trimester framework to selective reduction, one assumes that both will remain constant: that the technology supporting the accuracy of the trimester framework and the current techniques used for selective reduction will remain unchanged. Needless to say, this assumption will undoubtedly prove false. To begin, in her dissent in *Akron v. Akron Center for Reproductive Health*,[158] Justice O'Connor warned that the trimester framework is no longer workable. Because the trimester framework is intimately linked to medical technology, recent medical advances have set it "on a collision course with itself."[159] In predicting this collision, Justice O'Connor implied that the time of fetal viability was changing—that fetuses might even be able to survive outside the womb during the first trimester in the not-too-distant future.[160] Under *Roe*, this would mean that states could

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156 The delicate nature of the procedure dictates that it be performed by a doctor with a high degree of professional expertise in a setting where ultrasound and other technologies are readily available.

157 *See supra* notes 18-19 and accompanying text (discussing maternal morbidity associated with multiple pregnancy).

158 462 U.S. 416 (1983).

159 *Id.* at 458 (O'Connor, J., dissenting).

160 *Id.* at 457. For a discussion of Justice O'Connor's dissenting opinion in *Akron*, see Nancy K. Rhoden, *Trimesters and Technology: Revamping* Roe v. Wade, 95 YALE L.J. 639 (1986).

not regulate that which they could proscribe!

Moreover, given the dramatic improvements seen in the few short years of its existence, the technology supporting selective reduction is bound to change in the near future. For example, the optimum time for performing the procedure may change—either sooner in the pregnancy before much fetal development has occurred, or later when doctors can better identify whether a fetus is developing normally[161] and can perform the procedure without risk to the remaining fetuses. Whichever direction technology takes selective reduction, it should be free to travel without the constraints of the trimester framework. If Justice O'Connor is right and the trimester framework is deteriorating, the point of viability may ultimately precede the optimal time for reducing a multiple pregnancy. Are we willing to risk abandonment of safe selective reduction based solely on its affiliation with abortion?

This question gains in importance as the Court's hostility toward the trimester framework grows. In *Webster v. Reproductive Health Services*,[162] the plurality severely criticized the trimester framework.[163] Currently it appears that a majority of the justices

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161 I recognize that second-trimester reductions are performed because a doctor has discovered that one of several (usually two) fetuses is not developing normally. What I am referring to here is prolonging the multiple pregnancy until more is known about the fetuses through prenatal diagnostic techniques such as amniocentesis, which is generally performed from the 15th to the 18th week of pregnancy. *See* JACK A. PRITCHARD ET AL., WILLIAMS OBSTETRICS 268 (17th ed. 1984). Currently doctors favor performing selective reduction during the first trimester to minimize the amount of degenerating tissue. *See* Wapner et al., *supra* note 63, at 92.

From an emotional and psychological standpoint, I would urge doctors to perfect selective reduction as early in the pregnancy as possible. This helps alleviate what Barbara Katz Rothman refers to as "the tentative pregnancy" in her book of the same name. *See* ROTHMAN, *supra* note 116, at 86-115. In this book, she describes the sentiments of women as they wait to undergo and receive the results from amniocentesis. *See id.* Until they are assured their baby is "normal," many hover in a type of pregnancy limbo, not wanting to fully experience their pregnancy for fear that it may be aborted. *See id.* For women electing selective reduction, a very real pregnancy limbo begins as soon as they learn they are carrying multiple fetuses. The sooner the procedure is done, the sooner these woman can be relieved of the physical, emotional, and psychological stresses associated with multiple pregnancy.

162 492 U.S. 490 (1989).

163 *Id.* at 517. For a discussion of the Court's post-*Webster* view toward the trimester framework, see David J. Zampa, Note, *The Supreme Court's*

no longer support this aspect of *Roe*.[164] Thus, if *Roe* is to fade from our legal landscape, it is important to generate a set of legal principles governing selective reduction distinct from the trimester framework. In fact, legal standards governing selective reduction should be geared away from the gestational age of the fetuses toward a standard that allows a woman to maximize the well-being[165] of her fetuses. In this light, selective reduction can be viewed not as an abortion, but as a type of fetal therapy. As with other types of fetal therapy, decisions about whether and when to elect such procedures should be left exclusively to the informed consent of the pregnant woman.[166]

Abortion Jurisprudence: Will the Supreme Court Pass the "Albatross" Back to the States?, 65 NOTRE DAME L. REV. 731 (1990).

164 Chief Justice Rehnquist wrote the plurality opinion in *Webster*, joined by Justices Kennedy and White, in which he criticized and abandoned *Roe's* trimester framework. *Webster*, 492 U.S. at 517. Justice O'Connor, as noted earlier in the text, has expressed concern about the viability of the trimester framework, stating in a concurring opinion in *Webster*, "I continue to consider [*Roe's* trimester framework] problematic . . . ." *Id.* at 529 (O'Connor, J., concurring). Justice Scalia, concurring in part and concurring in the judgment, advocated overruling *Roe*. *Id.* at 532 (Scalia, J., concurring). Justice Souter, who joined the Court in October 1990, has yet to reveal himself on the *Roe* trimester framework. However, in the single abortion-related case decided during his tenure, he joined Chief Justice Rehnquist and Justices White, Kennedy, and Scalia in upholding regulations that prohibit family planning clinics from receiving federal funds for counseling clients about abortion. Rust v. Sullivan, 111 S. Ct. 1759 (1991). Granted, it is highly speculative to extrapolate Souter's views toward *Roe* based on a factually distinct case, but his allegiance with the anti-*Roe* forces is ominous. The Court's newest member, Clarence Thomas, to date has not ruled on any abortion-related matter, though his views on the issue were the subject of much debate and speculation during his confirmation hearings. *See, e.g.*, Linda Greenhouse, *Questions About Thomas, the Man, Obscured Clues About Thomas, the Jurist*, N.Y. TIMES, Oct. 27, 1991, Sec. 4, at 1.

165 I recognize that the term "well-being" is quite ambiguous; well-being could refer to a medical standard relating to physical health or to a more subjective standard embraced by the woman carrying the fetuses. Perhaps, as is now obvious, my inclination is to allow the woman to define the type and level of well-being she wishes her fetuses to attain.

166 Many legal scholars take the position that decisions regarding the treatment of a pregnant woman to benefit her fetus must be left exclusively to the woman. For an advancement of that position as well as a review of the literature in the area, see Susan Goldberg, *Medical Choices During Pregnancy: Whose Decision Is It Anyway?*, 41 RUTGERS L. REV. 591 (1989).

2. The Politics of Abortion

In 1973 when *Roe* entered the American scene, the abortion issue seemed to leap from the fringes of public concern into center stage.[167] Yet the two camps that comprise the two sides of the abortion debate were well formed long before *Roe* was decided.[168] Those who favor abortion, referred to as pro-choice, and those who oppose abortion, referred to as pro-life,[169] first confronted each other in the political arena in the early 1960s, when several states began to consider liberalizing restrictive anti-abortion laws.[170] This longstanding face-off, many have argued, has entrenched the pro-life and pro-choice movements in their positions, both dug in so deeply that even the appearance of compromise is equated with the surrender of ideology.[171] As a result, the abortion debate is viewed as ideologically bifurcated, with both sides solid in their view toward abortion—the pro-life movement opposing abortion under virtually all circumstances, the pro-choice side always favoring a woman's right to choose abortion without interference. Although the movements enjoy a fair degree of internal agreement, I believe that contemporary social philosophy toward abortion is more complex than the two starkly stated positions reflect. The following paragraphs will attempt to identify four different views on the abortion debate spectrum,[172] two within the pro-choice movement and two identified as pro-life. Identifying and carefully analyzing the various positions taken on the abortion question supports the argument that each segment of the debate, perhaps save one, can accept selective reduction under certain circumstances.

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167 I borrow this wonderful metaphor from Kristin Luker. *See* KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 1 (1984).

168 In her book, Luker traces the history of the abortion debate beginning with the Roman Empire. *See id.* at 12.

169 Like Luker, I adopt these terms to describe the two sides of the abortion issue. *See id.* at 2.

170 Prior to 1967, state laws regarding abortion generally held that anyone who provided any drug or instrument to procure the miscarriage (abortion) of a woman, unless necessary to save her life, was guilty of a crime. *See id.* at 67-68.

171 *See id.* at 1-3.

172 I realize that in no way do these four views comprise the entirety of views held toward abortion. They merely represent four randomly selected points along a crowded spectrum. I select these four positions because I do believe they represent, taken together, a majority of the arguments advanced for and against abortion.

To begin, some within the pro-choice movement believe a woman has the right to choose abortion for any reason at any point during her pregnancy.[173] For these cadres, any balancing between maternal and fetal rights should always be resolved in favor of a woman's right to self-determination.[174] I will call this group, for purposes of my argument, extreme pro-choice.

Not all those within the pro-choice movement agree that a woman can abort at any time for any reason. Some subscribe to the trimester framework set up in *Roe* and believe that once a fetus is capable of living outside the womb, it attains certain rights that cannot be trumped by a woman's right to self-determination.[175] This group would accord a woman total autonomy to choose abortion during the first half of her pregnancy, but if she chooses not to abort, she then implicitly assumes some responsibility toward her fetus and cannot cause it harm (certainly including death) thereafter.[176] I will call this group moderate pro-choice.

Like the pro-choice movement, the pro-life movement also is not unanimous in its view toward abortion.[177] At one end, a seg-

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[173] *See* LUKER, *supra* note 167, at 237.

[174] For a recent articulation of this position, see Nan D. Hunter, *Time Limits on Abortion, in* REPRODUCTIVE LAWS FOR THE 1990s, at 129-153 (Sherrill Cohen & Nadine Taub eds., 1989). In her position paper, Hunter argues that states should not deny a woman the right to have an abortion at any point during her pregnancy because to do so would impose on each woman forced pregnancy, followed by forced labor, childbirth, and parenting. *See id.* at 131. At the end of her article, Hunter proposes the following model law as a statement of the legal principle in favor of full reproductive choice:

> The state shall not compel any woman to complete or to terminate a pregnancy, nor shall the state restrict the use of medically appropriate methods of abortion.

Id. at 148. Ms. Hunter is identified in the book as the Director of the Lesbian and Gay Rights Project of the American Civil Liberties Union, though her position is not expressly attributed to the ACLU. *Id.* at 449.

[175] *See* LUKER, *supra* note 167, at 237.

[176] This is the position taken by Professor John A. Robertson in *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405 (1983).

[177] In addition, like any political or social movement, the pro-life movement includes a number of factions, with different motives, ideologies, and strategic approaches to their goal. *See* FREDERICK S. JAFFE ET AL., ABORTION POLITICS: PRIVATE MORALITY AND PUBLIC POLICY 77-83 (1981) (discussing affiliation of different groups that make up right to life movement).

ment of the pro-life movement opposes abortion at all times for all reasons.[178] Public opinion polls indicate that about one-fourth of all pro-life activists hold this view.[179] This group attributes the same moral and legal status to embryonic and fetal life as it does to after-born life.[180] Thus, to tolerate any abortions at all, even abortions to save the life of the mother, would be the first step on a slippery slope away from their moral position that pre-born and after-born life belong to the same moral order and possess equal rights.[181] I classify this group as extreme pro-life.

Finally, a portion of the pro-life movement accepts abortion under so-called tragic circumstances.[182] These circumstances occur when the woman's life is endangered, when the pregnancy is the result of rape or incest, and when there is a good chance that the child will be born with substantial handicaps.[183] I will refer to this group as moderate pro-life.

One may wonder how a pro-life advocate could tolerate abortion under even tragic circumstances, because to do so would be to acknowledge that at times the woman's rights are superior to those of the fetus. With respect to the circumstance in which the woman's life is at stake, pro-life advocates justify abortion under two doctrines: the doctrine of indirect effect and the doctrine of unjust aggressor.[184] Briefly, the doctrine of indirect effect holds that although it is never morally right to "directly" perform a forbidden act (such as killing an embryo), it is morally permissible to undertake another act that may have the forbidden action as an unintended consequence. For example, in the case of a pregnant

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178 *Cf.* LUKER, *supra* note 167, at 230 (stating that "the [pro-life] movement and individual activists have [argued] . . . that there are virtually no cases in modern obstetrical science where the life of the mother need be pitted against the life of the embryo").

179 *Cf. id.* at 229 (stating that in interviews "about three-quarters of the pro-life activists indicated that they found abortion in . . . [cases where mother's life is threatened] at least tolerable").

180 *See id.* at 230.

181 *Id.*

182 *Id.* at 230-35.

183 *See id.* at 229. According to the National Opinion Research Center (NORC), in 1980 the following percentages of Americans approved of abortions in these circumstances: 90% approved of abortion when the health of the mother was at stake, 83% approved when the pregnancy was the result of rape, and 83% approved when there was the likelihood of fetal deformity. *Id.* at 287.

184 LUKER, *supra* note 167, at 231.

woman with cancer of the uterus, although it would be wrong to surgically remove the fetus to treat the woman, it would be acceptable to treat the woman's uterus with radiation therapy, indirectly causing the death of the fetus.[185]

The doctrine of unjust aggressor holds that although it is never right to take another person's life, it is permissible to protect yourself when an unjust aggressor threatens your life, even at the cost of the intruder's life. Under this theory, fetuses that threaten the life of the woman can be considered unjust aggressors, however inadvertent, whose lives may be ended.[186]

With respect to the moderate pro-life's acceptance of abortion in the case of rape or incest, many consider this to be a political concession to gain public support, rather than a closely-held ideological tenet.[187] Because the pro-life movement focuses on the rights of the fetus and not on the rights of the woman, it is inclined to disregard the trauma a woman must suffer by being forced to bear the child of a rapist. Nevertheless, some commentators believe that because a wide majority of Americans favor abortion in the case of rape or incest, a portion of the pro-life movement has adopted this tragic circumstance as part of its platform.[188]

While it is tempting to blame seemingly hypocritical views on political compromise, I am inclined to believe that the pro-life acceptance of abortion in cases of rape or incest flows from some compassion for the plight of the violated woman. Perhaps the moderate pro-life group views the embryo that results from the unwanted act as an extension of the unjust aggressor himself, which may be killed to preserve the life, albeit the emotional life, of the mother.

The last so-called tragic circumstance described above, that of a defective fetus, creates some tension within the pro-life movement. Those in the extreme pro-life group are emphatic in their abhorrence of abortion for fetal defects.[189] To them, the logic of abortion in this case depends upon the judgment that the embryo is "damaged" and therefore can be destroyed. This suggests to the extreme pro-life group that humans can be ranked along

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185 *Id.* at 232.

186 *Id.*

187 *See, e.g., id.* at 234.

188 *Id.* at 235-36.

189 *Id.* at 236.

some scale of perfection, and people who fall below a certain arbitrary standard can be excluded. The extremists in the pro-life movement will not exclude human life for any reason.[190]

On the other hand, those in the moderate pro-life group find abortion for fetal defects acceptable. Public opinion polls suggest that this view is held by a majority of Americans,[191] and by all accounts it is held by a majority of those who state that in general they oppose abortion. In a Times Poll, fifty-four percent of those responding to the question, "Do you favor abortion in general?", stated that they oppose abortion in general.[192] In the same survey, eighty-one percent of those responding said they favored abortion "if there is a serious birth defect."[193] Perhaps as many as half of those respondents considered generally pro-life also favor abortion in cases of fetal defect.[194] Thus, it appears that at least some portion of the pro-life movement would condone abortion performed to avert the birth of a severely impaired child.

3. The Politics of Selective Reduction

The obvious question that arises from seeing a glimpse of the views held regarding abortion is will these views shape the way each segment views selective reduction? And if so, can such a wide spectrum of views accept selective reduction, with its seeming similarities to abortion? Can the extreme pro-life and the extreme pro-choice be united in their judgment regarding the

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190 *Id.*

191 *See supra* note 183; *infra* note 193 and accompanying text.

192 *See* George Skalton, *The Times Poll; Most Americans Think Abortion is Immoral*, L.A. TIMES, Mar. 19, 1989, Part 1, at 1. Specifically, the *Times* reported that 34% responded they favored abortion in general, while 40% said they opposed abortion in general. *Id.*

193 The actual results were that 74% said they favored abortion if there is a serious birth defect and 17% said they opposed abortion under those circumstances. *See id.*

194 This article does not attempt to analyze the statistical significance of these two sets of responses. My conclusion is based on a crude analysis of the figures. Since roughly 54% oppose abortion in general and only 17% oppose it in cases of serious birth defect, I assume that the 17% comes wholly out of the 54% group and not from the group that favors abortion in general. Let me note that I realize that the number of people responding to each question varied (74% total for the general abortion question and 91% total for the birth defect question). I am uncertain to what extent this difference skews my admittedly crude analysis, but I still believe that the numbers reflect that some within the pro-life movement do favor abortion for so-called fetal indications.

morality of killing a fetus under the special circumstances presented by multiple pregnancy? While I do not tout selective reduction as the compromise that has so eluded the abortion battle, I do believe that it presents a small piece of common ground for each segment of the debate.

It is fairly easy to understand the pro-choice approval of selective reduction. From the extreme pro-choice perspective, a woman can abort as many fetuses as she chooses at any point in her pregnancy. This would include termination of one or more normal fetuses[195] during the first trimester of pregnancy as well as termination of an anomalous twin during the second trimester. At all times, those in the extreme pro-choice camp would focus on the woman's right to control her reproductive destiny including, for example, the right to decide the number of fetuses to reduce.

It would also appear that because selective reduction is performed before the fetuses reach viability, the moderate pro-choice movement would likewise fully approve of the current procedure. This segment's opposition to abortion arises only after the fetus has reached viability and is based on the theory that because the woman has elected not to abort, she owes a duty of care to the fetus.[196] Does this mean that if selective reduction were some day optimally performed during the third trimester,[197] the moderate pro-choice group would not favor a woman's right to choose to reduce during this point in her pregnancy? I think not. This moderate position is premised on the assumption that a woman who enters her sixth month of pregnancy has actively decided not to abort; this assumption would not hold true for a woman facing third-trimester selective reduction. Most likely, she would have actively decided to reduce some of her fetuses early in

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195 I use the term "normal fetus" here merely to reflect that the fetus appears grossly normal to the physician through ultrasound, but the genetic, chromosomal, and biochemical make-up of the fetus is unknown, as prenatal testing of that caliber is generally not performed on multiple fetuses until later in the pregnancy. *See* Berkowitz & Lynch, *supra* note 26, at 873.

196 *See supra* note 176 and accompanying text.

197 This seems a highly unlikely scenario, given the physiologic realities of a multiple pregnancy. Since the goal of physicians managing a wanted multiple pregnancy is to keep the patient from going into labor before the fetuses reach viability, it seems ridiculous to suggest the procedure would ever be performed once the fetuses reach viability. If the woman has chosen to go forward with the pregnancy, presumably she is hoping for her fetuses to reach viability and would not want to reduce any at this point.

the pregnancy, but must wait to do so until the third trimester. Because a woman's intentions and actions early in pregnancy drive her choices later, according to the moderate pro-choice position, it seems that the right to choose selective reduction would be limited by this group only if the choice is made after the fetuses have reached viability.

Can those who espouse a pro-life position accept selective reduction under the circumstances of a multiple pregnancy? For those in the moderate pro-life group, acceptance will likely be based on their view toward abortion in cases of a known fetal deformity. First, in the case of a multiple pregnancy where all the fetuses have only a minimal chance of being born healthy,[198] this group may view selective reduction as a way to avoid fetal morbidity and mortality while at the same time enhancing the opportunity for a healthy birth. This is not to say that this group would favor allowing the woman to decide the number of fetuses to reduce. More likely, moderate pro-life acceptance of selective reduction would begin only when the number of fetuses posed a significant risk of long-term harm, such as death or severe handicap, and would be limited to reduction of as few fetuses as possible.[199] Because this number seems to be hovering between three and four,[200] the moderate pro-life movement would likely envision a more limited use of selective reduction when all the fetuses appear to be normal.

In the case of selective reduction for a known fetal anomaly, destruction of the anomalous fetus may be acceptable based on the same tenets that justify abortion for fetal defects. If moderate pro-life advocates see abortion for fetal defects as morally acceptable, then the moral rightness of selective reduction naturally follows. In this case, as in the case of selective reduction of a presumably normal multifetal pregnancy, the pro-life group

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198 *See supra* text accompanying notes 21-25.

199 In a recent study of attitudes on the ethics of selective reduction conducted among health care professionals, ethicists, and clergy, overall acceptance of selective reduction in the case of presumably normal fetuses increased as the number of fetuses increased and decreased with advancing gestational age. *See* Mark I. Evans et al., *Attitudes on the Ethics of Abortion, Sex Selection, and Selective Pregnancy Termination Among Health Care Professionals, Ethicists, and Clergy Likely to Encounter Such Situations*, 164 AM. J. OBSTET. & GYNECOL. 1092 (1991).

200 *See supra* text accompanying notes 23-24. *But see infra* note 213 (citing reports showing improving outcomes with triplet and quadruplet pregnancies).

would strongly consider the risks presented by the procedure to the remaining fetuses. If the risks were considered too great (a number I cannot begin to pinpoint), then selective reduction would be rejected even though it offered some hope of survival to fetuses that would have no hope without the procedure. For this segment of the pro-life movement, acceptance of selective reduction as morally just is not based on enhancing the chances of survival for some of the fetuses, but rather on assuring it.

The moderate pro-life group also accepts abortion to save the life of the mother, looking to the doctrines of indirect effect and unjust aggressor.[201] While the medical literature on multifetal pregnancy warns of severe and often long-term maternal morbidity, it does not speak of maternal mortality relating to carrying a multiple pregnancy.[202] Thus, in virtually all cases, a multifetal pregnancy would not threaten the life of the mother. This is not to say that selective reduction could not be justified under either of the doctrines justifying abortion. In the case of a multiple pregnancy, it is the fetus, not the mother, whose life is threatened by the other fetuses. The doctrines of indirect effect and unjust aggressor could apply equally to protect the life of the unborn fetus.

In a real sense, selective reduction is the killing of a fetus as an indirect effect of saving another fetus. Like a cancerous uterus that must be radiated to save the mother's life, the multiple-pregnancy uterus must have the number of fetuses reduced to save the lives of the remaining fetuses. Under the doctrine of indirect effect, selective reduction can be viewed as fetal therapy that indirectly causes the death of one or more fetuses. The moderate pro-life group would accept this loss, however, as an indirect effect of saving the remaining fetuses.[203]

Justifying selective reduction under the doctrine of unjust aggressor would likely be more troubling for the moderate pro-life group. Abortion to save the life of the mother is justified under the theory of unjust aggressor because the fetus is viewed as an intruder threatening the woman's life. The woman may protect herself even at the cost of the intruder's life. Likewise,

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201 *See* LUKER, *supra* note 167, at 231-35.

202 *See supra* note 18-19 and accompanying text.

203 The doctrine of indirect effect would probably not apply in the case of reduction of an anomalous twin that does not threaten the life of the normal fetus.

some of the fetuses should be able to protect themselves even at the cost of the other fetuses' lives. One problem with the unjust aggressor theory, in both the abortion and selective reduction context, is that it forces an image of a fetus as an unwanted intruder whose actions are judged as morally wrong. While this image is no doubt difficult for the pro-life advocate, it may be acceptable in the abortion context; if the fetus is not killed, the woman will die and will no longer be able to gestate the fetus. Thus, the fetus will die in either case. In the case of a multiple pregnancy, the woman will not die without the procedure. Left alone, she will be capable of gestating the fetuses, who will have a bare chance of surviving. But it is this bare chance that differentiates abortion from selective reduction under the unjust aggressor doctrine. The pro-life advocate would not approve of killing a fetus that had a bare chance of surviving as long as the fetus did not directly threaten the life of the mother.[204]

For those who embrace an extreme pro-life philosophy, selective reduction may be initially rebuffed because it appears to arbitrarily confer unequal status to the fetuses in a multiple pregnancy. Because doctors randomly select for termination those fetuses closest to the maternal abdominal wall,[205] selective reduction may seem to be trading one life for another—an act that the pro-life movement fundamentally rejects. But selective reduction is not trading one life that could be saved for another. In the case of a grand multiple pregnancy, the chance that even one fetus will survive is slight. Selective reduction maximizes the chance that any of the fetuses will survive. To reject the procedure is to doom the fetuses to an almost certain death. To reduce the pregnancy is the only way to show respect for the substantial moral status of fetal life.[206]

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[204] It is possible that the pro-life group could interpret the unjust aggressor theory to apply to the fetuses in relation to each other rather than in relation to the mother. Since the fetuses in a grand multiple pregnancy are a direct threat to each other, selective reduction could be justified to save the lives of some of the fetuses, who are threatened by the unjust aggressors with whom they share the womb.

[205] *See supra* text accompanying note 32.

[206] In the real world of politics and position-taking, it is difficult to anticipate how the various groups in the abortion debate will react to selective reduction. As to the pro-life movement, at least one of their spokespersons has spoken out on the procedure, although with little consistency. John Willke, President of the National Right to Life Committee, said he would only considered the procedure acceptable if the

4. On Selecting the Number of Fetuses: Who Decides?

Once a woman decides to undergo selective reduction, she faces the issue of how many fetuses to reduce. For those who favor selective reduction, the right of the woman to chose the number of fetuses to reduce may seem self-evident. Ideally, a woman should be fully informed about the risks associated with carrying various numbers of fetuses and then should decide what risks she is willing to take.

Notwithstanding the ideal of patient self-determination, not all those who extol the virtues of selective reduction likewise advocate the right of a woman to decide the number of fetuses she will ultimately carry. Some physicians who perform the procedure have taken the position that a multiple pregnancy with no known fetal defects should not be reduced to less than twins.[207] They argue that although the obstetric outcome for twins is slightly worse than that of singleton pregnancies, a twin pregnancy "leave[s] some margin for error in the event something happens to one of the remaining twins . . . ."[208] These doctors observe that because most of the patients undergoing selective reduction are infertility patients, "two children may satisfy their family planning desires."[209]

This position is highly troubling, particularly because these physicians practice what they preach—they report that one patient asked to go to a singleton pregnancy and they refused.[210] While physicians do have the right to refuse to treat a patient on the grounds of fundamental ethical or religious disagreement with the patient's wishes, they must transfer the patient's care to another physician who is willing to comply with the patient's wishes.[211] In the case of selective reduction, such a transfer is

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pregnancy clearly endangered the health of the woman. *See* Rob Stein, *Selecting Fetuses; Science Today: 'Selective Reduction' Controversial Procedure*, UPI (Regional News), May 15, 1988. This appears to reflect a moderate pro-life position. In a different interview, Mr. Willke stated that "[f]etal reduction is the thinly veiled killing of unwanted babies." *See* Denise Grady, *The Bitter Cost: Dangers of Multiple Births*, TIME MAGAZINE, May 2, 1988, at 63. This later statement reflects more of an extreme pro-life position, which would not accept selective reduction even if it were health-saving for the woman.

207 *See, e.g.*, Evans I, *supra* note 8, at 1571.

208 *Id.*

209 *Id.*

210 *Id.* at 1569.

211 This principle is set out by the Joint Committee on Biomedical Ethics of the Los Angeles County Medical Association and Los Angeles County

highly improbable. To date, only a handful of physicians are skilled in the techniques of the procedure.[212] Thus, the denial of care will be of predominant concern to the individual woman. Moreover, the long-term effects of this physician paternalism will do more harm to the advancement of selective reduction than good. If these physicians base their refusal to reduce to a singleton pregnancy, in part, on the assumption that twins fare nearly as well as single fetuses, inevitably neonatal care for triplets will advance to nearly match that for twins.[213] To be consistent, these physicians would have to refuse to reduce a triplet pregnancy,[214] and so on as neonatal care improves.

It is not clear why a physician should have the power to direct a woman's reproductive and maternal destiny. Forcing a woman to carry a twin pregnancy, with its well-known risks, because a physician believes it will satisfy her family planning desires belies the fundamental principle of choice. And ironically, it is these very physicians who must rely on women to make the very difficult choice to undergo selective reduction. Once this decision is made, the physician's responsibility is to inform the patient of the

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Bar Association in *Guidelines for Forgoing Life-Sustaining Treatment for Adult Patients* 4-5 (1990). Specifically, the guidelines state:

> Should the patient or patient's surrogate choose a course of action that would violate the ethical or religious beliefs of the physician, the physician may generally decline to participate in that course of action, where another physician who is willing to be guided by the patient's wishes will accept care of the patient. In so doing, however, the physician declining to participate must cooperate in transfer of the care of the patient to the new physician.

Id. Note that these guidelines do not (and are not intended to) address the situation where a patient requests some action that would violate a medical standard of care.

212 *Cf. supra* text accompanying note 99 (discussing limit of availability of selective reduction to a few major metropolitan areas).

213 Recent reports have shown improving outcomes with both triplet and quadruplet pregnancies. *See, e.g.*, Roger B. Newman et al., *Outpatient Triplet Management: A Contemporary Review*, 161 AM. J. OBSTET. & GYNECOL. 547 (1989); Michael S. Collins & Janet A. Bleyl, *Seventy-One Quadruplet Pregnancies: Management and Outcome*, 162 AM. J. OBSTET. & GYNECOL. 1384 (1990).

214 In fact, in an earlier report Dr. Evans, the first author of the article denouncing normal twin reduction, stated that he wanted to draw a moral line to permit selective reduction in multiple pregnancies of three or more to "insure that only the most dangerous cases see intervention, and that precedents for infanticide or euthanasia [are] not established." Evans II, *supra* note 16, at 295.

risks and benefits attendant to each gestational permutation available to her, not to dictate that permutation.[215]

III. Applying Moral Philosophy to Selective Reduction: Justifying Ends Over Means

Scholars who study the relationship between law and medical technology often remark on the inevitable gap that arises when our legal system fails to keep pace with technological developments.[216] Certainly this gap exists in the area of selective reduction. Currently no law exists regulating or even addressing the surgical procedure. Often when the legal system is forced to confront a situation anew, particularly one involving an emerging technology, it turns to existing principles to draw analogies.[217] Part II of this Article argues that analogies to abortion law may not be useful in interpreting selective reduction, in part because the existing abortion laws were drafted prior to and without consideration of the procedure. Additionally, Part II argues that

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215 *See* Christine Overall, *Selective Termination of Pregnancy and Women's Reproductive Autonomy*, Hastings Center Rep., May-June 1990, at 6. In her article, Christine Overall makes the argument that women facing multiple pregnancy are entitled to choose the number of fetuses to gestate because "[i]f women are entitled to choose to end their pregnancies altogether, then they are also entitled to choose how many fetuses and of what sort they will carry." *Id.* at 10. While I agree that the fetal number is a decision that should be left entirely to the woman, I tend to disfavor basing a woman's right to selective reduction on her right to abortion for reasons set out earlier in this Part.

216 *See, e.g.*, Katherine A. Knopoff, *Can A Pregnant Woman Morally Refuse Fetal Surgery*, 79 Cal. L. Rev. 499 (1991) (describing therapeutic fetal surgery as an example of clash between new medical technology and legal principles that are out of step). Knopoff cites as other examples of this phenomenon cases involving cell cloning, gene splicing, and in vitro fertilization—where technology far outpaces the law's ability to address the issues surrounding these developing techniques. *Id.* at 499.

217 An example of this can be seen in the area of surrogate mother contracts where the courts are asked to decide the legality of arrangements for which no formal law exists. *See, e.g., In re* Baby M, 537 A.2d 1227 (N.J. Sup. Ct. 1988) (banning commercial surrogacy contracts based in part on violation of adoption laws). *But see In re* Baby Girl L.J., 505 N.Y.S.2d 813 (1986) (holding that new procreative techniques such as surrogate mother contracts were not contemplated by New York Legislature when it adopted statute prohibiting payment in connection with adoption). For an excellent discussion of the court's strain to apply existing statutory schema to govern the Baby M case, see Marjorie M. Shultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 Wis. L. Rev. 297.

abortion and selective reduction are sufficiently distinct to warrant distinct legal standards. Without formal law and without reliable analogies, how can the legal system develop these standards? The search for standards to govern selective reduction leads to the world of moral philosophy.

What is moral philosophy? Two authors who contemplated this question responded that modern moral philosophy is the search for a rational mechanism to resolve moral controversy.[218] Although somewhat circular, this definition explains that moral philosophy is an attempt to develop standards to evaluate, criticize, and ultimately categorize the distinction between right and wrong conduct.[219] The term "moral philosophy" is often used interchangeably with the term "ethics," which is defined as the study of standards of conduct and moral judgment, that is, moral philosophy.[220]

Contemporary moral philosophy comprises competing theories, each advancing the supremacy of a distinct interest or theme. Two moral theories that seem particularly relevant to a study of selective reduction are utilitarianism and deontology. The basic idea behind utilitarianism is that human actions and practices should be evaluated ultimately in terms of their tendencies to advance the general welfare or social good—to produce as a consequence the happiness or well-being of a majority of persons. The essence of the theory is best summed up by the slogan, " 'The greatest happiness for the greatest number.' "[221] Utilitarianism requires following the course of action that leads to the best possible consequences, and thus the ends are permitted to justify the means.[222]

A standard objection to utilitarianism is that some actions which we feel are wrong would be morally permissible if they

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218 JEFFRIE MURPHY & JULES COLEMAN, THE PHILOSOPHY OF LAW: AN INTRODUCTION TO JURISPRUDENCE 73 (1984).

219 I derive this explanation of Murphy and Coleman's definition of moral philosophy, *supra* note 218, from C.E. HARRIS, JR., APPLYING MORAL THEORIES 2 (1986).

220 HARRIS, *supra* note 219, at 2. Harris argues that moral philosophy is synonymous with ethics because it involves a set of specifically elaborated principles of ethics. *Id.*

221 MURPHY & COLEMAN, *supra* note 218, at 74 (quoting JEREMY BENTHAM, PRINCIPLES OF MORALS AND LEGISLATION (1789)).

222 *See* Knopoff, *supra* note 216, at 505 (distinguishing utilitarianism from deontology as applied to maternal refusal of fetal surgery).

yielded an overall balance of good consequences.[223] Dire examples launched by critics of utilitarianism typically involve a person or small class of persons being treated in some horrendous way so that the majority can benefit by this victimization. A vivid illustration is a healthy young patient who goes to her physician for a routine examination only to be killed for her organs so that five dying patients can be saved. Utilitarianism would likely favor such action because one dead is better than five dead.[224] This finding clearly rests on the notion that the ends justify the means.

In contrast, deontology, or rights-based theory, demands that the means justify the ends.[225] Deontological ethic is closely associated with Immanuel Kant and his moral rule or categorical imperative: "*Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end.*"[226] Put in a more contemporary idiom, this imperative comes to the following: "All rational persons have a right not to be used without their consent even for the benefit of others."[227] Certainly this means that a deontologist would never condone the sacrifice of one to provide organs for five. Such an action is morally wrong because it violates the rights and autonomy of the individual.

With these seemingly opposite moral philosophies in mind, it is interesting to briefly peruse Anglo-American jurisprudence to observe whether philosophical underpinnings are reflected in legal reasoning and, if so, which themes dominate. If we ultimately believe that law is shaped by moral philosophy, whether grounded in utilitarianism or deontology, then we may be better able to anticipate the law's reaction to selective reduction, an act which reaches the heart of the ends-means debate.

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223 *See* Rhoden, *supra* note 50, at 1995 (discussing perils of judicial consequentialism in context of forced Cesarean sections).

224 *See id.* at 1996-97 & n.264 (citing Judith J. Thomson, Comment, *The Trolley Problem*, 94 YALE L.J. 1395, 1406-15 (1985)).

225 *See* SAMUEL SCHEFFLER, THE REJECTION OF CONSEQUENTIALISM 2-3 (1982).

226 IMMANUEL KANT, GROUNDWORK OF THE METAPHYSICS OF MORALS 96 (H. J. Paton trans., 1964) (emphasis in original). For a discussion of Kantian theory's focus on autonomy, rights, and treating persons as ends in themselves, see MURPHY & COLEMAN, *supra* note 218, at 78-86.

227 MURPHY & COLEMAN, *supra* note 218, at 83.

A. Moral Philosophy and the Criminal Law

On its surface, American criminal law seems to embody a deontological ethic; crimes are defined in terms of a human act and the state of mind surrounding that act,[228] generally focusing on whether the act violated the rights of another and not on whether the act resulted in more good than harm.[229] Yet a shining example of utilitarianism in criminal law can be found in the defense of necessity. When the necessity defense applies, it justifies the defendant's conduct in violating the literal language of the criminal law (hence, the rights of another) so that the defendant is not guilty of the crime in question.[230] Clearly when a necessity defense applies, the ends (or at least the anticipated ends) justify the means.

Do the ends ever justify the means in the case of homicide? Put more specifically, should one who intentionally kills another to save oneself be guilty of murder?[231] Two famous lifeboat cases, one English and one American, shed significant light on this question. In the English case, *Regina v. Dudley & Stephens*,[232] three sailors (the two defendants and a third seaman) and a seventeen-year-old cabin boy were adrift in an open lifeboat as a result of a shipwreck. On the twentieth day at sea, after having been without food and water for several days, Dudley and Stephens killed the ailing cabin boy with a knife.[233] The two reasoned that the boy, being in a much weaker condition, was likely to have died before

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228 *See* WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., CRIMINAL LAW 7 (1986) (defining a crime as conduct composed of an act or omission to act where there is a duty to act and state of mind that accompanies act or omission).

229 An example of the criminal law's focus on rights violation can be found in State v. Moe, 24 P.2d 683 (Wash. 1933), in which a crowd of unemployed people helped themselves to groceries in a grocery store and were charged with larceny. The court upheld the convictions, stating that their economic necessity was no defense to the crime. *Id.*

230 *See* LAFAVE & SCOTT, *supra* note 228, at 443.

231 Murder was defined at common law as the unlawful killing of another living human being with malice aforethought. *Id.* at 605. Today, the crime is generally defined by the type of murder involved (type according to the mental element) such as intent-to-kill murder or intent-to-do-serious-bodily-harm murder. *See id.* For purposes of my discussion, I intend that the word murder be given a broad meaning—the unlawful killing of another human being—and leave for debate the exact state of mind of the actor.

232 14 L.R.-Q.B. 273 (1884), *reprinted in* JAMES VORENBERG, CRIMINAL LAW AND PROCEDURE 372 (2d ed. 1981).

233 *Id.* at 373.

them.[234] For the next four days, the three men ate the body and blood of the slain boy, allowing them to stay alive until a passing vessel rescued them.[235]

Dudley and Stephens were charged with murder. As expected, they raised the defense of necessity, arguing that all four were doomed to death unless one was killed for the others to eat.[236] The court viewed this argument as a proclaimed duty of self-preservation. Rejecting this duty, the court instead held that "[t]he duty, in case of shipwreck . . . impose[s] on men the moral necessity, not of the preservation, but of the sacrifice of their lives for others . . . ."[237] Under the facts stated in the case, fulfilling the court's duty of self-sacrifice may have required one of the seamen to commit suicide because had they waited and done nothing, the boy would have died first. The only way to save the boy would have been to immediately provide him nourishment. But Dudley and Stephens worked to save themselves, and for this they were sentenced to death.[238] The holding in this case indicates that English law rejects a utilitarian ethic when human sacrifice is involved. The ends cannot justify the means when the rights of an innocent person are violated.

The American case, *United States v. Holmes*,[239] involved an overloaded lifeboat after a shipwreck. The lifeboat contained nine seamen and thirty-two passengers.[240] A storm began that threatened to sink the boat; to lighten the boat so that she might ride out the storm, some of the crew members, including the defendant, threw fourteen male passengers overboard to their certain death.[241] The lightened boat remained afloat and sailed to port.[242] Thereafter, the defendant was tried and convicted of manslaughter.[243]

In *Holmes*, the court instructed the jury that some crew mem-

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234 *Id.*

235 *Id.* at 372-73.

236 *Id.* at 373.

237 *Id.* at 375.

238 This sentence was later commuted by the Crown to six months' imprisonment. *See* Book Note, 98 HARV. L. REV. 1100, 1103 (1985) (reviewing A.W. BRIAN SIMPSON, CANNIBALISM AND THE COMMON LAW (1984)).

239 26 F. Cas. 360 (C.C.E.D. Pa. 1842) (No. 15,383).

240 *Id.* at 360.

241 *Id.* at 361.

242 *Id.* at 362.

243 In this case, the defendant was sentenced to six months' solitary

bers are necessary to navigate the boat, that any supernumerary seaman should be sacrificed before the passengers, and that, as between people in an equal situation, the determination of who is to be sacrificed for the safety of the whole is to be determined by lot.[244] This view is utilitarian in nature; violation of individual rights is acceptable because it will result in greater overall good.

These two lifeboat cases bear an almost eerie similarity to the case of a multiple pregnancy that is certain to result in death unless some of the fetuses are killed. Under what circumstances would a woman be justified in lightening the load of this lifeboat in her womb?[245] The English law's response to the lifeboat dilemma is to invoke the duty of self-sacrifice: a duty that requires one to die rather than kill an innocent person. In the case of a woman pregnant with seven fetuses, who should make that sacrifice? Should the woman have to sacrifice the option of selective reduction to avoid the killing that it entails?

To be true to the English doctrine of self-sacrifice, the answer is probably no. The court in *Dudley & Stephens* stressed that the self-sacrifice should be made only when it will save the life of another;[246] one does not have a duty to sacrifice oneself simply to avoid killing another. In undergoing selective reduction, a woman must sacrifice some of her fetuses to save others. In a real sense, the sacrifice of these much wanted fetuses is a self-sacrifice for the woman. Her choice is not made solely to benefit herself, but to benefit those remaining fetuses, who will have a far greater opportunity for life. Viewed this way, selective reduction is not the selfish act of self-preservation criminalized in *Dudley & Stephens*, but rather an acceptable act of self-sacrifice praised by this

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confinement at hard labor; the President refused to grant a pardon. *See* LAFAVE & SCOTT, *supra* note 228, at 445.

244 *See id.* The notion of lot-drawing to determine who should be sacrificed has biblical origins. In the story of Jonah, when a storm threatened to wreck the ship, those aboard drew lots. *See id.* at 445 n.32. The lot fell upon Jonah and he was pitched overboard. *Id.* As the story is told, a whale arrived to save Jonah and to prevent the development of a homicide situation that would raise the question whether, under the circumstances, including the drawing of lots, necessity justified the homicide. *See id.*

245 For purposes of this question and the analysis which follows, I assume that the laws on abortion are suspended. That is, I consider whether a woman is justified in electing selective reduction regardless of whether the law allows abortion "on demand" during the first trimester.

246 VORENBERG, *supra* note 232, at 374-75.

same court. In fact, in England selective reduction is an accepted practice, one viewed as inherently different from abortion. Since 1982, when English physicians first performed the procedure, selective reduction has been excluded from the Abortion Act of 1967, which regulates abortion.[247] Perhaps Dudley and Stephens helped establish an enduring Anglo precedent that recognizes and favors self-sacrifice over selfishness. Selective reduction, one could argue, reifies the former virtue in a modern setting.

Turning to American jurisprudence, it seems the court's language in *Holmes* is almost prophetic in its application to selective reduction. The court said that when people are of equal status (that is, none owes a special duty to another such as a seaman to a passenger), the determination of who should be sacrificed for the benefit of the rest of the group is to be made by lot. In the case of selective reduction, a decision about which fetuses are to be reduced is made essentially by lot. Those fetuses that are closest to the abdominal wall are reduced first because they are the most accessible to the physician; one could say that nature drew lots for the fetuses to determine their placement in the womb.

An obvious objection to this analogy is that in the case of selective reduction, it is the mother, and not the fetuses themselves, who decides that a sacrifice must be made. In a drowning lifeboat, those aboard will be able to decide whether some must be sacrificed to save the rest. But, in a multiple pregnancy, the woman is also a passenger in that boat in the sense that her well-being will be affected by the continuation of a doomed pregnancy. Her right to make the decision to draw lots arises in large part from the fact that she is the only one capable of making that decision. More philosophically, the American law's narrow acceptance of the utilitarian ethic that the ends justify the means would also serve to justify empowering the woman with the right to decide how many shall stay aboard her lifeboat. *Holmes*, it seems, set the stage for maternal lot drawing in the case of a multifetal pregnancy.

B. Forced Medical Therapy and the Ends-Means Dilemma

In the world of medical treatment decision-making, selective reduction poses the stark question: Is it ever right to harm one to benefit another? But this question is not unique to the use of selective reduction; several life-saving technologies require one

247 *See* Brahams, *supra* note 83, at 1409.

person to be harmed so another can benefit. Two such technologies are bone marrow transplants and organ transplants, each of which contains as an essential ingredient a portion of a healthy person's body. Our legal system has been two-faced in its response to one person's request to compel another to provide body parts so the one can live. In some instances, courts have authorized the intrusion; in other cases, courts have adopted the Kantian imperative that one human being should never be used as a means to an end and consequently have denied requests from ailing patients.

A stark example of this Kantian-like jurisprudence is the case of *McFall v. Shimp*.[248] In this case, David McFall, a victim of aplastic anemia, sought to force his cousin, David Shimp, to donate bone marrow to him. Wide testing of his family had revealed Shimp as the only member with potentially compatible bone marrow.[249] When Shimp refused to undergo further testing, McFall petitioned the court for a preliminary injunction, hoping to compel his cousin to serve as a bone marrow donor.[250] Although the court found Shimp's conduct morally reprehensible,[251] in the end it refused to compel Shimp to submit to further testing. The court expressed its view on the issue of involuntary sacrifice: "For a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence."[252] The court stressed that there is no legal duty to rescue others and concluded that requiring this Samaritan act "would change every concept and principle upon which our society is founded."[253]

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248 10 Pa. D. & C.3d 90 (1978).

249 *Id.* at 90.

250 *Id.*

251 *Id.* at 91.

252 *Id.* at 92 (emphasis in original).

253 *Id.* at 91. While our jurisprudence has generally rejected an affirmative duty to rescue others, it does make an exception where the potential rescuer is the one who injures or imperils another. *See* PROSSER, *supra* note 82, at 377. What then, can be said of a woman who purposely avails herself of potent fertility treatment, only to end up with four or more fetuses? Does she have a duty to rescue two or three of the fetuses because she "imperiled" them in the first place? One author has argued that a multiple pregnancy resulting from fertility treatment is not the fault of the woman but rather the fault of our "health care system that contributes to the generation of problematic multiple pregnancies" by "extensive socialization

McFall and other cases that follow its lead[254] can be contrasted with cases in which courts have authorized bodily intrusions on one to save the life of another. The key difference in these cases is that the would-be donor in every case was incompetent—either by minority or mental incapacity. This meant that an adult guardian (typically a parent, brother, or sister) was responsible to consent to the invasion on behalf of the incompetent. The first appellate decision of this kind came in 1969 in *Strunk v. Strunk*.[255] In *Strunk*, the mother of two adult sons, one mentally competent but suffering from a fatal kidney disease and the other physically sound but committed to a state mental institution, petitioned the court for authority to procure a kidney transplant from one son to the other.[256] Because the mentally impaired brother was not capable of consenting to the procedure, the court adopted the doctrine of substituted judgment,[257] which it said allowed the equity court to "speak for one who cannot speak for himself."[258] In speaking for the incompetent, the court authorized the transplant based on its belief that the operation was in his best interest.[259] The court based this conclusion on the testimony of those responsible for his care, namely his parents, his psychiatrist, and the institution where he was housed, that he was emotionally

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for maternity." Overall, *supra* note 215, at 8. In essence, Ms. Overall argues that women who avail themselves of various fertility therapies are themselves, in part, victims of the reproductive interventions, in the sense that our society actively encourages motherhood, but offers few options and little information about these alternative reproductive technologies. *See id.* Under Overall's analysis, women are not seen as the "imperiler" but more as the "imperiled." *Id.* Perhaps her analysis gives more support to my argument that a woman facing a multiple pregnancy is herself a passenger in the endangered lifeboat and thus is entitled to make a decision to sacrifice some of those on board. *See supra* text accompanying note 245.

254 *See, e.g., In re* George, 630 S.W.2d 614 (Mo. Ct. App. 1982) (adoptee with leukemia sought to open adoption records to contact natural father as possible bone marrow donor; court contacted father who denied paternity and refused to be tested; court refused to give dying man natural father's name); Head v. Colloton, 331 N.W.2d 870 (Iowa 1983) (court refused request of leukemia victim for access to name of potential unrelated bone marrow donor who had indicated she did not wish to donate to nonrelative).

255 445 S.W.2d 145 (Ky. 1969). In its opinion, the court noted that "no similar set of facts has come before the highest court of any of the states of this nation or the federal courts." *Id.* at 147.

256 *Id.* at 145.

257 *Id.* at 148 (describing common-law origins of doctrine).

258 *Id.* at 149 (Steinfeld, J., dissenting) (describing majority's holding).

259 *Id.* at 149.

dependent on his ailing brother.[260] Thus, in a sense the court felt the operation would provide a benefit to the incompetent donor.

The notion that an incompetent donor would benefit by providing an organ to a sibling was made explicit in *Hart v. Brown*.[261] This case involved identical twin girls, aged seven years and ten months.[262] One sister was hospitalized due to kidney failure; her only chance of survival was a kidney transplant.[263] The parents of the girls requested that the transplant be done and that their healthy daughter serve as kidney donor.[264] The doctors refused to perform the surgery unless the court declared that the parents had the right to consent to the operation.[265] The court, relying on *Strunk v. Strunk*, authorized the parents to consent to the transplant because, in part, "it will be most beneficial to the donee; and [it] will be of some benefit to the donor."[266]

While not all courts confronted with the question of compelled familial sacrifice have approved of the nontherapeutic invasion,[267]

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260 The evidence reflected the importance of his brother's visits and the vital link his brother provided to a sense of stability for the incompetent. *Id.* at 146-47.

261 289 A.2d 386 (Conn. Super. Ct. 1972).

262 *Id.* at 386.

263 *Id.* at 387.

264 *Id.*

265 *Id.*

266 *Id.* at 390-91. The court based its finding that the operation would benefit the donor on the testimony of a psychiatrist who examined the healthy twin. *Id.* He testified that the donor had a strong identification with her twin sister and that it would be a very great loss to the donor if her sister were to die from her illness. *Id.* at 389. This same line of reasoning can be seen in Little v. Little, 576 S.W.2d 493 (Tex. Ct. App. 1979), where the court authorized the mother of a 14-year-old mentally incompetent girl to consent to removal of her kidney for implant in her younger brother. The court believed there was "strong evidence to the effect that [the donor] will receive substantial psychological benefits from such participation." *Id.* at 500. For a discussion of the potential psychological benefits to persons who donate needed body parts, see John A. Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48, 68 (1976).

267 Two cases in which courts did not allow one family member to consent to organ donation on behalf of an incompetent are Lausier v. Pescinski, 226 N.W.2d 180 (1975) (court denied petition of sister of incompetent ward to allow his kidney to be transplanted to another ailing sister; court stated that no benefit to would-be donor was established), and *In re* Richardson, 284 So. 2d 185 (La. Ct. App. 1973) (relying on Louisiana statute prohibiting donation by guardian of minor's property, court refused parent's request to authorize kidney donation from 17-year-old retarded

those that have authorized the invasion have relied on a somewhat watered-down utilitarian ethic that the violation of some rights can be tolerated if a greater good is achieved. These courts have clearly felt that two healthy people, one with renewed renal function and the other with some short-term discomfort, are certainly better than only one healthy person. Adding to the overall good outcome is the court's perception that the donation will also benefit the donor, although the exact nature of that benefit is unarticulated in most cases.[268]

On their surface, the holdings in the *McFall* and *Strunk* line of cases appear irreconcilable. In one instance, the courts adopt a deontological ethic, protecting the rights of the individual to be free from unconsented to harm whatever the consequences; in another instance, the courts measure the overall benefit to be achieved and strive for the good outcome, overlooking lesser, individual harms. Despite their apparent, fundamental differences, these two approaches can be integrated to form a moral construct that would be useful in evaluating the ethics of selective reduction. The basis for this construct, the doctrine of informed consent, is set out below in Part IV.

IV. Informed Consent and the Fertility Patient: Incorporating Selective Reduction into the Spectrum

A. Forced Medical Therapy and Informed Consent

Courts that espouse a rights-based Kantian approach do so when one competent adult asks another competent adult to surrender some portion of her body. This surrender requires some degree of bodily invasion, whether it is minimal (such as extracting blood) or highly invasive (such as procuring a kidney for transplant). When any bodily invasion, in the medical context, is contemplated, courts harken back to the long-standing principle of informed consent first articulated by Benjamin Cardozo in 1914 that "[e]very human being of adult years and sound

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son to 32-year-old daughter; court held facts in case dissimilar to those in *Strunk v. Strunk* in that donation would not be in best interest of minor donor).

268 *See, e.g., Hart v. Brown*, where the court gave little value to the psychiatrist's testimony, which articulated the potential benefits to the donor twin, but in the end found that the donation was authorized because "it would be of some benefit to the donor." 289 A.2d 386, 391 (1972).

mind has a right to determine what shall be done with his own body."[269] The doctrine of informed consent gives every competent adult equal right to act as a good Samaritan and as a bad Samaritan. If one declines to provide needed body tissue, as did McFall's cousin, the law can think what it will about the moral character of the person, but it cannot compel submission. Thus, in the end it does not appear that *McFall* and like cases are grounded in deontological ethic, at least insofar as that ethic rejects any consideration of outcome. True, the courts in these cases care about protecting individual rights, but they do so in the context of upholding the informed consent doctrine, not because they reject the idea that the ends can justify the means. The *McFall* court best described this tension and ultimate triumph of informed consent over an outcome-oriented approach when it said:

> Morally, [Shimp's] decision rests with defendant, and, in the view of the court, the refusal of defendant is morally indefensible. For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded.[270]

The importance of the informed consent doctrine in cases in which one person seeks the tissue of another is made clearer when one considers the courts' position on incompetent would-be donors. There the courts face a person who is not "of adult years," or not of "sound mind," or both. The broad protections of the informed consent doctrine are not applied to those individuals. Instead, the court is asked to decide what is in the best interest of the incompetent person, given the totality of the circumstances.[271] In most instances, the courts authorize the donation, finding that the best interest of the person is served by allowing that person to be used as a means to another person's end. How does a court know what is in the best interest of the incompetent person? It can only guess at what a reasonable per-

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269 Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914). For a fuller discussion of the informed consent doctrine, see *infra* text accompanying notes 295-300.

270 McFall v. Shimp, 10 Pa. D. & C.3d at 91 (1978).

271 *See, e.g., In re* John Doe, 481 N.Y.S.2d 932 (N.Y. App. Div. 1984) (brother of incompetent adult petitioned court to authorize bone marrow donation; court allowed transplant, reasoning that procedure would be in incompetent's best interest because benefits to him of his brother's future company and advocacy outweighed any physical and psychological risks).

son in the incompetent's shoes, facing the identical set of circumstances, would do.[272] In a sense, the court becomes that reasonable person who is charged with evaluating the risks and benefits attendant to the bodily invasion. If the court felt that one person could never be harmed for the benefit of another, then it would never authorize the requested procedures. Instead, the court seems to believe that reasonable people would consent to some harm if they could at the same time be benefitted and if someone close to them could also be benefitted. This may not in fact be what the incompetent person would say if she had the capacity to make that decision. In the end, however, courts are willing to tolerate this usurpation of rights in the interest of overall benefit.

B. Multiple Pregnancy and Informed Consent

In the case of a woman experiencing a multiple pregnancy, the doctrine of informed consent should allow her free rein to decide how to proceed with her pregnancy. Because the pregnant woman is an autonomous decision-maker, she can decide the course of action that best fits her own moral construct. If she is carrying octuplets and rejects selective reduction because she fears the needle, no court is in a position to force her to undergo the procedure because it considers selective reduction potentially life-saving.[273] Likewise, if a woman chooses to reduce a twin pregnancy to a singleton, no court is in a position to override that decision because it considers her conduct morally reprehensible. This conclusion necessarily follows from *McFall v. Shimp*. If the written words in *McFall v. Shimp* mean anything, they mean that a court can assess the legality, but not the morality, of a decision based on informed consent.

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272 This discussion about third party decision-making on behalf of incompetent individuals is limited to the facts set out in the text. There is a wide body of doctrine and commentary on the issue of surrogate decision-making for incompetent patients, which, among other things, explains the various ways in which courts approach the task of intervening on behalf of a patient who cannot speak for herself. *See generally* Louise Harmon, *Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1 (1990).

273 This is not to say that courts never force pregnant women to undergo procedures that they consider potentially life-saving, either for the mother or the fetus. For a discussion of these cases, see *infra* notes 275-86 and accompanying text.

When the informed consent doctrine is in full force, the ends always justify the means because the ends represent the desired choice of the autonomous decision-maker. Whether or not that end brings greater overall good is irrelevant, so long as it is the result of an informed choice. Because the eventual outcome is the result of an informed choice, it brings the greatest good to the decision-maker. Ultimately, what this means is that affording a woman full autonomy in her decision-making satisfies both deontological and utilitarian ethic. From a rights-based perspective, her autonomy is intact, and in the end she will be benefitted from having made the decision that controls her destiny. While this benefit appears at first blush to accrue only to the individual, our jurisprudence recognizes that the right of self-determination ultimately produces an overall benefit for our society. "Our society," according to the court in *McFall*, "has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another."[274] Thus, informed consent comports with utilitarian goals by producing the greatest good for our society.

The informed consent model makes a rather obvious assumption that, in a multiple pregnancy scenario, the woman's right to control the progress of the pregnancy always overrides whatever rights the fetuses may have. Recent history has taught us that this assumption is not always true, at least not according to a number of courts and commentators. When courts confront a pregnant woman who is refusing medical treatment that is likely to benefit her fetus, it is a rare court that upholds the woman's right to refuse such treatment. These cases typically arise when a woman refuses a blood transfusion[275] or a Cesarean section.[276] As a

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[274] 10 Pa. D. & C.3d at 91.

[275] *See, e.g.*, Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537 (N.J.), *cert. denied*, 377 U.S. 985 (1964) (ordering blood transfusion over objections of Jehovah's Witness in thirty-second week of pregnancy to save her life and that of fetus); *In re* Jamaica Hosp., 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (ordering blood transfusion to refusing Jehovah's Witness in eighteenth week of pregnancy, reasoning state's interest in the not-yet-viable fetus outweighed patient's interests); Crouse Irving Memorial Hosp., Inc. v. Paddock, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985) (ordering transfusions over religious objections as necessary to save mother and fetus that was to be prematurely delivered); *cf. In re* President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (ordering transfusion, *inter alia*, because of mother's parental duty to her living minor children). *But see* Taft v. Taft,

whole, these cases give the impression that once a woman becomes pregnant, she sheds her right to make an informed choice about her medical care. Courts seem to equate the status of pregnancy with the status of incompetency and step into the shoes of the pregnant woman, forcing an outcome that they believe a "reasonable person" would choose.

A particularly stark example of this judicial pregnancy flip-flop is seen in *Fosmire v. Nicoleau*.[277] Denise Nicoleau was a Jehovah's Witness who gave birth to a healthy baby by Cesarean section.[278] No blood was needed for the operation, but later that day she began to experience severe hemorrhaging.[279] Her physicians recommended a blood transfusion, but Mrs. Nicoleau refused.[280] Undaunted by her refusal, the physicians sought and received an ex parte order authorizing them to do the transfusion without the patient's permission.[281] Mrs. Nicoleau received two blood transfusions over the next two days.[282] After her ordeal, Mrs. Nicoleau applied to the appellate court for an order vacating the trial court's ex parte order.[283] The court granted the order, citing the rights of individuals to refuse medical treatment, even if that treatment may be beneficial or even life-saving.[284] As to Mrs. Nicoleau, the court stated that "even if . . . [the] blood transfusion

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446 N.E.2d 395 (Mass. 1983) (vacating order which required woman in fourth month of pregnancy to undergo purse string operation because there were no compelling circumstances to justify overriding her religious objections and her constitutional right of privacy).

276 *See, e.g.*, Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981) (court ordered Cesarean section on woman with placenta previa in thirty-ninth week of pregnancy purportedly to save both mother and fetus); *In re* Madyun Fetus, Daily Washington Law Rep., Oct. 29, 1986, at 2233 (D.C. July 26, 1986) (court ordered Cesarean section over objections of mother). *But see In re* A.C., 573 A.2d 1235 (D.C. 1990) (vacating order of trial court ordering Cesarean section on terminally ill woman in her twenty-sixth week of pregnancy). For a discussion of the cases in which courts have ordered interventions, see Janet Gallagher, *Prenatal Invasions and Interventions: What's Wrong with Fetal Rights*, 10 HARV. WOMEN'S L.J. 9 (1987).

277 536 N.Y.S.2d 492 (N.Y. App. Div. 1989), *aff'd*, 551 N.E.2d 77 (1990).

278 *Id.* at 493.

279 *Id.* at 494.

280 *Id.*

281 *Id.*

282 *Id.*

283 *Id.*

284 *Id.* at 495.

would have saved [her] life, the State's interest in preserving her life . . . may not . . . be sufficient to overcome her expressed desire to exercise her religious belief and to forego the transfusion."[285] Despite this strong language supporting patient autonomy and self-determination, the court, in dicta, revealed its pregnancy flip-flop:

> [W]e note that this case does not present a situation in which a pregnant adult woman refuses medical treatment and, as a result of that refusal, places the life of her unborn baby in jeopardy. Clearly, in such a case, the State's interest, as *parens patriae*, in protecting the health and welfare of the child is deemed to be paramount.[286]

With this statement, the court confirmed that it would in fact treat a woman one way if she were pregnant and another if she were not.

The *Fosmire* court's blatant willingness to subvert the autonomy of the pregnant woman in favor of what it perceived to be a "good outcome" indicates that in this case, just as in cases of incompetent would-be tissue donors, the court believed that the ends justified the means. But does the court's penchant to "protect" the fetus over the autonomy of the woman mean that it will reject selective reduction as representing a woman's decision to cause harm to her fetus? Not necessarily. As noted above, courts favor good outcomes when fetuses are involved. Because in most cases selective reduction produces a better obstetric outcome than would occur without the procedure, one could surmise that courts would generally favor it.[287] Given that courts are willing to allow harm to come to one (the pregnant woman) for the benefit of another (the fetus), theoretically they could substitute the one harmed (the terminated fetus) so long as the outcome remains good (a maximum number of healthy fetuses are delivered).[288]

The notable flaw in this argument is that in the case of a forced

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285 *Id.* at 496.

286 *Id.* (citing *In re* Jamaica Hosp., 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) *and* Crouse Irving Memorial Hosp. v. Paddock, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985)).

287 This argument necessarily omits whatever effect the abortion analogy would have on the judicial decision-maker.

288 I want to note here that I am not arguing in favor of forced medical treatment for pregnant woman. To the contrary, I find myself agreeing with those who have criticized what I term the "pregnancy flip-flop." *See, e.g.*, Rhoden, *supra* note 50; Susan Goldberg, *Medical Choices During Pregnancy: Whose Decision Is It Anyway?*, 41 RUTGERS L. REV. 591 (1989). I break down

blood transfusion or Cesarean section, the mother may be harmed in some sense, but she emerges alive and, at times, physically better off. Certainly this is not the case in selective reduction; certain fetuses must actually be destroyed so that others may be benefitted. So the question then becomes what level of harm the courts would be willing to tolerate to achieve what they perceive to be an optimal outcome. This question is largely unanswerable because it depends on how the courts perceive the first-trimester fetus and its chances for a healthy birth. In a case involving a forced Cesarean section, the court perceives the late-term viable fetus as a person entitled to judicial protection.[289] In a case involving selective reduction, however, the court may not perceive the nascent fetus as entitled to such protection. In fact, the court may recognize that without intervention, none of the fetuses will survive. Ironically, this recognition might mobilize the court to compel selective reduction so that some of the fetuses could be given a chance to survive.

This analogy is admittedly far-fetched in our current technological and political state. But nevertheless it serves to reinforce the importance of respecting the autonomy and decision-making capacities of pregnant women. Even if one believes that the ends achieved using selective reduction justify its means, it is never justifiable to override a pregnant woman's decision to elect or forgo selective reduction simply to achieve a socially or judicially sought outcome.

C. Pretreatment Disclosure of Selective Reduction

Apart from concerns about the legal and moral acceptance of selective reduction in our society, there are practical concerns about how the procedure currently fits into the wide spectrum of available reproductive technologies. What are women contemplating infertility therapy told about the option of selective reduction in the event they conceive a multiple pregnancy? Empirically, there are no real answers to this question. Anecdotally, however, a few physicians have publicly shared their views toward counseling patients about selective reduction prior to

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the court's reasoning into notions of harm and benefit simply to draw an analogy to the case of selective reduction.

289 For example, in *Jefferson v. Griffin Spalding County Hospital Authority*, the court held that the thirty-nine week fetus was a viable human being entitled to the protection of the juvenile court. 274 S.E.2d 457, 458 (Ga. 1981).

commencing ovulation induction. As might be expected, there are two schools of thought on whether a doctor should discuss the procedure at the early stages of therapy—one says yes, the other no.

The "no-disclosure" position was recently articulated by Dr. Richard Marrs, a fertility specialist. When asked if he counsels patients about selective reduction before the need for the procedure arises, he said that he does "not discuss the option when counseling his patients about available treatments."[290] He explained, "I don't feel comfortable telling them: 'I'm going to do everything I can to get you pregnant, and by the way, if we overshoot the mark you can have selective reduction.' "[291]

The other school of thought, which favors disclosure, was expressed by Dr. Frank Boehm, a physician who participated in a round table discussion with other physicians on the ethics and practice of selective reduction.[292] In discussing whether selective reduction should be presented as an option at the pretreatment stage, he said:

> I maintain that all options should be offered to our patients, and that we do so before the process of ovulation induction. It is only in this pretreatment phase that a couple can be properly counseled as to the options they face, and may decide not to attempt medical induction of ovulation because of the potential ethical concerns and dilemmas should a multifetal pregnancy occur.[293]

Another doctor joining the discussion agreed that, in theory, the issue of multiple pregnancy and selective reduction ought to be discussed preconceptually, but added that "it is quite clear that many patients do not want to hear this kind of information and it does not register even if you spend a lot of time discussing it with them."[294]

Under our current state of jurisprudence, the way in which the question of pretreatment disclosure of selective reduction will be resolved is by application of the informed consent doctrine to fertility therapy. The legal doctrine of informed consent was first

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290 *Frustaci Fallout*, *supra* note 35.

291 *Id.* Presumably, then, this doctor does feel comfortable having patients not avail themselves of a treatment that could be of enormous benefit simply because they fear a high order multiple pregnancy.

292 *See* Evans I, *supra* note 8, at 1573.

293 *Id.*

294 *Id.* at 1574 (Dr. Evans, discussant).

announced in 1957, when the California Court of Appeal in *Salgo v. Leland Stanford Jr. University Board of Trustees*[295] stated:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent.[296]

While the court in *Salgo* did establish the physician's duty to disclose information, it did not discuss the nature of the patient's right under the informed consent doctrine, nor did it elaborate on the standard for determining whether the physician breached the duty to disclose.[297] It was not until 1972 that courts began to explain exactly what the patient was entitled to know (or, put another way, what the physician was required to disclose). In *Canterbury v. Spence*,[298] the court explained that the scope of the physician's duty to disclose was shaped not by the standard of care in the profession, but by the patient's need to know "information material to the decision."[299] This materiality standard enhances patient self-determination by focusing on what a reasonable person in the patient's position would find significant in making a decision.[300]

In the context of a woman contemplating fertility therapy, her physician must decide what a reasonable woman in the patient's position would find material to her decision-making process. Once warned about the possibility of multiple pregnancy,[301] it

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295 317 P.2d 170 (Cal. Dist. Ct. App. 1957).

296 *Id.* at 181. For a comprehensive overview of the legal doctrine of informed consent, see JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 48-84 (1984).

297 For a discussion of *Salgo* and the history of the informed consent doctrine, see Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379 (1990).

298 464 F.2d 772 (D.C. Cir. 1972).

299 *Id.* at 784.

300 *See* PROSSER, *supra* note 82, at 191. *But see* Jones, *supra* note 297, at 396 (explaining that in majority of jurisdictions, physicians' duty to disclose information is still judged by standard based upon practice within profession, but growing number of jurisdictions determine physicians' liability based on standard of information needed by reasonable patients in making decisions concerning their treatment).

301 *See supra* note 6 (explaining that makers of fertility drug Pergonal, Serono Laboratories, recommend that physicians prescribing drug advise

follows that patients should also be told about treatment options for multiple pregnancy. If the risk of multiple pregnancy is material, then the treatment for the condition is likewise material. One can easily imagine a scenario in which a woman, after being told of the possibility and risks of multiple pregnancy, would reject fertility treatment to avoid conceiving a pregnancy that could result in tragedy. But if the woman also knew of the option for reducing that pregnancy to a safe number, she might elect to proceed with treatment. Information that persuades one to act in one way or another is certainly material to that person's decision-making process.

As noted above, some fertility specialists admittedly do not inform patients about the option of selective reduction before proceeding with treatment. Perhaps physician silence on the option of selective reduction is related to a desire not to discuss the notion of abortion with a patient who desperately wants to become pregnant and have a child. Dr. Marrs conveyed this sentiment when he followed up his admission that he does not inform pretreatment patients about selective reduction with this statement: "These are individuals who have spent years and years trying to achieve a pregnancy. To ask them to abort one or two of their fetuses is a cruel and tortuous question—although it is a question that, unfortunately, we have to ask from time to time."[302] Dr. Marrs seems to be saying that he has only the good intention of protecting his patients from facing, perhaps unnecessarily but certainly prematurely, the dilemma of selective reduction.

I believe Dr. Marrs' purported good intentions are misguided. While patients may not wish to contemplate terminating one or more of their fetuses, they have the right to know that such an option exists. Courts have held that under certain circumstances, physicians are under a duty to disclose the option of abortion to their patients. For example, in *Berman v. Allan*,[303] the Bermans, parents of a child born with Down's Syndrome, sued the physician who had treated Mrs. Berman during her pregnancy for failing to inform her about the availability of amniocentesis. The Bermans alleged that had they known about the procedure, Mrs. Berman

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patients about potential risk of multiple gestation before starting treatment).

[302] *Frustaci Fallout*, *supra* note 35.

[303] 404 A.2d 8 (N.J. 1979).

would have submitted to it; upon learning that her child would suffer from Down's Syndrome, Mrs. Berman would have aborted the fetus.[304] The New Jersey Supreme Court found that in failing to inform Mrs. Berman of the availability of amniocentesis, the physician deprived her of the option to abort her fetus.[305] The court felt that the "loss of her right to abort the fetus" caused compensable harm.[306]

Like the woman in *Berman* who would have altered the course of her pregnancy had she been informed about all of her options, a woman undergoing fertility treatment has the right to know all of her options so that she can control the course of her treatment. Doctors should not wait until after a multiple pregnancy has occurred to introduce the option of selective reduction. Such a delay only means that couples have little time to make an enormously important decision. Couples contemplating fertility treatment need to consider all the potential consequences of their choices at the outset.[307] Their decision-making should be allowed to take place in an unhurried, nonpressured environment. Of course, this is not to say that if a multiple pregnancy does occur, the decision whether to undergo selective reduction

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304 *Id.* at 10.

305 *Id.* at 11.

306 *Id.* at 14. The court upheld this harm as a cause of action for wrongful birth. *Id.* In a wrongful birth suit, the parents of a deformed child sue a health care provider for failing to diagnose some deformity in the fetus or failing to inform the parents of risks threatening the fetus. *See* Shari S. Weinman, Note, *Birth Related Torts: Can They Fit the Malpractice Mold?:* Shelton v. Saint Anthony's Medical Center, 56 Mo. L. REV. 175, 177 (1991). The premise is that the provider's negligence deprived the parents of the choice between carrying the pregnancy to term or obtaining an abortion. *Id.* Damages allowed typically include the expenses of ordinary and extraordinary medical care and education of the deformed child, the expenses and pain and suffering of the mother during pregnancy, and the emotional distress of the parents. *Id.* To date, 18 states recognize wrongful birth claims to some extent. *Id.*

307 An interesting question that arises in discussing the application of the informed consent doctrine to selective reduction is whether physicians have a duty to inform patients of this newly developed procedure. After all, one could argue, the procedure is still being developed and thus does not represent the standard of care available to all patients. I would argue that selective reduction does represent the standard of care for multifetal pregnancies as it is the only therapy available, and therefore should be disclosed to patients. For a similar approach, see Hunter L. Prillaman, *A Physician's Duty to Inform of Newly Developed Therapy*, 6 J. CONTEMP. HEALTH L. & POLICY 43 (1990).

will be an easy one. Such a decision is never easy, but at least it will not have to be made amid a growing crisis.

CONCLUSION

The news of pregnancy to a fertility patient is always thrilling. The subsequent news that she is carrying not one but several bundles of joy can be shocking and even devastating for a woman who understands the significant risks associated with high order multiple pregnancy. Selective reduction offers the new hope of a healthy, normal pregnancy and delivery. But even those who avail themselves of this technology may forever dwell on the contradiction of their choice—killing some to save others. Multiple pregnancy presents the quintessential life boat dilemma. All will suffer if nothing is done, but some will have to die for others to live. A woman's decision to do what she can to best preserve the health of her fetuses should not be viewed as an abortion, which connotes pregnancy termination, but rather as the only available therapy for a multifetal pregnancy. The debate on selective reduction should focus not on abortion, but rather on ensuring access to and information about the procedure. Informing ourselves and, in particular, informing women faced with the prospect of fertility treatment about the option of selective reduction can only advance our understanding of how best to utilize this and other rapidly developing reproductive technologies.