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ARTICLES

DOUBLE TROUBLE: LEGAL SOLUTIONS TO THE MEDICAL PROBLEMS OF UNCONSENTED SPERM HARVESTING AND DRUG-INDUCED MULTIPLE PREGNANCIES

RONALD CHESTER*

Why seek ye the living among the dead?

-Luke¹

Death does not end all things.

-Sextus Propertius²

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1. *Luke* 24:5.

2. Sextus Propertius, *Elegies*, in *PUTNAM'S DICTIONARY OF THOUGHTS* 565b (1930). *See also* *PROPERTIUS* 307 (H.E. Butler trans., 1962) where the line is translated slightly differently: "death is not the end of all."

There was an old woman who lived in a shoe,
 She had so many children she didn't know what to do;
 She gave them some broth without any bread;
 She whipped them all soundly and put them to bed.

-Anonymous³

Every baby born into the world is a finer one than the last.

-Charles Dickens⁴

I. INTRODUCTION

In two previous articles, I called for government regulation of both assisted reproduction using frozen sperm after the death of the donor⁵ and human cloning.⁶ Despite the many calls for government regulation of the new reproductive technologies since those articles appeared, there has been little legislative reaction.⁷ Many experts in reproductive law and ethics seem content (or resigned) to leaving the control of such technologies to doctors and their individual arrangements with patients.⁸ Under this view, patients are free

3. Anon., *There Was an Old Woman Who Lived in a Shoe*, in THE OXFORD DICTIONARY OF NURSERY RHYMES 434 (Iona & Peter Opie eds., Oxford Univ. Press 1952).

4. CHARLES DICKENS, *LIFE AND ADVENTURES OF NICHOLAS NICKLEBY* 544 (Penguin Books, 1982).

5. See generally Ronald Chester, *Freezing the Heir Apparent: A Dialogue on Postmortem Conception, Parental Responsibility, and Inheritance*, 33 HOUS. L. REV. 967, 979 (1996) [hereinafter Chester, *Freezing the Heir Apparent*].

6. See generally Ronald Chester, *To Be, Be, Be Not Just to Be: Legal and Social Implications of Cloning for Human Reproduction*, 49 FLA. L. REV. 303, 311 (1997) [hereinafter Chester, *Cloning for Human Reproduction*].

7. See, e.g., Keith Alan Byers, *Infertility and In Vitro Fertilization: A Growing Need for Consumer-Oriented Regulation of the In Vitro Fertilization Industry*, 18 J. LEGAL MED. 265, 299-312 (1997) (in which the author proposes various forms of in vitro fertilization regulation, including requiring statistical honesty, licensing clinics, controlling the quality of IVF services, and demanding the safekeeping of embryos); Judith F. Daar, *Selective Reduction of Multiple Pregnancy: Lifeboat Ethics in the Womb*, 25 U.C. DAVIS L. REV. 773, 791 (1992) ("to date there are no federal regulations governing the clinical practice of infertility therapy."); Heidi Forster, *The Legal and Ethical Debate Surrounding the Storage and Destruction of Frozen Human Embryos: A Reaction to the Mass Disposal in Britain and the Lack of Law in the United States*, 76 WASH. U. L.Q. 759, 772-74 (1998) (discussing the lack of regulation and need for appropriate legislation over the disposal of frozen embryos); Lori B. Andrews, *The Sperminator*, N.Y. TIMES, Mar. 28, 1999, at 65 (a New York Bill banning posthumous sperm collection unless the man has previously consented to the procedure in writing is presently before the legislative assembly, Assembly Bill 8043, April 26, 1999); Marie McCullough, *Fertility Clinics Eyed After Error*, BOSTON GLOBE, Mar. 31, 1999, at A3 (the case of a medical mix-up that left a white New York couple with twin sons— one white, one black— spawned questions about quality-control procedures in the baby-making industry and calls for greater regulation.); Jeff Israely, *Italy Set to Pass Fertility Services Law, But Strictures Criticized*, BOSTON GLOBE, Sept. 12, 1999, at A25.

8. See Andrews, *supra* note 7, at 64. See generally Judith F. Daar, *Regulating Reproductive Technologies: Panacea or Paper Tiger?* 34 HOUS. L. REV. 609, 633-37 (1997)

to contract for reproductive assistance. Should legal problems arise, courts are left to fashion decisions from common law principles, with little legislative guidance.⁹

The dearth of statutory regulation of the new reproductive technologies led me to consider how common law and other approaches in fact or could work in different areas of assisted reproduction. Two problems in reproductive medicine have lately drawn my interest: unconsented sperm harvesting from dead or comatose males and multiple pregnancies caused by fertility drugs. Since systematic governmental regulation of such problems seems increasingly unlikely, I wondered whether the common law and other approaches could handle these situations and, if so, in what ways.

In this article, I first deal with non-statutory methods of addressing unconsented sperm harvesting and then use much the same method to deal with drug-induced multiple pregnancies. After summarizing the various methods and discussing to what degree I think each would work, I conclude that common law actions for damages have some chance of succeeding with regard to drug-induced multiple pregnancies, but that injunctions seem the best way available to control unconsented sperm harvesting.

II. UNCONSENTED SPERM HARVESTING

A. *The Problem In General*

I begin with the proposition, basic to classical contract law, that competent adults are free to enter into any bargains they choose, provided that these bargains do not contravene public policy.¹⁰ It apparently does not contravene public policy for an individual to seek to reproduce with most, if not all, technological aids. In fact, that individual may have a constitutional right to do so.¹¹ Therefore, reproductive bargains, at least those of patient with fertility or other doctor, seem permissible on their face.

(discussing the legal, ethical, and policy implications of assisted reproductive technologies ("ART")); Marjorie Maguire Schultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 WIS. L. REV. 297, 324-25 (1990) (the author proposes that legal rules governing the importance and the legitimacy of individual efforts to protect intentions and decisions into the future); Sandra Anderson Garcia, *Sociocultural and Legal Implications of Creating and Sustaining Life Through Biomedical Technology*, 17 J. LEGAL MED. 469, 525 (1996).

9. See Chester, *Freezing the Heir Apparent*, *supra* note 5, at 974-76; Chester, *Cloning for Human Reproduction*, *supra* note 6, at 330-31.

10. See, e.g., Ronald Chester & Scott E. Alumbaugh, *Functionalizing First-Year Legal Education: Toward a New Pedagogical Jurisprudence*, 25 U.C. DAVIS L. REV. 21, 29-30 (1991).

11. See John A. Robertson, *Posthumous Reproduction*, 69 IND. L. J. 1027, 1044-45 (1994).

Obviously, a comatose or dead man cannot enter into a contract.¹² A doctor may, however, act at the insistence of a third party, who wants the sperm (which some cases have called a type of “quasi-property”)¹³ for her own benefit. If the man has left no instructions or will transferring the rights to his sperm to the woman involved, she would appear to have no legal right to the sperm. Nevertheless, doctors can, and often do, harvest the man’s sperm for the woman’s procreative purposes.¹⁴ In the absence of a civil claimant, the doctor can do so without fear of either sanction or liability.¹⁵ While hospitals, fearful of litigation, generally demand a court order to refuse to treat or to terminate treatment, they do not appear similarly concerned by sperm harvesting.¹⁶

As Lori Andrews reports: “Our unregulated approach contrasts greatly with the system in England, where the Human Fertilization and Embryology Authority, a Government agency, passes judgment on which fertility techniques are beyond the pale.”¹⁷ This agency has prohibited both human cloning and the use of a dead man’s sperm without his prior consent. We have no such agency in the United States.¹⁸

To change this situation, a recent bill to prohibit the practice has been introduced in the New York State legislature.¹⁹ Whether it will pass and be

12. However, if a man consents in advance to having his sperm harvested at his death, the male may have made an enforceable third party beneficiary contract with the doctor in favor of his intended female beneficiary. To be sure of enforceability, such a contract should be in writing to avoid the Statute of Frauds prohibition in many states on contracts not to be performed until after death. In states without the applicable Statute of Frauds prohibition, a writing is also advisable to show to the attending physician. Although such a situation would be rare, one should also be used where the male intends to allow the harvesting to be done while he is merely comatose.

13. See, e.g., *Brotherton v. Cleveland*, 923 F.2d 477, 482 (6th Cir. 1991) (holding that the wife has a protected interest in her dead husband’s corneas); *Arnaud v. Odom*, 870 F.2d 304, 308 (5th Cir. 1989) (a “quasi-property” right of survivors in the remains of their deceased relatives); *Fuller v. Marx*, 724 F.2d 717, 719 (8th Cir. 1984) (under Arkansas law, the next of kin has a quasi-property right in a dead body); See also James E. Bailey, *An Analytical Framework for Resolving the Issues Raised by the Interaction Between Reproductive Technology and the Law of Inheritance*, 47 DEPAUL L. REV. 743, 763 (1998) (arguing that common law has increasingly begun to recognize quasi-property rights in the deceased’s body).

14. See Andrews, *supra* note 7, at 63.

15. See *id.* at 65.

16. See *id.* The U.S. Supreme Court held that comatose individuals cannot be forced to accept life-sustaining treatments. *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 284 (1990). Andrews argues that “[n]either should they be forced to contribute to life-creating ones.” Andrews, *supra* note 7, at 65.

17. Andrews *supra* note 7, at 64.

18. See *id.*

19. In January, State Senator Roy Goodman introduced a bill, now pending in the New York Legislature, that prohibits postmortem retrieval of sperm for reproduction purposes from a deceased man unless the decedent gave explicit written consent thereto before his death and

signed into law, and if it is, whether it will be copied by other states, are open questions. In addition to political difficulties, there may be constitutional problems with such statutes. The woman involved may claim that her right to procreate can only be abridged if there is a compelling state interest in such regulation.²⁰ It may be easier to overcome this problem in the case where the man is alive and has countervailing privacy, and perhaps property, rights of his own. Once dead he would seemingly have no such countervailing rights. Still, one might argue that although the woman might have procreative rights, she has no right to procreate with the sperm of this particular man in either of the described situations.²¹

A good hypothetical case that raises the various issues in unconsented sperm harvesting would involve the second wife of a dead or comatose husband who wanted the sperm so she could have the couple's only child. Pitted against her interests in creating a child and potential heir of the dead man might be those of existing children from the man's prior marriage. It would be well to keep this paradigm in mind during the discussion that follows.

B. *Self-Regulation By The Profession*

Can we look to the medical profession for self-regulation of sperm harvesting? It is true, for example, that the American Society of Reproductive Medicine has developed a protocol entitled "Posthumous Reproduction"²² that

unless the procedure is requested by his partner or spouse. See A.B. 8043, 222nd Leg., 1st Reg. Sess. (N.Y. 1999).

20. See Robertson, *supra* note 11, at 1044-45 (concluding that the right of women to conceive artificially includes the right to choose a donor, including a donor who is now dead).

21. *But see* Susan Kerr, *Post Mortem Spem Procurement: Is It Legal?* 3 DEPAUL J. HEALTH CARE L. 39 (1999). Ms. Kerr states "it is legal to procure sperm from a dead man and use it for reproductive purposes." In general, the reasoning to support her argument is unconvincing. For an example, see the bottom of page 47 where Kerr states that since a fetus is not a person for purposes of the Fourteenth Amendment [*Whitehurst v. Wright*, 592 F.2d 834, 834 (5th Cir. 1979)], then neither should a corpse be because it has "no potential for life." Surely Kerr would concede however, that sperm found within the male corpse has this "potential for life."

On page 48, Kerr lists a number of cases in which causes of action involving interference with a dead body were brought by spouses or next of kin; this list would seem to indicate that it is not legal to intrude into a corpse. Her explanation that "if the corpse were an entity capable of possessing rights, the action would belong to him or to his personal representative" is arguable, although it is neither necessarily true, nor dispositive. Whatever the theory, for standing or recovery, the law's distaste for such interference is plain.

On page 58, Kerr, without providing any case law to support her claim, states that "sperm has not been held to be legally willable." In apparent contrast on page 55 she states that "the issue in *Hecht* [*Hecht v. Superior Court of L.A. County*, 16 Cal. App. 4th 836 (Ct. App. 1993)] was whether the sperm is considered property and, therefore, permissibly willable." Also arguably inconsistent is her statement on page 60 that "some courts recognize a right of a person to dispose of his own body in his will."

attempts to address the problem. But as Lori Andrews reports, “doctors do not need to request permission from an ethics committee to undertake the harvesting procedure. Physicians can make their own ad hoc decisions for determining which requests should be honored.”²³ For example, Dr. Cappy Rothman, a co-owner of the California Cryobank, has been performing the procedure since 1978, and has decided not to collect sperm from men who have had vasectomies.²⁴ His assumption is that these men clearly did not want children.²⁵

When a Midwest teaching hospital consulted Andrews regarding six men in comas whose wives, girlfriends, or parents wanted their sperm, she recommended that the hospital not electroejaculate these men.²⁶ Since no law or regulation actually prohibited the procedure, the hospital went ahead anyway.²⁷ This example points out a reality about doctors: they are primarily in the business of trying to please patients and their relatives. If legislators or others concerned with larger societal issues do not prohibit a requested procedure, most doctors will eventually bend to the requests of those paying their bills, unless a genuine legal threat looms as in the case of termination of life support. Competition between fertility doctors and their refusal to endure the oversight of physicians in other specialties on hospital review committees further hinders effective self-regulation by the medical profession.²⁸

C. Tort

An eager district attorney might charge a doctor who removed sperm with an unconsented battery²⁹ (in the case of a comatose man) or “mutilation” of a dead body,³⁰ but this is highly unlikely, unless a particular district attorney is interested in making a moral or legal issue of unconsented sperm harvesting. I

Finally, on page 68 Kerr draws a conclusion with which many may differ: “post mortem sperm procurement” is “simply a minimally intrusive invasive medical procedure.” For a brief explanation of this procedure, *see infra* notes 37-39 and accompanying text.

22. *See Andrews, supra* note 7, at 61; *see also* Michelle L. Brenwald & Kay Redeker, *A Primer on Posthumous Conception and Related Issues of Assisted Reproduction*, 38 WASHBURN L.J. 599, 605 (1999).

23. *Andrews, supra* note 7, at 64.

24. *See id.* at 63.

25. *See id.* at 64.

26. *See id.* at 65. Andrews considers the idea of procreation without permission “a radical one.” *Id.* at 62. She believes that “collecting sperm from comatose or dead men is perilously close to rape.” *Id.* at 65.

27. *See id.* at 65.

28. Interview with Dr. Mihai Dimanescueu, Neurosurgeon of Freeport, New York in Lincoln, Mass. (Dec. 31, 1998). Dr. Dimanescueu has chaired a number of these review committees.

29. *See, e.g.*, MODEL PENAL CODE § 211.1.

30. *See, e.g.*, 22 AM. JUR. 2D *Dead Bodies* § 58 (1988).

assume, however, that most district attorneys have plenty of rapes, robberies, and killings to prosecute without looking for unusual cases like these. Still, such a battery could conceivably lead to liability in tort. As the court stated in *Cohen v. Smith*, “protecting personal integrity has always been viewed as an important basis [for the tort of] battery.”³¹ Furthermore, a person’s right to refuse medical care is not to be interfered with lightly. As Justice Cardozo stated, “. . . a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.”³²

Who would bring such an action for battery? If a comatose man has children, presumably one or more of them could petition to become guardian, or the court might even appoint a third party guardian (of the sperm) as a neutral between the children and the woman desiring the sperm. The guardian could then bring the civil action, but damages for the comatose man would seem to be minor or nonexistent.³³ However, if the children could establish the tort of battery against their father, they might then have an action for tortious interference with an expectancy of inheritance.³⁴ This would depend on whether the law would consider the child produced through the sperm both a child and an heir of their father (once dead).³⁵ There are a number of “ifs” in this equation. Under current law, however, if the child were conceived after the death of the man, it would probably be considered either a child but not an heir, or not a child of the dead man at all.³⁶

If the children would have no action for tortious interference with their inheritance, could they still have one for the doctor’s infliction of emotional distress? If the father was merely comatose, the use of machines to force ejaculation electrically might be highly disturbing to any children watching. An instrument resembling a cattle prod is inserted into the man’s rectum.³⁷ An electric shock then causes involuntary ejaculation.³⁸ If the father was already dead, the children or any relative or friend present would likely see the sperm being removed surgically,³⁹ which could also be upsetting.

It is unlikely, however, that children or others emotionally close to the father will be present, or within the tort laws’s “zone of harm,” particularly if their father is already dead. Still, the California case of *Christensen v.*

31. 648 N.E.2d 329, 332 (Ill. App. Ct. 1995).

32. *Id.* at 335 (citing *Schloendorf v. Society of New York Hosp.*, 105 N.E. 92 (1914)).

33. Also, the holder of a durable power of attorney for health care would presumably have standing if so authorized by the granting instrument. *Cf.* JESSE DUKEMINIER & STANLEY M. JOHANSON, *WILLS, TRUSTS, AND ESTATES* 403-04 (5th ed. 1995).

34. *See id.* at 204 (discussing *RESTATEMENT (SECOND) OF TORTS*, § 744 B (1979)).

35. *See* Chester, *Freezing the Heir Apparent*, *supra* note 5, at 987-93.

36. *See, e.g., id.* at 989-90.

37. *See* Andrews, *supra* note 7, at 62.

38. *See id.*

39. *See id.*

Superior Court,⁴⁰ may give them a cause of action. This case involved a mortuary where, instead of performing dignified burials and cremations as they were supposed to, workers mutilated the cadavers to procure organs to sell.⁴¹ The court held that the mortuary had assumed a duty to close relatives who later found out about the practice, even though they were not present at the mutilation.⁴²

Ironically, the plaintiffs would want to prove only negligent infliction of emotional distress,⁴³ rather than intentional infliction of such emotional harm, because the doctors' and hospitals' insurance policies would probably not cover intentional infliction of emotional distress. Under *Christensen*, a claim for emotional distress would probably lie regardless of whether the man was alive when the sperm was harvested. Mistreatment of a person's body, unless done with concern for close relatives, can cause compensable emotional distress.⁴⁴

Since the level of intrusion into or mutilation of comatose or dead bodies in sperm harvesting does not appear to reach the extremes found in the *Christensen* case, the emotional shock upon learning of the procedures would seem to create only a moderate level of emotional distress. Thus, damages, if available at all, would probably not be great.

There is at least one other possible tort in this situation. One might start with the proposition that sperm is a sort of property.⁴⁵ Certainly it has value and is regularly exchanged for money in the case of sperm "donors." If a man can contract for its use or, as in *Hecht v. Superior Court of Los Angeles County*,⁴⁶ will it or give it away at death, then taking it without the owner's consent would seem to be conversion of that property.⁴⁷

40. See generally *Christensen v. Superior Ct.*, 820 P.2d 181 (Cal. 1991).

41. See *id.* at 185-86.

42. See *id.* at 196, 200-01.

43. For a discussion of a cause of action for the negligent infliction of emotional distress see Jill Trachtenberg, *Living in Fear: Recovering Negligent Infliction of Emotional Distress Damages Based on the Fear of Contracting Aids*, 2 DEPAUL J. HEALTH CARE L. 529, 530-33 (1999).

44. See *Christensen*, 820 P.2d at 197. The court held that it is foreseeable that close relatives, who are aware that funeral related services are to be undertaken but who are not present to watch the manner in which the remains are to be prepared for burial or cremation, may suffer serious emotional distress on learning that the decedent's remains have been mistreated. *Id.*

45. See, e.g., Bailey, *supra* note 13, at 762-63. See also Erik S. Jaffe, "She's Got Bette Davis('s) Eyes": Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses, 90 COLUM. L. REV. 528 (1990) (arguing that property rights do exist in the human body and its constituent parts).

46. 20 Cal. Rptr.2d 275 (Cal. Ct. App. 1993).

47. Conversion is defined as "an unauthorized assumption and exercise of the right of ownership over . . . personal chattels belonging to another." BLACK'S LAW DICTIONARY 332 (6th ed. 1990). See also DAN B. DOBBS & PAUL T. HAYDEN, TORTS AND COMPENSATION: PERSONAL ACCOUNTABILITY AND SOCIAL RESPONSIBILITY FOR INJURY 53-55 (3d ed. 1997); Roy Hardiman, *Toward the Right of Commerciality: Recognizing Property Rights in the Commercial*

Conversion applies to the theft of a chattel, that is, to theft of physical property. An exhaustive study by Professor Steven Bailey concludes not only that sperm is different in kind than blood, tissue and organs, but that, when the question has been presented, sperm has generally been treated by the courts as property, although they may not admit to doing so.⁴⁸ The guardian or agent of a comatose man or heirs of a deceased man would arguably have an ownership interest in the sperm and thus a cause of action against the doctor and the woman for stealing the sperm.⁴⁹ Damages seem uncertain or nominal, but assumedly an action for replevin of sperm, or an injunction against its use would lie. Although such an action for conversion might well come too late to stop the retrieval of the sperm, it could generally be brought in time to prevent the sperm's use.

D. Contract

Contracts with doctors are generally actionable at common law only if the doctor contracts with the patient to achieve a particular result.⁵⁰ For example, in *Sullivan v. O'Connor*, a promise to perform plastic surgery, and thereby improve the plaintiff's appearance, was found to be actionable.⁵¹ The problem in the present situation is that the comatose or dead man made no contract with the doctor regarding the use of his sperm. He may, however, have previously contracted for a particular operation that proved unsuccessful. A breach of contract can be found only if the surgeon made an express or implied promise to avoid harvesting organs, or in this case, special tissue called sperm. If an organ donation directive has not been signed by the man, the surgeon might be held to an implied promise not to harvest reproductive tissue. The surgeon could then be sued by the man's representative for breaking that promise. The organ donation directive may not itself expressly cover harvesting of reproductive tissue like sperm.⁵²

Reproductive tissue is different from other tissue or organs because of its potential for creating new life. One might want his organs harvested in case of

Value of Human Tissue, 34 UCLA L. REV. 207 (1986) (discussing the rights individuals have in the commercial exploitation of his or her own body).

48. See Bailey, *supra* note 13, at 763.

49. See *supra* note 47 and accompanying text.

50. See *Sullivan v. O'Connor*, 296 N.E.2d 183, 185 (Mass. 1973).

51. *Id.* at 184-86.

52. See UNIFORM ANATOMICAL GIFT ACT, §1, 8A U.L.A. 29 (1993). Subsection (7) of Section 1 defines [body] part to include "an organ, tissue, eye, bone, artery, blood, fluid, or other portion of the human body." Although sperm is arguably a form of 'fluid' from the human body, sperm is unlike other fluids because of its capacity to procreate new life and thus it should not be covered by the Uniform Anatomical Gift Act. See discussion *infra* note 156 and accompanying text. For an opposing argument, see Kerr, *supra* note 21, at 63-64, in which Ms. Kerr recommends an amendment to the Uniform Act allowing procurement of sperm for reproductive purposes.

death in order to help others, but he may *not* want his sperm taken to create new offspring, and conceivably, new heirs. Not only does a man have a protectible expectation that a surgeon not use his sperm in such a way without his consent, but society would seem to have an interest in not allowing the possible creation of offspring or heirs that the individual did not intend to be born.

If we follow the Social Security Administration's ultimate ruling that the posthumously conceived Judith Hart was entitled to benefits as a *child* of her dead father, then such a child could be considered an heir.⁵³ This result may upset the estate plan of the father, or if no plan existed, the justifiable expectations of living heirs. If the posthumously conceived child were, by contrast, viewed in the traditional manner as not being the child of the father, then the father would not be liable for the child's support.⁵⁴ In this case, the posthumously conceived offspring could become a financial problem for the state.

E. *The Fiduciary Relationship And Unjust Enrichment*

Another line of attack on unconsented sperm harvesting may be found in the law of confidential or fiduciary relationships. A doctor is in a confidential relationship with his patient, including one who is comatose.⁵⁵ Is this relationship sufficient to create a fiduciary duty that is breached by the extraction of a kind of property, the patient's sperm, and the unconsented transfer of that sperm to others?

In the case of *Moore v. Regents of the University of California*, the California Supreme Court found that spleen cells extracted by a physician for his own profit did not constitute property.⁵⁶ However, the court said the

53. See Stipulation of Dismissal, Shalala (No. 94-3944) (dismissal dated Mar. 18, 1996). A statement by Shirley S. Chater, Commissioner of the Social Security Administration, explained the settlement:

In the interim, after consulting with the Department of Justice, we [Social Security Administration] believe it would be inappropriate to deny benefit payments to Judith Hart at this time. As a mother two times, I admire the deep feelings of love that brought Judith Hart into this world and I applaud the miracles of modern medicine that resulted in her birth.

Therefore, I have asked the Court to return the case to Social Security at which point I will order the immediate payment of benefits to Judith Hart.

News Release, Social Security Administration, Mar. 11, 1996; see also *Benefits Awarded to In Vitro Child*, NAT'L L.J., Mar. 25, 1996, at A8 (reporting that the Social Security Administration agreed to grant benefits to Judith Hart, therefore eliminating the need for continued litigation); Melissa M. Perry, *Fragmented Bodies, Legal Privilege, and Commodification in Science and Medicine*, 51 ME. L. REV. 169, 184-93 (1999).

54. See generally Chester, *Freezing the Heir Apparent*, *supra* note 5, at 1012-25.

55. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 488-90 (Cal. banc 1990).

56. *Id.* at 489.

patient had a right of informed consent in this situation and pointed to the fiduciary duty that would apply to the doctor in the use of these cells.⁵⁷ Similarly, when a physician extracts a patient's sperm, damages might be assessed against the doctor in tort for either breaching his duty to procure informed consent, or more broadly for breach of his fiduciary duty to the patient.

Who would enforce such rights? If the man remained alive, a guardian or holder of a durable power of attorney for health care could sue if so authorized; if the man was dead, the personal representative of his estate could sue.⁵⁸ If the person wanting the sperm were the man's wife, who might well be the lifetime representative or executor, she clearly would not bring the action. Although children of the couple or from a prior marriage, or their guardian ad litem might force the wife to resign due to a conflict of interest, this supposes that the children or guardian are cognizant of the threat to their interests as heirs and existing family members. If the man is merely comatose, there may also be an action available to these individuals for either violation of the man's privacy rights, or for battery. If the personal representative were someone other than the wife or girlfriend, she would still need to understand the cause of action in order to bring it.

Even if the doctor were found not to have breached a fiduciary duty, might his actions have unjustly enriched others? If a new heir was born as a result of sperm harvesting, and was to take a share under wills law, could the theory of unjust enrichment be used to force the new child to hold this share in constructive trust for the previous children? Under such a theory, the doctor could be viewed as unjustly appropriating the sperm—that is, doing something that the man did not consent to in his contract. The problem is that the doctor is not the one unjustly enriched, but instead it is the woman or her child. Furthermore, the enrichment is not in the form of property appropriated, but “quasi-property”⁵⁹ that has the potential to interfere with the existing children's inheritance. The possibilities of such an action succeeding seems too remote for further consideration.

F. Tentative Conclusions On Sperm Harvesting

In general, large sums of money are not involved in any of the causes of action discussed above. One exception includes the cases in which existing heirs are deprived of their expected inheritances because a posthumously-conceived child is allowed to share decedent's wealth. A second exception arises when relatives assert a cause of action for emotional distress. Recovery based on emotional distress will depend on a court's willingness to apply the

57. *Id.* at 485.

58. *See supra* note 33 and accompanying text.

59. *See* Bailey, *supra* note 13, at 762-63.

reasoning in *Christensen*. Even if a court were willing to do this, the damages might not be large.

An alternative to a suit for damages would be an action for an injunction based on a combination of one or more of the causes of action mentioned above. The extraction of sperm would probably occur before a plaintiff was able to stop it, so the injunction would most likely be against the use of the extracted sperm for procreative purposes. If the sperm were considered property, the suit could also be styled as an action in replevin.⁶⁰

III. MULTIPLE PREGNANCIES CAUSED BY FERTILITY DRUGS ALONE OR IN CONJUNCTION WITH IVF

A. *The Problem In General*

The failure of medical self-regulation in the area of unconsented sperm harvesting has also been present in cases of drug-induced multiple pregnancies. This costly medical nightmare has not been stopped by government legislation or regulation.

A recent case to receive wide media attention was that of Nkem Chukwu, who gave birth to octuplets in Houston, Texas in December 1998.⁶¹ The largest of these children weighed only twenty-six ounces. The smallest baby, who was fifteen weeks premature, weighed only 10.3 ounces, and was $9\frac{3}{4}$ inches long. This child died not long after birth. Nkem had undergone aggressive drug therapy to stimulate ovulation. Early in her pregnancy, she declined to undergo selective reduction⁶² “of the fertilized eggs, which might have given the remaining embryos a better chance of meaningful survival.”⁶³

60. Replevin is defined as “an action whereby the owner or person entitled to repossession of goods or chattels may recover those goods or chattels from one who wrongfully detains such goods or chattels.” BLACK’S LAW DICTIONARY 1299 (6th ed. 1990). For an argument that sperm would be considered property, and therefore a chattel, see Bailey, *supra* note 13, at 813-15.

61. See Rick Lyman, *As Octuplets Remain in Peril, Ethics Questions are Raised*, N.Y. TIMES, Dec. 22, 1998, at A1. See generally Janet L. Dolgin, *Suffer the Children: Nostalgia, Contradiction and the New Reproductive Technologies*, 28 ARIZ. ST. L.J. 473 (1996) (reporting on the American myths of family and children and the effects reproductive technologies have had on these myths); Laura Meckler, *Fertility Drugs Fuel Multiple Baby Boom*, BOSTON GLOBE, Sept. 16, 1999, at A25. (reporting that more than 104,000 babies were born with at least one sibling in 1997, a 52% increase in twins).

62. Selective reduction is the process by which the number of fetuses carried by the woman is reduced. The process involves inserting a needle through the woman’s abdomen into one of the gestational sacs where it is then maneuvered into the fetal chest and potassium chloride is injected. See Daar, *supra* note 7, at 779-80. Selective reduction may be performed because there are more fetuses than can be safely brought to term or because one or more have been found to be at risk for a disability. Compare Christine Overall, *Selective Termination in Pregnancy and Women’s Reproductive Autonomy*, in ISSUES IN REPRODUCTIVE TECHNOLOGY 145-59 (Helen Bequaert Holmes ed., New York Univ. Press, 1994), with Mary Anne Warren, *Abortion: New*

The cost of caring for the pregnancy and the post-birth difficulties of the seven surviving Chukwu children will run into the millions of dollars.⁶⁴ The risk of lifelong health problems and death for these infants is so high that Dr. Mark Perloe of the Atlanta Reproductive Health Center called their birth “a wake-up call for the profession.”⁶⁵ Commenting on the Chukwu births, Alan Copperman of Mt. Sinai Medical Center said “the vast majority of these cases end in disaster, sometimes for the mom, most often for the babies.”⁶⁶ Dr. Mark Evans of Wayne State University said that “although these babies were born alive, the odds are that there will not be happy outcomes for at least some of them.”⁶⁷ Thus, experienced medical professionals view the Chukwu births not as cause for great celebration, as did some of the mainstream media, but as a disaster.⁶⁸

In 1997, Bobbi McCaughey, still in her twenties, gave birth to septuplets. John Leo, a columnist for *U.S. News and World Report*, stated:

Th[e] doctor, Katherine Hauser, certainly can be second-guessed for overseeing a pregnancy begun when Bobbi McCaughey’s ovaries contained at least seven mature eggs. The drug Metrodin stimulates egg production, but those eggs can be counted through ultrasound, and doctors usually advise a couple to abstain from sex until the next cycle if the egg count is high. Instead of explaining what she did and why, Hauser opted for an irrelevant argument based on rights, testily asking reporters, “Should we as a society dictate to individuals the size of their families or their choices of reproductive care?” Answer: No. But doctors ought to be able to count to seven, and when counseling a couple, they have a moral obligation to explain the predicament and awful options that confront a woman who is carrying seven fetuses.⁶⁹

In addition to the health risks posed to infants,⁷⁰ the carrying of so many fetuses poses a threat to the mother’s health. As Leo points out, “[i]f Bobbi

Complexities, in *ISSUES IN REPRODUCTIVE TECHNOLOGY* 113-21 (Helen Bequaert Holmes ed., N.Y. Univ. Press, 1994.).

63. See Lyman, *supra* note 61, at A18.

64. *Id.* at A1.

65. *Id.*

66. *Id.* at A18.

67. *Id.* However, for an article claiming that the seven remaining Chukwu infants are doing well thus far, see *Last Texas Octuplet Now at Home*, CINCINNATI POST, June 26, 1999, at 16A.

68. See, e.g., Dave Goldfinger, *7 Wonders of the Modern World*, N.Y. DAILY NEWS, Sept. 30, 1999, at 32.

69. See John Leo, *A New Medical Skill: Counting*, U.S. NEWS & WORLD REPORT, Dec. 8, 1997, at 20.

70. On November 19, 1999, the septuplets—Kenny, Brandon, Joel, Nathan, Alexis, Kelsey and Natalie—turned two. Of the seven children, four suffer from some sort of adverse physical condition. Two of the children have cerebral palsy and must use walkers: Alexis has hypotonic quadriplegia which causes muscular weakness in all four limbs, and Nathan has spastic diplegia which causes uncontrollable muscle tightening in his legs. Nathan’s lower body and leg muscles have been rigid since birth and Alexis has little strength in her trunk and cannot walk or sit up

McCaughey had been in her late 30s or early 40s, like the typical woman seeking treatment, she might not have survived the seven births. Even in their 20s, women carrying multiple fetuses are at risk for fatal blood clots and other complications.”⁷¹

What induces doctors to recommend aggressive drug therapies? Leo again puts it well:

The fact that the fertility business is a rapidly expanding \$4 billion industry plays a role The industry is by and large for-profit and unregulated. Competitiveness and all the talk about “market forces” meeting “consumer demand” set the stage for overly aggressive treatment and quick results that can be advertised and used against competitors in the pursuit of more customers. Some sales pitches come with money-back guarantees. In this overheated commercial climate, many are skeptical that those doing the selling encourage the customers to think things through. Like all industries, the fertility business inevitably feels pressure to skip all the fuss about ethics and just give the customer what she wants.⁷²

Like Nkem Chukwu, the McCaugheys apparently had moral objections to “fetal reduction.” This made the dangers to the mother and infants inevitable. Ultimately, these objections cost the McCaugheys “one million dollars in medical costs to bring the septuplets through infancy.”⁷³

Generally, the possibility of multi-fetal reduction should be discussed with a patient like Ms. Chukwu *before* administration of fertility drugs. The doctor can then decide how aggressive to be with the drug therapy based on whether fetal reduction will later be permitted. In Ms. Chukwu’s case, the doctor evidently entered into an aggressive drug program before knowing whether the patient would agree to the reduction procedure if too many fetuses proved viable.⁷⁴

This apparent failure of the medical profession to timely disclose the risks of drug therapy may be related to a general problem with the use of reproductive drugs. Under pressure from anti-abortion groups, the United

without help. Recent scans revealed that both children have underdeveloped brain areas. Alexis also suffers from digestive problems and both she and her sister, Natalie, have to rely primarily on feedings of high-calorie formula through tubes in their stomachs. A fourth child, Joel, has a condition which causes one of his eyes to drift and cross. *See, e.g., 3 Iowa Septuplets Battling Serious Health Problems*, BOSTON GLOBE, Nov. 9, 1999 at A11. *See also* Becky Bohrer, *McCaughy Septuplets Turn 2 Today*, BOSTON GLOBE, Nov. 19, 1999, at A9.

71. *Id.*

72. *Id.* at 21.

73. *Id.* at 20. *See also* Daar, *supra* note 7, at 775. The lawsuit in the Frustaci case was settled for a reported sum of \$6.2 million almost six years after Patti Frustaci filed a malpractice and wrongful death lawsuit against the fertility specialist and the fertility medical center involved in her treatment. *Id.* at 775-83.

74. *See* Lyman, *supra* note 61, at A18.

States government has failed to allocate money for reproductive research.⁷⁵ Thus, the medical profession is not entirely clear on what the proper dosages and uses of these fertility drugs are.⁷⁶ In addition, a gynecologist with only four weeks training during residency has as much access to the drugs as an experienced practitioner.⁷⁷ This lack of knowledge and lack of self-regulation is present even though the demands for children from aging, childless couples, keep increasing.⁷⁸

In slightly under ten percent of cases resulting in drug-induced multiple pregnancies, in vitro fertilization is used.⁷⁹ Unlike the situation with Ms. Chukwu, this procedure gives the fertility doctor considerably more control over multiple births, since he or she can decide the number of eggs to be implanted. Still, there is pressure from infertile couples, even those who have not agreed in advance to selective reduction, to implant more, rather than fewer fertilized eggs to increase chances of success.

Of course there is the further question of whether selective reduction, even if chosen, is ethical and should be performed at all. Some patients and doctors consider it an unethical form of early abortion, despite the fact that it is legal under *Roe v. Wade*.⁸⁰ Usually, those embryos easiest to reach in the mother's womb are injected with fatal doses of potassium chloride.⁸¹ This lottery, which leaves to pure chance who shall have a chance at life and who shall not, is morally troublesome, but perhaps less so than culling out the "weakest" embryos.⁸² On the other hand, advocates of the procedure differentiate it from abortion, arguing that while abortion seeks merely to destroy life (or potential life), selective reduction seeks to *increase* the chance for life for those embryos not killed, by elimination of the others.⁸³

75. *Id.*

76. *See id.*

77. *See id.*

78. *See id.* at A1.

79. *See Lyman, supra* note 61, at A18.

80. *See Daar, supra* note 7, at 780.

81. *See id.* at 780-81; *see also* Geoffrey Cowley & Karen Springen, *More is not Merrier: When Fertility Drugs Work Too Well*, NEWSWEEK, Aug. 26, 1996, at 49 (reporting case of Mandy Allwood, a 31 year old British woman who conceived eight babies using the fertility drug Metrodin); Leo, *supra* note 69, at 21 (Dr. Mark Evans, the Wayne State University obstetrician who pioneered the procedure of selective reduction, recently told one couple, "We don't see anything obviously wrong with any of them, so we're just debating which one is easiest to get to").

82. *Cf. Daar, supra* note 7, at 781 (noting that doctors will sometimes first eliminate fetuses with gross abnormalities).

83. *See id.* at 783. Daar calls selective reduction "[A] lifeboat in the womb in which some must die for the others to live." *Id.* at 784; *see also* Leo, *supra* note 69, at 21 (Arthur Caplan, director of Bioethics at the University of Pennsylvania said, "you can make a moral case to end lives in order to rescue lives").

In England, the multiple-pregnancy problem does not have to be solved through common law means because there is government regulation. Under the Voluntary Licensing Authority's guidelines, English doctors are limited to implanting a maximum of three embryos.⁸⁴ There is, however, some evidence that doctors evade this regulation due to the lack of effective sanctions against them, particularly where no one wants to complain to the authorities.

If the United States tries to place such a limit on fetal implantation, the law and/or regulation would likely be struck down as an unconstitutional violation of a woman's right to procreate.⁸⁵ Only if a conservative court decided that women have a right to procreate only by "natural" means could such a law or regulation withstand strict scrutiny. Such a decision seems unlikely, however, because this would appear to create a discriminatory classification: fertile women would have the constitutional right to procreate, while infertile women would not.⁸⁶ With such constitutional problems brewing, politicians, already frightened of regulating in the explosive reproductive rights area, would most likely demur. Besides, the emphasis on individualism in this country⁸⁷ and the apparent preference to medicalize rather than to legalize such problems,⁸⁸ encourages legislators to defer to the arrangements made by doctors with patients.

As with unconsented sperm harvesting from the dead or comatose males, the multiple-birth conundrum leaves us asking how this procedure can or should be controlled. Meaningful legislation or administrative regulation seems unlikely, due to political fears of stirring up the anti-abortion advocates, general lack of sophistication of legislators, and possible constitutional problems. As long as the right to procreate is conceived of as extending to drug-induced pregnancy, the state needs a "compelling state interest" in order to regulate this procedure.⁸⁹

B. *Self-Regulation By The Profession*

As in the case of unconsented sperm harvesting, self-regulation of the multiple pregnancy problem by fertility specialists, who are in competition with each other, seems nearly hopeless. A leading physician who has headed a

84. See Daar, *supra* note 7, at 791-92 n.83.

85. Compare Chester, *Freezing the Heir Apparent*, *supra* note 5, at 979-85, with Lawrence Wu, *Family Planning Through Human Cloning: Is there a Fundamental Right?* 98 COLUM. L. REV. 1461 (1998) (presenting and then refuting arguments against affirmative constitutional right to procreate through assisted reproductive technologies).

86. Cf. Robertson, *supra* note 11, at 1029.

87. See Chester, *Freezing the Heir Apparent*, *supra* note 5, at 969-70.

88. See Chester, *Cloning for Human Reproduction*, *supra* note 6, at 309.

89. See Robertson, *supra* note 11, at 1040-41 (stating that if posthumous reproduction is a fundamental right, a state will have to show a compelling interest before it may interfere with that right).

number of medical ethics or review committees has pointed to their ineffectiveness in regulation.⁹⁰ Fertility specialists are, for example, unwilling to accept the verdict of physicians with other specialties, particularly when it involves their own livelihood.⁹¹

The truth is that doctors are more likely to reduce multiple pregnancies by improving their medical *techniques* than by regulating themselves. A recent advance at Stanford Medical School, for example, allows for greater time in the “petri dish” for the fertilized egg/embryo. Embryos stay in the IVF program’s specialized culture for five days rather than the usual three.⁹² This procedure, which corresponds more closely to nature’s timing, enables doctors to get a much better “read” on which embryos, when implanted, will produce successful fetuses.⁹³ With greater understanding of which embryos will be successful, fewer need to be implanted and the risk of multiple pregnancy is correspondingly reduced.⁹⁴

Amin Milki, medical director of Stanford’s IVF and Assisted Reproductive Technology Lab reports that this new technique has helped patients achieve a high pregnancy rate “without having to gamble too much with a risk of having more than twins.”⁹⁵ The new procedure achieved nearly a 70% pregnancy success rate for the first 43 women who used it—a rate that compares very favorably with the slightly less than 30% rate utilizing conventional techniques.⁹⁶

C. *Can Insurers Control The Multiple Pregnancy Problem?*

Since substantial money (and potential damages) are involved in these multiple-birth situations (unlike the unconsented sperm harvesting cases), health insurers and HMOs may have a significant role to play in controlling them. At last count, 12 states mandated that some form of insurance for fertility treatments at least be offered by insurers.⁹⁷ The Chukwu infants were

90. See Interview with Dr. Mihai Dimanescu, *supra* note 28; see also Andrews, *supra* note 7 (discussing the difficulty in discouraging doctors from forcibly removing sperm from comatose patients).

91. *Id.* (noting that doctors do not need to request permission before undertaking the procedure and can create their own criteria to determine when the procedure is appropriate).

92. See *In Vitro-With Fewer Multiple Births*, FARM REPORT NEWS, (Stanford University Alumni Bulletin), Jan.-Feb.

93. See *id.*

94. *Id.*

95. *Id.*

96. See *id.*

97. See Blaine LeCesne, *Access and Insurance Issues in Pushing Boundaries: An Interdisciplinary Examination of New Reproductive Technologies*, Address at Loyola university New Orleans School of Law, Symposium, Pushing the Boundaries: An Interdisciplinary Examination of New Reproductive Technologies, § K (Oct 16/17, 1998) (unpublished manuscript) (on file with author). Since 1987 Arkansas requires all health insurers, except

born in Texas, a state that requires certain insurers that cover pregnancy service to *offer* coverage for infertility services.⁹⁸

Presumably this coverage costs extra and was bought by Ms. Chukwu (whose husband is a respiratory therapist). Massachusetts has an even stronger law, *requiring* HMOs and insurance companies that cover pregnancy to cover medically necessary expenses of infertility diagnosis and treatment (not merely offer it as an option at increased cost).⁹⁹

Of course, the majority of states still do not have any statutes requiring health insurers to do anything about fertility treatments. If patients have no coverage at all, they will exert extreme pressure on their fertility doctors to achieve quick results with their expensive treatments. This in turn stimulates more aggressive drug protocols. However, even in a state such as Massachusetts that mandates the coverage, problems arise. Tufts Health Plan, one of Massachusetts' largest and most successful plans, recently announced that it was "cutting off" three fertility centers that were not achieving high enough success rates with their treatments.¹⁰⁰ It would seem then that such pressure from health insurers is *counterproductive* in reducing multiple pregnancies. After all, to achieve a higher "success rate," doctors need only increase their use and dosage of fertility drugs—more fertilized embryos will produce higher success rates.

Generally, if pregnancy services are covered by health insurance, so is the neonatal care of any resulting infants.¹⁰¹ Since the cost of this care in a case

HMOs, that cover maternity benefits to cover IVF; since 1989 California requires that certain insurers offer coverage for infertility diagnosis and treatment; since 1989 Connecticut requires that certain insurers offer coverage for infertility diagnosis and treatment; since 1987 Hawaii requires a one-time benefit for outpatient costs resulting from IVF; since 1991 Illinois requires that insurance policies that cover more than 25 people to cover the costs of diagnosis and treatment of infertility; since 1985 Maryland requires that insurance policies that cover pregnancy cover the cost of IVF; since 1987 Massachusetts requires that HMOs and insurance companies that cover pregnancy cover medically necessary of infertility diagnosis and treatment. Since 1987 Montana requires that insurers include infertility services as part of basic "health care services." Since 1990 New York requires that insurers provide coverage for the "diagnosis and treatment of correctable medical conditions," which definition does not encompass IVF. Since 1991 Ohio requires that HMOs cover basic preventive care, including infertility services. Since 1989 Rhode Island requires that insurers provide coverage for diagnosis and treatment of infertility, but allows co-payment up to 20% R.I. Gen. Laws. Since 1987 Texas requires that certain insurers that cover pregnancy service offer coverage for infertility services. *See id.*

98. *See id.*

99. MASS. GEN. LAWS ANN. ch. 175, § 47H (West 1997).

100. *See* Richard Saltus, *Insurer Drops 3 Fertility Clinics/ Tufts Health Plan Says Facilities Don't Meet Criteria*, BOSTON GLOBE, Jan. 6, 1999, at A1.

101. Telephone Interview with John A. Robertson (Oct. 5, 1999). For a discussion of the role of health insurance in reproductive technologies specifically in vitro fertilization see generally Peter J. Neumann, *Should Health Insurance Cover IVF? Issues and Options*, 22 J. HEALTH POL. POL'Y & L. 1215 (1997). *See also* Comment, *In Vitro Fertilization: Insurance and Consumer*

like that of Ms. Chukwu far exceeds the cost of the fertility treatments themselves, one would think that insurers offering this coverage would want to deter doctors from using overly aggressive therapies. So far, I have seen no evidence that this is the case. Highly expensive neonatal care situations like that of the Chukwu infants should persuade insurers like Tufts not to encourage “success rates” at any price. Of course, as long as medical oversight can keep extreme situations like that of the Chukwu infants to a minimum, insurers will be more concerned with the costs of fertility treatments themselves than with the relatively rare expenses stemming from post-birth care of infants from multiple pregnancies.¹⁰²

If the care of multiple-birth infants is not covered by insurance, couples like the Chukwus will have to rely on massive publicity by the media to stimulate donations (as well as payments for their story) in order to pay the millions of dollars required for their children’s care.¹⁰³ The more common multiple births become, however, the less publicity they will generate. Once couples can no longer rely on the media for help, uninsured couples having three to seven births will turn to private law and lawyers for aid with their dilemma.

D. Contract

Contract law is much more directly involved in the multiple pregnancy problem than in unconsented sperm harvesting. Since the American government is leaving fertility treatment largely unregulated, one may view an

Protection, 109 HARV. L. REV. 2092 (1996) (suggesting recommendations aimed at promoting predictability and protecting consumers’ ability to make rational and informed choices about insurance and about IVF treatment itself).

102. Since insurance usually covers neonatal care no matter how children are conceived, increased high-order multiple births may cause insurers to begin writing policies limiting their exposure for neonatal expenses, perhaps by covering expenses only for a set number of births. See Robertson Interview, *supra* note 101. Also, it is conceivable that insurers could simply put a dollar cap on neo-natal expenses from a given pregnancy.

103. See Lawrence K. Altman, *Ounce by Ounce, Surviving Octuplets Showing Progress*, CINCINNATI ENQUIRER, Jan. 17, 1999, at A14. The doctor for Ms. Chukwu and the head of the neonatal unit, Dr. Leonard E. Weisman, estimated the total cost for the octuplets at about \$2 million. The amount will be covered by the health insurance that the father receives though his work at a hospital; Leigh Hopper, *Multiple Blessings/ Prayers Mark Homecoming of Nos. 4 and 5*, HOUSTON CHRON., Apr. 18, 1999, at 35 (The father stated: “I have insurance, but there are some things that are not covered. I have to take care of the kids.”); Barbara Whitaker, *Sextuplet Survivors Aren’t in the Limelight, Miss Gifts Other Births, Backlash Seem to Block Aid*, ARIZ. REPUBLIC, July 5, 1999, at A6 (reporting that whereas the Chukwus received a 5,300 square foot home, a tractor-trailer loaded with baby furniture, and all the diapers they needed, the birth of sextuplets by Chris Ann Collins was overshadowed by the birth of the McCaughey septuplets in Iowa and the octuplets of Ms. Chukwu. Although insurance covered \$2.5 million of the cost of the births and extended hospital care, the Collinses are now faced with \$100,000 in remaining medical bills).

agreement for fertility services as merely another contract. However, upon closer analysis, it becomes clear that we are not dealing with an arm's-length bargain between roughly equal parties.

First of all, the patients are often psychologically desperate, viewing the fertility center as their last hope to help them conceive a child.¹⁰⁴ This puts them in a very weak bargaining position vis-a-vis the medical "experts" who offer this "one last chance." Moreover, the patients are confronted by sleek brochures and professionally prepared videotapes.

Despite my extensive review of the brochures and other materials offered by the Fertility Center of New England and Reproductive Science Associates,¹⁰⁵ I saw nothing at all about the risks of various infertility techniques, including multiple births and the option of selective reduction to prevent them. In general, the picture painted is one of caring professionals who, with many advanced techniques at their disposal, are almost certain to produce a successful pregnancy. Whether such a "picture" contains promises that might be actionable in the case of multiple pregnancy depends on the specific details of the advertising packet.

The "contract" between fertility doctor/clinic and patient may contain elements of the center's advertising, as well as oral assurances and the contents of any written release authorizing the services decided upon. States cannot prohibit such reproductive contracts because the constitutional right to procreate probably extends to the right of a couple, particularly a married one, to procreate by non-coital means.¹⁰⁶ Although the state may regulate the circumstances under which such contracts are formed, it could not bar or refuse to enforce such contracts altogether without a "compelling" reason.¹⁰⁷

Since such contracts would probably not be prohibited by statute, courts could not refuse to enforce them on the ground that the subject of the agreement is "illegal," as against established public policy.¹⁰⁸ The one-sidedness of these bargains could, however, give rise to relief for the weaker party (patient) under doctrines such as unconscionability, which apply to

104. See Leo, *supra* note 69, at 20.

105. See REPRODUCTIVE SCIENCE CENTER OF BOSTON, pamphlets: DIAGNOSING INFERTILITY; CONVENTIONAL INFERTILITY TREATMENTS; ASSISTED REPRODUCTIVE TECHNOLOGY PREDICTING SUCCESSFUL IVF; see also Fertility Center of New England, Inc. (visited Jan. 31, 2000) <<http://www.fertilitycenter.com>>.

106. See John A. Robertson, *Liberalism and the Limits of Procreative Liberty: A Response to My Critics*, 52 WASH. & LEE L. REV. 233, 233-34 (1995) [hereinafter Robertson, *Procreative Liberty*].

107. See Robertson, *Posthumous Reproduction*, *supra* note 11, at 1040-41.

108. See generally E. ALLAN FARNSWORTH, CONTRACTS 321-68 (3rd ed. 1999) (describing what types of contracts are "illegal").

contracts of adhesion.¹⁰⁹ Related actions might be brought under applicable statutes that cover these patients as consumers.¹¹⁰

Doctors can prevent a court from policing its fertility agreement for unfairness by making full disclosure of the risks to be undertaken. At the outset, each patient should be told of the twenty to thirty percent chance of multiple pregnancy and of the fetal reduction procedure that would be used to limit the difficulties should a multiple pregnancy occur.¹¹¹ If these facts are fully and fairly disclosed, most courts would probably not protect the patients even if their bargaining position is woefully weak *vis a vis* the fertility doctor.¹¹²

The starting point of the contractual inquiry is to examine what the doctor and clinic have promised the patient. Clinics that have made “money-back guarantees,”¹¹³ often to younger patients, have provided partial refunds to those that undergo several cycles of unsuccessful treatment.¹¹⁴ Of course “success” may be defined in several ways. Presumably, the patient would be expecting one fetus to be born alive and well. Some clinics might define success, however, as merely successful conception. The exact promise would have to be carefully analyzed.

Assuming that the promise was for a successful birth, would high order multiple birth be defined as success, blocking the money-back guarantee? One assumes that the fertility doctors would see the promise this way,¹¹⁵ particularly with the selective reduction procedure available to “cull out” unlucky supernumerary embryos.

“Success” in this context does not seem to me to include a pregnancy that results in triplets or more unless the patient was sufficiently warned of the risk of such a “high-order” multiple birth. If the doctor did not give these timely warnings and a multiple pregnancy resulted, and then, when told of selective reduction, the patient declined, the doctor may have breached his promise to achieve “success.” The next hurdle for the patient/client would of course be whether her remedy for this “failure” would be limited to the terms of the

109. *Id.*

110. For example, “baby FTC acts” such as Chapter 93A of the Massachusetts General Laws apply to unfair and deceptive practices by physicians. Telephone conversation of the author with Pasqua Scibelli, Assistant Attorney General of Massachusetts (Oct. 5, 1999). See MASS GEN. LAWS ANN. ch. 93A, § 2 (West 1997); Fitzgerald v. Goldberg, No. 94-6620-E, 1998 WL 77880 (Mass. Super.); Bartels v. Leighton, No. 91233, 1994 WL 879548 (Mass. Super.); Little v. Rosenthal, 382 N.E.2d 1037 (Mass. 1978).

111. See Cowley & Springen, *supra* note 81.

112. See Daar, *supra* note 7, at 840.

113. See Leo, *supra* note 69, at 20.

114. See Keith Alan Byers, *Infertility and In Vitro Fertilization: A Growing Need for Consumer-Oriented Regulation of the In Vitro Fertilization Industry*. 18 J. LEGAL MED. 265, 287 (1997).

115. See Sullivan v. O'Connor, 296 N.E.2d 183, 186 (1973).

money-back guarantee. It seems that it might not be so limited, due to the elements of adhesion and unconscionability in the contract.

Generally, doctors try to avoid contracting to provide a specific result, such as one healthy child. Such promises may be actionable in contract if the result is otherwise than promised.¹¹⁶ Fertility clinics that give money-back guarantees¹¹⁷ may, however, be promising just such a result. A court or jury might not limit the remedy to restitution of the amounts paid; they may find such a limitation of remedy unconscionable due to the adhesive character of the contract itself or the unequal bargaining power that produced it.

Lawyers generally prefer to subsume any contract claim under a tort theory, in this case one of simple malpractice or possibly, wrongful conception.¹¹⁸ The exception is where, as in *Sullivan v. O'Connor*, the plaintiff's attorney thinks there are assurances by the doctor that a specific result would be achieved.¹¹⁹ If assurances are made in the literature of the fertility clinic or by its staff that the procedure would result in a normal pregnancy producing only one child,¹²⁰ perhaps a contract claim could be raised. As to damages, the court in *Sullivan* gave alternatives to restitution based on the reliance or expectation measures.¹²¹ Reliance damages in such a case could give the patient all that was spent on the children born in excess of the expected number. Perhaps the mother's excess suffering would also be compensable under this measure.

Emotional distress damages might also be awarded for breach of contract.¹²² Surely, doctors and fertility clinics could reasonably expect emotional distress in a patient when a multiple pregnancy occurs. Not only is a pregnancy involving multiple fetuses more stressful than the norm, but the sight of her premature and afflicted newborns could be expected to cause severe and prolonged emotional distress in the mother.

Thus, *Sullivan* opens a host of possibilities for the plaintiff's lawyer. While a tort count in malpractice is the most obvious way to proceed, negligence may be hard to prove. By contrast, a contract count may be a straightforward winner if the plaintiff can prove that there were promises and assurances by the doctor or clinic that the pregnancy, if achieved, would not produce multiple infants. The trick is to find those assurances. Even if the assurances did not rise to the level of bargained-for promises, if it was

116. *See id.*

117. *See* Leo, *supra* note 69, at 20.

118. *See* Shari S. Weinman, *Birth Related Torts: Can They Fit the Malpractice Mold?: Shelton v. Saint Anthony's Medical Center*, 56 MO. L. REV. 175, 179 (1991).

119. *See Sullivan*, 296 N.E.2d at 184.

120. A 'normal' pregnancy would include two children, unlike three and over which is a very rare occurrence.

121. *See Sullivan*, 296 N.E.2d at 184.

122. *See Lamm v. Shingleton*, 55 S.E.2d 810, 814-15 (N.C. 1949).

reasonable for the patient to rely on them, promissory estoppel might lie, with the possibility of reliance or expectation damages.¹²³

E. Tort

At least one major malpractice case brought for a drug-induced multiple pregnancy has been successfully settled for plaintiffs. On May 21, 1985, Patti Frustaci, a thirty year old high school teacher from Riverside, California, gave birth to the first septuplets born in the United States.¹²⁴ This multiple birth quickly, and rather predictably, turned tragic. All the infants were born twelve weeks premature. One infant was stillborn and three others died within weeks of respiratory failure.¹²⁵ The four month hospitalization of the surviving three infants generated over one million dollars in hospital bills.¹²⁶ According to Judith Daar, “seven years after their birth, the three children continue to suffer severe physical and developmental impairment, including cerebral palsy and serious eye problems.”¹²⁷

According to Professor Daar, “[s]hortly after their third surviving child was discharged from the hospital, the Frustacis filed a lawsuit alleging malpractice and wrongful death against the fertility specialist and the fertility medical center involved in Mrs. Frustaci’s treatment.”¹²⁸ The Frustacis alleged that Mrs. Frustaci was not properly monitored with ultrasound screening to detect how many eggs were ready for fertilization, following treatment with the fertility drug Perganol. Almost six years later, the lawsuit was settled and the fertility center paid the Frustacis 6.2 million dollars.¹²⁹

Apparently, selective reduction was offered to Mrs. Frustaci early in her pregnancy, but she rejected it.¹³⁰ By reducing the number of fetuses from seven to two or three, Mrs. Frustaci could have optimized her opportunity to deliver full-term, healthy infants. Daar concludes that the availability of this procedure should be disclosed to the patient whenever the fertility treatment involved carries a risk of multiple births; “[t]his disclosure must come early in the treatment process so that a woman who would reject the procedure, as did

123. See generally FARNSWORTH, *supra* note 108, at 98-116.

124. See Daar, *supra* note 7, at 775, 775 n.1. For a discussion of the available tort remedies for women who have sought medical assistance or counseling services in responding to an unplanned pregnancy, see generally Kathy Seward Northern, *Procreative Torts: Enhancing the Common-Law Protection for Reproductive Autonomy*, 1998 U. ILL. L. REV. 489 (1998).

125. *Id.* at 775.

126. *Id.* (citing Gary Jarlson, *Septuplet Parents Name Doctor, Clinic; Frustacis Sue, Charge Malpractice*, L.A. TIMES, Oct. 9, 1985, Part 2 at 1).

127. See *id.* at 775.

128. *Id.* at 775 n.4.

129. See Daar, *supra* note 7, at 775 n.4.

130. See *id.* at 781.

Patti Frustaci, can make an informed decision about the course of her therapy.”¹³¹

Just what are women contemplating fertility treatment told about the option of selective reduction? According to Daar, “there are two schools of thought [among doctors] on whether a doctor should discuss the procedure at early stages of therapy—one says yes, the other no. . . .”¹³² Doctors who do not make an “up front” disclosure rationalize their behavior (which appears to have a profit motive) by arguing that such a disclosure would be too upsetting to a person who is doing everything possible to create life, not destroy it.¹³³

Whatever individual doctors may think, the legal doctrine of informed consent provides a legal answer to the dilemma. Informed consent protects the right of the patient to make a knowledgeable decision about her body. Thus, even where the medical procedure is successful despite the failure of disclosure, the woman’s right to informed consent is compromised.

The first test for informed consent was announced in 1957 by the California Court of Appeals in *Salgo v. Leland Stanford Jr. University Board of Trustees*.¹³⁴

A physician violates his duty to his patient and subjects himself to liability [in tort] 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 . . . to induce his patient’s consent.¹³⁵

This is the patient’s “right to have all information that is material” standard.¹³⁶ The majority test, somewhat more difficult from the plaintiff’s point of view, is the “professional standard.”¹³⁷ This test does not focus on the information the patient “needs” to make an informed decision, but on the level of disclosure practiced by other doctors regarding the procedure in question.¹³⁸

In the case of a woman contemplating fertility therapy, the *Salgo* standard requires the doctor to decide which facts a reasonable woman in the patient’s position would find material in her decision-making process.¹³⁹ Once warned of the possibility of multiple pregnancy, the patient should be told about the treatment options for multiple pregnancy, including selective reduction. Since a woman may initially accept or reject a proposed fertility treatment based on

131. *Id.* at 785.

132. *Id.* at 839.

133. *See id.*

134. 317 P.2d 170 (Cal. Ct. App. 1957).

135. *Id.* at 181.

136. *See, e.g., Carr v. Strobe*, 904 P.2d 489 (Haw. 1995). *See also* DOBBS & HAYDEN, *supra* note 47, at 360.

137. *See* DOBBS & HAYDEN, *supra* note 47, at 360.

138. *See id.*

139. *See* Daar, *supra* note 7, at 840.

the information about possible multiple births, her initial decision in this regard may also change in light of information about selective reduction. Thus, early information about selective reduction would be material to her decision-making process.

While some doctors purportedly withhold information about selective reduction for fear that their patients may not wish to contemplate terminating one or more of their fetuses, these patients have a right to know early on that such an option exists.¹⁴⁰ By analogy, courts have held that under certain circumstances, physicians are under a duty to disclose the option of abortion to their patients.¹⁴¹

In *Berman v. Allan*,¹⁴² the parents of a child born with Down's syndrome sued the doctor who had treated the mother during pregnancy for failure to inform her about the availability of amniocentesis. They alleged that had they known about the procedure the mother would have submitted to it.¹⁴³ Upon learning that her child would suffer from Down's syndrome, she would then have aborted the fetus.¹⁴⁴ The court held that this "loss of her right to abort the fetus"¹⁴⁵ caused compensable harm to the parents under the doctrine of wrongful birth.¹⁴⁶

Thus, if a woman undergoing fertility treatment is not timely told of the risk of a multiple pregnancy and the necessity of selective reduction to treat it, she may have a cause of action in tort for wrongful birth in the case of defective newborns. Causes of action may also lie for wrongful death for any infants who died, and for wrongful conception for those unwanted children who survived in reasonable health.¹⁴⁷

The wrongful birth suit might compensate the parents of a defective newborn resulting from multiple pregnancy by awarding the expenses of ordinary and extraordinary medical care and education of the child, the expenses and pain and suffering of the mother during pregnancy, and the emotional distress of the parents.¹⁴⁸ By contrast, damages for wrongful conception or pregnancy¹⁴⁹ resulting in relatively normal children could compensate the mother for her pain and suffering during pregnancy, medical

140. *See id.* at 841.

141. *Id.*

142. 404 A.2d 8 (N.J. 1979).

143. *See id.* at 10.

144. *See id.*

145. *Id.* at 14.

146. *See id.*

147. *See Weinman, supra* note 118, at 176-79.

148. *See id.* at 177.

149. *Cf. Fred Norton, Assisted Reproduction and the Frustration of Genetic Affinity: Interest, Injury, and Damages*, 74 N.Y.U. L. REV. 793, 796 (1999) (discussing the interest parents have in bearing children with whom they share symbolically identifying traits. Norton believes that this interest is a significant motivation in the decision to use assisted reproductive technology.).

expenses, and perhaps emotional distress. The husband might also recover for loss of consortium. Such damages might have to be offset, however, by the value of having a child in the first place.¹⁵⁰

Can the doctors protect themselves from potential lawsuits by fully informing the fertility patient before therapy begins of both the possibility of multiple birth¹⁵¹ and of the option of selective reduction to treat the multiple pregnancy? Several possibilities emerge. If the doctor does not initially disclose the risk of multiple pregnancy (rare today) then he would not initially disclose the option of selective reduction. If the patient is only told of the option of selective reduction *during* the multiple pregnancy, it would seem that she could decline it and still have an action for a birth-related tort. If the risk of multiple pregnancy is initially disclosed, but not the option of selective reduction, a disclosure of the latter during pregnancy would seem similarly actionable for the reasons Daar adduced above.¹⁵²

What if, however, the doctor makes a timely disclosure of both the risk of multiple-pregnancy and the option of selective reduction? In this case it would seem that no action would lie, whether or not selective reduction is performed. Although the fertility clinic may lose business by such frank, up-front disclosure, they would protect themselves from both tort and contract liability.

F. *The Fiduciary Relationship*

In the case of drug-induced multiple pregnancies, any breach of the physician's "fiduciary" duty to the woman patient would be the result of failing to disclose at the outset of treatment both the risks of multiple pregnancy and the necessity of selective reduction if the treatment were to produce too many fetuses. While the failure to disclose may cause the patient financial injury, the doctor is not misappropriating the patient's expenses. Thus, the doctor's duty to his patient seems adequately covered by contract and tort causes of action. The only legal gain I can see from calling the doctor's breach a fiduciary one is that such a breach might be more easily found: it would not have to involve a specific breach of contract or a neglectful violation of the standard of care. Since the problem is ultimately one of full disclosure, the tort theory of informed consent appears to address it. Although *Moore v. Regents of the University of California*¹⁵³ identifies the tort of breach of fiduciary duty by a doctor toward his patient, that precedent might be limited to the situation where the doctor misappropriates the patient's property for

150. See Weinman, *supra* note 118, at 179; Norton, *supra* note 149, at 837-39.

151. Twenty to thirty percent of drug induced or drug aided IVF pregnancies result in multiple pregnancies. See Leo, *supra* note 69, at 20.

152. See Daar, *supra* note 7, at 838-43.

153. 793 P.2d 479, 485 (Cal. 1990).

personal gain.¹⁵⁴ However, this mixing of tort and fiduciary law might arguably be extended to provide a viable cause of action in the multiple-pregnancy situation.¹⁵⁵

IV. SUMMARY

A. *Unconsented Sperm Harvesting*

In cases of unconsented sperm retrieval, the case-by-case common law approach is not particularly helpful when damages are sought. The first problem is that the party whose interests are most directly affected—the comatose or dead man—is not, for obvious reasons, in a position to protect himself. That leaves his protection in the hands of a guardian or representative who may in fact be the woman requesting the sperm retrieval. Unless there is an independent authority to intervene at the hospital when the request is made, the decision to harvest the sperm will be made at the doctor's whim. The only hope would be for such a person to get a court order to somehow prevent insemination of the woman with the harvested sperm. There would only be time to obtain this court order if the sperm was to be frozen for future use, but not if the doctors involved were to perform an insemination immediately after the retrieval.

Who might want to legally intervene in the sperm harvesting process? The most likely candidates are the man's existing children, if any. If the man is comatose, but not dead, these children face the real risk of having to share their father's estate with a newcomer. If the man is dead, there is much less likelihood that any child would be considered a child and/or heir of the father, although the *Hart* case opens up this possibility.¹⁵⁶

Under the *Hart* case, the public may also have to support the infant, although this would not be a concern motivating the children to intervene legally. If the outcome in *Hart* were to become routine, the state might eventually feel it necessary to intervene to protect the public purse. However, this would only seem possible via statute or regulations, which most states do not seem likely to enact because of political pressures.

Assuming that existing children of the man were able to intervene legally before conception, what would be the gravamen of their complaint? As we have noted, they may have a potential financial interest as heirs if state law would declare the child of such harvesting to be an heir of the decedent. If the

154. *Id.* at 483.

155. A more detailed discussion of the possible use of the cause of action of breach of fiduciary duty in the multiple-pregnancy situation can be found in the two paragraphs accompanying note 183, *infra*.

156. See *Hart v. Shalala*, No. 94-3944 (E.D. La. Dec. 12, 1993); see also *Chester, Freezing the Heir Apparent*, *supra* note 5, at 988.

man died intestate, the new child would take the same portion of the estate as existing children. If the man died testate, the new child might, in some states, be considered a pretermitted child and take a share.¹⁵⁷ These financial interests might be sufficient to get an injunction against use of the sperm before insemination, but once the woman is impregnated and the new embryo is granted "heir" status by state law,¹⁵⁸ others would appear incapable of intervening under wills law.

What about tort law as a more direct way to compensate the children already born? The *Christensen* case¹⁵⁹ seems to give such children the chance to show that they suffered from negligently inflicted emotional distress as a result of the physician's unconsented battery or mutilation of their father, even though they may have been kept away from the procedure. One problem is that the negligent infliction of emotional distress is often not seen as an independent tort; thus there must be an underlying battery or other tort.¹⁶⁰ If the man were dead, the woman requesting the sperm might well have statutory authority over the disposition of the cadaver, including its' parts and tissues.¹⁶¹

157. See *DUKEMINIER & JOHANSON*, *supra* note 33, at 550-60. Pretermitted child statutes have been enacted in almost all states and can be classified as either "Missouri" type or "Massachusetts" type. Under a Missouri type statute, the statute usually is drawn to benefit children "not named or provided for" in the will. Therefore, it must appear from the will itself that omission of the child or other heir was intentional. Extrinsic evidence of intent is not admissible. Under the Massachusetts-type statute, the child takes "unless it appears that such omission was intentional and not occasioned by any mistake." Extrinsic evidence is admitted to show both the presence or absence of intent to disinherit." *Id.* at 560.

158. See generally *Chester*, *Freezing the Heir Apparent*, *supra* note 5, at 977-93.

159. *Christensen v. Superior Ct.*, 820 P.2d 181 (Cal. 1991).

160. See *Trachtenberg*, *supra* note 43, at 530-31.

161. See UNIFORM ANATOMICAL GIFT ACT (1987) § 3(a), 8A U.L.A. 40 (1993).

Any member of the following classes of persons, in the order of priority listed, may make an anatomical gift of all or a part of the decedent's body for an authorized purpose, unless the decedent, at the time of death, has made an unrevoked refusal to make that anatomical gift:

- (1) the spouse of the decedent;
- (2) an adult son or daughter of the decedent;
- (3) either parent of the decedent;
- (4) an adult brother or sister of the decedent;
- (5) a grandparent of the decedent; and
- (6) a guardian of the person of the decedent at the time of death.

Under the organ donor law, a wife or other relative can donate the deceased's organs or tissue and can choose the recipient. Daar believes it would then follow that the wife could technically donate the sperm to herself. See *Daar*, *supra* note 7, at 65. However, although § 1(7) of the Act includes in the definition of body "part" not only "tissue", but "fluid", the wife, on closer reading, does not seem to be a permissible donee of the sperm. Under § 6(a)(3) of the Act, a wife or other woman desiring the sperm for use in procreation does not appear to be someone needing it "for therapy or transplantation." UNIFORM ANATOMICAL GIFT ACT (1987) § 1(7), § 6(a)(3), 8A U.L.A. 30, 53 (1993).

In the case of a comatose man, this same woman might have the legal authority to dispose of tissues if such disposal would not be life threatening.¹⁶² The question, however, is whether sperm is similar enough to other tissues to fall under her authority. I argue, with others,¹⁶³ that semen is dissimilar to other tissue because of its' potential for producing life and should not come under any such authority.

The same conclusion should hold for tissue cloned for reproductive purposes, when that technology is perfected.¹⁶⁴ Some may disagree, however, and find the intrusion justifiable, thereby eliminating the underlying tort of battery or mutilation of the cadaver. Even if the underlying tort were found, the question of whether the emotional distress from electroejaculation or simple incision in the man's body is sufficient to be compensable. All in all, the children, even under tort, may have a tough time prevailing. Even if they were awarded minor damages, they would not have succeeded in stopping either the feared behavior or the problems it may cause them in the future. Therefore, an injunction, either against the procedure itself or against the use of the retrieved sperm, is the most useful remedy.

If the underlying tort were not proven, emotional distress damages could be supported under breach of contract. In *Lamm v. Shingleton*,¹⁶⁵ a widow who watched her husband's vault rise above the ground following burial, was compensated for her severe emotional distress.¹⁶⁶ There, however, the party claiming emotional distress was in privity of contract with the undertaker, who breached the contract for a proper burial. Here, the children are not parties to the underlying contract. A suit for emotional damages by the children will lie only if the breach of any contract, even one not made with the party claiming emotional harm, is held to support a claim for emotional distress damages. While this seems plausible, courts are unlikely at this juncture to extend the existing, narrow exception to the general rule that penal damages are not allowed in a contract action.¹⁶⁷

Due to these difficulties, it is my reluctant conclusion that lawsuits for damages are probably not the answer to the unconsented sperm harvesting

162. See DUKEMINIER & JOHANSON, *supra* note 33, at 403-04. In most states a durable power of attorney for health care is provided whereby a person can appoint an agent to make health care decisions in case of the person's incompetence. *Id.*

163. See generally Bailey, *supra* note 13, at 759-61.

164. See generally Chester, *Cloning for Human Reproduction*, *supra* note 6 (addressing arguments on whether cloned tissue should be treated in the same ways as other tissue).

165. 55 S.E.2d 810 (N.C. 1949).

166. See *id.* at 813-14.

167. See FARNSWORTH, *supra* note 108, at 544-45. For general discussions of punitive damages, see, e.g., Michael L. Rustad, *Unraveling Punitive Damages: Current Data and Further Inquiry*, 1998 WIS. L. REV. 15, 16 (1998); and A. Mitchel Polinsky & Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 870, 896 (1998).

problem. In many cases an injunction may be effective if a proper plaintiff can be found to bring the action in time. Otherwise, the government will have to develop a compelling interest (perhaps through the necessity of its paying for these unauthorized children) to have both the will to intervene and the constitutional authority to do so.

B. Drug-Induced Multiple Pregnancies

My conclusion is different, however, in the case of drug-induced multiple pregnancies. There are some real possibilities, particularly for tort lawyers under traditional malpractice theory or the new tort of wrongful conception, against a fertility industry with deep pockets.

The consensus of academic opinion appears to be that there is an affirmative constitutional right to procreate that probably includes the right to procreate using assisted reproduction technologies.¹⁶⁸ Although the Supreme Court has never specifically held that there is such a right, there is ample reason to believe it would if the opportunity arose. After all, it is hard to see procreation as anything other than a fundamental human right. It is not so clear whether the Supreme Court would, despite the fundamental nature of the right, hold that the government has an obligation to help persons pay for such treatment when they cannot afford it.¹⁶⁹

The result is probably that anyone paying for fertility services can have them on whatever basis she and her doctor decide, with very little fear of government intrusion. Given the proximity of assisted reproduction issues to those of abortion, it is highly unlikely that legislators are going to find the “compelling state interest”¹⁷⁰ necessary to regulate the fertility industry. In fact, the most we can probably hope for is disclosure legislation which treats the fertility patient either as a general consumer or as a special type of one. Thus, although government regulation is generally preferable to indirect regulation through the common law because of its power to deal with problems *before* they happen, the common law is likely to provide the chief regulatory mechanism in this area.

We start with the strong bias of an American system that leaves the complex and emotionally-charged issues of assisted reproduction to private contract between patient and doctor/fertility center. However, fertility patients are among the more desperate patients that doctors see. They are willing to put up with all sorts of invasive, painful, costly and uncertain procedures in hope of conceiving and delivering a child. This sets the contract model askew, due to the gross disparity in bargaining power between a fertility doctor and that

168. See Robertson, *supra* note 11, at 1028-30.

169. See *id.* at 1042-43.

170. See *id.* at 1044.

doctor's patient. Thus, private contract is not a particularly good way of regulating fertility matters before a dispute arises.

Fertility doctors will claim that this disparity in bargaining power means little because self-regulation by the doctors prescribes what services they offer and how they deliver them. The fact remains, however, that these doctors and clinics are in competition with one another for patients and that no mandatory guidelines have been placed on them by any medical group. Thus, market pressures are always present. If one doctor will not harvest the sperm from a dead or comatose man at a woman's request, then another probably will. If one doctor refuses aggressive drug therapy to overstimulate egg production during a cycle, then another will probably prescribe it. If one doctor will, after IVF, implant only three embryos for fear of causing multiple pregnancy, another may implant nine to increase chances of success. Competition, the driving engine of capitalism, is hard at work in reproductive medicine. The result is that medical ethics are constantly under pressure, with quantifiable "results" usually trumping the ethicists' pleas for caution.

The health insurance industry is another potential regulator of assisted reproduction. If the industry will not pay a doctor to harvest sperm from a dead or comatose man, nor for the freezing of that sperm or implantation of it in his wife or lover, this will diminish demand for such services. One can imagine a regime under which such procedures would be covered by insurance when there is prior written consent of the donor, but not otherwise. But the problem is that all these procedures are relatively simple and inexpensive. Sperm retrieval and artificial insemination are straightforward in themselves, and although freezing of the sperm may be desired, presumably such storage will be of short duration and at little expense. Thus, the health insurance industry cannot be counted on for regulation because of the lack of financial incentives for them to do more.

The health insurance industry may have more to say about drug-induced multiple pregnancies, with or without the use of IVF. To the extent these pregnancies become frequent, the costs of hospitalization for mother and infants becomes a factor for the insurance industry. For now, in states like Massachusetts where fertility services must be covered,¹⁷¹ the industry appears to be concentrating on the cost of the treatments themselves. So far their policing of this end of the problem seems counterproductive. What they demand from fertility clinics is high success rates.¹⁷² This pressures the clinics to overstimulate egg production to improve these success rates. Not only does

171. See LeCesne, *supra* note 97.

172. See Saltus, *supra* note 100, at A1.

such overstimulation increase the risk of high-order multiple-pregnancies (three or more children), it puts the mother's health at risk.¹⁷³

As long as "success rates" of clinics can stay high enough to satisfy the health insurance industry without inducing enough high-order multiple deliveries to concern insurers, insurers will accept the high costs of the relatively few such deliveries they have to bear. Only if greater use of fertility drugs increases costs to insurance companies can we expect them to penalize clinics producing too many multiple pregnancies.

In states that do not mandate or offer coverage of fertility services, the question arises whether a given policy would cover pregnancy and neonatal expenses resulting from assisted reproduction. Although most do, insurers might seek to exclude or limit such coverage in the future.¹⁷⁴ If, however, a given insurer did not cover fertility treatments, but had to cover expenses of the pregnancy and neonatal care, it would still have an incentive to reduce a fertility clinic's record of multiple pregnancies. But because such a company would not be covering the fertility treatments themselves, it would seem to have no *leverage* to prevent multiple pregnancies in the first place.

With neither the government, the medical profession, nor the health insurance industry in a good position to regulate assisted reproduction issues, we must reluctantly turn to after-the-fact policing by private lawyers. If there are enough successful lawsuits against the doctors, not only will individual clients be recompensed, but their recompense will caution doctors to better behave themselves in the future.

In sum, the lawyer with a client who has endured a drug-induced high-order multiple pregnancy with its attendant costs and suffering should first examine the exact nature of the relationship between fertility doctor and patient. Although the possibility of bringing the tort action should be foremost in the lawyer's mind, contract is important here. *Sullivan v. O'Connor* reminds us that a jury reluctant to find medical negligence may still find that the contract is breached.¹⁷⁵

Most clinics and fertility doctors are careful not to make guarantees, whether of a "money-back" nature or otherwise. The job of the lawyer is then to comb the literature and statements of the fertility clinic to find actionable promises, whether of an expressly contractual nature or sufficient to support an action of promissory estoppel. According to *Sullivan*, either reliance or expectation damages might be awarded for breach of contract, with the reliance measure including damages for pain and suffering as well as costs

173. See Leo, *supra* note 69, at 20-21; see also Dorothy M. Robins, Comment, *When the Glean in Your Eye Becomes a Glare: Capped Damages in Fertility Malpractice Actions*, 26 U.S.F. L. REV. 717, 722 n.35 (1992).

174. See Robertson Interview, *supra* note 101.

175. See *Sullivan*, 296 N.E.2d at 184.

incurred.¹⁷⁶ Further, the case notes that restitution damages might also be available, but would be unsatisfactory since they are limited to amounts paid for the doctor's fee.¹⁷⁷ However, if the restitution damages in the high-order multiple birth case could include costs paid by the family not only for the fertility services, but by extension, those for the pregnancy and neonatal care, this measure might also be attractive.¹⁷⁸ If the successful count was promissory estoppel, reliance or expectation damages are also generally available.

What if no actionable promises can be found? Then we are in the realm of tort, where the questions center around whether the doctor exhibited the requisite standard of care in a scenario that ended up with a high-order multiple birth.¹⁷⁹ If he or she has not, the action could succeed under a generalized malpractice (negligence) theory or under the newer concept of wrongful conception, which holds the doctor/clinic liable for failing to prevent unwanted infants, even if born normal.¹⁸⁰ Damages in these actions can be quite high and could include costs of the treatments to mother and children, physical and emotional distress of the mother, emotional distress for other family members and, in the case of malpractice, (rather than wrongful conception, which is limited to parental injury), perhaps the physical and mental distress of the infants themselves.¹⁸¹ A wrongful death action might also be brought on behalf of an infant in a high-order multiple-birth who succumbs to his deficiencies.¹⁸² The prospect of high damages in such a malpractice case presumably brought the Frustacis their large settlement for Patti Frustaci's 1985 septuplets.

There are other tort claims that might be made in these scenarios. Whether or not the doctors' actions reached the standard of medical malpractice (which in jurisdictions like Massachusetts, juries notoriously refuse to find),¹⁸³ there is also the tort of failure to receive the patient's informed consent to a procedure.¹⁸⁴ Several scenarios can be envisioned in which fertility patients are not timely informed of the risk and consequences of multiple pregnancies and of the necessity of selective reduction if multiple births are to be avoided. Under the modern approach, such a failure to timely inform would generally be

176. *See id.* at 188-89.

177. *See id.* at 186-87.

178. Such a lawsuit would involve joining the hospital as a defendant.

179. *See* DOBBS & HAYDEN, *supra* note 47, at 336-37.

180. *See id.* at 526.

181. *See id.*

182. *See* Daar, *supra* note 7, at 775 n.4.

183. *See generally* RICHARD DANZIG, *THE CAPABILITY PROBLEM IN CONTRACT LAW: FURTHER READINGS ON WELL-KNOWN CASES* 17 (1978).

184. *See* DOBBS & HAYDEN, *supra* note 47, at 359-62.

treated under a negligence theory (rather than as an intentional tort) and possible damages would be similar to those for other forms of negligence.

Furthermore, the doctor-patient relationship may be seen as a "confidential" or "fiduciary" relationship which can be abused by the doctor in a tortious way. This cause of action was expressly recognized by the court in *Moore*,¹⁸⁵ although the reference there was to the gaining of monetary compensation by the doctors via the unauthorized use of their patient's cells. Although the specific outlines of the cause of action and resultant damages are left unclear in *Moore*, there are analogies that can be drawn from ordinary fiduciary law. The doctor, like a trustee, owes certain duties to his or her "beneficiary" (the patient); primary among these would seem to be the placing of that patient's interests above those of all others, including himself. Just as a trustee can be surcharged for violation of this duty of loyalty to the beneficiary, so could the doctor be liable for violation of such a duty to his patient.

Arguably, failure by the doctor/clinic to timely advise the patient of the multiple pregnancy/selective reduction problems might be seen as directly benefiting the fertility doctor's own financial interest or that of his or her clinic. When the interests of the patient are placed second to the doctor's profit, the doctor and/or clinic should at least be liable to the patient for the profit thereby wrongfully obtained. Whether this rather limited theory of damages obtained from general fiduciary law could be expanded if the abuse here was seen as tortious would be a question for future courts.

V. CONCLUSION

There are numerous possibilities for the lawyer attacking, after the fact, the fertility doctor's involvement in an unwanted high-order multiple pregnancy. This stands in sharp contrast to the chances for the private bar to control unconsented sperm harvesting, except by injunctions offering no direct financial incentive to a plaintiff. Just as tort lawyers have successfully targeted other "deep-pocket" industries such as asbestos and tobacco, they may be encouraged to turn their attention to the problems such as high-order multiple pregnancies that arise in a largely unregulated fertility industry. If a number of lawyers start suing and winning *after the fact*, in these situations there will be a benefit *before the fact*: doctors and clinics can be expected to be much more careful about their consent and disclosure procedures. As imperfect as these solutions may be, they may provide some answers for victims of multiple births like those of the Frustacis. By contrast, those seeking compensation for unconsented sperm harvesting from dead or comatose males must probably await governmental action. The possibility of such action seems remote unless a number of children result from this procedure and become a burden on the

185. 793 P.2d 479 (Cal. 1990).

state. Plaintiffs will thus probably have to be content with injunctive relief based on the common law actions mentioned in this article.

