

**In Support of a Gender-Neutral Framework
for Resolving Selective Reduction Disputes**

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Multifetal pregnancies, particularly those involving high order multiples, are becoming increasingly common as more and more couples are turning to fertility drugs to have children. While successful high order multiple births are often celebrated, such as the sextuplets who star in the television show *John and Kate Plus Eight*, not all couples' stories turn out as happily. Multifetal pregnancies present significant health risks to the mother and the fetuses.¹

Imagine the heartbreak of an infertile couple faced with multifetal pregnancy. After they have spent months—if not years—undergoing intensive and costly fertility treatments aimed at the creation of a child, they are finally successful. However, the pregnancy is a mixed blessing: they discover that they are pregnant with more fetuses than intended—three, four, or even, in the extreme cases, eight or nine. While it is true that “[t]he news of pregnancy to a fertility patient is always thrilling[, t]he subsequent news that she is carrying not one but several bundles of joy can be shocking and even devastating [because of the] significant risks associated with high order multiple pregnancy.”²

One option available to those who find themselves in this difficult position is selective reduction. Selective reduction is the elective termination of one or more fetuses in an effort to increase the chances of success for the pregnancy. As one doctor who performs the procedure explained, selective reduction “turn[s] three into two.”³ Despite whatever moral concerns, emotional issues, or physical risks the procedure brings, many doctors and scholars see selective reduction as an option that “offers the new hope of a healthy, normal pregnancy and delivery” for couples facing multifetal pregnancies.⁴

¹ See discussion *infra* p. 4-6 for a detailed discussion of the complications associated with multifetal pregnancy.

² Judith F. Daar, *Selective Reduction of Multiple Pregnancy: Lifeboat Ethics in the Womb*, 25 U.C. DAVIS L. REV. 773, 843 (1992).

³ LIZA MUNDY, EVERYTHING CONCEIVABLE: HOW ASSISTED REPRODUCTION IS CHANGING MEN, WOMEN, AND THE WORLD 253 (2007).

⁴ Daar, *supra* note 1, at 843.

This choice, between carrying all the fetuses and selectively reducing the pregnancy “presents the quintessential life boat dilemma. All will suffer if nothing is done, but some will have to die for others to live.”⁵ This difficult choice is made even more challenging when the pregnant couple does not agree on whether or not they should undergo selective reduction.

While it is generally taken for granted that a woman facing a multifetal pregnancy will have the option of selective reduction, little attention is paid to man’s interests in considering this difficult decision.⁶ At first blush, this seems to comport with our understanding of the rights associated with reproductive decision-making: in traditional coital reproduction, men are limited to the choice of whether or not to ejaculate, while women are given exclusive decision-making rights concerning abortion and prenatal care—at least until the point of viability.⁷

However, men’s legal rights in procreative decision-making are not so limited in all procreative decisions. Men enjoy more expansive rights when assisted reproductive technologies are used. Specifically, in the context of frozen embryo disputes, courts have recognized a man’s interest in reproductive decision-making that is equal to that of a woman.⁸ This understanding of a couple’s reproductive rights as equal is supported by traditional reproductive freedom cases. The respect accorded to an individual’s choice to avoid genetic parenthood has its origins in Supreme Court jurisprudence stating that the right to procreate is “one of the basic civil rights of

⁵ *Id.* The phrase “lifeboat dilemma” refers to the classic English case, *The Queen v. Dudley & Stephens*, (1884) 14 Q.B.D. 273 (K.B.), in which two sailors were charged with murder for killing and eating an ill cabin boy while stranded for nearly a month on a lifeboat—their defense, which ultimately proved unsuccessful, was that they acted out of necessity, sacrificing one so that the rest might survive.

⁶ Indeed, this issue can only arise where there is an intact couple interested in the child. If a sperm donor is used and there is no intended father, the issue is moot. Also, because a partner in a same sex relationship who does not contribute genetic material would not be given any more rights than a man in an intact couple, I have conflated the two for the purpose of this argument.

⁷ See *Planned Parenthood of So. Pa. v. Casey*, 505 U.S. 833 (1992).

⁸ See, e.g., *A.Z. v. B.Z.*, 725 N.E.2d 1051 (Mass. 2000); *Davis v. Davis* 842 S.W.2d 588 (Tenn. 1992).

man.”⁹ Additionally, the Court has held that individuals have the right to avoid procreation through contraception or abortion.¹⁰ These rights are recognized by the Court because they are “the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy,”¹¹ and “are central to the liberty protected by the Fourteenth Amendment.”¹² These individual, constitutional rights are not weakened simply because two individuals choose to become a couple.

The question thus becomes: which legal rationale applies to men’s rights in selective reduction cases: those limiting men’s rights, as in abortion case law, or those giving men an equal interest, as in frozen embryo dispute case law?

This Note argues that a man’s right to choose should be given legal protection equal to that of a woman in selective reduction disputes. Part I provides background information on the process of, and the need for, selective reduction. In Part II, I argue that current abortion laws, which limit legal decision-making rights to women, should not apply in the selective reduction context. In Part III, I examine the judicial reasoning behind granting men’s preferences additional consideration in frozen embryo dispute cases, and argue that this reasoning should be applied to disputes between couples over whether to undergo selective reduction.

I. THE HOWS AND WHYS OF SELECTIVE REDUCTION

Multifetal pregnancies are on the rise in the United States. In 1980, only 37 in every 100,000 live births were high order multiples; by 2000, that number had risen to 181 in every

⁹ *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (holding that a statute which permitted the forced sterilization of convicted felons was in violation of the right to procreate because the plaintiff would be “forever deprived of that basic liberty”).

¹⁰ *See, e.g., Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (recognizing “the right of the *individual*. . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child”); *see also Casey*, 505 U.S. at 833; *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹¹ *Casey*, 505 U.S. at 851.

¹² *Id.*

100,000 live births.¹³ This significant increase in high order multiples is, in large part, the result of increased use of infertility treatments. Specifically, experts point to the increased use of ovary-stimulating fertility drugs, which increases the number of eggs available for fertilization at any one time, and in vitro fertilization (IVF), which more often than not involves the implantation of more than one embryo in a patient.¹⁴

Multifetal pregnancies present significant health risks to both the mother and the fetuses. The most prominent health concern, for both mother and fetus, is the risk of premature birth. Reports indicate that 15% of women with singleton pregnancies have preterm labor, while 40% of women carrying twins, 75% of women carrying triplets, and 99% of women carrying quads deliver prematurely.¹⁵ Premature babies are at increased risk for health complications at birth, such as breathing problems, and for lasting disabilities, such as mental retardation, learning and behavioral problems, cerebral palsy, lung problems and vision and hearing loss.¹⁶ Furthermore, women who gestate high order multiples are significantly more likely to suffer from anemia, pregnancy-induced hypertension, preeclampsia, gestational diabetes, and preterm premature rupture of membranes.¹⁷ Risks for the potential children are significant and vary at each stage of development: fetuses are at risk for developmental complications and prenatal death; infants are at risk for premature births and decreased birth weight; and children are at risk for long-term

¹³ Carson Strong, *Too Many Twins, Triples, Quadruplets, and So On: A Call for New Priorities*, 31 J.L. MED. & ETHICS 272, 272 (2003).

¹⁴ *Id.*

¹⁵ *Id.* at 274.

¹⁶ See Premature Birth – March of Dimes, http://www.marchofdimes.com/professionals/14332_1157.asp (last visited Apr. 2, 2009).

¹⁷ *Id.*

health issues, such as physical handicaps and cerebral palsy.¹⁸ As one practitioner noted, “[r]eduction is not bad for you. . . . [s]tarting out as quint is bad for you.”¹⁹

In addition to these health concerns, families of higher order multiples also face greater psychological and financial burdens—considerations that couples with multifetal pregnancies must also take into consideration. Not surprisingly, studies have documented a substantial increase in fatigue and stress based on caring for multiples; research has also shown an increased likelihood of depression, substance abuse, and divorce among mothers of multiples.²⁰ The American Society for Reproductive Medicine lists psychological and social costs of raising multiples as including the following:

- Multiples may be hard to tell apart even if they are not identical. . . .
- Parents may bond to multiples differently than to singleborn children (singletons). . . .
- Managing the physical care of multiples is more difficult than managing singletons, especially in early infancy and childhood, and may lead to chronic stress and fatigue in the parents. . . .
- Older siblings may have difficulty adjusting to multiples, especially in competing for your attention. . . .
- Some parents and schools prefer that multiples be in separate classes to promote individuality, particularly if the children have different abilities. However, some schools may not have enough classes to separate multiples, and logistical difficulties are magnified if the children need to be placed in different schools. . . .
- Parents of multiples may feel socially isolated. . . .
- Multiples often attract attention. This may have positive or negative consequences depending on the personalities of the parents and children and the nature of the attention. . . .
- Help from family and friends is often short-term. . . .²¹

Beyond these psychological and emotional burdens, couples face additional financial burdens when raising multiples. Starting at birth, “health care cost for delivery and newborn care for

¹⁸ *Id.* at 273.

¹⁹ MUNDY, *supra* note 2, at 266 (quoting Dr. Mark Evans, a New York obstetrician who is one of the leading selective reduction practitioners in the country.)

²⁰ Strong, *supra* note 13, at 274.

²¹ AM. SOC. FOR REPRODUCTIVE MED., PATIENT’S FACT SHEET: CHALLENGES OF PARENTING MULTIPLES (Jan. 2003), *available at* <http://www.asrm.org/Patients/FactSheets/challenges.pdf>.

twins is four-fold higher when compared to a singleton birth.”²² Additionally, “[t]he total cost of raising multiples is likely higher than the cost of raising the same number of singletons”²³ and parents of multiples are finding that “[c]ompanies are not as willing to donate formula, diapers, etc., to parents of multiples as in the past.”²⁴ While some may argue that “perhaps the most important [reason to consider selective reduction is] the risks to children of multiple pregnancies,”²⁵ couples facing the reality of high order multiples would be negligent not to consider the financial and psychological issues that may effect quality of life that they will be able to provide for their children.

For most couples faced with multifetal pregnancies, doctors will recommend that they consider having a selective reduction.²⁶ The procedure is well-accepted within the medical community as a means to reduce the risks inherent in multifetal pregnancies—particularly miscarriage of the entire pregnancy. Statistics have shown that a fetal loss rate for selectively reduced pregnancies is from 0% to 9.5%—much lower than the 16% to 41% fetal loss rate reported for multifetal pregnancies.²⁷

Selective reductions, which are performed during the first trimester of a pregnancy, have been used to reduce multifetal pregnancies since 1988.²⁸ Typically, the procedure is used to reduce the number of fetuses in a pregnancy from a higher, riskier number (i.e. nine) down to

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ Strong, *supra* note 13, at 274.

²⁶ In fact, a doctor’s failure to offer the option of selective reduction may result in a wrongful life suit. For a discussion of wrongful life actions, see Phillip G. Peters, Jr., *Rethinking Wrongful Life: Bridging the Boundary Between Tort and Family Law*, 67 Tul L. Rev. 397 (1992); *see also* Harbeson v. Parke-Davis, Inc., 656 P.2d 483 (Wash. 1983).

²⁷ Daar, *supra* note 1, at 788.

²⁸ *Id.* at 787, 787 n.62 (citing Richard L. Berkowitz et al., *Selective Reduction of Multifetal Pregnancies in the First Trimester*, 318 NEW ENG. J. MED. 1043 (1988)). One author has called selective reduction “one of fertility medicine’s most unpleasant secrets, and one of the best kept” because there is no way to know how many pregnancies “start out as triplets or quads and are quietly turned into something more manageable.” MUNDY, *supra* note 2, at 254. This is because the Center for Disease Control does not track “the ultimate fate” of IVF pregnancies, and because many multifetal pregnancies are achieved using ovarian stimulation, which is not tracked.

one or two—ideally resulting in the birth of a healthy infant or twins. The process of 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. Once cardiac asystole, or complete standstill of the heart, is achieved, the needle is removed. The needle can be reinserted into one or more gestational sacs, depending on the number of fetuses to be reduced. The terminated fetuses remain in the woman’s uterus where they are resorbed, allowing the remaining fetuses to grow normally.

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.²⁹

Doctors choose which fetuses to reduce based primarily on the results of chorionic villi sampling (CVS), which is a genetic test that checks each fetus for birth defects.³⁰ If there are no serious health considerations, doctors will consider the accessibility of each fetus, and some doctors may consider a couple’s gender preference.³¹

However attractive selective reduction may be to preserve the ultimate success of a pregnancy, the procedure presents its own health and psychological risks. The most common complication associated with selective reduction is the loss of the entire pregnancy. Though, as noted before, the fetal loss rate for selectively reduced pregnancies is significantly lower than for multifetal pregnancies, the risk of loss increases dramatically as the number of original fetuses increases.³² “[F]or pregnancies that begin with triplets, the loss rate in reduction to twins is

²⁹ Daar, *supra* note 1, at 780-81. While Daar explained that the reduced fetus tissue would be reabsorbed, this is not always the case. For example, one of the couples Mundy talked with in writing her book said that “they had been able to see traces of the two reduced fetuses in [later] ultrasounds” and that “remains of the reduced two. . . were visible in the placental tissue” after birth. MUNDY, *supra* note 2, at 272.

³⁰ MUNDY, *supra* note 2, at 258-59.

³¹ *Id.* at 260 (explaining that Dr. Evans’ own ethics, constructed over 20 years of selective reduction practice, will permit him to consider gender when all other factors are equal—particularly when the patients seek to have one boy and one girl).

³² Strong, *supra* note 13, at 275.

approximately 8 percent for experienced operators; by contrast, when the initial number is six or higher, the loss rate is about 21 percent.”³³

Additionally, selective reduction carries with it heavy psychological burdens. It is a “highly stressful and emotionally painful experience for the women who undergo it,” particularly in the case of couples who “have been struggling to get pregnant.”³⁴ There are numerous Web sites which function as support networks for those considering, or dealing with the effects of, selective reduction.³⁵ Postings on such Web sites explain the emotional state of these women. Five weeks after a selective reduction, one woman wrote

I still feel sad about my twins. Some days are better than others. But when I start thinking about it I just start crying. I am trying to stay strong for my little boy but my heart still aches. I know I made the right decision, I just wish it was a decision I had never had to make.³⁶

Another woman, writing several years after a selective reduction, wrote:

I still think about the reduction every day, and sometimes it makes me sad. . . .

During my pregnancy, I really blocked out as much of the pain as I could. This allowed me to survive [the procedure] and the subsequent awfullness [sic] that came with it. . . .

We ended up cremating the remains after delivery. . . . I then ‘put’ his soul into a local park that I can visit. . . . This place is now so moving for me -- I still cry for a good half and [sic] hour whenever I go there. . . .

I hope that with time, the sadness will begin to lessen. . . .³⁷

These sentiments—which reflect what women were willing to discuss in a public forum—show the deep and lasting psychological scars selective reduction can leave. These psychological

³³ *Id.*

³⁴ *Id.*

³⁵ See, e.g., Fertile Thoughts, <http://www.fertilethoughts.com> (last visited Apr. 2, 2009).

³⁶ Posting of bluesky27 to FertileThoughts.com, <http://www3.fertilethoughts.com/forums/showthread.php?t=542989> (Oct. 16, 2007, 09:53 EST).

³⁷ Posting of bags to FertileThoughts.com, <http://www3.fertilethoughts.com/forums/showthread.php?t=542989> (Oct. 25, 2007, 09:25 EST).

consequences of the procedure are not to be taken lightly, and are, for many couples, the most difficult factor in deciding whether or not to reduce.

In addition to considerations of the serious health and psychological risks to both the mother and fetuses, many couples face moral or ethical dilemmas when considering the procedure. Studies show as many as one third of couples facing multifetal pregnancies would not consider selective reduction for moral, religious, or ethical reasons.³⁸

Furthermore, the decision between carrying a multifetal pregnancy and selectively reducing the pregnancy is one that must be made: by not actively choosing either, a couple tacitly accepts the choice of carrying the pregnancy. In some cases, as one commenter noted, “refusing to choose essentially is equivalent to choosing the death of all concerned.”³⁹ Further complicating the decision is the time-sensitive nature of the choice: selective reduction is least risky and most beneficial when performed before the end of the first trimester, and doctors will generally only perform it when the fetuses are between ten and thirteen weeks old.⁴⁰ Whether or not to selectively reduce is, undoubtedly, a dreadful decision, and the decision of how to proceed is not one that is taken lightly. One individual described it as an “utterly heart-wrenching and life-changing” decision that was “made alone without the support of loved ones.”⁴¹

The decision of whether or not to undergo selective reduction is not only an important one for the mother and the fetuses, but for the entire family. Choosing whether or not to undergo the procedure involves a complex consideration of the medical and psychological risks, the

³⁸ Strong, *supra* note 13, at 275. A full discussion of the moral and ethical dilemmas a couple may consider is beyond the scope of this paper, but they are likely very similar to those women considering abortion face.

³⁹ Mary V. Rorty & Joann V. Pinkerton, *Elective Fetal Reduction: The Ultimate Elective Surgery*, 13 J. CONTEMP. HEALTH L. & POL’Y 53, 63-64 (1996) (relying on Mary Faith Marshall, *Patient Selection: Tragic Choices*, in INTRODUCTION TO CLINICAL ETHICS 195, 196-97 (John C. Fletcher et al., eds. 1995)).

⁴⁰ According to one study, “[i]n 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.” Daar, *supra* note 1, at 780 n.27 (and sources cited therein).

⁴¹ Posting of onward with 3 to FertileThoughts.com, <http://www3.fertilethoughts.com/forums/showthread.php?t=585260> (May 8, 2008, 12:18 EST).

financial and emotional burdens, and the moral and ethical implications of either option. Despite this being an important decision that has a significant effect on the health and wellbeing of all members of the potential family, the desires of the father are given little or no attention in academic or medical literature.⁴²

While it may seem an obvious point, it bears emphasis here: men who are undergoing infertility treatments and participating in IVF have a demonstrated interest in having and raising a child. The most life-threatening of multifetal pregnancies, those with extremely large numbers of fetuses, are generally a result of years of effort and thousands of dollars—these are not cases of accidental failure of birth control precautions between strangers. These are men who are involved in and dedicated to the process. All the emotional stress of the decision of whether or not to selectively reduce will affect them, as will all of the physical, psychological, and moral complications that may be ramifications of either choice. Men weigh the same factors and struggle with the same issues as women facing the choice. For example, one doctor recalled: “I remember one dad turning to me with tears in his eyes: ‘You can say the survival is only 20 to 25 percent (without a reduction), but if I reduce one of those babies, that’s a 100 percent mortality rate, isn’t it?’”⁴³

Ideally, couples facing the difficult choice between carrying a multifetal pregnancy or undergoing selective reduction will be able to work together to make the best choice for their

⁴² Currently, the academic discussion of selective reduction focuses primarily on the rights of the fetuses/children and ethics/regulation of medical professionals using techniques that increase the possibility of multifetal pregnancy. See, e.g., Siddharth Khanijou, *Multifetal Pregnancy Reduction in Assisted Reproductive Technologies: A License to Kill?*, 8 DEPAUL J. HEALTH CARE L. 403 (2005) (arguing for federal regulation of medical professionals to reduce the possibility of multifetal pregnancies); Rorty & Pinkerton, *supra* note 37 (focusing on ethics of the medical profession); Jennifer L. Rosato, *The Children of ART (Assisted Reproductive Technology): Should the Law Protect Them From Harm?*, 2004 UTAH L. REV. 57 (2004) (focusing on protecting the child created through ART generally); Strong, *supra* note 13 (focusing on ethics of the medical profession).

⁴³ Jeremy Olson, *The Cruel Dilemma of Multiple Fetuses: Some Parents Choose to Terminate Some to Lower Risks for Others*, ST. PAUL PIONEER PRESS (Minn.), June 17, 2007, at A1, available at 2007 WLNR 11527574 (quoting Dr. Diane Danilenko, a St. Paul-based specialist in high-risk pregnancies).

family. One woman explained, “my husband and I were both very much in agreement that the reduction was what we needed to do, and we got through it together.”⁴⁴ However, there are bound to be situations in which couples disagree.

What happens if the woman is not willing to risk the loss of the entire pregnancy, but the man worries about the family’s ability to provide for a large number of children, some with life-long, serious health issues? What happens if the man has moral objections to selective reduction because of his religion, but the woman feels unable to deal with the emotional drain that raising multiples would bring? In these cases, how should conflicts be resolved?

II. THE LEGAL FRAMEWORK SURROUNDING ABORTION IS INADEQUATE FOR SELECTIVE REDUCTION DISPUTES

Because selective reduction involves the termination of a fetus, the comparisons to abortion are tempting. Even scholars who argue that selective reduction fits within a different legal framework acknowledge the similarities: “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.”⁴⁵ However, treating the two procedures as legally equivalent would be a mistake. First, the intentions of the parties choosing the procedure are very different between the abortion and selective reduction contexts, making a direct comparison of the two problematic. Second, because of procedural differences between the two, selective reduction does not fit within the legal definition of abortion. Third, the rationales for limiting the abortion decision to a woman’s right to choose do not apply in the

⁴⁴ Posting of onward with 3 to FertileThoughts.com, <http://www3.fertilethoughts.com/forums/showthread.php?t=585260> (May 8, 2008, 12:18 EST).

⁴⁵ Daar, *supra* note 1, at 796.

selective reduction context. Finally, the legal issue presented in the abortion context is of a different nature than the legal issue presented in selective reduction disputes.

A. Intent: Termination or Preservation Pregnancy

An obvious difference between abortion and selective reduction is the purpose of the procedure. The former is designed to terminate a pregnancy, while the latter is designed to make a pregnancy viable. One doctor who performs selective reductions was very clear: “Technically this is not an abortion, a procedure that kills the fetus and empties the uterus. . . . The bottom line is, abortion ends the pregnancy. We don’t end the pregnancy. We very specifically don’t end the pregnancy.”⁴⁶ A sonographer who works in an office that performs selective reductions further explained that what she does is different that what an abortion clinic does: “Here it is completely different. You are helping people have healthy babies. Have babies period.”⁴⁷ Because of this intention to promote the wellbeing of the mother and remaining fetuses, the difference in the procedures is significant.

Judith Daar argues that this distinction in purpose is legally significant. She points to *United States v. Holmes*⁴⁸ as support for the proposition that in some cases, the “violation of individual rights is acceptable because it will result in greater overall good.”⁴⁹ In that case, male passengers were thrown out of an overcrowded lifeboat after a shipwreck, to certain death, so that boat and the rest of the passengers might stay afloat during a storm. The court did not find the defendants guilty of murder, noting that in order to save the greatest number of individuals, the sacrifice was necessary. If, Daar argues, the court in *Holmes* was willing to accept the need to sacrifice fourteen living persons so that twenty-seven others could survive, why would the

⁴⁶ MUNDY, *supra* note 2, at 265 (quoting Dr. Mark Evans)

⁴⁷ *Id.* (quoting Rachel Greenbaum, sonographer in Dr. Evans’ office).

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

⁴⁹ Daar, *supra* note 1, at 827.

rationale not extend to the sacrifice of one or more fetuses so that its siblings and mother could survive?⁵⁰

B. Process: Problematic Legal Definitions of Abortion

While some commentators argue that selective reduction should really be considered “selective abortion” for moral or ethical reasons,⁵¹ or because abortion provides a ready-to-use legal framework,⁵² the legal definition of abortion has no room to encompass selective reduction. This argument was first advanced by Daar,⁵³ who noted that while “there are nearly as many definitions of abortion as there are positions in the debate. . . none would embrace the practice of selective reduction.”⁵⁴ A majority of states define abortion as termination of pregnancy.⁵⁵ Because selective reduction does not terminate a pregnancy, but is in fact aimed at preserving a pregnancy, “no canon of statutory construction could produce an interpretation of these statutes that would include selective reduction within the definition of abortion.”⁵⁶ A substantial minority of states define abortion as intent to procure a miscarriage.⁵⁷ However, the definition of miscarriage requires the expulsion of the fetus from the uterus; because selective reduction leaves the fetal tissue in the uterus, it cannot be considered an abortion under this definition.⁵⁸

⁵⁰ See *id.* at 825-828.

⁵¹ See, e.g., Interview by Ann Curry, Reporter, NBC, with Nadya Suleman, *Dateline* (NBC television broadcast Feb. 10, 2009) (explaining that selective reduction, even in the face of seven embryos, was not an option for her for moral reasons). Suleman, dubbed “octomom” after successfully delivering octuplets, said she never considered selective reduction as an option for religious reasons: “You know, what gives any human being a right to – to pick and choose which embryo – which fetus is more valuable than another. You know, that’s not up to human beings.” *Id.*

⁵² Stacey Pinchuk, *A Difficult Choice in a Different Voice*, 7 DUKE J. GENDER L. & POL’Y 29, 36 (2000) (arguing that the abortion analogy provides “a clear framework for the understanding of selective reduction”).

⁵³ See generally, Daar, *supra* note 1. Note that Daar canvassed the legal definition of abortion in all jurisdictions for this 1992 paper. While an updated 50-state survey is beyond the scope of this paper, the most commonly accepted definitions of abortion continue to be those referenced here.

⁵⁴ *Id.* at 798.

⁵⁵ *Id.* at 802 n.130.

⁵⁶ *Id.* at 803.

⁵⁷ *Id.* at 803 n.134.

⁵⁸ *Id.* at 803.

Finally, while there are some states that define abortion as “intent to destroy an unborn child,”⁵⁹ Daar argues that courts in such jurisdictions may find that selective reduction is not covered in the definition, despite this broad language. She suggests that court would consider “not only the plain meaning of the words, but also the intent behind the words that seeks to protect fetal life”⁶⁰—and because selective reduction is aimed at preserving the pregnancy, it would thus not be encompassed within the definition of abortion.

C. Rationales: The Same Interests Are Not Implicated

Perhaps the most persuasive reason for not looking to abortion laws to resolve disputes over selective reduction is that the rationales for the legal rule do not apply. The pinnacle Supreme Court case that recognizes the right to choose an abortion is *Roe v. Wade*.⁶¹ In that case, the Court clearly stated that the “right of privacy... is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy.”⁶² The Court has since reiterated that a woman’s “suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman’s role,”⁶³ despite the fact that the procedure is “fraught with consequences for others,”⁶⁴ including the woman’s husband.⁶⁵

The Court’s rationale for giving a woman the exclusive right to choose is that forcing a woman to bear the burden of another living thing violates her liberty interest in reproductive freedom. A woman’s right to procreational autonomy trump a man’s liberty interest in the same

⁵⁹ *Id.* at 804.

⁶⁰ *Id.* at 805.

⁶¹ 410 U.S. 113 (1973).

⁶² *Id.* at 153.

⁶³ *Planned Parenthood of So. Pa. v. Casey*, 505 U.S. 833 (1992).

⁶⁴ *Id.* at 852.

⁶⁵ In fact, the only plaintiffs that presented the Court with an option to review this option, a married couple who wanted to avoid pregnancy because of health implications for the mother, were dismissed because their claim was based on a potential pregnancy. The Court explained that the plaintiffs were “a childless married couple, the woman not being pregnant, who have no desire to have children at this time because of their having received medical advice that Mrs. Doe should avoid pregnancy” and that they would want to terminate any pregnancy for this reason. *Roe v. Wade*, 410 U.S. at 127-28. Their complaint was dismissed for a lack of standing because they were not pregnant at the time of the case. *Id.* at 129.

because “it is the woman who physically bears the child and who is the more directly and immediately affected by the pregnancy. . . [and thus] the balance weighs in her favor.”⁶⁶

Furthermore:

the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice.⁶⁷

This argument has also been advanced by Judith Jarvis; her famous and graphic example of a person waking up to find they must support an ill violinist emphasizes the point.⁶⁸

While this is true for abortion, where the decision is between terminating a pregnancy that is not necessarily life-threatening and raising a child, the rationale has little application in the selective reduction—primarily because in the case of selective reduction, the woman would continue to carry the pregnancy. The issue becomes whether she will be carrying three or two infants to term, rather than if she will be carrying any infants at all. Thus, Jarvis’s concern of a woman being forced to support a child against her will becomes inapplicable because the mother has, in essence, already committed to the emotional, physical and financial burdens of a child.

Furthermore, in the case of IVF, the woman has already *specifically* consented to bearing a child. In contrast with coital reproduction, women with pregnancies achieved through IVF have

⁶⁶ Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 71 (1976).

⁶⁷ Casey, 505 U.S. at 852.

⁶⁸ See Judith Jarvis Thomson, *A Defense of Abortion*, PHIL. & PUB. AFF., Autumn 1971, at 47. She wrote:

You wake up in the morning and find yourself back to back in bed with an unconscious violinist. A famous unconscious violinist. He has been found to have a fatal kidney ailment, and the Society of Music Lovers has canvassed all the available medical records and found that you alone have the right blood type to help. They have therefore kidnapped you, and last night the violinist’s circulatory system was plugged into yours, so that your kidneys can be used to extract poisons from his blood as well as your own. ... To unplug you would be to kill him. But never mind, it’s only for nine months. By then he will have recovered from his ailment, and can safely be unplugged from you.

Id. at 48-49.

consulted fertility doctors, discussed the procedure and outcomes, and signed informed consent forms. Because of this, the woman undergoing IVF cannot argue that she had not planned or intended to have a child, or that she is being forced to support a child against her will. While one might argue that a woman consented to implantation of embryos knowing selective reduction was an option,⁶⁹ the woman has still consented to implantation of the embryos—making the policy against forced support, like Jarvis’ violinist, inapplicable.

D. Issues: Different Cases Should Not Be Treated Alike

A final distinction between the abortion case law and selective reduction disputes is that the legal issue presented and the interests at stake are entirely different. There are several major differences. First, the abortion cases do not directly deal with disputes between couples on whether or not to abort. The Court grants sole decision-making power to the woman, but the issue it confronts is balancing her liberty interests with the state’s interest in the unborn child. Balancing the liberty interests of two individuals requires a different analysis. Second, because selective reductions are performed during the first trimester—well before the point of viability—the state’s interest is at its weakest.⁷⁰ It is well established that before viability the individual’s reproductive decision-making freedom, and not the state’s interest, take priority.⁷¹ Finally, the abortion cases focus on a woman’s ability to elect to terminate a pregnancy when it is not life-threatening. Even in *Roe*, all nine Justices agreed that abortion was legal when it was performed to save a woman’s life.⁷² In the case of many multifetal pregnancies, the pregnancies *are* life

⁶⁹ For a discussion of informed consent in IVF contracts, see *infra* n.74 and accompanying text.

⁷⁰ See, e.g., *Casey*, 505 U.S. at 869-76; *Roe v. Wade*, 410 U.S. at 162-65.

⁷¹ See, e.g., *Casey*, 505 U.S. at 870 (noting that viability is “the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman”).

⁷² “[S]ubsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.” *Roe v. Wade*, 410 U.S. at 164-165.

threatening. For these reasons, the legal differences are too vast for the same rules to apply to each situation.

III. USING COURTS' TREATMENT OF FROZEN EMBRYO DISPUTES AS A MODEL FOR RESOLVING SELECTIVE REDUCTION DISPUTES

While abortion regulations do not provide a useful analogy to selective reduction disputes, the legal framework for dealing with frozen embryo disputes is much more applicable. First, frozen embryo disputes and selective reduction disputes are factually similar—much more so than selective reduction disputes and abortion cases. Second, the frozen embryo dispute cases have established a policy against “unwanted parenthood,” a policy with reasoning that is equally applicable to selective reduction disputes. Finally, frozen embryo dispute cases have provided a legal framework for balancing the competing rights of two individuals in the reproductive decision-making context.

A. A Better Fit: Similarities between Frozen Embryo and Selective Reduction Disputes

Because frozen embryo disputes and selective reduction disputes arise in factually similar situations, and potentially from the same initial IVF procedure, the two conflicts should be treated similarly under the law.

First, as with frozen embryo disputes, selective reduction issues arise only when circumstances change *after* the embryo or fetus is created. In embryo disputes, these changes can include divorce of the couple or death of one of the partners after the embryos are created and frozen. In selective reduction disputes, the change in circumstance is the increased health risks to both the mother and fetuses after the discovery that there is more than one. This contrasts in the abortion context, where the change in circumstance *is* the creation of the fetus.

Second, in both frozen embryo disputes and selective reduction disputes, the parties may have a contractual agreement concerning the resolution of the dispute. In most cases, multifetal pregnancy is a result of fertility drugs or IVF. In undergoing these treatments, the man plays a vital role: he is required to consent to the procedure.⁷³ Thus, in IVF, both parties should be aware of the risk of multifetal pregnancy and the potential of selective reduction—particularly given the fact that fertility clinics’ informed consent forms, which the man must sign, disclose multifetal pregnancy as a potential side effect of the procedure and discuss the potential need for selective reduction.⁷⁴ The consent form will also typically specify the disposition of any remaining embryos in the event of particular circumstance (such as divorce, death of one of the partners, or successful conception), and they have been viewed by courts as a contract between the parties when disputes over the disposition of the frozen embryos arise later. Courts have held that “an agreement regarding disposition of any untransferred preembryos in the event of contingencies . . . should be presumed valid and should be enforced.”⁷⁵ This same agreement, often the same consent form, should not be any less enforceable if it contains provisions dealing with the resolution of selective reduction disputes. While the informed consent forms do not require the parties to contract to selectively reduce, a couple may consent to having a large number of embryos implanted—more than they ever intend to bring to term—in an attempt to increase the chances of a successful pregnancy, knowing that selective reduction is an option if a

⁷³ This is particularly true if donor sperm is used. *See, e.g.*, UNIFORM PARENTAGE ACT § 801 (2002).

⁷⁴ *See, e.g.*, Informed Consent Contract from Boston IVF, at 7 (on file with author). The informed consent form notes “the chance of a multiple pregnancy increases with the number of embryos that are transferred” and states that “[a]pproximately 65-70% of pregnancies following the transfer of multiple embryos result in the birth of only one baby.” *Id.* The contract continues:

If a multiple pregnancy develops, the couple may consider a multi-fetal reduction procedure. This procedure, which is performed at three months of pregnancy, reduces the number of fetuses to a lower and safer number. Although the success rate is 90-95% a miscarriage may result from the procedure. The best time to discuss the risks of multiple pregnancy and multifetal pregnancy reduction with your physician is before your treatment cycle begins.

Id.

⁷⁵ *Davis v. Davis*, 842 S.W.2d 588, 597 (Tenn. 1992).

multifetal pregnancy should result. If the couple has contemplated this choice previously, their mutual agreement on the matter should be given some consideration.

Finally, both embryos and fetuses can be seen, at the very least, as “potential lives” or “lives in waiting.” Embryos and preembryos are tiny clusters of cells that, if implanted into a uterus, will grow into fetuses. Courts have found that embryos are thus entitled to special respect—more than property but less than a fully born human being.⁷⁶ Both previability fetuses (the only fetal age at issue in selective reduction disputes) and embryos may become a life, and neither can survive outside the womb, making gestation by a living, human female necessary to bring either one to life. Thus, both are deserving of, at the very least, special respect.⁷⁷ Because courts have already developed a method for deciding disputes between a couple over frozen embryos that accords special respect to these “lives in waiting,” it provides an apt analogy to selective reduction. While it is true that a fetus is much closer to becoming an infant than a frozen embryo, this is not a reason to accord it less respect: if anything, implantation should entail granting the fetus more respect. The mere difference in location—cryogenic freezer or womb—does not serve to reduce the amount of respect accorded to “lives in waiting.”

B. Resolving Differences: Public Policy and Avoiding Particular Kinds of Procreation

In frozen embryo dispute cases, courts will, for policy reasons, favor the party wishing to avoid procreation. This is true even if the parties had previously consented to be parents because “prior agreements to enter into familial relationships... should not be enforced against

⁷⁶ *Id.* (“We conclude that preembryos are not, strictly speaking, either “persons” or “property,” but occupy an interim category that entitles them to special respect because of their potential for human life.”); *see also* Hecht v. Superior Court, 20 Cal.Rptr.2d 275, 281 (Cal.App. 2 Dist. 1993); Janicki v. Hospital of St. Raphael, 744 A.2d 963, (Conn. 1999). The Tennessee Supreme Court explicitly followed ethical standards set by The American Fertility Society. *Davis*, 842 S.W.2d at 596-97.

⁷⁷ *Davis*, 842 S.W.2d at 597.

individuals who subsequently reconsider their decisions.”⁷⁸ The policy rationale is that a person has the right to change their mind concerning past reproductive choices, and the state cannot enforce as binding any past reproductive decision-making. This is because “forced procreation is not an area amenable to judicial enforcement.”⁷⁹ The result of this policy view is that, in essence, if there is a dispute between parties as to the disposition of frozen embryos, “[w]hen one of the gamete donors wishes to avoid procreation, that party will prevail.”⁸⁰

However, this is far from a simple extension of the right to avoid procreation generally, as recognized under the birth control and abortion cases. Instead, this is a right to avoid “unwanted parenthood.”⁸¹ In adjudicating the rights of a divorcing couple to frozen embryos in *Davis v. Davis*⁸² for example, the Tennessee Supreme Court allowed a husband to prevent the wife from transferring the embryos into herself or a surrogate because he was “vehemently opposed to fathering a child that would not live with both parents.”⁸³ The court made it clear that it was considering not just the man’s interest in avoiding genetic parenthood, but it was balancing “the joys of parenthood that is desired [and] the relative anguish of a lifetime of unwanted parenthood.”⁸⁴

If the *Davis* court is to be taken seriously, an individual’s interest in avoiding genetic parenthood a child raised in a single parent home should be no less compelling in the selective

⁷⁸ *A.Z. v. B.Z.*, 725 N.E.2d 1051, 1059 (Mass. 2000). For example, the Massachusetts Supreme Court, in *A.Z. v. B.Z.*, held that even in a case where a “husband and wife enter[] into an unambiguous agreement between themselves regarding the disposition of frozen preembryos, we would not enforce an agreement that would compel one donor to become a parent against his or her will.” *Id.* at 1051.

⁷⁹ *Id.* at 1058.

⁸⁰ Judith F. Daar, *Frozen Embryo Disputes Revisited: A Trilogy of Procreation-Avoidance Approaches*, 29 J.L. MED. & ETHICS 197, 197 (2001). Some might argue that in frozen embryo disputes, rather than treating the couple’s rights as equal, woman’s right to reproduce is suspended from the time embryos are fertilized ex vivo until the embryos are implanted in the womb because until that point a man can refuse to become a genetic parent. However, it is important to note that either partner, the man or the woman, could refuse to continue with the process.

⁸¹ *Davis*, 842 S.W.2d at 603.

⁸² *Id.*

⁸³ *Id.* at 604.

⁸⁴ *Id.* at 601.

reduction context. A man may object to raising children by himself in a single parent home, particularly if the gestational health risks to the mother are extremely high. A woman may object to raising children as multiples, or to raising children with serious health conditions caused by premature birth. The burden of “unwanted parenthood” is equally troubling in the selective reduction context as in the frozen embryo disputes, and is, in point of fact, a much more immediate and less speculative concern.

C. Gender Equality and Balancing Rights

In the case of frozen embryo disputes, courts have evolved a straightforward test:

[D]isputes involving the disposition of preembryos produced by in vitro fertilization should be resolved, first, by looking to the preferences of the progenitors. If their wishes cannot be ascertained, or if there is dispute, then their prior agreement concerning disposition should be carried out. If no prior agreement exists, then the relative interests of the parties in using or not using the preembryos must be weighed.⁸⁵

Thus, in a dispute over frozen embryos, a court will balance one parent’s interest in procreation against the other parent’s interest in avoiding procreation.⁸⁶ Because a court will “consider the positions of the parties, the significance of their interests, and the relative burdens that will be imposed by differing resolutions” and balance “the two aspects of procreational autonomy - the right to procreate and the right to avoid procreation,”⁸⁷ it will necessarily need to consider the rights of both the man and the woman in a gender-neutral way.

Furthermore, in the frozen embryo context, the courts have given some guidance as to how to weigh the competing interests of the two parties—namely, that “the party wishing to avoid procreation should prevail, assuming that the other party has a reasonable possibility of

⁸⁵ *Id.* at 604.

⁸⁶ *See id.*

⁸⁷ *Id.* at 603.

achieving parenthood by means other than use of the preembryos in question.”⁸⁸ The courts, then, clearly prioritize a party’s right to avoid particular kinds of procreation unless their partner is otherwise unable to become a genetic parent.

A similar model can be used in the selective reduction context. First, in the case where both parties express the same preference, their wishes should, of course, be honored. Second, because the parties will have been warned of the risk of multifetal pregnancies before undergoing IVF, they may have expressed a preference to have or avoid a selective reduction procedure. If a couple has signed an agreement in the context of IVF that indicates what they wished to do in the case of multifetal pregnancies, it should be given significant weight. As a final step, if the couple cannot agree and if there is a lack of, or problem with, any prior agreement, a court should balance the interests of the parties seems the appropriate approach.

The problem, however, with applying a balancing test is that it would necessarily involve the courts. With a procedure like selective reduction, which must be performed in a narrow two-week window, the judicial process is simply too slow. Thus, a preference should be given, modeling the frozen embryo dispute context. I argue that the preference should be given to the party wanting to have the selective reduction procedure performed. The reasons are twofold, and align with the court’s rationale for giving preference to the party who wishes to avoid procreation in frozen embryo disputes.

First, unwanted parenthood is a significant consideration. The party who wants the selective reduction performed is likely concerned about the health of the mother and infants, the ability of the fetuses to survive, the psychological, emotional and financial burdens of raising higher order multiples, and all the other issues previously discussed in this Note. These are not light considerations, and, as in the case of frozen embryo disputes, the law should consider, as a

⁸⁸ *Id.* at 604.

matter of policy, the right of a party to avoid a particular kind of “unwanted parenthood.” Furthermore, the party who opposes selective reduction, be it the man or the woman, is endangering more than just themselves. The additional health risks that accompany high order multiples may be severe, and will likely have life-long effects on any surviving children.

Second, failure to have a selective reduction may cause a termination of the entire pregnancy, depriving one or both parties of genetic parenthood—perhaps indefinitely. For example, if one of the partners cannot provide additional reproductive material (*i.e.*: if the man has undergone a vasectomy), a failure to reduce the number of fetuses which results in termination of the entire pregnancy may eliminate any future chance that party has to become a genetic parent. This contrasts with the same interest in the frozen embryo dispute cases, where the party who seeks implantation of the embryo is the party interested in genetic parenthood. Here, because this interest aligns with the party seeking to selectively reduce, it further supports giving a preference to the party interested in reduction.

IV. CONCLUSION

For couples facing multifetal pregnancies and who have disagreements over whether or not to pursue selective reduction, there must be a way to resolve the dispute quickly and consistently. A clear legal standard is need so that fertility clinics, and courts if necessary, can quickly resolve the issue fairly and within the unique time constraints inherent in selective reduction disputes.

One option, following the abortion model, is to defer all decision-making to the woman. This is problematic because giving such deference to the woman ignores the reality of many multifetal pregnancies: that an intact couple has actively pursued genetic parenthood together.

The man is just as involved in the process. Furthermore, there are sufficient factual and legal differences between abortion and selective reduction that the comparison becomes untenable.

Instead, a legal framework similar to that employed in frozen embryo disputes is appropriate. In addition to being legally and factually similar situations, the legal standard used for resolving frozen embryo disputes offers a meaningful way to analyze disputes over selective reduction. Treating interests of both the man and the woman in such a dispute by balancing the rights of each, and deferring to the interest of the party wishing to undergo a selective reduction in close cases, will ultimately preserve the reproductive autonomy of both individuals and the couple as a whole. Furthermore, it may provide the resulting children with the best chance at a healthy birth and a happy life in an intact home.