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## Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth

Hutton Brown

Miriam Dent

L. Mark Dyer

Cherie Fuzzell

Anita Gifford

*See next page for additional authors*

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### Authors

Hutton Brown, Miriam Dent, L. Mark Dyer, Cherie Fuzzell, Anita Gifford, Sam Griffin, A. G. Kasselberg M.D., Jayne Workman, and Melinda Cooper

# SPECIAL PROJECT

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## I. Introduction

Advances in medicine are reported almost daily in the media. Medical researchers have developed and are continuing to develop new methods of creating, saving, and prolonging life. This Special Project examines the impact that rapidly advancing medical technology has on the law governing conception, pregnancy, and birth.

Although medical techniques have advanced rapidly during the past decades, state and federal legislatures have responded inadequately to the legal consequences of these new birth technologies. The resulting lag between technology and the law has forced courts to confront new situations that do not fit neatly into the statutory framework created to deal with past fact situations. For example, courts have applied statutes prohibiting "child bartering" to surrogate parenting cases<sup>1</sup> and statutes prohibiting fetal experi-

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1. See *infra* notes 197-99 and accompanying text in the Surrogate Parenting section.



mentation to artificial insemination cases<sup>2</sup> although it is clear that the legislators never considered such fact patterns when passing the statutes. A lag is inevitable because the law can only respond to, rather than predict, emerging medical developments. Nonetheless, legislators must respond promptly by confronting the new legal issues that result from new medical technologies.

One impediment to prompt legislative response to the lag between medical technology and the law is the controversial nature of the legal problems posed. Abortion continues to be an extremely controversial issue thirteen years after the Supreme Court legalized it in the landmark decision *Roe v. Wade*.<sup>3</sup> The "Baby Doe" issue of whether to force hospitals and parents of severely deformed newborns to provide medical care is another extremely controversial issue. "Baby Doe" has become highly politicized as the Reagan administration, Congress, right-to-life groups, disability groups, medical professionals, and other groups have taken stances.<sup>4</sup> Surrogate parenting also has produced controversial situations. In one incident, a New York couple contracted with a California surrogate mother. When the surrogate mother breached the agreement, the couple brought suit. The court discovered that the couple consisted of a man and a transsexual, thus raising the issue of whether transsexuals or homosexuals should be allowed to adopt children by contracting with surrogate mothers.<sup>5</sup>

A second impediment to prompt legislative response to the lag between medical technology and the law is the need to understand thoroughly the new medical procedures. Obviously, legislators can-

2. See *infra* notes and accompanying text in the Surrogate Parenting section.

3. 410 U.S. 113 (1973). The abortion controversy is particularly emotional and polarized. Thirteen years after the Supreme Court legalized abortion, the controversy still swirls at full tide. Antiabortion demonstrators marked the anniversary of the *Roe* decision on January 22 with a mass march through the nation's capital and smaller protests elsewhere across the country. The National Organization for Women and other abortion-rights groups held vigils and counterdemonstrations in more than 100 cities. Those who seek to again outlaw abortions vowed to keep fighting. Declared one marcher: "We aren't going to quit—ever." U.S. NEWS & WORLD REP., Feb. 3, 1986, at 5.

The abortion controversy has become so emotional that it has resulted in violence. For examples of bombings at abortion clinics, see *Ohio Abortion Clinic Damaged in Blast*, N.Y. Times, Aug. 11, 1985, at A-22, col. 6; *Abortion Clinic Bombs Bring 10-Year Sentence*, N.Y. Times, July 31, 1985, at A-19, col. 6; *Man Sentenced in Bombings*, N.Y. Times, July 13, 1985, at A-42, col. 6.

4. See *infra* notes 1112-1138 and accompanying text in the Baby Doe section for a discussion of the Baby Doe controversy.

5. The "Malahoff incident" was discussed by legal commentator Lori Andrews in *New Conceptions* 239-41 (1984) and in *The Stork Market: Legal Regulation of the New Reproductive Technologies*, 6 WHITTIER L. REV. 789, 791 (1984).

not regulate a medical technique until they understand not only its mechanics but also its legal implications. Legislators have a responsibility to educate themselves by studying the new technology and by utilizing the expertise of the medical profession.

The courts also have a duty to confront the impact of medical technology on the law. Judges have applied old common law rules to modern prenatal tort cases even though the modern fact situations could not have been contemplated when the rules were developed decades or centuries earlier.<sup>6</sup> Judicial failure to examine thoroughly the new causes of action arising as medical technologies expand has led to confusion of the issues and mislabeling of causes of action,<sup>7</sup> most notably in wrongful pregnancy and wrongful conception suits.

This Special Project focuses on several areas of the law that are directly related to the medical technology regarding conception, pregnancy and birth. Part II lays the foundation for the analysis by explaining the medical procedures themselves. An understanding of the various medical advances is crucial to developing a legal analysis. Part III examines the legal consequences of the surrogate parenting process. Part IV discusses the inheritance consequences when a child is conceived by artificial insemination. Part V focuses on the role of the physician in the judicial and statutory framework regulating the decision whether to abort a fetus. Parts VI, VII, VIII and IX examine the birth torts, including wrongful pregnancy and conception, wrongful birth, wrongful life, and wrongful death. Part X describes the Baby Doe controversy and the legislative attempts to regulate the decision whether to deny medical treatment to a severely defective newborn. Part XI discusses the broader implications that medical technology poses for the tension between maternal and fetal rights.

## II. Medical Technology

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6. See *infra* notes 7-10 and accompanying text in the Wrongful Death Section.

7. See *infra* notes 1-5 and accompanying text in the Wrongful Pregnancy and Conception Section.

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### A. INTRODUCTION

Rapid advances in many scientific disciplines have led to the application of new methods and technologies in every aspect of medicine. Often these new capabilities require fundamental changes in legal analysis or raise legal questions that never before have required consideration. This Part explains new technologies that potentially influence fetal and neonatal<sup>8</sup> rights; it lays the technical foundation for the discussions that follow. Although countless new technologies have developed, this Part will empha-

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8. For a definition of fetus, see *infra* note 15. The fetal period extends to birth. When born alive the fetus becomes a neonate. The neonatal period extends for the first four weeks (28 days) of life. *STEDMAN'S MEDICAL DICTIONARY* 931 (24th ed. 1982).

The term infant refers to a child from either birth or the end of the neonatal period until one year of age. *DORLAND'S ILLUSTRATED MEDICAL DICTIONARY* 663 (26th ed. 1985). For a general discussion of the relationship between period of development and mortality statistics, see M. AVERY & H. TAEUSCH, *SCHAFFER'S DISEASES OF THE NEWBORN* 2-5 (1984).

size three areas in which the impact of modern medical technology on legal analysis is particularly acute. Section B discusses noncoital or "artificial" initiation of pregnancy. This Section first examines artificial insemination and *in vitro* fertilization and then turns to an explanation of embryo transfer and of preservation of embryos for future use. Section C focuses on the medical problems of the fetus during pregnancy. This Section explores the technology for detection and therapy of genetic diseases, chromosomal abnormalities, and physical malformations. This Section also examines fetal-maternal interactions, including maternal blood group antibodies; infections; and the use of drugs, alcohol, and tobacco. Section D analyzes the medical aspects of pregnancy termination—either by abortion or by delivery—with a focus on fetal "viability," a term central to legal analysis in this area.

### B. INITIATION OF PREGNANCY

Reproduction is either natural or artificial.<sup>9</sup> Natural, or coital, reproduction has been the exclusive form of reproduction available to mankind for many centuries.<sup>10</sup> Artificial, or noncoital, reproduction includes all other forms of reproduction—artificial insemination, *in vitro* fertilization, and embryo transfer.<sup>11</sup> A brief review of the biological facts surrounding natural reproduction<sup>12</sup> will lay a foundation for subsequent analysis of the problems raised by artificial reproduction.

A normal female of child-bearing age ovulates approximately every twenty-eight days. At ovulation, one of her two ovaries releases an ovum, or egg.<sup>13</sup> The fallopian tube, a tube-like structure

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9. This section discusses human reproduction, but many of the technologies are applicable to other mammals. Animal studies are the source of much of the understanding of human reproduction.

10. See *infra* notes 13-16 and accompanying text.

11. See *infra* text accompanying notes 17-37. For an overview of the social policy considerations related to artificial reproduction, see Elias & Annas, *Social Policy Considerations in Noncoital Reproduction*, 255 J.A.M.A. 13 (1986). For a summary of the historical aspects of artificial reproduction, see Alfredsson, Gudmundsson & Snaedal, *Artificial Insemination by Donor with Frozen Semen*, 38 OBSTETRICAL & GYNECOLOGICAL SURVEY 305, 305-06 (1983) and references cited therein.

12. See generally BEST AND TAYLOR'S PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE 934 (J. West ed. 1985); A. GUYTON, TEXTBOOK OF MEDICAL PHYSIOLOGY 983 (1986); Kaiser, *Fertilization and the Physiology and Development of Fetus and Placenta*, in OBSTETRICS AND GYNECOLOGY 294 (D. Danforth ed. 1982).

13. Occasionally two ova, or eggs, are released. If each is fertilized by different sperm, fraternal, or dizygotic, twins that are not genetically identical will develop. If one ovum is fertilized and then divides into two embryos, both embryos will be genetically identical and develop into identical, or monozygotic, twins. K. MOORE, THE DEVELOPING HUMAN 130-33 (3d

that connects to the inside of the uterus, or uterine cavity, draws the released ovum into its opening, or lumen, and propels the egg toward the uterine cavity. The egg's trip through the fallopian tube takes three to five days. Meanwhile, if a male has deposited sperm in the upper vagina by sexual intercourse, the mobility of the sperm will cause them to enter the uterine cavity and migrate up the fallopian tube. If a viable sperm<sup>14</sup> reaches a viable ovum during its transit through the fallopian tube, fertilization will occur and the fertilized ovum will divide to begin formation of the embryo, or early fetus.<sup>15</sup> If fertilization does not occur, then the ovum will die and no pregnancy will occur. Upon fertilization, the early embryo continues down the fallopian tube until it reaches the uterine cavity, where the embryo implants on the surface and grows to form a fetus and placenta. Three trimesters of approximately three months each comprise the stages of fetal development.<sup>16</sup>

### 1. Fertilization

*In vivo* fertilization is fertilization that occurs within the body of a woman. Natural reproduction, of course, involves *in vivo* fertilization. Artificial insemination, another form of *in vivo* fertilization, is similar to natural reproduction except that no sexual inter-

ed. 1982). For a glossary of terms used in human reproduction, see *id.* at 1-6.

14. Although the terms sperm and semen are sometimes used interchangeably this use is not technically correct. The sperm, or spermatozoa, are the male sex cells that contain the male's genetic information to be transmitted to his offspring when they fertilize ova from the female. When the sperm are viable they move with a swimming-like motion. Semen, a fluid produced by the male, contains sperm and the secretions from various glands along the male reproductive tract including the seminal vesicles and the prostate.

15. The technical terms used to designate the various stages of development are as follows: The fertilized ovum is a zygote. After repeated divisions during the first three days after fertilization the zygote becomes a small ball of cells called morula. After entering the uterine cavity the morula continues to divide and becomes a blastocyst, which then implants in the uterine lining. At about two weeks the cells of the blastocyst become organized into layers; at this point the developing human is referred to as an embryo. The embryo stage continues until about the end of the eighth week after fertilization. During this stage the body organs, such as heart, lungs, and liver, are formed. At the end of the embryo stage the developing human is called a fetus. See K. MOORE, *supra* note 12, at 1-6.

Although not technically correct, the term embryo is widely used to include the stages from zygote through embryo. This Special Project will use the term early embryo to refer to the stages from zygote until the beginning of the embryo stage, i.e. approximately the first two weeks after fertilization.

16. The medical literature defines a full term pregnancy as forty weeks. This forty week interval is measured from the beginning of the last menstrual period, not from ovulation. Consequently, approximately two of the forty weeks are before fertilization. OBSTETRICS AND GYNECOLOGY 295-96 (D. Danforth ed. 1982).

course takes place.<sup>17</sup>

During artificial insemination, sperm is collected from a male and deposited by a plastic syringe into the opening of the woman's uterus shortly after she has ovulated. Processing the sperm between collection and deposition in the uterine cavity may include freezing and storing the sperm for future use, concentrating the sperm to increase the chance of fertilization, or selectively concentrating the sperm to increase the probability of a genetic trait such as the sex of the child. The source of sperm may be either the husband of the woman inseminated or another male. When the husband is the source of the sperm, the insemination process is called homologous artificial insemination.<sup>18</sup> When another male is the source of the sperm, the term is heterologous artificial insemination.<sup>19</sup> The usual reasons to use homologous artificial insemination are related to processing of the sperm between collection and insemination. These reasons include: infertility<sup>20</sup> in the male from medical problems that cause a low sperm count or that prevent effective sexual intercourse; storage of sperm for future use; and selection of the sex of the offspring. A woman typically may elect to use heterologous artificial insemination to overcome the sterility<sup>21</sup> of her husband, to reproduce without sexual contact with the father,<sup>22</sup> or to select the genetic traits of her offspring.

*In vitro* fertilization is fertilization that takes place outside the body.<sup>23</sup> One or more ova removed from the woman by a surgical

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17. See generally Batzer & Corzon, *AIH: New Approaches to Therapeutic Insemination*, 13 *OBSTETRICS & GYNECOLOGY ANN.* 289 (1984); Alfredsson, Gudmundsson, & Snaedal, *supra* note 11, at 305.

18. Batzer & Corson, *supra* note 17.

19. See generally Curie-Cohen, Luttrell & Shapiro, *Current Practice of Artificial Insemination by Donor in the United States*, 300 *NEW ENG. J. MED.* 585 (1979) [hereinafter cited as Curie-Cohen].

20. Infertility is the failure to achieve conception by natural reproduction despite repeated attempts. Among infertile individuals a subset of individuals have an "absolute factor," such as complete failure to produce sperm or ova, preventing natural reproduction. These individuals have sterility or absolute infertility. Coulam, *The Diagnosis and Management of Infertility* in 5 *GYNECOLOGY AND OBSTETRICS* (Sciarra ed. 1983).

21. See *supra* note 20.

22. Of course, a woman also may use homologous artificial insemination to reproduce without sexual contract with her husband. As a practical matter, however, this practice rarely occurs.

23. See generally Garcia, *In Vitro Fertilization*, 14 *OBSTETRICS & GYNECOLOGY ANN.* 45 (1985); Grobstein, Flower & Mendeloff, *External Human Fertilization: An Evaluation of Policy*, 222 *SCIENCE* 127 (1983). For a discussion of the legal issues raised by *in vitro* fertilization, see Fanta, *Legal Issues Raised by In vitro Fertilization and Embryo Transfer in the United States*, 2 *J. IN VITRO FERTILIZATION & EMBRYO TRANSFER* 65 (1985).

technique<sup>24</sup> are placed in a dish in the laboratory under conditions designed to maintain viability. Processed sperm<sup>25</sup> are mixed with the ova. If fertilization occurs, the ovum undergoes division. After several divisions, typically within two or three days,<sup>26</sup> the early embryo is ready for implantation in the uterine cavity. The source of the ovum may be either the woman into whose uterus the embryo is implanted or another woman. Likewise, sperm may come from the husband of the implantee or from another male. *In vitro* fertilization most often is used to overcome infertility due to obstruction of the fallopian tubes,<sup>27</sup> but also may be used to store embryos for future use<sup>28</sup> or to control the genetics of the offspring.<sup>29</sup>

## 2. Implantation

After fertilization, the next step in reproduction is implantation of the early embryo in the uterine cavity. Following *in vivo* fertilization, the early embryo will progress down the fallopian tube and implant in the uterine cavity. Immediately before, or more likely, shortly after implantation, the early embryo may be flushed out of the uterine cavity and collected. This embryo then may be implanted in another uterus or in the uterus of the same woman<sup>30</sup> after storage of the embryo for some period of time.<sup>31</sup> The

24. See Ayers, *In Vitro Fertilization: A Perinatal Perspective*, 10 CLINICS IN PERINATOLOGY 285, 287 (1983); Belaisch-Allart, Hazout, Guillet-Rosso, Glissant, Testart & Frydman, *Various Techniques for Oocyte Recovery in an in Vitro Fertilization and Embryo Transfer Program*, 2 J. IN VITRO FERTILIZATION & EMBRYO TRANSFER 99 (1985).

25. McDowell, *Preparation of Semen for in Vitro Fertilization*, 6 INFERTILITY 149 (1983).

26. Purdy, *Methods for Fertilization and Embryo Culture in Vitro*, in HUMAN CONCEPTION IN VITRO 147 (R. Edwards & J. Purdy eds. 1982) 147.

27. Previous pelvic infection may cause blockage of the fallopian tubes. In addition, a woman who has had her fallopian tubes surgically interrupted as a means of contraception may now want to have a child. See Edwards, Fishel, Cohen, Fehilly, Purdy, Slated, Steptoe & Webster, *Factors Influencing the Success of in Vitro Fertilization for Alleviating Human Infertility*, 1 J. VITRO FERTILIZATION & EMBRYO TRANSFER 3 (1984).

28. See *infra* notes 35 & 36 and accompanying text; Grobstein, Flower & Mendeloff, *supra* note 15, at 1585. Embryo storage may occur if a doctor anticipates that a spouse will be infertile because of surgery or chemotherapy.

29. See *infra* notes 37-54 and accompanying text.

30. Implantation in the same uterus would follow storage of the previously removed early embryo. This practice might be used if a doctor anticipates that the woman would become infertile as a result of ovarian surgery or chemotherapy or if the woman desires to store the embryo until a more "convenient" time for childbirth. As a practical matter, implantation of the embryo into the same uterus from which the embryo was removed rarely occurs.

31. For a discussion of the technique of storing embryos, see *infra* notes 35 and 36 and accompanying text.

technique consists of inserting a small tube through the uterine opening, or cervix, into the uterine cavity, then washing the cavity and separating the embryo(s) from the washings.<sup>32</sup>

Whether the early embryo is harvested in this way following *in vivo* fertilization or is produced by *in vitro* fertilization, it then must be placed into a uterine cavity. The uterus may be that of the wife of the sperm donor, the same woman who supplied the ovum, or a third woman.<sup>33</sup> This process of transporting the early embryo to its site of implantation following either *in vivo* or *in vitro* fertilization is known as embryo transfer.<sup>34</sup>

After fertilization either *in vivo* or *in vitro*, but before implantation, the early embryo also may be frozen and stored by a process known as cryopreservation.<sup>35</sup> The early embryo is placed in a protective medium that allows the embryo to be frozen and then to be thawed and implanted at a later time. In practice, to avoid subjecting the woman to the risk of repeated surgery and time delays, it is common to remove several ova from the woman and fertilize each *in vitro*. One embryo then is implanted while the others are frozen. If the first implantation fails, one of the other frozen embryos then is implanted.<sup>36</sup>

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32. Unlike *in vitro* fertilization, the *in vivo* method does not require surgical removal of ova from the woman, but she must have a normal reproductive tract, including unblocked fallopian tubes. Bustillo, Buster, Cohen, Thorneycroft, Simon, Boyers, Marshall, Seed, Lauw & Seed, *Nonsurgical Ovum Transfer as a Treatment in Infertile Women*, 251 J.A.J.A. 1171 (1984). For a discussion of the legal issues raised by this method, see Blumberg, *Legal Issues in Nonsurgical Human Ovum Transfer*, 251 J.A.M.A. 1178 (1984). As a practical matter, the requirement of a normal reproductive tract, the limitation on the number of embryos available, and the technical difficulty involved in collecting the early embryo mean that this *in vivo* method of embryo flushing is seldom used.

33. See Utian, Sheean, Goldfarb & Kiwi, *Successful Pregnancy After In Vitro Fertilization and Embryo Transfer from an Infertile Woman to a Surrogate*, 313 NEW ENG. J. MED. 1351 (1985). This article reports that an ovum from a woman who previously had her uterus removed was fertilized *in vitro*. The resulting embryo was implanted in another woman. The source of the sperm was the ovum donor's husband. The technology would be the same, however, if no marital relationship existed between the ovum donor and the sperm donor.

34. Edwards S. Steptoe, *Current Status of In Vitro Fertilization and Implantation of Human Embryos*, 2 LANCET 1265 (1983); Bustillo, Buster, Cohen, Thorneycroft, Simon, Boyers, Marshall, Seed, Louw & Seed, *supra* note 32.

35. Mohr, Trounson & Freeman, *Deep-Freezing and Transfer of Human Embryos*, 2 J. IN VITRO FERTILIZATION & EMBRYO TRANSFER 1 (1985); Cohen, Simons, Edwards, Fehilly & Fishel, *Pregnancies Following the Frozen Storage of Expanding Human Blastocysts*, 2 J. IN VITRO FERTILIZATION & EMBRYO TRANSFER 59 (1985). For a discussion of policy issues related to frozen embryos, see Grobstein, Flower & Mendeloff, *supra* note 15, and the letters written in response, 313 NEW ENG. J. MED. 1541-41 (1985).

36. Mohr, Trounson, & Freeman, *supra* note 35; Cohen, Simons, Edwards, Fehilly & Fishel, *supra* note 35.



### C. MEDICAL PROBLEMS DURING PREGNANCY

This section addresses the problems during pregnancy that may adversely affect the fetus and result in a defective or unhealthy child. These problems fall into two broad categories: (1) those determinable at conception—genetic disease and chromosomal abnormalities—and (2) those related to the intrauterine environment of the developing fetus—nongenetic physical anomalies and fetal-maternal interactions.

#### 1. *Medical Problems Determined at Conception*

The genetic and chromosomal makeup of the fetus is determined at conception, when the maternal genetic information in the ovum is joined with the paternal genetic information contained in the sperm. If this information is sufficiently defective, the fetus will have a genetic disease or a chromosomal abnormality.

##### (a) Genetic Disease

###### (i) *Patterns of Inheritance and Detection*

Deoxyribonucleic acid (DNA) in every cell carries the information for all the inherited characteristics of human beings. The chemically encoded information tells the cell how to produce every substance the body can make, and how and when to start and stop the production.<sup>37</sup> Normally, one-half of the DNA information comes from each parent. The information related to any one substance coming from any one parent is referred to as a gene.<sup>38</sup> Thus, each individual has two genes for each substance, one from each parent. For some genes, one gene from one parent will cause the individual to have that trait regardless of the gene from the other parent; these are called dominant characteristics. For example, in some populations, the gene for brown eyes is dominant. Thus, an individual inheriting a gene for brown eyes from one parent will have brown eyes regardless of the eye color gene from the other parent. Other characteristics are recessive—meaning that they will not be expressed unless both genes for the characteristic, one from

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37. The term substance, as used here, means any chemical product that the body makes. Most of these are proteins. Examples of proteins include: hemoglobin and albumin in the blood, enzymes throughout the body, and collagen in the skin and connective tissue. J. STANBURY, J. WYNGAARDEN, D. FREDRICKSON, J. GOLDSTEIN & M. BROWN, *THE METABOLIC BASIS OF INHERITED DISEASE* 61-63 (1983) [hereinafter cited as J. STANBURY]. See generally *id.* at 2-32 and references cited therein.

38. *Id.* at 7.

each parent, are present. Some characteristics show variation from these patterns.<sup>39</sup>

Genetic disease results when sufficient error exists in the DNA information.<sup>40</sup> Just as in the case of normal traits, genetic disease traits may be dominant or recessive.<sup>41</sup> For recessive diseases, both parents must be carriers of the defective gene.<sup>42</sup> For a dominant disease, the presence of the defective gene in only one parent may result in a child with the disease.<sup>43</sup> However, because the trait is dominant, the parent also will have the disease.<sup>44</sup>

Three basic methods exist to establish the diagnosis of a genetic disease using laboratory tests<sup>45</sup>: (1) quantification of the gene product, (2) study of the DNA itself, and (3) linkage studies. Similar methods may be used to detect the carriers of recessive diseases. The first method, quantification of the gene product, is an indirect way to determine if the DNA contains an error.<sup>46</sup> The laboratory measures the presence or absence of the substance coded for by the defective gene. From this data doctors may infer the presence of the defective gene. A second method is to study the

39. These variations include variable expressivity and reduced penetrance. With variable expressivity variation occurs in the effects produced by the same gene in different individuals. An example of variable expressivity is the dominant gene for multiple exostoses. Some individuals with this gene have many large disfiguring bone tumors while other individuals with the same gene have a few small tumors only detectable by x-ray.

Reduced penetrance results in a failure to produce any clinically detectable effect in some individuals who inherit the gene. An example of reduced penetrance is the gene for hypophosphatemic rickets. One individual with this gene may have the characteristic bone changes of rickets while others with the gene have normal bones. J. NORA & F. FRASER, *MEDICAL GENETICS: PRINCIPLES AND PRACTICE* 103-05 (1981). In addition, theoretically mitochondrial DNA may transmit some of the traits from the mother. V. MCKUSICK, *MENDELIAN INHERITANCE IN MAN* xxi-xxii (1983) (a catalog of human genetic traits).

40. J. STANBURY, *supra* note 37, at 12-20.

41. *See id.* at 39-59; *see generally*, V. MCKUSICK *supra* note 39.

42. J. STANBURY, *supra* note 37, at 17-18. A carrier for a recessive genetic disease is an individual who has only one gene for the disease, and, therefore is not afflicted with the genetic disease but can pass the gene onto his or her offspring. *See infra* note 53 and accompanying text.

43. The disease will result if the defective gene is the one passed on to the child. There is a 50% chance of that occurring because the parent has two genes for the characteristic, one of which is defective, and only one gene will be passed to the child. *See infra* note 53.

44. J. STANBURY, *supra* note 37, at 14-17. This general statement has two exceptions: the case of characteristics carried on the sex chromosomes and the rare case of a new error of mutation. In either of these cases, the parent could pass on the defective gene without having the disease himself. *Id.* at 19-20 and 72-74.

45. *Id.* at 27-29; Antonarakis, Phillips & Kazazian, *Genetic Diseases: Diagnosis by Restriction Endonuclease Analysis* 100 J. PEDIATRICS 845 (1982).

46. White, *DNA in Medicine: Human Genetics*, 3 LANCET 1257 (1984).

DNA itself and identify errors using restriction endonucleases<sup>47</sup> either alone or in combination with recombinant DNA.<sup>48</sup> The third method, linkage studies, uses one of the first two methods to determine the presence or absence of another gene that is physically linked to the defective gene site.<sup>49</sup>

An important feature of these tests is that each of these three methods looks for a specific gene defect. In other words, each method asks: Is genetic disease X present? Thus, a separate test must be performed for each suspected gene defect.<sup>50</sup> All three methods are available for some genetic diseases; for other diseases current technology makes only one or two of the methods available; for still other genetic diseases no definitive laboratory test is available—especially for carriers.<sup>51</sup>

### (ii) Genetic Counseling

Available laboratory tests allow doctors to diagnose genetic diseases shortly after birth by studying cells from the child. Even more helpful is the ability of these tests to identify individuals or couples at risk of having an affected child.

If the genetic disease under scrutiny is recessive and is present in an identifiable population, then that population can be tested for the defective gene.<sup>52</sup> Individuals found not to carry the gene may be reassured. Those individuals found to be carriers are informed of the likelihood that they may have an affected child. Depending on their preferences and on the seriousness of the genetic disease in question, these persons may decide to ignore the infor-

47. A restriction endonuclease is an enzyme—a special function protein—that cuts DNA into small pieces. The size of the pieces depends on the genetic information carried on that piece of DNA. See Antonarakis, Phillips & Kazazian, *supra* note 45.

48. Antonarakis, Waber, Kittur, Patel, Kazazian, Mellis, Counts, Stamatoyannopoulos, Bowie, Fass, Pittman, Wozney & Toole, *Detection of Molecular Defects and of Carriers by DNA Analysis*, 313 *NEW ENG. J. MED.* 842 (1985); Caskey, *Recombinant DNA Methods for Prenatal Diagnosis*, 99 *ANNALS INTERNAL MED.* 718 (1983); Tsipouras, Myers, Ramirez & Prockop, *Restriction Fragment Length Polymorphism Associated with the Pro- $\alpha$ -2(I) Gene of Human Type I Procollagen*, 72 *J. CLINICAL INVESTIGATION* 1262 (1983).

49. Bakker, Hofker, Goor, Mandel, Wrogemann, Davies, Kunkel, Willard, Fenton, Sandikuyl, Majoor-Krakauer, Essen, Jahoda, Sachs, VanOmmen & Pearson, *Prenatal Diagnosis and Carriers Detection of Duchenne Muscular Dystrophy with Closely Linked RFLPs*, 5 *LANCET* 655 (1985).

50. See *infra* text accompanying note 71.

51. J. STANBURY, *supra* note 37, at 1896-98 (no definitive laboratory test for carriers of cystic fibrosis). *Id.* at 32 (no definitive laboratory test for carriers of Huntington's chorea). The situation is quickly changing, however. See Merz, *Markers for Disease Genes Open New Era in Diagnostic Screening*, 254 *J.A.M.A.* 3153 (1985).

52. J. STANBURY, *supra* note 37, at 31-33.

mation, to have no children, to use some form of artificial reproduction that eliminates the risk, to have further testing of their spouse (or other reproductive partner), or to test the fetus while it is still in the uterus. Screening a large population for a genetic disease carrier state, however, creates major problems. They include the cost in both dollars and manpower, the low incidence of positive results, and the ethical dilemma presented by a positive test.

An alternative strategy is to screen a narrower population—couples who are concerned about a particular genetic disease either because the disease is present in a family member or because the couple's racial or ethnic origin increases their risk. When testing a specific couple, unlike screening the general population, the physician can state the exact probability that the offspring of that couple will have the specific genetic disease. The probability typically is either zero or twenty-five per cent (or in some cases fifty per cent).<sup>53</sup> If the probability is zero, with this information the couple can dismiss their concern. If the probability is twenty-five per cent or higher, the couple has several alternatives: have no children, have children using one of the artificial reproductive methods that employs sperm or ova from a noncarrier donor,<sup>54</sup> or have children by natural reproduction. The couples following this last counsel may simply take the risk that their offspring will not have the genetic disease, or they may test the fetus in the uterus and have an abortion if the fetus has the genetic disease.

### (iii) Detection In Utero

Detection of genetic disease while the fetus is in the uterus requires fetal cells. Amniocentesis is the oldest method for obtaining fetal cells.<sup>55</sup> A hollow needle is inserted through the mother's abdominal wall, through the uterine wall, and into the amniotic fluid that surrounds the developing fetus. A small portion of this fluid is removed. The cells floating in the fluid can be stud-

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53. If both parents are carriers for a recessive genetic disease, then there is a one in four (25%) chance that a child of the couple will inherit both recessive genes and, therefore, have the genetic disease. There is a one in two (50%) chance the child will be a carrier for the genetic disease and a one in four chance the child will neither have the disease nor be a carrier.

If only one parent is a carrier for a recessive genetic disease, no offspring will have the disease, but one in two (50%) will be a carrier. If one parent has a dominant genetic disease, one of two (50%) offspring will have the disease.

54. See *supra* notes 17-29 and accompanying text.

55. J. PRITCHARD, P. MACDONALD & N. GANT, *WILLIAMS OBSTETRICS* 268-278 (1985) [hereinafter cited as J. PRITCHARD]; J. STANBURY, *supra* note 37, at 30-31.

ied directly, but usually they are allowed to multiply in the laboratory until enough cells are available for detailed studies. Amniocentesis cannot be performed until the end of the first trimester or early in the second trimester. Culturing and testing the cells introduces additional delays. Consequently, if the fetus is defective and abortion is desired, a second trimester method of abortion<sup>56</sup> must be used. Second trimester abortions are accompanied by risks and costs that include the psychological cost of a late abortion.

The recent development of two new techniques—chorionic villus biopsy and the fetoscope—allow sampling of fetal cells. The first technique, chorionic villus biopsy,<sup>57</sup> allows safer sampling at an earlier stage of pregnancy and consists of removing a minute piece of the placenta. The fetal cells in this piece of placenta then can be tested for fetal genetic traits. The second technique requires the use of a fetoscope.<sup>58</sup> The fetoscope is a small diameter fiberoptic device that has a light source and lens.<sup>59</sup> When introduced into the uterine cavity through the mother's abdominal wall, the fetoscope allows the physician to see the fetus directly and to remove samples of fetal blood cells<sup>60</sup> or fetal skin<sup>61</sup> by using instruments inserted through the fetoscope. The fetoscope cannot be used until the second trimester and has risks associated with its use.<sup>62</sup>

Once a fetus is found to have a genetic disease, the only choices currently existing are to allow the pregnancy to continue to term or to abort the fetus. *In utero* therapy for genetic disease is not available, but as treatments for affected newborns are developed they may have the potential for use *in utero*. Once a child is born with a genetic disease, effective therapy is very limited. For a few diseases, a restrictive diet,<sup>63</sup> protective environment,<sup>64</sup> or re-

56. See *infra* notes 131-36 and accompanying text.

57. Gosden, Mitchell, Gosden, Rodeck & Morsman, *Direct Vision Chorion Biopsy and Chromosome-specific DNA Probes for Determination of Fetal Sex in First-Trimester Prenatal Diagnosis*, 2 LANCET 1416 (1982).

58. J. PRITCHARD, *supra* note 55, at 280; Rodeck and Nicolaidis, 39 BRIT. MED. BULL. 332 (1983); Elias, *Fetoscopy in Prenatal Diagnosis*, 10 CLINICS IN PERINATOLOGY 357 (1983).

59. The fetoscope, thus, is similar to the brochoscope, used to visualize a patient's lungs, and the gastroscope, inserted to visualize a patient's stomach.

60. Modell & Ward, *Antenatal Diagnosis of the Haemoglobinopathies* in FETOSCOPY 87, 104 (I. Rocker & K. M. Laurence eds. 1981).

61. Elias & Esterly, *Prenatal Diagnosis of Hereditary Skin Disorders*, 24 CLINICAL OBSTETRICS GYNECOLOGY 1069 (1981).

62. See *infra* note 94 and accompanying text.

63. J. STANBURY, *supra* note 37, at 33.

64. *Id.* at 21 & 29.

placement therapy<sup>65</sup> may help, but these measures do not "cure" the genetic disease. For a few diseases, organ transplantation has had limited success.<sup>66</sup> So far, no human genetic disease has been "corrected" after birth by altering the DNA of the cells, but the ability to do this is close at hand.<sup>67</sup>

### (b) Chromosomal Abnormalities

Normally each cell has twenty-three pairs of chromosomes (46 total) that carry the cell's DNA.<sup>68</sup> When an individual's cells have too many or too few chromosomes, he usually has multiple physical deformities, and possibly mental retardation.<sup>69</sup> A well-known example of chromosomal abnormality is trisomy 21, commonly known as Down's Syndrome.<sup>70</sup> In patients with Down's Syndrome, instead of having two of the number twenty-one chromosomes, the individual has three.

Two distinctions between chromosomal abnormalities and genetic diseases influence the application of medical technology in their detection. First, chromosomal abnormalities are a quantitative, not qualitative, problem. In contrast to genetic diseases, the DNA is normal in chromosomal abnormalities; it is just present in the wrong amount. A test, therefore, that determines whether a normal complement of chromosomes are present will also test for all known chromosomal abnormalities.<sup>71</sup> Second, because the parents have a normal number of chromosomes, laboratory tests on the parents will not predict who will have children with chromosomal abnormalities.<sup>72</sup> Thus, both these distinctions indicate the importance of intrauterine detection.

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65. *Id.* at 33.

66. *Id.* at 35.

67. *Id.* at 74-76; see also Anderson, *Human Gene Therapy: Scientific and Ethical Considerations*, 8 RECOMBINANT DNA TECHNICAL BULL. 55 (1985); Culliton, *Gene Therapy: Research in Public*, 227 SCIENCE 493 (1985); Ledley, Grenett, DiLella, Kwok & Woo, *Gene Transfer and Expression of Human Phenylalanine Hydroxylase*, 228 SCIENCE 77 (1985). For a congressional report on the background of genetic therapy up until 1984, see *Human Gene Therapy—A Background Paper*, Office of Technology Assessment, U.S. Congress (1984).

68. J. STANBURY, *supra* note 37, at 54.

69. *Id.* at 13; J. STANBURY, J. WYNGAARDEN & D. FREDRICKSON, *THE METABOLIC BASIS OF INHERITED DISEASE* 51 (1978); see generally F. VOGEL & A. MOTULSKY, *HUMAN GENETICS: PROBLEMS AND APPROACHES* (1979) (an examination of physical, mental and social problems).

70. D. SMITH, *RECOGNIZABLE PATTERNS OF HUMAN MALFORMATION* 10 (1982).

71. *But cf. supra* text accompanying note 50 (noting that specific testing is required to screen for each genetic defect).

72. There is one exception to this general rule. In rare instances, chromosomal abnormalities in the offspring result from one parent having a translocation of his chromosomes. This parent is called a translocation carrier. J. STANBURY, *supra* note 37, at 13.

As a practical matter, chromosomal abnormalities are much more common than genetic disease.<sup>73</sup> The abnormal chromosome number results from an error during cell division, either during the formation of an ovum or sperm or shortly after fertilization. These errors are much more common in older women; therefore, the incidence of chromosomal abnormalities increases with maternal age.<sup>74</sup> If the mother is thirty-five years old or older, and would want an abortion if the offspring had a chromosomal abnormality, then the risk of abnormality is sufficiently great to warrant testing the fetus *in utero*.<sup>75</sup> Fetal cells are obtained, usually by amniocentesis,<sup>76</sup> and the chromosomes are studied by visual analysis.<sup>77</sup> Chromosomal analysis also will reveal the sex of the fetus. This information may lead some parents to want an abortion.

No present "cure" for chromosomal abnormalities exists. Surgery after delivery may correct some, but usually not all, of the physical defects. Measures to prevent the birth of a child with chromosomal abnormalities include: contraception, abortion, and artificial reproduction, possibly using ova from a younger female.<sup>78</sup>

## 2. Medical Problems Related to the Intrauterine Environment

The intrauterine environment influences the fetus as it develops. If the environment is altered sufficiently to interfere with normal development, physical malformations of the fetus may result. Other fetal-maternal interactions that do not cause malformations also may adversely affect the health of the fetus.

### (a) Physical Malformations

#### (i) Causes

Physical malformations result from improper development of an organ or tissue during early pregnancy.<sup>79</sup> Most malformations

73. Compare J. STANBURY, *supra* note 37, at 13 Table 1-3 (indicating prevalence of chromosomal disorders among live-born infants) with J. STANBURY, *supra* note 37, at 14 Table 1-4 (indicating prevalence of some common monogenic disorders among live-born infants).

74. J. PRITCHARD, *supra* note 55, at 801.

75. Additional reasons to perform the test are (1) to reassure the parent(s) if the result is negative, and (2) to fulfill the physician's duty to provide the patient with information sufficient to make an abortion decision and thereby to avoid liability in a wrongful-birth lawsuit. See generally *infra* section V of this Special Project.

76. See *supra* note 55 and accompanying text.

77. Yunis, *High Resolution of Human Chromosomes*, 191 SCIENCE 1268 (1976).

78. See *supra* text accompanying notes 17-36.

79. D. SMITH, *supra* note 70, at 540; see generally D. SMITH, *RECOGNIZABLE PATTERNS*

occur in otherwise normal children.<sup>80</sup> During the first trimester the fertilized ovum develops from one cell into a complete fetus with formation of all of its organs. These organs, including the heart, lungs, brain, and liver, grow and mature during the second and third trimester.<sup>81</sup> Anything that interferes with cell movement and differentiation during this critical early period may lead to malformations. The cause of most malformations is not understood. Known causes, however, include some maternal viral infections,<sup>82</sup> alcohol,<sup>83</sup> some drugs,<sup>84</sup> and some environmental agents<sup>85</sup> such as radiation.

(ii) *Detection and Treatment*

Because malformations occur during pregnancy, it is impossible to predict before pregnancy who will have a malformed child.<sup>86</sup> Once a woman is pregnant her physician relies on clinical findings, such as an unusually rapid or slow increase in the size of the uterus, to decide if further studies for malformations are needed. For one of the most common and severe malformations, meningo-myelocele,<sup>87</sup> a laboratory test on maternal blood is now available that can predict the need for further diagnostic tests.<sup>88</sup> If the

OF HUMAN DEFORMATION (1981) (a compendium of physical deformities).

80. Of course, some physical malformations result from chromosomal abnormalities, but these are only a small minority of all malformations. See *supra* notes 68-78 and accompanying text.

81. K. MOORE, *supra* note 13 at 262; D. SMITH, *supra* note 70, at 540.

82. See *infra* notes 105-114 and accompanying text.

83. See *infra* note 123 and accompanying text.

84. See *infra* notes 115-22 and accompanying text.

85. Brent, *The Effects of Ionizing Radiation, Microwaves, and Ultrasound on the Developing Embryo: Clinical Interpretations and Applications of the Data*, 14 CURRENT PROBLEMS IN PEDIATRICS 1 (1984); Harvey, Boice, Honeyman & Flannery, *Prenatal X-Ray Exposure and Childhood Cancer in Twins*, 312 NEW ENG. J. MED. 541 (1985). See *infra* text accompanying notes 90-93.

86. D. SMITH, *supra* note 70, at 552. If a couple has one child with a malformation, the chance of a recurrence in a second child is slightly higher than in the normal population. *Id.* This is in contrast to genetic diseases in which the probability of disease in the offspring can be predicted from the parents' genetic makeup. See *supra* text accompanying notes 37-54.

87. Meningomyelocele is a failure of the spinal cord and its coverings to form properly, which can result in extensive paralysis, other nervous malfunctions, and frequent severe infections. It is one of a family of malformations called neural tube defects. The tests for meningo-myelocele also detect other neural tube defects. See D. SMITH, *supra* note 70, at 462.

88. The use of maternal serum alpha fetoprotein as a screening test in the United States has been the subject of controversy. The Food and Drug Administration at first proposed restricting its use but later withdrew consideration of the restrictions. See 45 Fed. Rep. 74158 (1980) (withdrawn) and 48 FR 2778 (1983) (withdrawn). The test is currently available and recommended for screening. A positive result dictates the need for more spe-



screening test is positive, the doctor then uses more specific tests to confirm the diagnosis.<sup>89</sup>

Detection of specific fetal malformations usually depends on the availability of methods to "visualize" the fetus. Several indirect methods are available. The most commonly used method is ultrasonography or ultrasound imaging.<sup>90</sup> In ultrasound imaging, a high frequency sound source is aimed at the fetus and the echos produced are recorded. This method produces a picture of the fetus *in utero*. The risk of injury to the fetus from exposure to high frequency sound waves appears to be minimal. Doctors rarely use x-rays to examine the fetus *in utero* because of the risk to the fetus and mother from radiation,<sup>91</sup> and because of the availability of safer alternatives, such as ultrasound. Magnetic resonance imaging is a new method of visualizing internal tissues.<sup>92</sup> This method uses magnetic fields to create a visual image. The quality and resolution of the pictures are superior to those pictures produced by either x-ray or ultrasound. The risk to the fetus or mother from exposure to magnetic fields, however, is unknown. Because magnetic resonance imaging has been used only recently to visualize fetuses *in utero*, experience in detecting malformations is limited, but use of magnetic resonance imaging is likely to expand in the future.<sup>93</sup> The physician also can observe the fetus directly by using a fetoscope.<sup>94</sup>

In addition to the visualization methods, a laboratory test is available to confirm the diagnosis of a specific malformation. This test determines the alpha fetoprotein levels in the amniotic fluid to detect the presence of a malformation called meningomyelcele.<sup>95</sup>

cific testing. See *infra* notes 90-96 and accompanying text. Some obstetricians have opposed use of the screening test for fear it might be misused as more than a screening test. See G. Annas, *Is a Genetic Screening Test Ready When the Lawyers Say It Is?* 15 *Hasting Center Rept.* 16 (Dec. 1985); see also Ferguson-Smith, *Maternal Serum Alpha-Fetoprotein Screening For Neural Tube Defects*, 39 *BRIT. MED. BULL.* 365 (1983).

89. See *infra* notes 90-96 and accompanying text.

90. J. PRITCHARD, *supra* note 55, at 278; Campbell & Pearce, *Ultrasound Visualization of Congenital Malformations*, 39 *BRIT. MED. BULL.* 322 (1983).

91. See *supra* note 85.

92. Lowe, Weinreb, Santos-Ramos & Cunningham, *Magnetic Resonance Imaging in Human Pregnancy*, 66 *OBSTETRICS & GYNECOLOGY* 629 (1985). In the medical literature, magnetic resonance imaging sometimes is referred to by the abbreviation MR or MRI. Formerly, it was called NMR, for Nuclear Magnetic Resonance, but this terminology has fallen into disfavor.

93. *Id.* at 632.

94. See *supra* notes 58-62 and accompanying text.

95. J. PRITCHARD, *supra* note 55, at 277-78; Brock, *Amniotic Fluid Tests for Fetal Neural Tube Defects*, 39 *BRIT. MED. BULL.* 373 (1983); see *supra* notes 87-88 and accompanying text (discussing maternal blood test as screening test for this malformation).

An amniocentesis<sup>96</sup> must be done and the levels in the fluid must be compared with normal values that vary depending on the stage of pregnancy.

Until recently there was no reason to diagnose malformations *in utero* except to determine the desirability of abortion. Once a malformation is detected *in utero* the parents may elect to have an abortion. Now, at least two conditions exist in which *in utero* diagnosis has led to successful *in utero* surgery.<sup>97</sup> If the parents do not elect abortion, or if *in utero* surgery is either not available or not successful, or if the malformations are not detected before delivery, the diagnosis and management of malformations after delivery depends on clinical signs and symptoms, numerous laboratory tests, and ultrasound and x-ray procedures. For some malformations, surgical repair or perhaps transplantation is possible.<sup>98</sup>

### (b) Fetal-Maternal Interactions

The fetus may have medical problems as a result of its interaction with the mother. Among these interactions are maternal antibodies against fetal red blood cells; infections acquired by the mother and transmitted to her fetus; and drug, alcohol, or tobacco use by the mother.

#### (i) Maternal Antibodies

In a sense, a fetus is foreign tissue growing within the mother. At no other time is there such tolerance of the tissue of another person and corresponding lack of tissue rejection.<sup>99</sup> The mother may, nonetheless, develop antibodies against fetal cells. An Rh negative mother will make antibodies against Rh positive cells if she is exposed to them by a transfusion or previous pregnancy.<sup>100</sup>

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96. See *supra* notes 55-76 and accompanying text.

97. The two conditions are obstructive hydrocephalus and obstructive urinary tract malformations, for which openings are made to relieve the pressure of built-up fluid caused by the obstruction.

98. See, e.g., M. AVERY & H. TAEUSCH, *supra* note 8, at 248, 351 (discussion surgical correction of malformations); Najarian, Mayer & Howard *Kidney Transplantation* in 2 *PEDIATRIC SURGERY* 1293-94 (M. Ravitch, R. Welch, C. Benson, E. Aberdeen & J. Randolph eds. 1979) (discussing transplantation to treat malformations).

99. Scott & Jenkins, *Immunology of Human Reproduction*, in 2 *CLINICAL IMMUNOLOGY* 982, 982-83 (C. Parker ed. 1980).

100. J. PRITCHARD, *supra* note 55, at 772. The woman's first exposure to Rh positive red blood cells, whether by blood transfusion or pregnancy with a Rh positive fetus, rarely leads to problems. She does make antibodies during this first exposure, but the levels are low. If, however, she has a Rh positive fetus in a later pregnancy, there is a booster effect and she rapidly makes antibodies to fetal blood cells. This higher level of antibodies results

Once this sensitization has occurred, these maternal antibodies can cross the placenta and, if the fetus is Rh positive,<sup>101</sup> destroy the red blood cells of the fetus. The level of maternal antibodies can be measured. If the antibody levels are high it may be necessary to give the fetus a blood transfusion.<sup>102</sup> To transfuse the fetus *in utero*, ultrasound or x-ray is used to guide the placement of a hollow needle through the mother's abdominal wall into the uterus, and then into the fetus within the uterus. Red blood cells are then transfused into the fetus to replace the cells that were destroyed by the maternal antibody. In less severe cases, the fetus is not treated *in utero*. Instead, after delivery the blood of the newborn is replaced in a procedure called exchange transfusion.<sup>103</sup> To prevent Rh antibody problems, doctors avoid giving positive blood transfusions to Rh negative women and doctors give Rh immune globulin to any Rh negative woman who had a previous pregnancy that ended either in abortion or in an Rh positive child.<sup>104</sup>

### (ii) Maternal Infections

Maternal infections may be transmitted to the fetus either indirectly, through the mother's blood stream, or directly when the baby passes through the mother's vagina during delivery. Acquired Immunodeficiency Syndrome (AIDS) is an example of an often fatal infection acquired from the mother.<sup>105</sup> Some infections acquired through the mother's blood stream during pregnancy may result in malformations. Examples include rubella (German measles),<sup>106</sup> cytomegalic virus,<sup>107</sup> syphilis,<sup>108</sup> and toxoplasmosis.<sup>109</sup> Other infec-

in fetal problems. P. MOLLISON, *BLOOD TRANSFUSION IN CLINICAL MEDICINE* 344-82, 678-80 (1983). Other blood group antibodies can also cause fetal problems. *Id.* at 677.

101. A similar course of events may occur with other blood group members in addition to the RH factor. J. PRITCHARD, *supra* note 55, at 779.

102. *Id.* at 776; Bowman, *The Management of Rh-isoimmunization*, 52 *J. OBSTETRICS & GYNECOLOGY* 1 (1978).

103. J. PRITCHARD, *supra* note 55, at 778.

104. See Freda, Gorman, Pollack & Bowe, *Prevention of Rh Hemolytic Disease—Ten Years' Clinical Experience with Rh Immune Globulin*, 292 *NEW ENG. J. MED.* 1014 (1975).

105. The fetus may acquire AIDS through the mother's blood stream or by direct infection during vaginal delivery. See *Leads from the MMWR: Recommendations for Assisting in the Prevention of Perinatal Transmission of HTLV-III/LAV and Acquired Immunodeficiency Syndrome*, 255 *J.A.M.A.* 25 (1986).

106. D. SMITH, *supra* note 70, at 424; J. PRITCHARD, *supra* note 55, at 786; Cooper, *Congenital Rubella in the U.S.* in *INFECTIONS OF THE FETUS AND THE NEWBORN INFANT 1* (S. Krugman & A. Gerhson eds. 1975). (Also cited as 3 *PROGRESS IN CLINICAL AND BIOLOGICAL RESEARCH* 1 (1975)).

107. McCracken, Shinefield, Cobb, Rausen, Dische & Eichenwald, *Congenital Cytomegalic Inclusion Disease*, 117 *AM. J. DISEASES CHILDREN* 522 (1969); Stagno & Whitley,

tions, including Group B streptococcus<sup>110</sup> and herpes simplex virus,<sup>111</sup> may be acquired from the mother's vagina at the time of delivery and result in severe neonatal disease. Treatment of fetal or neonatal infections depends on the type of disease acquired. Bacterial diseases, such as syphilis and Group B streptococcus infection, can be treated with antibiotics either before or after delivery. Viral diseases, such as rubella, cytomegalic virus, and herpes, generally cannot be treated by antibiotics or analogous means.<sup>112</sup> Neonatal infections acquired during vaginal delivery may be prevented by caesarean section<sup>113</sup> delivery.<sup>114</sup>

### (iii) *Maternal Drug, Alcohol, and Tobacco Use*

Drug, tobacco, or alcohol use during pregnancy may adversely affect the fetus by causing malformations, poor development, or drug dependence. Most prescription drugs carry a warning indicating that the safety of their use during pregnancy is unknown.<sup>115</sup> Some prescription drugs are known to be detrimental to the fetus.<sup>116</sup> In prescribing these and similar drugs to pregnant women, a physician weighs the benefit to the mother against the risk to the

*Herpesvirus Infections of Pregnancy Part I: Cytomegalovirus and Epstein-Barr Virus Infections*, 313 *NEW ENG. J. MED.* 1270 (1985).

108. Oppenheimer & Dahms, *Congenital Syphilis in the Fetus and Neonate*, 6 *PERSPECTIVES IN PEDIATRIC PATHOLOGY* 115 (1981).

109. Eichenwald, *A Study of Congenital Toxoplasmosis*, in *HUMAN TOXOPLASMOSIS* 41 (J. Siim ed. 1960).

110. Barton, Feigin, & Lins, *Group B beta Hemolytic Streptococcal Meningitis in Infants*, 82 *J. PEDIATRICS* 719 (1973).

111. Stagno & Whitley, *Herpesvirus Infections of Pregnancy Part II: Herpes Simplex Virus and Varicella-Zoster Virus Infections*, 313 *NEW ENG. J. MED.* 1327 (1985).

112. There have, however, been recent advances in the treatment of herpes simplex infections. *Id.* at 1328.

113. This Special Project will refer to delivery by "caesarean" section. Readers should note, however, that medical and legal literature also refer to "cesarean" section. Legal researchers using computers should type in both spellings.

114. The ability to avoid this infection is especially important in herpes simplex virus infections because this disease is often fatal in the neonatal. Stagno & Whitley, *supra* note 111, at 1328.

115. AMERICAN MEDICAL ASSOCIATION, *AMA DRUG EVALUATIONS* 31 (5th ed. 1983) [hereinafter cited as *AMA DRUG EVALUATIONS*]. For individual drugs see *PHYSICIANS' DESK REFERENCE* (40th ed. 1986).

116. D. SMITH, *supra* note 70, at 414 (fetal hydantoin or Dilantin syndrome), 418 (fetal trimethadione or Tridione syndrome), 420 (fetal warfarin or Coumarin syndrome) & 422 (fetal aminopterin effects). See also *AMA DRUG EVALUATIONS*, *supra* note 115, at 31-40; R. BEHRMAN & V. VAUGHAN, *NELSON TEXTBOOK OF PEDIATRICS*, 325 (12th ed. 1983) (table linking drugs to fetal malformations).

This Special Project will signify use of a drug's trade name by capitalizing the name of the drug.

fetus. When the well-being of the mother and that of the fetus are opposed, this judgment raises difficult medical, ethical, and legal problems.<sup>117</sup> In addition to prescription drugs, common over-the-counter drugs, such as those drugs containing aspirin, caffeine, or antihistamines, also may adversely affect the fetus.<sup>118</sup>

Drug abuse also may cause fetal problems. Illicit drugs may contribute to a mother's general poor health and thereby increase her risk of an infection. Even more harmful, narcotic addiction in the mother causes a similar addiction of the fetus *in utero*.<sup>119</sup> After delivery, the newborn will exhibit narcotics withdrawal and the accompanying medical problems.

Maternal smoking also may adversely affect the fetus. Babies born to mothers who smoke tobacco are smaller than normal.<sup>120</sup> In addition, long-term developmental problems are associated with maternal tobacco use.<sup>121</sup> Recently, the term fetal tobacco syndrome<sup>122</sup> has been used to describe the group of problems observed in the offspring of smoking mothers. A group of physical and mental development problems known as fetal alcohol syndrome<sup>123</sup> may occur in the offspring of mothers who abuse alcohol.

#### D. TERMINATION OF PREGNANCY

All pregnancies terminate in either abortion or delivery.<sup>124</sup> In both abortion and delivery the interests and well-being of the mother may be directly adverse to those of the fetus. This section examines the medical technology involved in abortion and delivery and explores the meaning of the term "viability."

117. See generally *infra* section XI of this Special Project.

118. AMA DRUG EVALUATIONS, *supra* note 115, at 34-40; R. BEHRMAN & V. VAUGHAN, *supra* note 116, at 325.

119. J. PRITCHARD, *supra* note 55, at 788.

120. Wainright, *Change in Observed Birth Weight Associated with Change in Maternal Cigarette Smoking*, 117 AM. J. EPIDEMIOLOGY 668 (1983).

121. Nieburg, Marks McLaren & Remington, *The Fetal Tobacco Syndrome*, 253 J. A.M.A. 2998 (1985) (see references cited herein).

122. *Id.* at 2998-99.

123. D. SMITH, *supra* note 70, at 411; Jones, Smith, Ulleland & Streissguth, *Pattern of Malformation in Offspring of Chronic Alcoholic Mothers*, 1 LANCET 1267 (1973).

124. Technically, there is a third alternative. The pregnancy can terminate with the death of the mother and fetus while the fetus is still *in utero*. The legal implications of this occurrence are discussed *infra*, see generally section III of this Special Project.

### 1. Abortion

Abortion is the interruption of pregnancy. In the medical literature the term abortion does not imply an intentional interruption of pregnancy.<sup>125</sup> Abortions that occur naturally are called spontaneous abortions or miscarriages, and those abortions that are intentional are called induced abortions. This subsection will deal exclusively with induced abortions, but legal scholars need to remember this distinction between medical and legal terminology when they research the medical literature.

The method used to induce abortion depends on the stage of pregnancy, on the woman's and physician's preferences, on the woman's other medical diagnoses, and perhaps on statutory requirements.<sup>126</sup> The stage of pregnancy and the method of abortion profoundly influence the probability that the fetus will be aborted alive.

#### (a) Traditional First Trimester

Approximately ninety per cent of the abortions in the United States<sup>127</sup> are performed in the first trimester.<sup>128</sup> The usual method<sup>129</sup> at this stage in pregnancy is mechanical evacuation of the uterus by dilating the cervix, the opening to the uterus, inserting a hollow tube connected to a vacuum, and scraping or sucking the fetus out of the uterine cavity. This procedure, known as dilatation and curettage (D & C)<sup>130</sup> or dilatation and evacuation (D & E), requires less than thirty minutes and often is done as an outpatient procedure. The early stage of the pregnancy and the re-

125. Compare *STEDMAN'S MEDICAL DICTIONARY* 3 (24th ed. 1982) with *BLACK'S LAW DICTIONARY* 7 (5th ed. 1979).

126. See *infra* notes 134-35 and accompanying text for a discussion of statutes regulating the method of abortion. See generally *J. PRITCHARD, supra* note 55, at 479-88. (discussing methods used to induce abortion).

127. In 1983 there were 1.3 million legal abortions in the United States. For the same year there were 3.6 million live births. *J. PRITCHARD, supra* note 55, at 477.

128. LaFerla, *Midtrimester Abortion: Techniques and Complications*, 10 *CLINICS IN-PERINATOLOGY* 305 (1983).

The term "traditional" first trimester abortions refers to abortions performed after implantation but before the end of the first trimester. See *supra* note 16 and accompanying text. An implantation is technically part of the first trimester but this paper discusses separately abortion before implantation. See *infra* notes 137-44 and accompanying text.

129. *Id.*; Grimes & Cates, *Gestational Age Limit of Twelve Weeks for Abortion by Curettage*, 132 *AM. J. OBSTETRICS & GYNECOLOGY* 207 (1978).

130. Dilatation and curettage (D & C) is the dilatation of the cervix and the scraping of the uterine lining. This procedure is also used for reasons unrelated to abortion such as biopsy of the uterine lining.

sultant fragmentation of the fetus assure that the fetus will not be aborted alive. The relative simplicity of the procedure, low incidence of complications, and avoidance of the psychological trauma associated with a late abortion are all advantages of first trimester abortions.

### (b) Second and Third Trimester

After the first trimester, the increasing size of the fetus makes mechanical evacuation of the uterus more difficult. Chemical agents, therefore, are used to cause expulsion of the fetus. Saline abortion<sup>131</sup> and prostaglandin abortion<sup>132</sup> are typical.

In a saline abortion, a hollow needle is inserted through the mother's abdominal wall, through the uterine wall, and into the amniotic fluid surrounding the fetus. A concentrated salt solution, which is toxic to the fetus, is injected into the amniotic fluid. Fetal death usually occurs within a few hours.

In a prostaglandin abortion, the mother is given one of a class of drugs called prostaglandins. The drug causes the uterus to start contracting, usually within twelve hours, and to expel the fetus. Notably, prostaglandins do not directly cause fetal death; the fetus is usually alive up until its separation from the uterus. Compared to saline abortion, prostaglandin abortion is technically easier and has fewer serious complications. In addition, prostaglandin abortion results in a greater availability of viable fetal tissue for genetic testing and research.<sup>133</sup> The Supreme Court held unconstitutional a legislative attempt to prohibit saline abortions,<sup>134</sup> but there have been renewed efforts to control the methods of abortion.<sup>135</sup>

Hysterectomy and hysterotomy are surgical procedures used infrequently for abortion.<sup>136</sup> Typically, hysterectomy and hysterotomy are attempts to correct some other problem, but, if the woman is pregnant, these procedures will terminate the pregnancy. Hysterectomy is the surgical removal of the uterus. Usually, this

131. LaFerla, *supra* note 128, at 312.

132. *Id.* at 313; Robins & Surrage, *Early Midtrimester Pregnancy Termination*, 27 J. REPRODUCTIVE MED. 415 (1982).

133. See *supra* notes 37-78 and accompanying text.

134. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976). The Missouri statute prohibited saline abortions after the twelfth week. The Court declared this unconstitutional as an "unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks." *Id.* at 79.

135. For discussion of recent Supreme Court cases concerning abortion, see *infra* notes 513-616 and accompanying text.

136. LaFerla, *supra* note 128, at 316.

method of abortion is not used unless there is some other medical reason for removing the uterus, such as a tumor. Hysterectomy can be used, however, to terminate a pregnancy at any stage. Because the blood supply to the uterus, and therefore to the fetus, is interrupted before removal, this method causes fetal death even very late in pregnancy. Hysterectomy subjects the woman to the risks of a major surgical procedure and leaves her infertile.

A hysterotomy is the surgical opening of the uterus. In this procedure, similar to a caesarean section delivery, the surgeon opens the uterus, removes the fetus, and then sews up the opening in the uterus. Reluctance to subject the woman to an unnecessary surgical procedure militates against this method unless a separate medical reason for performing surgery on the uterus exists, such as congenital malformation of the uterus.<sup>137</sup> Of all the abortion methods, however, hysterotomy has the greatest probability of producing a viable fetus.

### (c) Abortion Before Implantation

The methods of abortion discussed above are concerned with removing the fetus once it has implanted in the uterus and started to grow. The time between fertilization of the ovum and implantation of the developing embryo<sup>138</sup> presents a more difficult problem for analysis. Debate has arisen on the issue of defining pregnancy. If pregnancy begins at the time of fertilization, then prevention of implantation is a method of *terminating* the pregnancy. If pregnancy begins at implantation, then prevention of implantation is a method of *preventing* the pregnancy.

Two methods of preventing implantation are the intrauterine contraceptive device (IUD) and postcoital contraception ("morning after pill"). An IUD is a specially designed plastic or metal device, often containing medications, that is placed in the uterine cavity.<sup>139</sup> Exactly how the IUD works is not understood. Unlike other contraceptive methods, however, the IUD does not prevent fertilization of the ovum. Rather, the IUD has a local effect on the uter-

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137. Malformations of the uterus may dictate the use of hysterotomy for abortion because they increase the difficulty and risk of other abortion methods. In addition, the woman often needs surgical correction of the uterine malformation, which may be preformed at the same time and under the same anesthesia as the hysterotomy.

138. See *supra* note 15 for precise technical terminology of early developmental stages; see generally notes 18-36 and accompanying text (describing fertilization and implications).

139. J. PRITCHARD, *supra* note 55, at 819-20.



ine lining that prevents implantation and subsequent development of the embryo. Postcoital contraception likewise prevents implantation and subsequent development.<sup>140</sup> In this technique large doses of estrogen-like hormones given shortly after coitus make the uterine lining unreceptive to implantation.

Fertilized ovum transfer is another area in which conception, implantation, and abortion may be closely related.<sup>141</sup> These relationships are best illustrated by considering the nearly identical stages of biological development achieved when an early embryo (1) is affected by IUD contraception; (2) is flushed from the uterine cavity following *in vivo* fertilization; or (3) is readied for storage or implantation following *in vitro* fertilization. In IUD contraception, the ovum is fertilized and develops to the morula<sup>142</sup> stage before entering the uterine cavity. Once the morula enters the uterine cavity, however, the IUD prevents effective implantation and halts development. Following *in vivo* fertilization the fertilized ovum progresses through the same developmental stages before being shed from the uterus, except that the flushing process rather than the IUD prevents effective implantation. If the displaced early embryo later is discarded rather than being transferred or frozen, the parallel with IUD contraception becomes complete. In *in vitro* fertilization the fertilized ovum develops in the laboratory to the morula stage, just as occurs *in vivo* in the two previous examples of the IUD and "morning after pill." If, instead of being implanted, the early embryo is destroyed, then development is halted at the same stage as in IUD contraception or in the flushing of an early *in vivo* embryo. Focusing strictly on the developmental status of the early embryo, there is no *biologically* significant difference between IUD contraception and destruction of the early embryo produced by *in vitro* or *in vivo* fertilization. This biological identity leads to three possible divergent approaches in legal analysis of the rights and duties associated with early embryos created by *in vitro* fertilization: (1) regard as controlling the historical acceptance<sup>143</sup> of the legitimacy of IUD contraception,<sup>144</sup> which rejects

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140. Yuzpe & Lance, *Ethinylestradiol and dl-Norgestrel as a Postcoital Contraceptive*, 28 FERTILITY & STERILITY 932 (1977).

141. *Postcoital Contraception*, 1 LANCET 855 (1983); see also *supra* notes 18-36 and accompanying text.

142. See *supra* note 15 for terminology of early embryonic development.

143. Most states seem simply to accept IUD's as contraception. In Pennsylvania, the legislature specifically exempted IUD's from its abortion statute. 18 PA. CONS. STAT. ANN. § 3203 (Purdon 1983).

144. Because *Roe v. Wade*, 410 U.S. 113 (1973) removed first-trimester abortion from

protection of the early embryo and gives the woman the right to decide; (2) rethink IUD contraception; or (3) continue to accept IUD contraception but elaborate a *nonbiological* distinction between the status of early embryos created by *in vitro* fertilization and those affected by IUD contraception.

## 2. Delivery

During labor and delivery, the well-being of the fetus may demand subjecting the mother to a number of potentially threatening procedures. Drugs may be needed to stop premature labor.<sup>145</sup> The fetal heart rate routinely is monitored during labor. This may require the attachment of an electrode to the scalp of the fetus<sup>146</sup> *in utero*. In addition, monitoring devices may be attached to the mother's abdominal wall.<sup>147</sup> The anesthesia used during labor and delivery may be dictated by the condition of the fetus.<sup>148</sup> Caesarean section delivery may be required. Often the mother's pelvic anatomy, and perhaps her history of previous caesarean sections, will dictate the need for caesarean section delivery. However, *in utero* fetal distress, as evidenced by a falling or irregular fetal heart rate, may require emergency caesarean section delivery to save the life of the fetus.<sup>149</sup> Maternal vaginal herpes infection is one example of another reason for caesarean section delivery.<sup>150</sup> When the mother refuses to consent to one of these procedures, a conflict between the rights of the fetus versus the rights of the mother comes into sharp focus.<sup>151</sup>

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states rejection, the Supreme Court never has had to analyze in legal terms.

The postfertilization actions of the IUD. In discussing the background for its decision in *Roe v. Wade*, the Supreme Court noted that "[s]ubstantial problems for precise definition [of the beginning of life] are posed . . . by new embryo embryological menstrual extraction, the 'morning-after' pill, implantation of embryos, artificial insemination, and even artificial wombs." *Id.* at 161 (footnote omitted). The Court's omission of the IUD from this list is interesting.

The Supreme Court has granted certiorari and heard oral arguments of a challenge to an Illinois informed consent statute that requires physicians who prescribe the IUD or the "morning after pill" to tell their patients that these devices are "abortifacients" which cause fetal death by preventing implantation. *See infra* notes 688-693 and accompanying text.

145. J. PRITCHARD, *supra* note 55, at 751-54.

146. *Id.* at 284-85.

147. *Id.* at 286.

148. *Id.* at 353-54.

149. A caesarian section delivery takes less time than a vaginal delivery. *Id.* at 287, 866-69.

150. *See supra* note 111 and accompanying text.

151. *See infra* notes 1447-74; 1524-29 and accompanying text.

### 3. Viability

The concept of fetal viability is a central feature in the legal analysis of the right to abortion. In *Roe v. Wade*<sup>152</sup> the Supreme Court held that, for the stage of pregnancy subsequent to the point of fetal viability, the state can regulate or even proscribe abortion.<sup>153</sup> According to the Court, the states' interests in protecting fetal life become "compelling" at the point of viability because the fetus then "presumably has the capability of meaningful life outside the mother's womb."<sup>154</sup> The court, however, did not provide a definition of "meaningful life."<sup>155</sup>

Viability of a fetus—that is, the fetus' ability to live—outside the uterus is influenced by many interactive factors. As discussed above,<sup>156</sup> the method of abortion is one factor. Other factors include fetal age, fetal medical condition, maternal health, and application of medical technology to sustain the fetus after removal from the uterus.

Nowhere has medical technology had a more profound influence on the concept of viability than in techniques utilized in the perinatal and neonatal intensive care unit<sup>157</sup> of a modern hospital. Drugs given the mother can promote maturation of the fetus.<sup>158</sup> Hysterotomy or caesarean section delivery assures removal of the fetus from the uterus with a minimum of fetal trauma. A respirator supports breathing if needed. Intravascular fluids and, later, special formulas for oral feeding provide for nutritional needs.<sup>159</sup> Modern electronic and computer technology enable constant monitoring of vital functions and control of life support equipment.

152. 410 U.S. 113 (1973).

153. *Id.* at 163.

154. *Id.*

155. At another place in the opinion, however, the Court noted that "physicians and their scientific colleagues historically have regarded a "viable" fetus as one "potentially able to live outside the mother's womb, albeit with artificial aid." *Id.* at 160.

156. See *supra* notes 127-36 and accompanying text.

157. Perinatal refers to the time before, during, and after birth. The usual definition is from the twenty-eighth week of pregnancy through the first seven days after birth. *STEDMAN'S MEDICAL DICTIONARY* 1055 (24th ed. 1982). A perinatal intensive care unit is a hospital unit for treating and monitoring the mother and fetus during late pregnancy, labor, delivery, and immediately thereafter. The neonatal intensive care unit cares for the baby from delivery until about one month of age. See *supra* note 8.

158. J. PRITCHARD, *supra* note 55, at 869; Korenbrot, Aalto & Laros, *The Cost Effectiveness of Stopping Preterm Labor with Beta-adrenergic Treatment*, 310 *NEW ENG. J. MED.* 691 (1984).

159. See generally M. AVERY & H. TAEUSCH, *supra* note 8, at 791-97; COMMITTEE ON NUTRITION, *AM. ACADEMY OF PEDIATRICS, PEDIATRIC NUTRITION HANDBOOK* 66 (2d ed. 1985).

Numerous laboratory tests, radiographic ("x-ray") procedures, and ultrasound techniques allow rapid detection of complications and changing conditions.

A major threat to life once the fetus leaves the uterus is the immaturity of its lungs.<sup>160</sup> *In utero* the fetus does not need to have functioning lungs because it gets oxygen from the maternal blood circulation. At the moment of separation from the mother, however, life depends on the functioning of the lungs. Recent clinical trials have indicated that membrane oxygenators may temporarily bypass the need for lung function.<sup>161</sup> The net effect of this technology on the definition of fetal viability can be seen in the changes in the rate of newborn survival since 1973, the year of the *Roe v. Wade*<sup>162</sup> decision. Since 1973, the age at which the majority of fetuses survive outside the woman's womb has become significantly earlier in pregnancy.<sup>163</sup>

Thus, when determining fetal viability, it may not be enough simply to establish the point at which the fetus has "the capability of meaningful life outside the mother's womb."<sup>164</sup> One must go on to ask: (1) viable in what setting and with what technology?; and (2) viable at what cost to the mother's well-being and at what expenditure of dollars and resources? There also looms a related

160. M. AVERY & H. TAEUSCH, *supra* note 8, at 133-45. Researchers continue to investigate the development of fetal lungs and other tissues. Stahlman, Kasselberg, Orth & Gray, *Ontogeny of Neuroendocrine Cells in Human Fetal Lung II. An Immunohistochemical Study*, 52 LABORATORY INVESTIGATION 52 (1985); Kasselberg, Orth, Gray & Stahlman, *Immunocytochemical Localization of Human Epidermal Growth Factor/Urogastrone in Several Human Tissues*, 33 J. HISTOCHEMISTRY & CYTOCHEMISTRY 315 (1985).

161. Roloff, Cornell, Andrews, Dillon & Zwischenberger, *Extracorporeal Circulation in Neonatal Respiratory Failure: A Prospective Randomized Study*, 76 PEDIATRICS 479 (1985).

162. 410 U.S. 113 (1973).

163. Numerous centers have documented the remarkable change in survival of preterm infants. M. AVERY & H. TAEUSCH, *supra* note 98, at 86-88; Schechner, *For the 1980s How Small is Too Small? 7 CLINICIS IN PERINATOLOGY* 135 (1980); Stahlman, *Newborn Intensive Care: Success on Failure?*, 105 J. PEDIATRICS 162 (1984). Although individual infants born after only twenty-five weeks of gestation have been known to survive, the real change in the limits of viability is illustrated by the shift in the gestational age at which there is fifty percent survival in the best medical centers. In the early 1970's fifty percent survival was associated with a gestational age of twenty-nine weeks. By the late 1970's the age had moved to twenty-six weeks of gestation. Compare R. BEHRMAN & V. VAUGHAN, *supra* note 116, at 339 with M. AVERY & H. TAEUSCH, *supra* note 98, at 87. Some believe that the current limits of viability will not change significantly until there are major technological changes in the care of newborns. M. AVERY & H. TAEUSCH, *supra* note 98, at 87. It is important to note that the survival data cited was compiled in neonatal intensive care units in major university hospitals and may not correlate with the figures in other facilities.

164. *Roe*, 410 U.S. at 163.

question: Who will pay for it?<sup>165</sup>

### III. Surrogate Parenting: A Quagmire of Legal Issues

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165. See generally *infra* section III of this Special Project.

## I. INTRODUCTION

A "surrogate" is "a person appointed to act in the place of another."<sup>166</sup> "Mother," when used as a verb, includes the meaning "to give birth to."<sup>167</sup> Thus, a "surrogate mother"<sup>168</sup> is a woman appointed to give birth to a child in the place of another.<sup>169</sup>

Although defining a "surrogate mother" is not difficult, surrogate parenting involves complex and uncertain legal consequences.<sup>170</sup> The parties to the surrogate parenting process usually enter into a contract. State statutes and public policies appear to regulate and often prohibit surrogate parenting, but their applicability to these contracts is unclear. And even if applicable, the statutes and policies that render the contract unenforceable may be unconstitutional. Furthermore, ultimate enforceability of the surrogate parenting contract may depend on whether the court views the contract as one for adoption or for custody. Consequently, it is not clear whether a party to a surrogate parenting contract has contract rights upon a possible breach, or whether the party must seek redress exclusive of the contract. Surrogate parenting is a viable and popular method of birth even though it is subject to great unpredictability and legislation is necessary.

Three main methods of surrogate parenting exist.<sup>171</sup> The first method, the artificial insemination method, is the traditional one and includes three steps. First, the surrogate mother is artificially inseminated<sup>172</sup> with the biological father's sperm.<sup>173</sup> Second, the surrogate mother carries the fetus in her uterus for nine months

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166. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 2302 (1981).

167. *Id.* at 1474.

168. Commentators have argued that the term "surrogate mother" is a misnomer because the woman is in fact the biological mother in most instances. S. GREEN & J. LONG, MARRIAGE AND FAMILY LAW AGREEMENTS 246 n.128 (1984) [hereinafter cited as GREEN & LONG].

169. "Surrogate mother describes a woman's conceiving a child [usually] by artificial insemination by donor, carrying it to term, and relinquishing it to the sperm donor after birth in accordance with a preconception agreement. Usually the sperm donor's wife will adopt the child after the surrogate mother relinquishes it." Pierce, *Survey of State Activity Regarding Surrogate Motherhood*, 11 FAM. L. REP. (BNA) 3001, 3002 (Jan. 29, 1985) (quoting the National Committee For Adoption, Inc.'s policy statement).

170. Because this section analyzes the relationship between all parties rather than focusing solely on the surrogate mother carrying the fetus, the Author has chosen to use the term "surrogate parenting" rather than "surrogate mothering."

171. For a discussion of the inheritance problems resulting from surrogate parenting, see *infra* notes 486-91 and accompanying text.

172. Artificial insemination is accomplished by inserting a syringe into the vagina and injecting semen toward the uterine opening. GREEN & LONG, *supra* note 168, at 235. See also *supra* notes 17-22 and accompanying text.

and gives birth to the child. Last, the surrogate mother terminates all parental rights to the child and gives it to the biological or adopting father for his custody or adoption. This method normally is used when the wife is infertile and the husband is fertile.

The second method of surrogate parenting, *in vitro* fertilization<sup>174</sup>, involves five steps. First, a fertile couple desiring a child gives an egg and semen to a doctor.<sup>175</sup> Second, the doctor fertilizes the egg through *in vitro* fertilization. Third, the fertilized egg is implanted in the surrogate mother's uterus. Fourth, the surrogate mother carries the fetus in her uterus for nine months and gives birth. Last, the surrogate mother terminates all parental rights to the child and gives it to the couple who donated the egg and semen. This method is used when the wife has an abnormality in her reproductive organs that prevents her egg from being fertilized by her husband's sperm or when the wife is unable to carry a child to term because she has an abnormality in her uterus. If the wife is able to conceive, but unable to then carry the gestating fetus, embryo transfer methods allow transfer of the naturally fertilized egg from the biological mother's womb to the surrogate mother's womb.

The third method of surrogate parenting is a modification of the *in vitro* fertilization method and involves five steps. The first four steps are identical to those of the *in vitro* fertilization method. The fifth step, however, differs. Instead of giving the child to the couple who donated the semen and egg, the surrogate mother gives the child to adoptive parents who are not biologically related to the child.<sup>176</sup> There have been no reported incidents of the use of this method, but the method could be utilized in a situation in

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173. A variation of this method is sometimes used. This variation is known as "confused, combined, or comingled artificial insemination" because it is accomplished by taking the semen of the adopting father and combining it with donor semen and then artificially inseminating the surrogate mother with the mixture. This variation is used when the adopting father's sperm count is low; by using this method, there is a possibility that the child is biologically related to the adopting father. See GREEN & LONG, *supra* note 168, at 235-36.

174. The *in vitro* fertilization method of surrogate parenting is a new approach. The first reported incident in which this method of surrogate parenting was utilized occurred in August 1985 at Cleveland's Mount Sinai Medical Center. Wellborn, *Birth: To Couples that Could Never be Parents, a Thousand Children are Born*, U.S. NEWS & WORLD REP., Nov. 11, 1985, at 48. See also *supra* notes 23-29 and accompanying text.

175. If only one member of the couple is fertile, this step of the *in vitro* method may be varied by using either donor sperm or a donor egg.

176. In this situation, one commentator maintains that the child would have "five parents: an egg donor, sperm donor, surrogate mother who gestates the fetus and the couple who raise the child." Andrews, *The Stork Market: Legal Regulation of the New Reproductive Technologies*, 6 WHITTIER L. REV. 789, 791 (1984).

which both the husband and wife are infertile.

Although the three above-mentioned methods of surrogate parenting involve very different medical techniques, and although the biological relationship of the couple receiving custody to the child may vary depending upon the method used, the legal consequences of contracting to perform each method are surprisingly similar.<sup>177</sup> The methods are treated very much the same because most states presume that the woman who gives birth to a child is the natural, biological mother of the child.<sup>178</sup>

This Part discusses the legal aspects of surrogate parenting from the perspective of an attorney faced with the problem for the first time. Section B presents the typical provisions of a surrogate parenting contract. Section C introduces the question of the applicability of state statutes and public policies to the surrogate parenting situation. Section D examines the enforceability of surrogate parenting contracts, focusing on whether the court characterizes the contract as an adoption agreement or a custody agreement. Section E discusses possible criminal liability resulting from the surrogate parenting process. Section F examines the constitutionality of state statutes and public policies that make a surrogate contract illegal and, hence, unenforceable. Section G considers the remedies available for breach of an enforceable surrogate contract. Section H explains the methods of acquiring child support and child custody exclusive of the surrogate contract. Section I calls for legislation to deal with the legal aspects of surrogate parenting that remain unresolved.

## B. TYPICAL PROVISIONS IN A SURROGATE PARENTING CONTRACT

In all three methods of surrogate parenting, the surrogate mother agrees to provide a womb for the fetus for nine months, to relinquish all parental rights to the child, and to give the child to a specified couple at birth.<sup>179</sup> The couple receiving the child typically

177. Throughout this section the Author will note the instances in which different methods of surrogate parenting result in different legal consequences.

178. See sources cited *infra* notes 184 and 323 (creating a presumption that the child is that of the woman giving birth and her husband).

179. There are many possible surrogate parenting scenarios, but for purposes of clarity, this section will use as a model the situation in which a married couple proposes to adopt a child carried by a surrogate mother who is also married. In fact, many doctors and lawyers refuse to handle a surrogate parenting case for single parents or unwed couples.

For a review of commentary discussing ethical issues posed by the surrogate parenting process, see Brahams, *The Legal and Social Problems of In Vitro Fertilisation: Why Parliament must Legislate—II*, 133 *New L.J.* 881 (1983); Sherwyn, *Attorney Duties in the Area of*



agrees to pay for the surrogate mother's medical, hospital, and legal expenses related to conception of the child, pregnancy, and termination of the surrogate mother's parental rights to the child. In most instances the couple also agrees to pay the surrogate mother a specified fee for her services.<sup>180</sup> The parties usually execute a surrogate parenting contract.<sup>181</sup> Simply specifying rights in a contract,

*New Reproductive Technologies*, 6 WHITTIER L. REV. 799 (1984); Comment, *Love's Labor Lost: Legal and Ethical Implications in Artificial Human Procreation*, 58 U. DET. J. URB. L. 459 (1981).

180. An estimate of the fee paid to a surrogate mother for carrying the child to term is \$12,000. Handel, *Surrogate Parenting, In Vitro Insemination and Embryo Transplantation*, 6 WHITTIER L. REV. 783, 786 (1984).

181. One commentator has drafted a sample surrogate parenting contract that attempts to solve some of the legal problems associated with surrogate parenting.

Surrogate Mother Contract Agreement

THIS AGREEMENT is made this \_\_\_\_ day \_\_\_\_, 198[ ], by and between \_\_\_\_ (hereinafter referred to as "Surrogate") and her husband, \_\_\_\_ (hereinafter referred to as "Husband") and \_\_\_\_ (hereinafter referred to as "Natural Father").

RECITALS

THIS AGREEMENT is made with reference to the following facts:

- (1) The Natural Father is a married individual over the age of eighteen (18) years who is desirous of entering into the following agreement.
- (2) The Natural Father desires to have a child who is biologically related to him.
- (3) The Surrogate and her Husband are a married couple each over the age of eighteen (18) years who are desirous of entering into the following agreements in consideration of the financial remuneration incident hereto.

....  
 NOW, THEREFORE, in consideration of the mutual promises contained herein and with the intentions of being legally bound, hereby the parties agree as follows:

SECTION I. The Surrogate represents that she is capable of conceiving children, but agrees that she will not form or attempt to form a parent-child relationship with any child she may conceive pursuant to the provisions of this contract and shall freely and readily, in conformance with applicable statutory regulations, terminate all parental rights to said child pursuant to this agreement.

....  
 SECTION II. The Surrogate and her Husband have been married since \_\_\_\_ and the Husband is in agreement with the purposes, intents, and provisions of this agreement and agrees that his wife, the Surrogate, shall be artificially inseminated pursuant to the provisions of this agreement. The Husband will not form a parent-child relationship with any child the Surrogate may conceive by artificial insemination as described herein and agrees to freely and readily terminate all parental rights to said child and acknowledges he will do all acts necessary to rebut the presumption of paternity (including blood testing) . . . .

SECTION III. The Natural Father is hereby entering into a written contractual agreement with the Surrogate and her Husband, whereby the Surrogate shall be artificially inseminated, with the semen of the Natural Father, by \_\_\_\_, M.D. The Surrogate, upon her becoming pregnant, shall carry said embryo/fetus(s) (hereinafter referred to as "child") until delivery. Delivery shall occur in the state of \_\_\_\_\_. The Surrogate and her Husband agree that they will on the fifth day after delivery of the child, or as soon thereafter as is medically possible, institute proceedings in [\_\_\_\_], to terminate their respective parental rights to said child and sign any and all necessary

however, may not bind the parties because a court can stike down

affidavit documents, etc., in order to further the intent and purposes of this agreement. The Surrogate and her Husband agree to sign all necessary affidavits, prior to the birth of the child in order to have the Natural Father's name placed on said child's birth certificate as the biological father . . . .

. . . *SECTION IV.* The Natural Father and the Surrogate and her Husband recognize and acknowledge that the Attorney(s) for the Natural Father shall act as agent for the Natural Father is all matters pertaining to this agreement in order to maintain complete confidentiality.

*SECTION V.* The consideration for this agreement, in addition to other provisions contained herein, shall be as follows: (a) \$\_\_\_\_\_ shall be paid to the Surrogate and her Husband upon entry of the judgment fully terminating the parental rights of the Surrogate and her Husband as defined by the law in [ ] to the child to be born pursuant to these provisions between the Surrogate and the Natural Father.

*ALTERNATE PROVISION,*

*SECTION V (a)* The Natural Father shall not pay the Surrogate a fee of any kind pursuant to this agreement but shall pay the Surrogate's pregnancy and confinement expenses beginning on the date her pregnancy is verified and continuing for (1) one month subsequent to the contemplated birth. Said pregnancy and confinement expenses shall not exceed \$\_\_\_\_\_ per month in addition to the following:

See (c)(1).

(b) The consideration to be paid said Surrogate and her Husband shall be deposited with the attorney for the Natural Father at the time of the signing of this agreement and held in escrow until completion of the duties and obligations of the Surrogate and her Husband as herein described.

(c) The Natural Father shall pay the expenses incurred by the Surrogate and her Husband pursuant to her pregnancy, more specifically defined as follows:

[(1)-(5) describe the expenses paid in detail. (contents summarized)]*SECTION VI.* Immediately subsequent to the birth of the child, the Surrogate, the Natural Father, and the child shall undergo the following tests under the direction of the pathologist designated by \_\_\_\_\_ M.D.:

- (1) Blood Group
- (2) Serum Proteins
- (3) Red Cell Enzymes
- (4) White Cell/H.L.A.\*

. . . .  
In the event that the Natural Father is excluded by one (1) or more of the aforementioned tests, this contract shall be immediately terminated and all monies and/or all other consideration paid to the Surrogate and her Husband, or in their behalf, or expended to screen and/or investigate the Surrogate and/or her Husband in contemplation of this contract by the Natural Father shall be immediately returned by the Surrogate and her Husband to the Natural Father. In addition, the Surrogate and her Husband shall pay interest on said monies at the United States prime rate existing at the time said sum(s) were expended.

. . . .  
*SECTION VII.* The Natural Father shall pay the cost of a term life insurance policy payable to a named beneficiary of the Surrogate with a policy amount of \$\_\_\_\_\_ and said policy shall remain in effect for six (6) weeks subsequent to the birth of the child. In addition, the Natural Father shall make appropriate arrangements in his will for the support of the infant child should he die prior to the birth of said child and shall pay the cost of a term life insurance policy on his life payable in trust to said unborn child.

. . . *SECTION VIII.* The Surrogate and her Husband understand and agree to as-

sume all risks, including the risk of death which are incident to conception, pregnancy, childbirth and postpartum complications.

. . . *SECTION IX.* This section provides for psychiatric and psychological examinations of the Surrogate and her Husband, with the reports given to the Natural Father. (contents summarized)*SECTION X.* Defines "Child" (contents summarized)*SECTION XI.* In the event that the child is miscarried prior to the fifth (5th) month of pregnancy, no compensation as enumerated in Section V(a) shall be paid to the Surrogate. However, the expenses enumerated in Section V(c) shall be paid or reimbursed to the Surrogate and her Husband in addition to any and all travel and incidental expenses incident hereto incurred by the Surrogate and/or her Husband. In the event the child is miscarried, dies, or is stillborn subsequent to the fourth (4th) month of pregnancy, and said child does not survive, the Surrogate shall receive \$\_\_\_\_\_ in lieu of the compensation in Section V(a) only if the paternity testing enumerated in Section VI(6) is completed and satisfactory as to said child. In the event of a miscarriage or stillbirth as described above, this agreement shall terminate and neither the Surrogate nor the Natural Father will be under any further obligation under this agreement.

. . . *SECTION XII.* Surrogate and Natural Father must undergo physical and genetic examination (contents summarized)*SECTION XIII.* In the event that custody of the child is awarded to the surrogate and/or her Husband or their family, or any individual or organization not related to the Natural Father, by any court decision or otherwise, the Natural Father shall be indemnified by the Surrogate and/or her Husband, both jointly and severally . . . .

. . . *SECTION XIV & SECTION XV.* None of the parties to the contract will attempt to learn the identity of the others. (contents summarized)*SECTION XVI.* If pregnancy hasn't occurred within a reasonable time, the inseminating physician will terminate the contract. (contents summarized)*SECTION XVII.* All parties agree not to tell news media (contents summarized)*SECTION XVIII.* If Surrogate or Husband violate any provision, Natural Father can terminate contract—Surrogate and Husband must indemnify Natural Father for any expenses. (contents summarized)*SECTION XIX.* Surrogate and Husband agree to provide no interviews without Natural Father's permission. (contents summarized)*SECTION XX.* Surrogate agrees not to abort child unless her health is in danger, or child is physiologically abnormal. In either of these contingencies, Surrogate agrees to abort child. (contents summarized)*SECTION XXI.* The Natural Father assumes the legal responsibility for any child who may possess congenital abnormalities and he has been previously advised of the risk of such abnormalities. (See attached medical statement of Natural Father).

. . . *SECTION XXII.* In the event that the Natural Father predeceases the birth of the child, said child shall be placed in the custody of \_\_\_\_\_, for placement through a private adoption to a designated person upon consent of the appropriate social agency.*SECTION XXIII.* Surrogate and Husband agree not to try to view child after birth. (contents summarized)*SECTION XXIV.* Surrogate agrees to follow physician's instructions. (contents summarized)

. . . *SECTION XXV.* All parties understand and sign voluntarily. (contents summarized)*SECTION XXVI.* Any provision which is invalid is severable. (content summarized)*SECTION XXVII.* The contract may be executed in two or more counterparts, if together, constitutes same instrument. (contents summarized)*SECTION XXVIII.* All of the agreement is set out in this (contents summarized) document; all prior agreements are viewed, merged, or superseded; This is an integrated agreement. (contents summarized)*SECTION XXIX.* This contract can be amended only by a writing signed by all parties. (contents summarized)*SECTION XXX.* Governed by law of [\_\_\_\_\_]. (contents summarized)*SECTION XXXI.* This agreement is not to be interpreted for or against the party that drafted provisions. (contents summarized)

Signatures

any term it deems contrary to public policy.<sup>182</sup>

### C. APPLICABILITY OF STATE STATUTES AND PUBLIC POLICIES TO SURROGATE PARENTING

#### 1. State Statutes

Arkansas is the only state that has a statute specifically dealing with surrogate parenting.<sup>183</sup> The Arkansas statute provides that a child born to an unmarried surrogate mother is the child of the intended parents.<sup>184</sup> Most state legislatures have not passed legislation specifically intended to regulate surrogate parenting.<sup>185</sup> As of 1985, no state has passed legislation specifically prohibiting surrogate parenting. At least one court has held that a legislature's failure to authorize surrogate parenting indicates the state's desire to

Brophy, *A Surrogate Mother Contract to Bear a Child*, 20 J. FAM. L. 263, 266-84 (1981-82), reprinted in GREEN & LONG, *supra* note 168, at 385-401.

182. See Note, *Surrogate Mothers: The Legal Issues*, 7 AM. J. L. & MED. 323, 326 (1981).

183. See ARK. STAT. ANN. § 34-720-21 (Supp. 1985).

*Child born as result of artificial insemination shall be deemed legitimate natural child of husband.* Any child born to a married woman by means of artificial insemination shall be deemed the legitimate natural child of the woman's husband if the husband consents in writing to the artificial insemination. *Child born to married or unmarried woman—Presumptions—Surrogate mothers.*(A) A child born by means of artificial insemination to a woman who is married at the time of the birth of such child, shall be presumed to be the child of the woman's husband.

(B) A child born by means of artificial insemination to a woman who is unmarried at the time of the birth of the child, shall be for all legal purposes the child of the woman giving birth, except in the case of a surrogate mother, in which event the child shall be that of the woman intended to be the mother. For birth registration purposes, in cases of surrogate mothers, the woman giving birth shall be presumed to be the natural mother and shall be listed as such on the certificate of birth, but a substituted certificate of birth can be issued upon orders of a court of competent jurisdiction.

*Id.*

184. See ARK. STAT. ANN. § 34-721(B) (Supp. 1985). Even the Arkansas statute does not deal adequately with all of the problems surrounding surrogate parenting because it addresses only arrangements involving an unmarried surrogate mother.

185. One student commentator has proposed a Uniform Surrogate Parenting Act to fill the void resulting from the failure of state legislatures to pass statutes regulating this area. See Note, *Developing a Concept of the Modern "Family": A Proposed Uniform Surrogate Parenthood Act*, 73 GEO. L.J. 1283, 1299 (1985).

This proposed Act is subject to criticism. First, it addresses only the artificial insemination method of surrogate parenting. Because the proposed Act does not contemplate the legal implications of other methods of surrogate parenting, the Act would have to be re-drafted as other medical techniques are developed or utilized. Second, the Act requires a large volume of paperwork that may be justified only in the event that one party attempts to breach the agreement. In the majority of undisputed cases, the paperwork will only increase the cost of surrogate parenting arrangements rather than aid the parties.

prohibit these arrangements.<sup>186</sup>

Often states have statutes that on their face appear applicable to surrogate parenting, but the statutes do not specify whether state lawmakers intended the statutes to regulate surrogate parenting arrangements.<sup>187</sup> Analysis of the goals and purposes underlying the statute is useful because most states enacted their statutes before advanced medical technology made surrogate parenting a viable option.<sup>188</sup> If a statute appears to prohibit aspects of the surrogate parenting process, courts should undertake an analysis to determine whether the surrogate parenting process would frustrate the purposes and goals behind the statute. Specifically, before a court applies any state statute to the surrogate situation, the court should examine the legislative history of the statute to determine what legislative goals the state meant to further by enacting the statute. If the surrogate parenting situation frustrates the goals of the state statute, the legislature probably would have intended to regulate the activity if it considered surrogate parenting before passing the act. The court in that instance should apply the statute to cases concerning surrogate parenting. If, however, the surrogate parenting situation does not frustrate the state legislature's goals, the court should not apply the statute to surrogate parenting cases because the legislature probably would not have intended to regulate the surrogate parenting process had it considered surrogate parenting before passing the act.

At first glance, the group of various state statutes dealing with adoption and custody of children appears to prohibit various aspects of the surrogate parenting arrangement. For example, many state statutes prohibit a mother from receiving compensation for allowing another person to adopt her child.<sup>189</sup> State statutes also

186. *Kentucky ex rel Armstrong v. Surrogate Parenting Assoc., Inc.*, 11 FAM. L. REP. (BNA) 1359 (Ky. Ct. App. Ap. 26, 1985).

187. Statutes that appear to regulate surrogate parenting arrangements include: statutes regulating fetal experimentation, statutes prohibiting a mother from receiving compensation for giving her child up for adoption, statutes prohibiting agencies from receiving compensation for placing children, statutes prohibiting a parent from assigning rights to the care and custody of a child, and statutes prohibiting advertisement of placement matters. See *infra* notes 192-97 and accompanying text.

188. Commentators have noted that it is unclear whether legislators intended baby brokerage statutes to include surrogate motherhood arrangements because such arrangements were not prevalent when the state drafted the legislation. See GREEN & LONG, *supra* note 168, at 251.

189. Cf., e.g., ARIZ. REV. STAT. ANN. § 8-114 (Supp. 1985) (stating that spouse of natural parent is exempt from prohibition, and that a mother can receive medical and legal expenses if they are approved by the court); COLO. REV. STAT. § 19-4-115(1) (1978) (mother

prohibit any unlicensed agency or person from receiving compensation for placing a child for adoption.<sup>190</sup> Still other state statutes require that an agency placing a child for adopting have a li-

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can receive attorney's fees and other fees approved by the court); DEL. CODE ANN. tit. 13, § 928(a) (1981); FLA. STAT. ANN. § 63.212(1)(d) (West 1985) (indicating that the mother can receive actual medical, hospital, confinement and living expenses); IDAHO CODE § 18-1511 to -1512 (1979) (allowing mother to receive payment of medical bills); IND. CODE ANN. § 35-46-1-9 (Burns 1985) (allowing payment and receipt of attorney's fees, medical expenses, reasonable charges by a licensed agency, and other court-approved charges); IOWA CODE ANN. § 600.9 (West 1981) (allowing receipt of actual expenses); KY. REV. STAT. ANN. § 199.590 (2) (Bohbs-Merrill Supp. 1985); MD. FAM. LAW CODE ANN. § 5-327(a) (1984) (permitting receipt of medical and legal expenses); MASS. GEN. LAWS ANN. ch. 210, § 11A (West Supp. 1985); MICH. COMP. LAWS ANN. § 710.54(1) (West Supp. 1985) (allowing receipt of court-approved fees); N.Y. SOC. SERV. LAW § 374(6) (McKinney 1977) (permitting receipt of medical expenses); N.C. GEN. STAT. § 48-37 (1984); OHIO REV. CODE ANN. § 3107.10 (Page 1980) (noting that the prohibition does not apply to adoption by a stepparent, and that the mother can receive payment for medical and legal expenses); OKLA. STAT. ANN. tit. 21, § 866 (West Supp. 1985) (allowing receipt of medical and legal expenses); S.D. CODIFIED LAWS ANN. § 25-6-4.2 (1984); TENN. CODE ANN. § 36-1-135(a) (1984) (permitting receipt of medical and legal expenses); UTAH CODE ANN. § 76-7-203 (1979) (allowing receipt of actual, reasonable medical, hospital, and confinement expenses); WIS. STAT. ANN. § 946.716(1)(a) (West 1982) (permitting hospital, medical, and legal expenses); *see also* CAL. PENAL CODE § 273 (West 1970) (prohibiting payments in excess of medical expenses to the mother or agency); GA. CODE ANN. § 74-418(b) (Harrison Supp. 1984) (prohibiting payments in excess of medical expenses); ILL. ANN. STAT. ch. 40, § 1702 (Smith-Hurd 1980) (prohibiting payments to mother or agency).

190. *Cf., e.g.*, COLO. REV. STAT. § 19-4-115 (1978); DEL. CODE ANN. tit. 13, § 928(b) (1981) (attorney's fees, court costs, and a service fee can be received); ILL. ANN. STAT. ch. 40, §§ 1526, 1701 (Smith-Hurd 1980); IND. CODE ANN. § 35-46-1-9 (Burns 1985) (allowing receipt of attorney's fees, medical expenses, reasonable charges by a licensed agency, and other court-appointed charges); KY. REV. STAT. ANN. § 199.590(2) (Bohbs-Merrill Supp. 1985) (allowing licensed placement agencies to charge a fee for placement); ME. REV. STAT. ANN. tit. 22, § 8204(3) (1980) (allowing receipt of reasonable costs for services); MD. FAM. LAW CODE ANN. § 5-327 (1984) (allowing receipt of medical and legal expenses); MASS. GEN. LAWS ANN. ch. 210, § 11A (West Supp. 1985); MICH. COMP. LAWS ANN. § 710.54(1) (West Supp. 1985) (allowing receipt of court-approved fees); NEV. REV. STAT. §§ 127.285, .290 (1981) (attorneys and licensed agencies can receive reasonable compensation); N.J. STAT. ANN. § 9:3-54 (West Supp. 1985) (permitting receipt of medical expenses, birth-related expenses, and fees charged by a licensed agency); N.Y. SOC. SERV. LAW § 374(6) (McKinney 1977) (permitting receipt of medical expenses); N.C. GEN. STAT. § 48-37 (1984); OHIO REV. CODE ANN. § 3107.10 (Page 1980) (permitting medical and legal expenses and exempting step-parents from the prohibition); OKLA. STAT. ANN. tit. 21, § 866 (West Supp. 1985) (allowing receipt of medical and legal expenses); S.D. CODIFIED LAWS ANN. § 25-6-4.2 (1984) (permitting receipt of court-approved fees & licensed agency's fees); TENN. CODE ANN. § 36-1-135(a) (1984) (permitting receipt of medical and legal expenses); UTAH CODE ANN. § 55-8a-1 (Supp. 1985) (allowing receipt of medical and legal expenses); W. VA. CODE § 48-4-5(e) (Supp. 1985) (limiting fees to value of services rendered); WIS. STAT. ANN. § 946.716(1)(b) (West 1982) (only licensed agencies); *see also* FLA. STAT. ANN. §§ 63.097, 63.212(1)(g) (West 1985) (allowing agencies to receive a compensation, but requiring court approval for more than \$500 over the actual documented medical and legal expenses); IOWA CODE ANN. § 600.9 (West 1981) (allowing receipt of a reasonable fee).

cense.<sup>191</sup> Many states also statutorily prohibit advertisement of child placement matters by anyone other than a licensed agency.<sup>192</sup> Other state statutes prohibit a parent from assigning or transferring rights to the care and custody of a child, except for adoption purposes.<sup>193</sup>

Generally, the primary purposes and goals underlying the group of statutes relating to custody and adoption are to promote the best interests of the child<sup>194</sup> and the natural family unit by preventing a process similar to "child bartering."<sup>195</sup> Arguably, the surrogate parenting process would not frustrate these purposes and goals because aspects of child bartering, which the legislatures intended to prevent, are not present in surrogate parenting.<sup>196</sup> The state legislatures probably intended to prevent black market baby bartering that, in many instances, involves young, frightened, pregnant girls who did not choose to become pregnant and are uncertain about what to do with their babies. The typical surrogate

191. Cf., e.g., CAL. CIV. CODE § 224q (West 1982); COLO. REV. STAT. § 19-4-108 (1978) (the guardian of the child is also allowed to place the child); CONN. GEN. STAT. ANN. § 17-49a (West Supp. 1985); DEL. CODE ANN. tit. 13, § 904 (Supp. 1984) (no requirement to use licensed adoption agency if stepparent or blood relative adopts); NEB. REV. STAT. ANN. § 170-E:3 (Supp. 1985); N.M. STAT. ANN. §§ 40-7-19, 40-7A-8 (1983) (no requirement to use licensed agency if adoption by a stepparent or through a religious organization); N.D. CENT. CODE § 50-12-02 (1981); R.I. GEN. LAWS § 15-7-1(a) (Supp. 1985) (no need for licensed agency if child is placed by parent, or with close relative or stepparent); TENN. CODE ANN. § 35-1-134 (1984); UTAH CODE ANN. § 55-8a-1(2) (Supp. 1985); VA. CODE § 63.1-220.1 (Supp. 1985) (parent can place child without license). *But see* ME. REV. STAT. ANN. tit. 22, § 8204(2) (1980) (allowing unlicensed agencies to place children).

192. See, e.g., ALA. CODE § 26-10-8 (1975); CAL. CIV. CODE § 224p (West 1982); GA. CODE ANN. § 74-418(a) (Harrison Supp. 1984); KY. REV. STAT. § 199.590(1) (Supp. 1985); ME. REV. STAT. ANN. tit. 22, §§ 8240(1)-(2) (1980) (must have a license to advertise); NEV. REV. STAT. § 127.310 (1981) (licensed agencies can advertise); N.H. REV. STAT. ANN. § 170-E:14 (Supp. 1985) (licensed agencies can advertise); N.C. GEN. STAT. § 48-38 (1984); OKLA. STAT. ANN. tit. 21, § 866(5) (West Supp. 1985); UTAH CODE ANN. § 55-8a-1(3) (Supp. 1985).

193. See, e.g., CAL. PENAL CODE § 181 (West Supp. 1986); FLA. STAT. ANN. § 63.212(1)(e) (West 1985); MINN. STAT. ANN. § 257.02 (West 1982); MO. ANN. STAT. § 453.110 (Vernon 1977); TENN. CODE ANN. § 36-1-135(3) (1984); WASH. REV. CODE ANN. § 26.33.370(1) (Supp. 1986).

194. See, e.g., ALASKA STAT. § 25.20.060(a) (1983); DEL. CODE ANN. tit. 13, § 722 (1981); GA. CODE ANN. § 74-107(a) (Harrison Supp. 1984); ILL. ANN. STAT. ch. 40, § 602, 1525 (Smith-Hurd 1980); IND. CODE ANN. § 31-6-6.1-11 (Burns Supp. 1985); MINN. STAT. ANN. § 257.025 (West 1982); MO. ANN. STAT. § 453.110 (Vernon 1977); N.D. CENT. CODE § 14-09-05 (Supp. 1983); OHIO REV. CODE ANN. § 3109.04(A) (Page Supp. 1984); OR. REV. STAT. §§ 107.137, 109.175 (1983); PA. STAT. ANN. tit. 23, § 1002 (Purdon Supp. 1985); TEX. FAM. CODE ANN. § 14.07 (Vernon 1975); WIS. STAT. ANN. § 767.24(2) (West 1981).

195. "Child bartering" is the selling of children for a fee or for some other item of value.

196. See GREEN & LONG, *supra* note 168, at 250-51, for an argument that the child's best interests are not taken into account.

parenting fact situation is very dissimilar from the black market adoptions that the legislatures visualized when they wrote the statutes because most surrogate mothers are women who choose to carry the child after being made aware of the consequences.<sup>197</sup>

Black market adoptions include child bartering elements. In the typical black market adoption a third-party intermediary arranges for a married couple to adopt an unwed mother's baby. The intermediary rarely investigates the mental and physical health of the couple, the child, or either's suitability for adoption.<sup>198</sup> Unlike the unwed mother in the typical black market adoption, a surrogate mother willingly agreed to relinquish parental rights to the child before she became pregnant.<sup>199</sup> Accordingly, no one is pressuring the surrogate mother into making a serious decision in a small span of time. Surrogate parenting actually may further a state's goal of promoting the best interests of the child. The adopting couple or the couple receiving custody have planned carefully for the child<sup>200</sup> and intend to treat the child as their own. In fact, a child carried by a surrogate mother may be biologically related to one or both adopting parents.<sup>201</sup> When the state legislatures passed their respective statutes, they believed that they were promoting the best interests of the child by having the child stay with its natural mother.<sup>202</sup> Today, however, many state legislatures hold

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197. Greenburg & Hirsh, *Surrogate Motherhood and Artificial Insemination: Contractual Implications*, 1983 MED. TRIAL TECHNIQUE Q. 149, 155 [hereinafter cited as Greenburg & Hirsh]; see also GREEN & LONG, *supra* note 168, at 250-51 (stating that surrogate parenting is distinguishable from black market adoptions because the child is biologically related to the husband and because surrogate agency investigations lessen the chance of unsuitable parents).

198. Greenburg & Hirsh, *supra* note 197, at 155.

199. *Id.*

200. See *supra* note 181 for a sample surrogate parenting agreement containing detailed provisions regulating all involved parties' conduct.

201. For a review of the possible sperm and egg combinations in the surrogate parenting process, see *supra* text accompanying notes 172-76.

202. For custody statutes providing that the state shall not prefer one parent over the other, see e.g., ALASKA STAT. § 25.20.060 (1983); ARK. STAT. ANN. § 34-718 (Supp. 1985); DEL. CODE ANN. tit. 13, § 722(b) (1981); ILL. ANN. STAT. ch. 40, § 602 (Smith-Hurd 1980); IND. CODE ANN. § 31-6-6.1-11 (Burns Supp. 1985); MD. FAM. LAW CODE ANN. § 5-203(c)(2) (1984); MINN. STAT. ANN. § 257.025 (West 1982); MO. ANN. STAT. § 453.110 (Vernon 1977); N.D. CENT. CODE § 14-09-05 (Supp. 1983); OHIO REV. CODE ANN. § 3109.03 (Page Supp. 1984); OR. REV. STAT. § 109.030 (1983); PA. STAT. ANN. tit. 23, § 1002 (Purdon Supp. 1985); S.D. CODIFIED LAWS ANN. § 25-5-10 (1984); TEX. FAM. CODE ANN. § 14.07 (Vernon 1975); WIS. STAT. ANN. § 767.24(2) (West 1981). *But see* CAL. CIV. CODE § 197 (West 1982); GA. CODE ANN. § 74-203 (Harrison Supp. 1984) (mother is entitled to custody of illegitimate child unless father legitimizes him, then custody is based on best interests of child); S.C. CODE ANN. § 20-7-953 (Law. Co-op. 1985); WIS. STAT. ANN. § 48.435 (West Supp. 1985).



the view that the best interests of the child are promoted just as much by permitting the child to live with the natural father as by permitting the child to live with the natural mother.<sup>203</sup> Under the artificial insemination and *in vitro* fertilization methods, the natural father receives custody of the child. In some cases, the *in vitro* method may result in both biological parents getting custody of the child. Accordingly, the state would accomplish its goal of promoting the family unit by enforcing the surrogate contract because the surrogate mother is not biologically related to the child.<sup>204</sup> Under the modified *in vitro* fertilization method, however, no party to the contract is biologically related to the child and, concededly, neither leaving the child with the surrogate mother nor giving the child to the intended parents would further the state's goal of promoting the natural family unit.

A second group of state statutes dealing with fetal experimentation may render surrogate contracts illegal and, hence, unenforceable. Virtually all states have fetal experimentation laws in one form or another.<sup>205</sup> These statutes may apply to the *in vitro* fertilization<sup>206</sup> and modified *in vitro* fertilization<sup>207</sup> methods of surrogate parenting because conception takes place outside of the womb. The statutes probably do not apply to the traditional artificial insemination method<sup>208</sup> of surrogate parenting because conception takes place in the surrogate mother's womb and because the states do not consider artificial insemination experimental. When analyzed by examining the underlying purposes and goals, however, the fetal experimentation statutes should not apply to any of the surrogate parenting methods because the purpose of the statutes is to prevent cruelty and harm to fetuses.<sup>209</sup> The surrogate

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203. The surrogate mother could argue that she has a bond with the child that the natural mother does not have. This argument is more persuasive when the parties used the modified *in vitro* fertilization method with donor sperm and a donor egg because the adoptive couple, in this situation, is completely unrelated to the child.

204. See, e.g., ARIZ. REV. STAT. ANN. § 36-2302 (Supp. 1978-1979); ILL. ANN. STAT. ch. 38, § 81-26(7) (Hurd-Smith Supp. 1985); IND. CODE § 35-1-58.5-6 (1985); KY. REV. STAT. § 436.026 (1985); LA. REV. STAT. ANN. § 14:87.2 (West 1974); ME. REV. STAT. ANN. tit. 22, § 1593 (1980); MICH. COMP. LAWS ANN. §§ 333.2685-.2692 (West 1980); MINN. STAT. ANN. § 145.-422 (West Supp. 1986); MO. ANN. STAT. § 188.037 (Vernon 1983); N.D. CENT. CODE § 14-02.2-01 (1981); OHIO REV. CODE ANN. § 2919.14 (Page 1982); PA. STAT. ANN. tit. 18, § 3216 (Purdon 1983); S.D. CODIFIED LAWS ANN. § 34-23A-17 (1977); UTAH CODE ANN. § 76-7-310 (1978); WYO. STAT. § 35-6-115 (1977).

205. See *supra* notes 175-76 and accompanying text.

206. See *supra* note 177 and accompanying text.

207. See *supra* notes 173-74 and accompanying text.

208. See Note, *supra* note 182, at 328.

209. *Id.*; see also Andrews, *supra* note 176, at 791-94 (1984); Flannery, Weisman, Lip-

parenting process, rather than harming fetuses, promotes the health and safety of the fetus.

In conclusion, statutes appearing to regulate or prohibit surrogate parenting are of questionable applicability because surrogate parenting actually furthers the statutes' underlying purposes and goals. Under the modified *in vitro* fertilization method, however, the statutes may apply to prevent frustration of legislative goals. Because of the confusion surrounding the applicability of statutes that do not address specifically surrogate parenting, an attorney also should examine public policy in attempting to predict whether a state court would enforce or strike down a surrogate parenting agreement.

## 2. Public Policies

State public policy may render the surrogate parenting contract unenforceable<sup>210</sup> even when state statutes do not appear to regulate surrogate parenting or when state statutes that appear to regulate surrogate parenting do not apply.<sup>211</sup> Public policies of a state that could preclude surrogate parenting contracts include: preventing child bartering, promoting the best interests of the child, and promoting the natural family unit. Because these public policies are identical to the goals and purposes of statutes that appear to apply to surrogate parenting, the arguments for not applying these public policies to the surrogate parenting situation remain the same.<sup>212</sup>

Although considering the underlying purposes and goals of existing statutes and public policies is an appropriate way to measure a state's attitude toward the surrogate parenting process, courts may tend to make decisions based on other considerations. Whether a court would apply these public policies to find a surrogate parenting contract unenforceable may depend on whether the

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sett & Braverman, *Test Tube Babies: Legal Issues Raised by In Vitro Fertilization*, 67 GEO. L.J. 1295, 1299-1300 (1979) (stating that because fetal experimentation statutes were enacted to address abortion and not *in vitro* fertilization it seems unlikely that courts would construe their terms so broadly that they apply to *in vitro* fertilization).

210. S. WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 1744A, at 88 (3d ed. 1972 & Supp. 1985).

211. In theory, a court can find that the state statutes that appear to prohibit surrogate parenting do not apply and then find that public policy prohibits surrogate parenting. In reality, however, a court looks to the state's public policy to determine whether the statutes apply. Therefore, if the statutes do not apply, the public policy behind the statute will not apply.

212. See *supra* text accompanying notes 189-200.

court views the contract as an adoption agreement or as a custody agreement.

#### D. ENFORCEABILITY OF THE SURROGATE PARENTING CONTRACT

Assuming that a state statute appears to prohibit aspects of surrogate parenting, a court most likely would hold that the surrogate contract is unenforceable either because the object of the contract is illegal<sup>213</sup> or because the consideration is illegal.<sup>214</sup> Whether the contract is enforceable, however, ultimately may depend on whether the court views the contract as an adoption agreement<sup>215</sup> or as a custody agreement.<sup>216</sup>

##### 1. Contract Viewed as an Adoption Agreement

If a court views the surrogate agreement as an adoption contract, it probably will hold that the contract is unenforceable because statutes prohibiting payments to a mother for her child<sup>217</sup> and statutes prohibiting payments to persons aiding in adoptions<sup>218</sup> appear to invalidate the contract.<sup>219</sup> In *Kentucky v. Surrogate Parenting Associates, Inc.*,<sup>220</sup> a Kentucky court of appeals held that a surrogate parenting contract was, in effect, an adoption contract,<sup>221</sup> and in *Doe v. Kelley*,<sup>222</sup> a Michigan court of appeals implicitly held that adoption statutes applied to a surrogate parenting arrangement.<sup>223</sup> If other courts follow this lead and find

213. J. MURRAY, *MURRAY ON CONTRACTS* § 344, at 729 (2d ed. 1974).

214. S. WILLISTON, *supra* note 210, § 1782, at 332-33. No cases have been reported in which either the surrogate mother or the intended parents have tried to enforce a surrogate parenting contract. The reported cases involving surrogate parenting have not been conflicts between the contracting parties, but conflicts with the state or problems with using state laws to adopt the child produced through surrogate parenting.

215. See *infra* text accompanying notes 219-35.

216. See *infra* text accompanying notes 232-46. For a thorough discussion of fetal experimentation, see generally *supra* section II of this Special Project.

217. See *supra* note 189.

218. See *supra* note 190.

219. Most courts apply state statutes to fact situations that appear to fall within the statute's prohibition without considering the purposes and goals of the legislature when it passed the statute. See *supra* text accompanying notes 189-200.

220. 11 FAM. L. REP. (BNA) 1359 (Ky. Ct. App., Apr. 26, 1985).

221. *Id.* at 1359-60. The Kentucky Court of Appeals held that Surrogate Parenting Associates, Inc., by receiving payments for arranging surrogate parenting situations, violated a Kentucky statute providing that "no person, agency, or institution not licensed by the cabinet for Human Resources may accept remuneration for the procurement of any child for adoption."

222. 106 Mich. App. 169, 307 N.W.2d 438 (1981).

223. *Id.* at 173-74, 307 N.W.2d at 441. The court held that Michigan's adoption stat-

that state adoption statutes apply, the surrogate parenting contract could be illegal and, therefore, unenforceable.<sup>224</sup>

In theory, once the court characterizes the surrogate parenting contract as an adoption contract, the court could hold that state statutes do not apply, but that public policy prohibits the contract anyway. In reality, however, once a court determines that state statutes do not apply to the surrogate/adoption contract it probably will hold that state public policy does not apply because the state's public policy is precisely what the court examined in order to determine whether the statutes applied to the surrogate/adoption contract. The only occasion, therefore, when a court probably will examine whether state public policy prohibits a contract to adopt is when there are no statutes that appear to regulate the surrogate/adoption contract.

In *Reimche v. First National Bank of Nevada*,<sup>225</sup> the United States Court of Appeals for the Ninth Circuit held that an adoption contract between the mother of an illegitimate child and the putative father was enforceable when the adoption was in the child's best interests and financial gain was not the mother's motivating factor.<sup>226</sup> This analysis could apply to a surrogate parenting contract. When the parties agree to use the artificial insemination method, the surrogate/adoption contract is between parents and, therefore, under the *Reimche* analysis, the contract would not violate public policy if it is in the best interest of the child and the surrogate mother's motivation is not pecuniary. Arguably, the surrogate contract furthers the best interests of the child by placing it with parents who desire a child strongly enough to go to extraordinary lengths.<sup>227</sup> The surrogate mother's motivation, however, may be pecuniary.<sup>228</sup> Usually the receiving parties agree to pay the sur-

utes did not unconstitutionally preclude surrogate parenting arrangements; the statutes simply prohibited payments "in conjunction" with the "use of the state's adoption procedures." *Id.*

224. See *supra* notes 213-14 and accompanying text.

225. 512 F.2d 187 (9th Cir. 1975). The "[m]other of illegitimate child brought suit for specific performance of a contract with the putative father to make a will" and the court "held that it is not against public policy to enforce an agreement to provide for the mother of an illegitimate child in the putative father's will, incidental to an agreement to permit the adoption of the child by its father, where the adoption was in the best interests of the child and pecuniary gain was not the motivating factor on the mother's part." *Id.* at 187.

226. *Id.* at 189; cf. *Wooley v. Shell Petroleum Corp.*, 39 256, 45 P.2d 927 (1935).

227. See Gelman & Shapiro, *Infertility: Babies by Contract*, NEWSWEEK, Nov. 4, 1985, at 74 (reporting the difficulties that couples seeking children must go through to get a child of their own).

228. According to the records of an attorney's surrogate agency, during the first five

rogate mother a fee.<sup>229</sup> Many surrogate mothers claim that their primary motivation is not pecuniary, but simply a desire to help childless couples.<sup>230</sup> In *Gray v. Maxwell*,<sup>231</sup> the Nebraska Supreme Court took a stricter view than the *Reimche* court and held that the adoption agreement was unenforceable because an agreement to pay a mother more than the "legitimate expenses of confinement and birth" is against public policy.<sup>232</sup> Under the *Gray* analysis, the surrogate/adoption contract would be unenforceable as against public policy if the surrogate mother received a fee for her services. If, however, the surrogate mother does not receive any compensation other than medical and confinement expenses, the adoption/surrogate contract probably would be enforceable.<sup>233</sup>

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years of the operation the adopting couple did not pay the surrogate mothers and only five babies were born. During the following two and a half years, the adopting couples using his agency paid surrogate mothers and there were 41 births and 10 women pregnant at the time of recordkeeping. *Surrogate Mothers: Problems and Goals*, N.Y. Times, Feb. 27, 1984. These figures lead to the conclusion that many surrogate mothers may be providing their services for the money rather than out of compassion.

229. See *supra* note 180. Commentators have debated whether the fee paid a surrogate mother should be characterized as payment for the service of carrying the child or as payment for the child itself. Some commentators argue that because the surrogate mother has agreed to the procedure with full knowledge that she will relinquish all rights to the child after its birth, she is being paid for the service of carrying the child to full term. See Greenburg & Hirsh, *supra* note 197, at 155. The surrogate mother's services include: (1) undergoing the medical technique of artificial insemination or embryo transplant; (2) providing a womb for the child for nine months; and (3) giving birth to the child. Other commentators argue that a surrogate mother receives payment for the child rather than the service performed. These commentators acknowledge that part of the fee is intended to compensate the surrogate for the physical act of carrying the child to term, but maintain that the primary object of the parties is that the surrogate ultimately give a baby to the adopting couple. See Cohen, *Surrogate Mothers: Whose Baby Is It?*, 10 AM. J.L. & MED. 243, 250 (1984).

230. Surrogate mothers admit that the surrogate fee is important to them, but they reiterate that their primary motivation is simply the desire to help a childless couple have a child. See *supra* note 227; see also Gelman & Shapiro, *supra* note 60, quoting an associate professor of parent-child nursing at the University of Michigan who believes that, although money is a factor, surrogates truly want to make infertile couples happy and to have an important impact in life.

231. 206 Neb. 385, 293 N.W.2d 90 (1980). The court held that payments to the mother "in excess of the legitimate expenses of confinement and birth" were against public policy and that such payments "vitiat[e] the relinquishment previously given" by the mother. *Id.*

232. *Id.* at 393, 293 N.W.2d at 95; see also *In re Clements*, 201 Tenn. 98, 296 S.W.2d 875 (1956); *Benefield v. Faulknor*, 248 Ala. 615, 29 So. 2d 1 (1974).

233. See 83 OP. ATT'Y GEN. LA. 869 (1983) (stating that any payment other than medical and living expenses violates adoption statute prohibiting the sale of children); 83 OP. ATT'Y GEN. OKLA. No. 83-162 (Sept. 29, 1983) (stating that only medical, legal, and hospital expenses can be paid to a surrogate parent). *But see* 81 OP. ATT'Y GEN. KY. 18 (1981) (stating that no payments are allowed even for medical and legal expenses of surrogate mother); 45 OP. ATT'Y GEN. N.C. 24 (1975) (stating that an agreement to pay travel and medical ex-

## 2. Contract Viewed as a Custody Agreement

A few states have statutes that prohibit a parent from assigning or transferring the right to custody of a child.<sup>234</sup> The legislative intent of these statutes was to prevent parents from bargaining for custody of a child.<sup>235</sup> When the surrogate contract is viewed as a contract for custody of the child, the legislature probably would have intended these statutes to apply to the surrogate parenting situation because the main purpose of the surrogate/custody contract is to transfer custody of the child to the intended parents for a fee. Whether a court would apply the statutes to the surrogate/custody contract may depend on whether the surrogate mother is receiving the fee for her services or for custody of the child.<sup>236</sup> Applying such a statute to the surrogate/custody contract would render the contract void and illegal because the surrogate mother, as a parent, is assigning or transferring her right to custody of the child through the surrogate contract.

Because most states do not have statutes prohibiting custody agreements, several courts have found such agreements unenforceable on public policy grounds.<sup>237</sup> In *Ford v. Ford*,<sup>238</sup> the United States Supreme Court found that Virginia had a public policy of promoting the welfare or best interests of the child<sup>239</sup> and a policy of preventing the custody and welfare of children from being the "subject of barter."<sup>240</sup> Because of these policies, the Court held

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penses violates adoption statute).

234. See *supra* note 193.

235. No statutes say that the purpose of the statutes is to prevent parents from bargaining for children, but two cases, *In re R.W.S.*, 370 S.W.2d 698 (Mo. App. 1963) and *In re Smith*, 339 S.W.2d 490 (Mo. App. 1960), say that the purpose of the Missouri law is to prevent indiscriminate transfer of children.

236. See *supra* note 229.

237. See, e.g., *Ford v. Ford*, 371 U.S. 187 (1962). The parents of 3 children made an agreement as to the custody of the children and the Virginia court dismissed the case because the parents had made the agreement. The mother sued for full custody of the children in South Carolina. The issue before the Supreme Court was whether the dismissal in Virginia, which had the effect of approving the parents' custody agreement, was entitled to full faith and credit in South Carolina. The Supreme Court held that the parents' custody agreement would not be controlling in a Virginia court because Virginia public policy does not allow parents to make custody agreements that bind the court and, hence, South Carolina courts are not bound by the full faith and credit clause to enforce the agreement; *Ex parte Smith*, 118 Wash. 1, 202 P. 243 (1921). (involving a custody agreement between the father of a baby girl and the child's maternal grandparents that the court found void as against public policy).

238. 371 U.S. 187 (1962).

239. *Id.* at 193; see also *Ex parte Smith*, 118 Wash. 1, 202 P. 243 (1921).

240. 371 U.S. at 193 (quoting *Buchanan v. Buchanan*, 170 Va. 458, 477, 197 S.E. 426, 434 (1938)).

that custody agreements do not bind courts.<sup>241</sup> The Court's reasoning indicates that all surrogate/custody contracts, regardless of the method of surrogate parenting used, would be unenforceable as against public policy.

Other courts have held that public policy does not prohibit custody contracts.<sup>242</sup> The Kansas Supreme Court, in *In re Shirk's Estate*,<sup>243</sup> held that a contract between a mother and daughter for the custody of the granddaughter was enforceable because the contract was a "family agreement" in the best interests of the child,<sup>244</sup> rather than an agreement between a parent and a stranger or non-family member.<sup>245</sup> In *Tiffany & Co. v. Spreckels*,<sup>246</sup> the California Supreme Court held that an agreement between parents concerning their child's custody was legal.<sup>247</sup> When the surrogate mother uses the artificial insemination method,<sup>248</sup> the surrogate/custody agreement is between biological parents and, therefore, under *Shirk* and *Tiffany*, the contract would not violate public policy because one biological parent would get custody of the child. With the *in vitro* fertilization method,<sup>249</sup> the contract is between biologi-

241. 371 U.S. at 193. One commentator has suggested that courts should treat surrogate parenting contracts as "revocable prebirth agreements"—contracts that the surrogate mother is free to breach at any time without being held liable. Cohen, *supra* note 229, at 281-84.

242. See, e.g., *Tiffany & Co. v. Spreckels*, 202 Cal. 778, 262 P. 742 (1927); (holding that a custody agreement between parents as to the custody of their child is legal, subject to the control of the court in proceedings when the child's welfare is involved); *Nelson v. Wilson*, 97 S.W.2d 287 (Tex. Civ. App. 1936) (under the theory of quantum meruit the court held that it is not against public policy for a father to receive land in exchange for custody of his children); *Bassett v. American Baptist Publication Soc'y*, 215 Mich. 126, 183 N.W. 747 (1921) (holding an agreement between a father and a spinster in which the father agreed to relinquish custody to her and the spinster agreed to will all her property to the child at her death to be enforceable after the spinster's death).

243. 186 Kan. 311, 350 P.2d 1 (1960).

244. *Id.* at 324, 350 P.2d at 11-12; see also *In re Book's Estate*, 297 Pa. 543, 147 A. 608 (1929); *Nelson v. Wilson*, 97 S.W.2d 287 (Tex. Civ. App. 1936).

245. The result may be different with the *in vitro* fertilization method and the modified *in vitro* fertilization method because the surrogate contract is between strangers. See *infra* text accompanying notes 249-50.

246. 202 Cal. 778, 262 P. 742 (1927). The agreement was a formal written agreement between the husband, wife, and Tiffany jewelry store whereby the husband agreed to pay if the wife defaulted and the wife agreed to give up custody of the child if she defaulted. The contract between the husband and Tiffany was unenforceable because Tiffany gave no consideration, but the custody agreement between the husband and the wife was enforceable.

247. *Id.* at 791, 262 P. at 747. See also *Bassett v. American Baptist Publication Soc'y*, 215 Mich. 126, 183 N.W. 747 (1921) (upholding a custody contract between unrelated persons).

248. See *supra* notes 173-74 and accompanying text.

249. See *supra* notes 174-75 and accompanying text.

cal parents and a stranger; therefore, the contract is not an agreement between family members as in *Shirk* and *Tiffany*. The biological parents, however, are the ones getting custody of the child. Arguably, because biological parents were a part of the agreement and they receive custody of the child, the parties meet both requirements of *Shirk* and *Tiffany*. The *Shirk* and *Tiffany* line of cases would not apply to a surrogate/custody agreement involving the modified *in vitro* fertilization<sup>250</sup> method because none of the contracting parties is biologically related to the child. Public policy may prohibit such an agreement simply because the situation appears to be pure child bartering.

### E. CRIMINAL LIABILITY

Not only may state statutes or public policies render the surrogate parenting contract unenforceable, statutes also may create criminal liability for some or all of the parties involved in the surrogate parenting situation. Every state has legislation that makes baby-selling a crime.<sup>251</sup> As a result, each party to the surrogate parenting arrangement—the surrogate mother, the adopting couple, the placement agency, the doctor, and the attorney—may be criminally liable for his or her actions.<sup>252</sup>

#### 1. Surrogate Mother

Many state statutes prohibiting the payment or receipt of money in exchange for giving a child over for adoption or in exchange for placing a child also impose criminal penalties for violation of the statutes.<sup>253</sup> The statutes usually classify the above ac-

250. See *supra* text accompanying note 177.

251. See Pierce, *Survey of State Activity Regarding Surrogate Motherhood*, 11 FAM. L. REP. 3001 (Jan. 29, 1985). See *infra* notes 253-55, 258-64 and accompanying text.

252. Handel, *Surrogate Parenting, In Vitro Insemination and Embryo Transplantation*, 6 WHITTIER L. REV. 783, 784 (1984). ("If a court holds that we are buying somebody in this process, we are guilty of a felony. Of course, if we are planning any of these 'crimes,'—all of us, doctors, lawyers, psychologists, surrogates, couples, are all talking about and planning it, before it occurs . . . we are looking at 26 years in jail").

253. See, e.g., ARIZ. REV. STAT. ANN. §§ 8-114, 8-128 (Supp. 1985); CAL. PENAL CODE § 273 (a) (West 1970); COLO. REV. STAT. § 19-4-115 (2) (1978); FLA. STAT. ANN. § 63.212 (6) (West 1985); GA. CODE ANN. § 74-418(c) (Harrison Supp. 1984); IDAHO CODE § 18-1511 (1979); ILL. ANN. STAT. ch. 40, § 1705 (Smith-Hurd 1980); IND. CODE ANN. § 35-46-1-9(a) (Burns 1985); MD. FAM. LAW CODE ANN. § 5-327 (d) (1984); MASS. GEN. LAWS ANN. ch. 210, § 11A (West Supp. 1985); OKLA. STAT. ANN. tit. 21, § 867 (West Supp. 1985); S.D. CODIFIED LAWS ANN. § 25-6-4.2 (1984); TENN. CODE ANN. § 36-1-135(b) (1984); TEX. PENAL CODE ANN. § 25.06(c) (Vernon Supp. 1986); UTAH CODE ANN. § 76-7-203 (1978); WASH. REV. CODE ANN. § 26.33.370(3) (1982); WIS. STAT. ANN. § 946.716(1) (West 1982).



tivities as felonies,<sup>254</sup> but many states classify the activities as misdemeanors.<sup>255</sup> If a court determines that the state's criminal statutes apply to the surrogate parenting arrangement,<sup>256</sup> and that the surrogate mother violated the statutes either by accepting a fee for her services or by aiding the placement process, she will be subject to fines and possible imprisonment. Whether the state actually prosecutes a surrogate mother for violation of the criminal statutes will depend on the state attorney general's disposition toward surrogate parenting.<sup>257</sup>

## 2. Adopting Couple

Many of the same criminal statutes that prohibit receipt of money for a child also prohibit payment of money for a child.<sup>258</sup> An adopting couple, therefore, could be subject to criminal penalties for paying the surrogate mother. Many state statutes also prohibit payments to placement agencies for their help in procuring a child.<sup>259</sup> States usually classify violations of these statutes as misdemeanors rather than felonies.<sup>260</sup> If the state prosecutes the couple and a state court finds that they violated any of these statutes, they will be subject to a fine and possibly imprisonment.

## 3. Placement Agencies and Attorneys

Most states have statutes prohibiting an agency or an attorney from receiving a fee<sup>261</sup> or from receiving an unreasonable fee<sup>262</sup> for placing a child with a couple. Other states have statutes prohibiting an unlicensed agency or person from placing a child.<sup>263</sup> Assum-

254. See ARIZ. STAT. ANN. § 8-128 (Supp. 1985); FLA. STAT. ANN. § 63.212(6) (West 1985); GA. CODE ANN. § 74-418(c) (Harrison Supp. 1984); IDAHO CODE § 18-1511 (1979); IND. CODE ANN. § 35-46-1-9 (Burns 1985); MASS. GEN. LAWS ANN. ch. 210, § 11A (West Supp. 1985); OKLA. STAT. ANN. tit. 21, § 867 (West Supp. 1985); S.D. CODIFIED LAWS ANN. § 25-6-4.1 (1984); UTAH CODE ANN. § 76-7-203 (1978); WIS. STAT. ANN. § 946.716(1) (West 1982).

255. See, e.g. CAL. PENAL CODE § 273(a) (West 1970); COLO. REV. STAT. § 19-4-115(2) (1978); ILL. ANN. STAT. ch. 40, § 1705 (Smith-Hurd 1980) (first violation is a misdemeanor, second violation is a felony); MD. FAM. LAW CODE ANN. § 5-327(d) (1984); WASH. REV. CODE ANN. § 26.33.370(3) (1982).

256. See *supra* text accompanying notes 183-203.

257. See *supra* note 233 for several state Attorney General opinions on surrogate parenting.

258. See *supra* note 189.

259. See *supra* note 190.

260. Compare note 254 with note 255.

261. See *supra* note 190.

262. See *supra* note 190.

263. See *supra* note 191. Other statutes also prohibit advertising by placement agencies. See *supra* note 192.

ing these types of statutes apply, the surrogate parenting situation probably violates the statutes. The possible criminal penalties that courts could impose for violation of these statutes includes fines and imprisonment.<sup>264</sup> In *Kentucky ex rel. Armstrong v. Surrogate Parenting Associates, Inc.*,<sup>265</sup> a Kentucky court of appeals held that the state's adoption statutes applied to activities of the Surrogate Parenting Associates, activities that included placing the children and preparing the documents for the surrogate mother and adoptive couple.<sup>266</sup> Because this action was not criminal, however, Surrogate Parenting Associates did not have to pay a fine.<sup>267</sup>

#### F. CONSTITUTIONALITY OF STATE STATUTES AND PUBLIC POLICIES RENDERING SURROGATE PARENTING CONTRACTS UNENFORCEABLE

Although state courts have the power to interpret and apply state statutes or pronounce public policy to render a surrogate parenting contract void and unenforceable, the statutes or public policy may be unconstitutional. A party seeking to enforce the surrogate parenting contract may challenge the constitutionality of the applicable state statutes and public policies.<sup>268</sup> Substantive due process and equal protection are the two constitutional rights at issue in the surrogate parenting arrangement.

##### 1. *Substantive Due Process*

The fourteenth amendment<sup>269</sup> to the United States Constitution provides that a state may not deprive an individual of his or her rights unless the state's interest is substantial enough to outweigh the individual's right. A state statute or public policy that prohibits a married couple from procreating in whatever means they desire, or that prohibits a single or married woman from having a child for another couple, may violate the substantive due process rights of the married couple and the surrogate mother by interfering with their right to procreate and right to privacy. For

264. See, e.g., ALA. CODE § 26-10-9 (Supp. 1985); CAL. CIV. CODE §§ 224p-224q (West 1982); CONN. GEN. STAT. ANN. § 17-52 (West 1975); N.H. REV. STAT. ANN. § 170-E:19 (Supp. 1985); R.I. GEN. LAWS 15-7-1(b) (Supp. 1982); see also *supra* notes 254-55.

265. 11 FAM. L. REP. (BNA) 1359 (Ky. Ct. App. Apr. 26, 1985).

266. *Id.* at 1359.

267. See *id.* at 1359-60.

268. An attorney representing parties to a surrogate parenting agreement lacks standing to challenge the constitutionality of state statutes prohibiting surrogate parenting. See *Sherwyn & Handel v. California State Dep't of Social Serv.*, 12 FAM. L. REP. (BNA) 1010 (Cal. Ct. App. 2d Dist. Oct. 9, 1985).

269. U.S. CONST. amend. XIV, § 1.

example, a state statute or public policy that prohibits a couple from paying for the services of a surrogate mother has the effect of prohibiting the couple from procreating by means of a surrogate mother. Arguably, a statute or public policy prohibiting a surrogate mother from receiving payment for her services effectively abridges her right to procreate in the manner she chooses.<sup>270</sup> This prohibition also may interfere with the couple's right to privacy in family matters. At least one court,<sup>271</sup> however, has held that the right to privacy was not involved in the surrogate parenting situation.<sup>272</sup>

Because the right to privacy<sup>273</sup> and the right to procreate<sup>274</sup> are fundamental rights, a state attempting to interfere with these rights must meet a two-pronged strict scrutiny test<sup>275</sup> in order for the regulation to be constitutional.<sup>276</sup> In *Carey v. Population Services International*,<sup>277</sup> the Supreme Court summarized the two-prong test as follows: "[W]here a decision as fundamental as that whether to bear or beget a child is involved, regulations imposing a burden on it may be justified only by compelling state interests, and must be narrowly drawn to express only those interests."<sup>278</sup>

#### (a) Compelling State Interest

In the surrogate parenting situation, states rarely possess a compelling interest sufficient to meet the first prong of the strict scrutiny test.<sup>279</sup> The states generally have two interests for enacting statutes regulating surrogate parenting. First, states are interested in preventing child bartering. Clearly, the statutes further

270. Concededly, a surrogate mother could agree to carry the child without receiving compensation. This, however, may discourage a woman from ever agreeing to serve as a surrogate mother.

271. *Doe v. Kelley*, 106 Mich. App. 169, 307 N.W.2d 438 (1981), *cert. denied*, 459 U.S. 1183 (1983). See *supra* note 223 for a discussion of the case.

272. *Id.* at 173-74, 307 N.W.2d at 441.

273. See *Carey v. Population Serv. Int'l*, 431 U.S. 678 (1977); *Roe v. Wade*, 410 U.S. 113 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

274. See *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977); *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

275. The two prongs are (1) that the state have a compelling interest in regulating the activity, and (2) that the state regulation be narrowly drawn to further only the compelling interest. *Carey v. Population Services Internat'l*, 431 U.S. 678, 686 (1977).

276. *But see Doe v. Commonwealth's Attorney*, 425 U.S. 901 (1976) (refusing to review a federal district court's holding that a law prohibiting homosexual conduct was constitutional).

277. 431 U.S. 678 (1977).

278. *Id.* at 686.

279. See *supra* note 275 for a statement of the first prong.

this interest when they are applied to black market adoptions. The Supreme Court has held that the state's interest in promoting the best interests of the child is compelling.<sup>280</sup> The states designed the statutes to prevent a pregnant mother from being pressured into doing something she really does not want to do. The state interest in preventing child bartering arguably does not exist in the surrogate situation. When the surrogate mother signs the surrogate parenting contract she is agreeing to become pregnant and is not being coerced into giving up her baby by an unplanned situation. The states also designed the statutes to prevent black market agencies from profiting by the misfortune of infertile couples and young pregnant girls. Concededly, a surrogate parenting agency may derive financial gain from the misfortune of the infertile couple.<sup>281</sup> The agency, however, is not dealing with naive girls, but with informed women who are voluntary participants. Accordingly, a state's interest in preventing child bartering may qualify as a compelling interest in the context of black market adoptions, but not in the context of surrogate parenting. A Michigan circuit court held that the state's interest in preventing baby bartering would be compelling if the right to privacy were involved in the surrogate parenting situations,<sup>282</sup> but the Michigan Court of Appeals did not address the issue when it affirmed the holding of the circuit court.<sup>283</sup>

Second, states are interested, when enacting statutes prohibiting surrogate parenting, in promoting the best interests of the child. In *Prince v. Massachusetts*,<sup>284</sup> the Supreme Court held that the state could regulate activities of the family if the regulations furthered the child's best interest.<sup>285</sup> Arguably, regulations prohibiting surrogate parenting actually may frustrate, rather than further, the best interests of a child. The surrogate parenting arrangement promotes a child's interests because the child is conceived

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280. See *Prince v. Massachusetts*, 321 U.S. 158 (1944) (holding that Massachusetts could limit the parents' privacy right in raising their children when the regulation furthered the best interest of the child).

281. One owner of a surrogate agency estimated in 1984 that the agency charged the adopting parents from \$18,000 to \$22,000. Lawyers and doctors took approximately \$12,000-\$16,000 and the agency kept the remaining \$6,000. Thompson, *Bill Seeks to Clarify Limbo of Surrogate Births*, Wash. Post, Mar. 19, 1984, at B7, col. 4.

282. *Doe v. Kelley*, 6 FAM. L. REP. (BNA) 3011, 3013-14 (Feb. 19, 1980), *aff'd* 106 Mich. App. 169, 307 N.W.2d 438 (1981), *cert. denied*, 459 U.S. 1183 (1983).

283. 106 Mich. App. 169, 174 307 N.W.2d 438, 441 (1981), *cert. denied*, 459 U.S. 1183 (1983).

284. 321 U.S. 158 (1944).

285. *Id.* at 166-67.

and carried in order to live with a family that anxiously has awaited his or her arrival and has made preparations for his or her care.<sup>286</sup> Furthermore, if states prohibit the surrogate parenting process, the result is that the child never will be created. Arguably, one's interests are furthered by being created rather than never existing.

In conclusion, states prohibiting surrogate parenting should not be able to satisfy the first prong of the strict scrutiny test by demonstrating that their statutes further a compelling interest. The state interest in preventing child bartering is not a problem and, thus, not compelling in the surrogate parenting process. The state interest in promoting the child's best interests actually is furthered by the surrogate parenting process. Having failed to meet the first prong of the strict scrutiny test, statutes and policies prohibiting surrogate parenting should be held unconstitutional for violating substantive due process.

#### (b) Narrowly Drawn Regulation

Assuming that the prevention of child bartering and furthering the child's best interests are compelling state interests, the state still must pass the second prong of the strict scrutiny test. The state must show that its statutes are drawn narrowly to effectuate only the state's compelling interests. If a state passes a statute clearly applicable to the surrogate parenting process, such as that of Arkansas,<sup>287</sup> the state would have to show that the statute was narrowly drawn to further the interests of preventing child bartering and promoting the child's best interests. This showing will be difficult given the current state of confusion about whether existing statutes are applicable to the surrogate parenting process.<sup>288</sup>

### 2. *Equal Protection*

The equal protection clause of the fourteenth amendment guarantees that no state will deny any person "the equal protection of the laws."<sup>289</sup> Arguably, a state is treating the surrogate mother unequally if it prohibits her from receiving payment for

286. See *supra* note 228; see also *A Surrogate's Story of Loving and Losing*, U.S. NEWS & WORLD REP., June 6, 1983, at 77.

287. See *supra* notes 183-84 and accompanying text.

288. See text accompanying notes 183-209.

289. U.S. CONST. amend. XIV, § 1.

her services as a surrogate mother but allows a man to receive payment for sperm donations. The unfairness of this unequal treatment is exacerbated because the medical risks and legal involvement of the surrogate mother are much greater than those of the sperm donor.<sup>290</sup> No state has a statute prohibiting payments to men for sperm donations,<sup>291</sup> but many states prohibit a woman who gives birth to a child from receiving payment for terminating her parental rights in favor of the biological father and adoptive mother.<sup>292</sup> This gender-based distinction or unequal treatment of privacy and procreation rights may be unconstitutional.

In *Skinner v. Oklahoma*,<sup>293</sup> the Supreme Court held for the first time that a state must justify its unequal treatment of various individuals' right to procreate by showing a compelling state interest. *Skinner* thus applied a strict scrutiny test to unequal treatment of the right to procreate.<sup>294</sup> In *Caban v. Mohammed*,<sup>295</sup> however, the Court applied a heightened scrutiny test. Unequal treatment based on gender must serve important governmental objectives and be substantially related to achievement of those objectives to withstand a constitutional challenge under the equal protection clause.<sup>296</sup> In *Frontiero v. Richardson*,<sup>297</sup> another case involving a gender-based distinction, a plurality of the Court applied the *Skinner* strict scrutiny test rather than the *Caban* heightened scrutiny test.

Unquestionably, if a case concerns the unequal treatment of procreation or privacy rights, the two-pronged strict scrutiny test

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290. S. GREEN & J. LONG, *supra* note 168, at 251 (citing Handel & Sherwyn, *Surrogate Parenting: Coming to Grips with the Future*, TRIAL Apr. 1982, at 58).

291. In 1984, the average semen donor received \$20 to \$35 per ejaculation. GREEN & LONG *supra* note 168, 253 (citing Curie-Cohen, Luttrell & Shapiro, *Current Practice of Artificial Insemination by Donor in the United States*, 300 NEW ENG. J. MED. 585, 587 (1979)).

292. See *supra* notes 193 & 197 and accompanying text.

293. 316 U.S. 535 (1942) (holding unconstitutional as a violation of equal protection an Oklahoma statute that provided for sterilization of "habitual criminals" who committed "felonies involving moral turpitude," but excepted certain felonies such as embezzlement).

294. 316 U.S. at 541.

295. 441 U.S. 380 (1979) (holding, under the heightened scrutiny test, that a New York statute that treated an unmarried man unequally by allowing an unmarried woman to block the adoption of her child while not allowing the unmarried man to do the same was unconstitutional as a violation of the equal protection clause).

296. *Id.* at 388.

297. 411 U.S. 677 (1973) (holding unconstitutional, under the equal protection clause, United States statutes treating female members unequally in comparison to male members of the uniformed services by creating a presumption that spouses of male members were "dependent" and that spouses of female members were not "dependent").

applies.<sup>298</sup> However, whether the strict scrutiny test of *Skinner* or the heightened scrutiny test of *Caban* applies to a case concerning gender-based unequal treatment of women remains uncertain. The two state interests advanced by unequal treatment of the surrogate mother and a sperm donor are the state's interest in preventing baby bartering and in promoting the best interests of the child.

If the heightened scrutiny test is applied, a state that has unequal treatment might be able to satisfy the test's requirements. The courts would value highly the state's interests in preventing baby bartering and promoting the best interests of the child. The state's interest, therefore, would meet the "important governmental objective" standard. The state's unequal treatment probably is "substantially related" to achievement of those objectives because a man's selling of his semen cannot result in child bartering, while the surrogate mother's selling of her egg and renting of her womb could result in child bartering.

If the strict scrutiny test applies, courts should use the same analysis discussed in the substantive due process subsection of this Section.<sup>299</sup> The state probably would meet the first prong of this test, even in the surrogate situation, because the state's interest in preventing baby bartering is compelling. The state then would have to show that its statute was drawn narrowly to accomplish only the compelling state interests of preventing baby bartering and promoting the best interests of the child.

#### G. REMEDIES FOR BREACH OF A SURROGATE PARENTING CONTRACT IF THE CONTRACT IS ENFORCEABLE

If a surrogate parenting contract is enforceable because the state statutes do not apply to prohibit surrogate parenting or because the state statutes that do prohibit surrogate parenting are unconstitutional, the parties may have various remedies for breach of the agreement.<sup>300</sup> This section assumes that a baby was born, but one of the parties to the surrogate parenting agreement decides not to comply with the terms of the agreement. The surrogate mother may try to keep the child or the adoptive parents may refuse to accept the child.

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298. Other members of the Court applied the "heightened scrutiny" standard. *Id.* 691-92.

299. See *supra* note 176.

300. See *supra* notes 269-288 and accompanying text.

### 1. *Specific Performance*

A party to a surrogate parenting agreement could require specific performance if a state statute expressly recognizes the propriety of this agreement. Under Arkansas law,<sup>301</sup> a surrogate mother or the adoptive couple could require specific performance of the contract if the surrogate mother was unmarried. The Arkansas statute provides that when the surrogate mother is unmarried the child belongs to the adoptive mother.<sup>302</sup> Because, however, the vast majority of states do not have surrogate parenting legislation, specific performance probably would not be available regardless of whether or not the surrogate mother was married.

Alternatively, a party to a surrogate parenting contract could attempt to require specific performance by relying on general contract theory. Courts require specific performance when the object contracted for is unique and no value has been placed on the object.<sup>303</sup> One could argue that few objects of an agreement could be more unique than a child. Courts, however, do not require specific performance when an agreement is a personal service contract.<sup>304</sup> If courts accept the contention that a surrogate parenting agreement provides a fee for the surrogate mother's service of carrying the child to term,<sup>305</sup> then courts likely would characterize the agreement as a personal service contract not subject to specific performance.

Regardless of the theory the litigants rely on, a court is unlikely to require specific performance for a surrogate parenting agreement. This is particularly true if the surrogate mother is seeking specific performance. Requiring a couple to take custody of an unwanted child would not further the child's best interests. Of course, a court's refusal to order specific performance in such a case effectively would require the surrogate mother, who never intended to keep the child, to maintain custody of a similarly "unwanted" child, at least until she could put the infant up for adoption. A court may be more likely to require specific performance

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301. If the child dies before birth, both the surrogate mother and the adopting couple might have a wrongful death cause of action. S. GREEN & J. LONG, *supra* note 168, at 258 (citing Dodd, *The Surrogate Mother Contract in Indiana*, 15 IND. L. REV. 807, 821 (1932)); see generally *infra* section IX of this Special Project.

302. See *supra* notes 185-86.

303. See *supra* note 185.

304. 11 S. WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 1418, at 644-46 (3d ed. 1968).

305. See 5A A. CORBIN, CORBIN ON CONTRACTS § 1204 (1964).



when the adoptive parents are suing for breach of the surrogate parenting agreement. In this instance, the court might conclude that the surrogate parenting arrangement constituted abandonment by the surrogate mother<sup>306</sup> and require specific performance on the rationale that the surrogate mother has no right to the child. Regardless of the final result, a suit for specific performance would be a tragic experience for all parties to the surrogate parenting agreement.<sup>307</sup>

## 2. Compensatory Damages

If the surrogate mother is the breaching party, most courts probably would require her to return all fees paid to her by the adopting couple. The court is unlikely to award any further damages to the couple based on emotional harm because of the speculative nature of the damages.<sup>308</sup> Although the surrogate mother breaches the agreement, she may be able to obtain child support from the biological couple if she can prove paternity. In most states the biological father has a duty to support his child.<sup>309</sup> The adopting couple, therefore, is ultimately in a losing position when the surrogate mother breaches the contract: they do not get the child and they may have to pay child support.

Under general contract principles, if the adopting couple is the breaching party, the surrogate mother has a duty to mitigate damages.<sup>310</sup> The surrogate mother would be able to recover her medical

306. See *supra* note 229.

307. See Coleman, *Surrogate Motherhood: Analysis of the Problems and Suggestions for Solutions*, 50 TENN. L. REV. 71, 97-100 (1982).

308. In the Stiver-Malahoff incident, a widely publicized surrogate parenting arrangement, the baby was born with microcephaly. Malahoff, the man who had contracted for the child, told the hospital to withhold treatment from the child. Later blood tests revealed that the child was not Malahoff's but the child of the surrogate Judy Stiver's husband. As a result of the incident, Malahoff has sued the surrogate mother Stiver for not producing the child he ordered. The Stivers have sued doctors, lawyers, and psychiatrists for not advising them about the timing of sex. Andrews, *supra* note 176, at 796-97; see generally *infra* section X of this Special Project.

309. See generally 11 S. WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 1341, at 214-223, § 1345, at 231-34 (3d ed. 1968).

310. See, e.g., ARIZ. REV. STAT. ANN. § 8-601 (Supp. 1985); ARK. STAT. ANN. § 34-716 (Supp. 1985); CAL. CIV. CODE §§ 196-196a (West 1982); COLO. REV. STAT. § 19-7-101 (1978); DEL. CODE ANN. tit. 13, § 1305 (1981) (indicating father must pay support to the state if the state takes care of child); GA. CODE ANN. §§ 74-202, 74-312 (Harrison Supp. 1984); ILL. ANN. STAT. ch. 40, §§ 2514 (Smith-Hurd Supp. 1985); MD. FAM. LAW CODE ANN. § 5-1032 (1984); N.M. STAT. ANN. § 40-5-1 (1983); OHIO REV. CODE ANN. § 3109.05(H) (Page Supp. 1984); OKLA. STAT. ANN. tit. 10, § 83 (West Supp. 1985); OR. REV. STAT. §§ 109.0101-109.015 (1983); S.C. CODE ANN. § 20-7-957 (Law. Co-op 1985); S.D. CODIFIED LAWS ANN. §§ 25-7-7, 25-8-5

expenses, legal expenses, and possibly the fee promised to her by the couple.<sup>311</sup> She also would be able to recover child support.<sup>312</sup> The requirement of mitigation, however, may demand that she give the child up for adoption or give the child to the state for state care<sup>313</sup> rather than keep the child and receive child support from the biological father.

#### H. ACQUIRING RELIEF EXCLUSIVE OF THE SURROGATE PARENTING AGREEMENT IF THE CONTRACT IS UNENFORCEABLE

Assuming, on the other hand, that the contract is unenforceable and that the statutes and public policy rendering the contract unenforceable are constitutional, one must determine whether there are any means by which the surrogate mother or biological father can receive child support or child custody.<sup>314</sup> Under the artificial insemination method<sup>315</sup> and the *in vitro* fertilization method,<sup>316</sup> relief exclusive of the contract may be available<sup>317</sup> because under these methods the adoptive father is the biological father. Relief in the form of child support probably is not available under the modified *in vitro* fertilization method<sup>318</sup> because the adoptive father has no biological relationship to the child.

##### 1. Surrogate Mother's Recovery

If the surrogate mother is the party trying to recover for breach of the agreement, she probably will be able to recover child support from the biological father if she keeps the child. In addition, she most likely will be able to get medical and confinement expenses from the biological father.<sup>319</sup> This relief is exclusive of the

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(1984 & Supp. 1985); TENN. CODE ANN. §§ 36-2-102, 36-2-108 (1984 & Supp. 1985); UTAH CODE ANN. § 78-45a-1 (1977); W. VA. CODE §§ 48-7-3 to -4 (Supp. 1985); WIS. STAT. ANN. § 767.25 (West 1981 & Supp. 1985); WYO. STAT. §§ 14-2-115, 14-2-204 (1978). *See also* OR. REV. STAT. § 109.230 (1983) (stating that a contract between a mother and father of a child born out of wedlock is a legal contract).

311. *See* S. WILLISTON, *supra* note 309, § 1353, at 274-79.

312. *See supra* notes 191 & 329.

313. *See supra* note 310 and accompanying text.

314. The state may be able to get child support from the biological father. *See supra* note 310.

315. The adopting couple could have an action in tort for intentional infliction of emotional distress because the surrogate mother knows a breach of the contract will result in emotional distress to the couple.

316. *See supra* notes 172-73 and accompanying text.

317. *See supra* notes 174-75 and accompanying text.

318. *See supra* notes 320-41 and accompanying text.

319. *See supra* note 176 and accompanying text.

contract. Before the surrogate mother can recover child support, medical expenses, and confinement expenses, however, she must prove that the contracting father is the biological father of the child.<sup>320</sup> In states that have adopted the Uniform Parentage Act (UPA),<sup>321</sup> a married surrogate mother would have to overcome a presumption that the child is her husband's child.<sup>322</sup> Most states allow the mother to admit the Human Leucocyte Antigen (HLA) blood test, which almost is conclusive evidence of paternity.<sup>323</sup>

320. Some state statutes specifically state that the father must pay medical and confinement expenses. *See, e.g.*, OKLA. STAT. ANN. tit. 10, § 84 (West 1966); S.D. CODIFIED LAWS ANN. § 25-8-3 (1984); TENN. CODE ANN. § 36-2-102 (1984); UTAH CODE ANN. § 78-45a-1 (1977).

321. *See supra* notes 310 & 320.

322. 9A U.L.A. 579 (1979 & Supp. 1985). States adopting the UPA include: Alabama, California, Colorado, Delaware, Hawaii, Illinois, Minnesota, Montana, Nevada, New Jersey, North Dakota, Ohio, Rhode Island, Washington, and Wyoming. *Id.* at Supp. 329. Delaware, Hawaii, North Dakota, and Ohio adopted most of the UPA, but did not adopt § 5.

Section 5 provides:

(a) If, under the supervision of a licensed physician and with the consent of her husband, a wife is inseminated artificially with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of a child thereby conceived. The husband's consent must be in writing and signed by him and his wife. The physician shall certify their signatures and the date of the insemination, and file the husband's consent with the [State Department of Health], where it shall be kept confidential and in a sealed file. However, the physician's failure to do so does not affect the father and child relationship. All papers and records pertaining to the insemination, whether part of the permanent record of a court or of a file held by the supervising physician or elsewhere, are subject to inspection only upon an order of the court for good cause shown.

(b) The donor of semen provided to a licensed physician for use in artificial insemination of a married woman other than the donor's wife is treated in law as if he were not the natural father of a child thereby conceived.

9A U.L.A. at 592-93.

323. *Id.* § 5(a), at 592. UPA state sections include: ALA. CODE § 26-17-21(a) (Supp. 1985); CAL. CIV. CODE § 7005(a) (West 1983); COLO. REV. STAT. § 19-6-106(1) (1978); ILL. ANN. STAT. ch. 40, § 1453(a) (Smith-Hurd Supp. 1985); MINN. STAT. ANN. § 257.56(1) (West 1982); MONT. CODE ANN. § 40-6-106(1) (1985); NEV. REV. STAT. § 126.061(1) (1983); N.J. STAT. ANN. § 9:17-44(a) (West Supp. 1985); WASH. REV. CODE ANN. § 26.050 (Supp. 1986); WYO. STAT. § 14-2-102(a) (1978). Other states also have the same provision or provisions creating a presumption of legitimacy. *See, e.g.*, ALASKA STAT. § 25.20.045 (1983); ARIZ. REV. STAT. ANN. § 8-601 (Supp. 1985); ARK. STAT. ANN. § 34-720 (Supp. 1985); CONN. GEN. STAT. ANN. § 45-96i (West 1981); FLA. STAT. ANN. § 742.11 (West Supp. 1985); GA. CODE ANN. § 74-101.1 (Harrison Supp. 1984); HAWAII REV. STAT. § 584-4(a)(1) (1976); IDAHO CODE § 39-5405(3) (1985); IND. CODE ANN. § 31-6-6.1-9(1) (Burns 1980); KAN. STAT. ANN. § 23-129 (1981); LA. CIV. CODE ANN. art. 188 (West Supp. 1986); MD. EST. & TRUSTS CODE ANN. § 1-206 (1974); MD. FAM. LAW CODE ANN. § 5-1028(c) (1984); MASS. GEN. LAWS ANN. ch. 46, § 4B (West Supp. 1985); MICH. COMP. LAWS ANN. §§ 333.2824(6), 700.111(2)-(3) (West 1980); N.Y. DOM. REL. LAW § 73 (McKinney 1977); N.C. GEN. STAT. § 49A-1 (1984); N.D. CENT. CODE § 14-09-01 (1981); OKLA. STAT. ANN. tit. 10, § 552 (West Supp. 1985); OR. REV. STAT. § 109.070(1) (1983); S.D. CODIFIED LAWS ANN. § 25-5-1 (1984); TRNN. CODE ANN. § 68-3-306 (1983); TEX. FAM. CODE ANN. § 12.03 (Vernon 1975); VA. CODE § 64.1-7.1 (1980); WIS. STAT. ANN. § 891.40(1) (West Supp.

Under the UPA<sup>324</sup> and other state statutes<sup>325</sup> a married or unmarried surrogate also would have to prove that statutes stating that a sperm donor has no duty to a child conceived through artificial insemination do not apply to surrogate parenting arrangements. Once the surrogate mother establishes paternity,<sup>326</sup> most states statutorily require the father to pay child support.<sup>327</sup> Some states also specifically require the biological father to pay for the mother's medical, hospital, and confinement expenses.<sup>328</sup>

## 2. Biological Father's Recovery

If the biological father is the party trying to enforce the surrogate parenting contract, he may be able to get child custody exclusive of the contract. To get custody, he must prove that he is the biological father.<sup>329</sup> In many states, however, the biological father may not have standing to sue to establish his paternity of the child unless he is married.<sup>330</sup> Denying unmarried sperm donors standing to sue to establish paternity, while granting married donors the

1985); WYO. STAT. § 20-2-117 (1977).

324. The Human Leucocyte Antigen (HLA) test is accurate more than ninety percent of the time. Herzog, *The HLA Test: New Method for Resolving Disputed Paternity Cases*, N.Y. Sr. B.J., May 1983, at 34.

325. See *supra* note 150, § 5(b), at 593. UPA state sections include: ALA. CODE § 26-17-21(b) (Supp. 1985); CAL. CIV. CODE § 7005(b) (West 1983); COLO. REV. STAT. § 19-6-106(2) (1978); ILL. ANN. STAT. ch. 40, § 1453(b) (Smith-Hurd Supp. 1985); MINN. STAT. ANN. § 257.56(2) (West 1982); MONT. CODE ANN. § 40-6-106(2) (1985); NEV. REV. STAT. § 126.061 (2) (1983); N.J. STAT. ANN. § 9:17-44(b) (West Supp. 1985); WASH. REV. CODE ANN. § 26.26.050 (Supp. 1986); WYO. STAT. § 14-2-103(b) (1978).

326. See, e.g., CONN. GEN. STAT. ANN. § 45-69j (West 1981); IDAHO CODE § 39-5405(1)-(2) (1985); ILL. ANN. STAT. ch. 40, § 1452(b) (Smith-Hurd Supp. 1985); OR. REV. STAT. § 109.239 (1983); TEX. FAM. CODE ANN. § 12.03(b) (Vernon 1975); WIS. STAT. ANN. § 891.40(2) (West Supp. 1985).

327. See *supra* note 310.

328. See *supra* note 320.

329. One commentator has argued that, as a practical matter, if threatened with a lawsuit, the surrogate mother may relinquish her rights to the child under duress, knowing that she cannot afford to defend a custody suit. Cohen, *Surrogate Mothers: Whose Baby Is It?*, 10 AM. J.L. & MED. 243, 246 (1984).

330. See, e.g., MISS. CODE ANN. § 93-9-9 (Supp. 1985); NEB. REV. STAT. § 43-1411 (1984); N.D. CENT. CODE § 14-09-03 (1981); OKLA. STAT. ANN. tit. 10, §§ 3, 70 (West Supp. 1985); S.D. CODIFIED LAWS ANN. § 25-5-4 (1984); TENN. CODE ANN. § 36-2-103 (Supp. 1985); see also notes 151B & 152. *But see*, e.g., ARK. STAT. ANN. § 34-716 (Supp. 1985); GA. CODE ANN. § 74-103 (Harrison Supp. 1984); IND. CODE ANN. § 31-6-6.1-2(a)(2) (Burns Supp. 1985); MD. FAM. LAW CODE ANN. § 5-310(a)(6) (1984); MICH. COMP. LAWS ANN. § 722.714(f) (West Supp. 1985); NEV. REV. STAT. § 126.071 (1983); N.H. REV. STAT. ANN. § 460.29 (1983); N.C. GEN. STAT. § 49-14 (Supp. 1985); OR. REV. STAT. § 109.125 (1983); TEX. FAM. CODE ANN. § 11.03(a)(7) (Vernon Supp. 1986); WIS. STAT. ANN. § 767.45 (1)(d) (West 1981 & Supp. 1985-1986).

necessary standing to sue to establish paternity may be unconstitutional unequal treatment.<sup>331</sup>

In *Syrkowski v. Appleyard*,<sup>332</sup> the Michigan Supreme Court held that the biological father could use state paternity statutes to prove his paternity of a child conceived through a surrogate mother.<sup>333</sup> In other states, the biological father has standing to sue, but if the surrogate mother is married he must overcome a presumption that the child is the legitimate child of the married surrogate's husband.<sup>334</sup> Assuming the biological father has standing to sue to establish paternity, he can use the HLA test<sup>335</sup> to prove his paternity.

After proving his paternity, several states require a biological father to overcome a presumption that child custody should remain with the mother.<sup>336</sup> If he does not overcome this presumption, he will not receive custody of the child. In states that have adopted the UPA,<sup>337</sup> he may have no right to child custody because the UPA provides that a sperm donor has no interest in a child conceived through artificial insemination.<sup>338</sup> Such statutes may be unconstitutional as violations of the equal protection clause of the fourteenth amendment.<sup>339</sup> If the biological father successfully proves his paternity but is unable to overcome the presumption that child custody should remain with the surrogate mother, his paternity may subject him to liability for child support.<sup>340</sup> A biological father who cannot get child custody at least should be able

331. See Greenberg & Hirsh, *Surrogate Motherhood and Artificial Insemination: Contractual Implications*, 1983 MED. TRIAL TECH. Q. 149, 157 (stating that "[w]hile there may be legitimate state interests in maintaining the unity of the family, the failure to allow standing to an unmarried donor to adjudicate paternity where standing is allowed on the part of a husband may run afoul of the United States Supreme Court decisions . . . that have held that reproductive autonomy belongs to the individual and not to the family as a unit").

332. 420 Mich. 367, 362 N.W.2d 211 (1985).

333. *Id.* at 374-75, 362 N.W.2d at 214.

334. See *supra* note 323.

335. See *supra* note 333.

336. As a practical matter, the surrogate mother's chance of prevailing in a custody battle increases the longer the child stays with her after birth because of the child's increasingly dependent relationship with her. See *supra* note 3, at 258.

337. See *supra* note 322.

338. See *supra* notes 325; see also *supra* note 326 (listing non-UPA statutes).

339. It may be unconstitutional for the state to treat males unequally in comparison to women. See *Stanton v. Stanton*, 421 U.S. 7 (1975); *Craig v. Boren*, 429 U.S. 190 (1976); *Califano v. Goldfarb*, 430 U.S. 199 (1977).

340. See *supra* note 313.

to get visitation rights.<sup>341</sup>

### I. LEGISLATIVE REFORM

State legislatures generally have failed to address the unresolved legal problems<sup>342</sup> that have arisen as medical technological advances have made surrogate parenting an increasingly viable means of procreating. Children born through surrogate parenting are being born into a legal vacuum. The validity of such contracts and their legal consequences must be clarified. Surrogate parenting is not a fad that will be forgotten in a few years. Medical technology makes it possible for more and more couples each year to discover that they are unable to have children.<sup>343</sup> Not enough babies are available for adoption. As a result, thousands of couples each year are turning to surrogate parenting as a means of having children.

Either the states or the federal government must act in this area of legal and moral confusion. Adoption and custody typically have been governed by state statute, but federal legislation may be more desirable to achieve uniformity because most of the surrogate parenting cases reported have involved parties from different states.

### J. CONCLUSION

Because of the lack of surrogate parenting statutes and the uncertain applicability of existing statutes, the enforceability of a surrogate parenting agreement is unpredictable. The situation be-

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341. See, e.g., ARK. STAT. ANN. § 34-715 (Supp. 1985); ILL. ANN. STAT. ch.40, § 607 (Smith-Hurd Supp. 1985); OHIO REV. CODE ANN. § 3109.05(B) (Page Supp. 1984); WIS. STAT. ANN. § 767.245(1) (West 1981 & Supp. 1985); see also *C.M. v. C.C.*, 377 A.2d 821, (N.J. Cumberland Cty. Ct. 1977) (holding that a sperm donor had a right to visit the child conceived by his girlfriend through artificial insemination).

342. As of 1984, surveys of the National Committee For Adoption found legislative activity related to surrogate parenting in 21 states and the District of Columbia. Discussions in Alabama, D.C., Kentucky, and Oklahoma were centered on prohibiting surrogates. Missouri and Ohio had considered similar prohibition, but took a neutral stance. In 15 states, however, activity focused on allowing surrogate arrangements. These states included: Alaska, California, Connecticut, Hawaii, Illinois, Kansas, Maryland, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, South Carolina, and Virginia. The Committee concluded that Michigan is the only state with strong advocates, legislatively and otherwise, on both sides of the issue. See Pierce, *supra* note 169, at 3003.

343. In the United States one in six couples has difficulty conceiving or bearing a child. Approximately 27 percent of women between the ages 15 and 44 cannot have children. The sperm count of males has fallen more than 30 percent in 50 years. Approximately 25 percent of men are considered sterile. Wellborn, *Birth: To Couples That Could Never Be Parents, a Thousand Children Are Born*, U.S. NEWS & WORLD REP., Nov. 11, 1985, at 48.

comes even more complex when parties to the surrogate parenting agreement are from different states. Statutes and policies appear to regulate the contract, but a closer analysis reveals the suspect nature of their applicability. Even if applicable, existing statutes and policies may violate substantive due process and equal protection. How the courts characterize the surrogate parenting contract may affect its enforceability. Possible criminal liability or recovery upon breach are subject to ambiguity because of the unpredictable characterization and validity of the surrogate parenting arrangement.

The chaotic atmosphere of this particular method of parenting must be recognized and alleviated. Lawyers faced with these arrangements must be aware of the multifarious problems and alert their clients accordingly. Furthermore, judges must pay more attention to the need for predictability and stability. Finally, the legislature should act to fill this vast legal vacuum.

#### IV. Inheritance Implications of Artificial Reproduction Methods

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## A. INTRODUCTION

A tragic plane crash killed a husband and wife, both participants in the frozen embryo artificial reproduction program in Melbourne, Australia.<sup>344</sup> The couple's death left two frozen embryos in a social, ethical, and legal quagmire because neither of the parent's wills contained any reference to the embryos.<sup>345</sup> The tragedy tossed the husband's one million dollar estate into chaos.<sup>346</sup> The accident forced scholars, physicians, ethicists, and particularly lawyers to consider the inheritance rights of artificial reproduction products.<sup>347</sup> Although the new artificial reproduction technologies raise various legal,<sup>348</sup> social,<sup>349</sup> ethical,<sup>350</sup> and medical<sup>351</sup> issues, this Part addresses the question: "Who should inherit what from whom?"

Because natural, or coital, reproduction was the exclusive form of reproduction available for many centuries,<sup>352</sup> bodies of law have developed to control the inheritance rights of children born as a result of a man and woman engaging in sexual intercourse. Artificial reproduction, by contrast, has become an option made possible only fairly recently by advances in medical technology. As a result, bodies of law have not developed yet to control the inheritance rights of children born as a result of artificial, or noncoital, reproduction. Law, by nature, must lag behind technology because lawmakers cannot regulate a phenomenon until it is known to society. Once aware of the availability of a technology, however, society must regulate the use of these technologies. Lawmakers, therefore, must now determine the appropriate legal response to recent medi-

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344. Wallis, *Quickening Debate over Life on Ice*, TIME, July 2, 1984, at 68.

345. *Id.*

346. *Id.*

347. Georgetown law professor Alexander Morgan Capron states: "Many of the new reproductive possibilities remain so novel that terms are lacking to describe the human relationships they can create . . . I'm not even sure we know what to call the area under inquiry." Friedrich, *A Legal, Moral, Social Nightmare*, TIME, Sept. 10, 1984, at 54.

348. *E.g.*, *Legal Aspects of New Reproductive Technologies - A Panel Discussion*, 6 WHITTIER L. REV. 781-810 (1984).

349. *E.g.*, Wadlington, *Artificial Conception: The Challenge for Family Law*, 69 VA. L. REV. 465 (1983).

350. *E.g.*, Fleteher, *Moral Problems and Ethical Issues in Prospective Human Gene Therapy*, 69 VA. L. REV. 515 (1983). *See generally*, *Symposium on Biomedical Ethics*, 69 VA. L. REV. 405 (1983).

351. *E.g.*, *Human Gene Therapy - A Background Paper*, Office of Technology Assessment, U.S. Congress (1984).

352. For a more thorough discussion of natural reproduction, see *supra* notes 8-13 and accompanying text in section II of this Special Project.



cal advances in reproduction technologies, specifically addressing the issue of the inheritance rights of a child produced by artificial reproduction. A related issue is whether a couple or a single parent possesses a "right" under the United States Constitution to use the new techniques.<sup>353</sup> At least two attorneys practicing in the artificial reproduction field believe that the Constitution guarantees a fundamental right to procreate.<sup>354</sup> Several commentators,<sup>355</sup> relying on a fundamental right to procreate<sup>356</sup> or a fundamental right to privacy,<sup>357</sup> assert that potential parents may have a constitutional right to use the new reproduction technologies.<sup>358</sup> Even absent constitutional protection, "there is no way to return the genie to the bottle,"<sup>359</sup> and the use of the techniques is likely to continue growing. Given these prospects, the legal profession should encourage legislation addressing the novel issues presented, regardless of whether constitutional rights are implicated.

Section B of this Part analyzes the legal inheritance rights of children by examining the five types of possible parent-child relationships: legitimate, halfblood, adopted, foster and illegitimate. Section C scrutinizes the various artificial reproduction technologies in which third party donors may participate: artificial insemination, *in vitro* fertilization, *in vivo* fertilization, and surrogate motherhood. Following an explanation of the numerous possible artificial reproduction combinations and a probe of the reasons for using the various techniques, Section C raises and answers the question "Who should inherit what from whom?". Section C also establishes a framework for analyzing this question by considering the law's historic approach to child inheritance, the technologies of the reproduction alternatives, and public policy considerations.

353. See *infra* note 439.

354. Handel, *Surrogate Parenting, In Vitro Insemination and Embryo Transplantation*, 6 *WHITTIER L. REV.* 783, 788 (1984) (citing *Roe v. Wade*, 410 U.S. 113 (1973) and *Skinner v. Oklahoma*, 316 U.S. 535 (1942)). Handel states:

any laws which adversely affect surrogate parenting and in vitro fertilization are probably unconstitutional . . . [because] we believe that there is a fundamental right to procreate. If it happens that the couple does not have the normal means of conceiving and has to go to outside sources to do so, that does not diminish their rights. We believe the cases will go in our direction as the law is formulated in this field.

*Id.* at 788.

355. See *infra* note 439.

356. See *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

357. See *Roe v. Wade*, 410 U.S. 113 (1973).

358. See *infra* note 439.

359. L. ANDREWS, *supra* note 5, at 263 (paraphrasing John F. Kennedy).

Section D applies the analytical framework developed in Section C to the special inheritance problem posed by the storage of frozen embryos. Section E concludes by urging state legislatures to define clearly the inheritance rights of the participants in and products of artificial reproduction.

## B. CHILDREN AND INTESTATE INHERITANCE

If a person dies without a will,<sup>360</sup> state intestate succession laws govern the distribution of the estate among the decedent's heirs and relatives.<sup>361</sup> A child's legal relationship to the decedent dictates that child's inheritance rights under the intestate succession laws.<sup>362</sup> The following five categories constitute the possible classifications of the child's legal status under present law: legitimate, halfblood, adopted, foster and illegitimate.<sup>363</sup>

Legitimate children receive maximum protection under most intestate succession statutes.<sup>364</sup> The law classifies a legitimate child as any child born to and biologically related to a married woman whose husband fathered the child.<sup>365</sup> Under most state intestate laws, a legitimate child inherits one-half of the deceased parent's estate; if more than one child survives, the children equally share two-thirds of the decedent's estate.<sup>366</sup>

360. This section focuses only on intestate succession. Because a person can devise assets to a child simply by naming the child as a beneficiary or by using an inter vivos or testamentary trust, inheritance problems arise only when a person dies intestate. *See generally*, J. DUKEMINIER & S. JOHANSON, *WILLS, TRUSTS, AND ESTATES*, 137-290, 451-611 (3d ed. 1984).

A testator can avoid problems raised by artificial reproduction by addressing these issues in his or her will. A typical will clause could read as follows:

The term "child" or "children" shall not include any of the following: any frozen embryos which are biologically related to me; any children resulting from donation of my eggs [sperm]; or any children whom I may have carried full term but who were adopted upon their birth or shortly thereafter.

361. *Id.* at 89. Under the English common law doctrine of primogeniture, a family's property descended to the eldest son. Primogeniture remained the dominant inheritance system until the adoption of the Statute of Wills in 1540. *Id.* at 266-67.

362. *Id.* at 94 (showing Table of Consanguinity).

363. *Id.* at 95.

364. *Id.* at 92.

365. *See, e.g.*, CAL. PROB. CODE §§ 6152, 6205 (West Supp. 1986); N.Y. DOM. REL. LAW § 33 (McKinney 1977); TEX. PROB. CODE ANN. § 42 (Vernon 1980). *But see* N.Y. DOM. REL. LAW § 73 (McKinney 1977) (classifying as legitimate a child born as a result of artificial insemination).

366. *See, e.g.*, CAL. PROB. CODE §§ 6401-6402 (West Supp. 1986); N.Y. EST. POWERS & TRUSTS LAW § 4-1.2 (McKinney 1981); TEX. PROB. CODE ANN. § 38 (Vernon 1980). *But see* UNIF. PROBATE CODE § 2-102, 8 U.L.A. 59 (1982) (providing spouse fifty thousand dollars plus one-half remaining estate, even when decedent leaves issue).

Traditionally, a will bequest to the "children" excluded half-bloods.<sup>367</sup> As the term "halfblood" suggests, discrimination against halfbloods resulted from the child's lack of a "pure" bloodline relationship with the testator.<sup>368</sup> The notion of "pure" blood descendants often resulted in the stepchild receiving no inheritance from the stepparent. Modern laws largely eradicate this prejudice by allowing halfbloods to inherit as though they were whole blood.<sup>369</sup>

Adopted children also suffered prejudice under early intestate succession laws, which denied adopted children the protection and benefits available to legitimate children.<sup>370</sup> With the increased popularity of adoption in America in the early twentieth century, however, the intestate laws began to treat adopted children equitably.<sup>371</sup> Although a court may interpret the term "child" in a will to exclude adopted children,<sup>372</sup> the intestate succession statutes of all states provide that adopted children inherit from the adopting parents.<sup>373</sup> By removing the needless stigma formerly attached to adopted children, the law now encourages adoptions and attempts to minimize the adopted child's feelings of alienation. The justification for the transformation in the law's treatment of adopted children is that the adopting parents undertake an obligation to

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367. 4 W. BOWE & D. PARKER, PAGE ON THE LAW OF WILLS § 34.17 (1961).

368. Intestate statutes, in fact, often do not mention stepchildren. J. DUKEMINIER & S. JOHANSON, *supra* note 360, at 92.

369. For example, Uniform Probate Code § 2-107 provides: "Relatives of the half blood inherit the same share they would inherit if they were of the whole blood." UNIF. PROBATE CODE § 2-107, 8 U.L.A. 66 (1982).

370. In fact, adoption did not exist under the common law of England, for as Glanville penned, "God alone, and not man, can make an heir." See J. DUKEMINIER & S. JOHANSON, *supra* note 360, at 111 n.19 (citing R. GLANVILLE, DE LEGIBUS ET CONSUETUDINIBUS REGNI ANGLIAE, bk. 7, ch. 1, at 98 (Woodbine ed. 1932) (original in Latin)).

371. J. DUKEMINIER & S. JOHANSON, *supra* note 360, at 111.

372. *Noreen v. Sparks*, 103 F. Supp. 588, 590 (D.D.C. 1952), *rev'd on other grounds*, 204 F.2d 56 (D.C. Cir. 1953). The *Noreen* court did conclude, however, that the adopted child is included in the term "children" if that is the testator's intent. *Id.*

373. See, e.g., UNIF. PROBATE CODE § 2-109, 8 U.L.A. 66 (1982) ("[F]or purposes of intestate succession . . . an adopted person is the child of an adopting parent." See also J. DUKEMINIER & S. JOHANSON, *supra* note 360, at 111. Some states even allow adopted children to inherit from both the natural and adopting parents. *Id.*

The doctrine of equitable adoption has developed to allow a child to inherit from a decedent when the decedent has not formally adopted the child but has openly treated the child for all purposes as if she were an adopted child. See e.g., *Barlow v. Barlow*, 170 Colo. 465, 463 P.2d 305 (1969), *Heien v. Crabtree*, 369 S.W.2d 28 (Tex. 1963) (discussing in dicta the principles of equitable adoption). But see Note, *Equitable Adoption: They Took Him into Their Home and Called Him Fred*, 58 VA. L. REV. 727 (1972) (eight states refuse to allow equitable recovery by the child because adoption is purely a creature of statute). For examples of adoption statutes, see, e.g., CAL. PROB. CODE § 6408 (West Supp. 1986); N.Y. DOM. REL. LAW § 117 (McKinney 1977); TEX. PROB. CODE ANN. § 40 (Vernon 1980),

rear, educate, support, and love the adopted child. Because of these obligations, the intestate succession laws dictate that adopted children inherit from the estate of an adopting parent.

Foster children, however, do not enjoy the same inheritance rights as adopted children.<sup>374</sup> Intestate succession laws completely deny foster children any inheritance, despite the foster parents' acceptance of a moral, if not legal, obligation to rear the child. As in adoption, a foster child bears no biological relationship to either parent. The inheritance distinction between adopted and foster children apparently exists because the adopting parents legally obligate themselves to care for the child, whereas foster parents undertake no similar legal obligation.<sup>375</sup>

English common law treated illegitimate children, or bastards, as *filius nullius*.<sup>376</sup> The law, consequently, did not allow illegitimate children to inherit from either parent.<sup>377</sup> The negative moral, social, and religious connotations associated with birth to an unwed mother precipitated the legal system's denial of any inheritance rights to the illegitimate child.<sup>378</sup> The inconsistency of allowing a child to inherit from parents unwilling to claim the child as their own was another rationalization for the inferior treatment afforded illegitimate children. Although states eventually passed legislation that allowed an illegitimate child and its mother to inherit from one another,<sup>379</sup> the United States Supreme Court has

374. *But see* Note, *supra* note 373, at 727.

375. The doctrine of equitable adoption arguably should not apply to foster children. In the typical equitable adoption case, the decedent planned to adopt the child but failed to do so prior to death. *See* Monahan v. Monahan, 14 Ill. 2d 449, 153 N.E. 2d 1 (1958). Foster parents generally do not intend to adopt their foster child and often maintain custody of the foster child only temporarily. *See* Mayberry v. Pryor, 422 Mich. 579, 374 N.W.2d 683 (1985); Commonwealth v. Bibb, No. 82-CA-2569-MR & 82-CA-2389-MR (Ky.Ct. App. Sept. 16, 1983) (available March 27, 1986, on LEXIS, States library, Ky file)' *see also* 1979 Att'y Gen. Op. Utah 78-291.

376. Meaning "the child of no one," J. DUKEMINIER & S. JOHANSON, *supra* note 360, at 113.

377. *Id.* Blackstone advocated withholding inheritance rights from illegitimates:

The incapacity of a bastard consists principally in this, that he cannot be heir to any one, neither can he have heirs, but of his own body; for, being *nullius filius*, he is therefore of kin to nobody, and has no ancestor from whom any inheritable blood can be derived.

Interestingly, Blackstone labelled as "odious, unjust and cruel to the last degree" any other form of discrimination against illegitimates. Stenger, *The Supreme Court and Illegitimacy: 1968-1977*, 11 FAM. L.Q. 365, 367 (1978) (quoting 1 W. BLACKSTONE COMMENTARIES \*459).

378. *See* Helmholz, *Support Orders, Church Courts, and the Rule of Filius Nullius: A Reassessment of the Common Law*, 63 VA. L. REV. 431 (1977), *cited in* J. DUKEMINIER & S. JOHANSON, *supra* note 360, at 113 n.20.

379. Stenger, *supra* note 377, at 370; *see also* H. DRAUS, ILLEGITIMACY? LAW AND SO-

held<sup>380</sup> that this type of statute is unconstitutional as a violation of the equal protection clause.<sup>381</sup> The Court reasoned that none of the justifications<sup>382</sup> asserted for the rule was "consistent with a purpose of ameliorating the condition of illegitimate children to inherit from intestate parents."<sup>383</sup> The illegitimate child, therefore, must inherit from both parents or neither.

The foregoing examination of the established law of intestate succession reveals three primary considerations in determining a child's inheritance rights: (1) the existence of the bloodline or biological genetic connection;<sup>384</sup> (2) the care, support, and comfort that the parents provide;<sup>385</sup> and (3) society's acceptance and approval of the method of reproduction.<sup>386</sup> These three considerations also should govern the determination of an artificially reproduced child's inheritance rights. Presently, the most certain way to establish a legal relationship for inheritance purposes between "intended parents"<sup>387</sup> and their child produced by artificial reproduction is for one of the parents to adopt the child.<sup>388</sup> Yet some methods of artificial reproduction dictate a biological relationship between the intended parents and child.<sup>389</sup> Accordingly, requiring a

CIAL POLICY 25 (1971).

380. *Trimble v. Gordon*, 430 U.S. 762 (1977). *Trimble* represented one of fourteen illegitimacy cases that the Supreme Court decided between 1968 and 1977. Stenger, *supra* note 377, at 365.

381. *Trimble*, 430 U.S. 762, 776 (1977).

382. The Supreme Court in *Trimble* discussed the following four justifications set forth by the Illinois Supreme Court for the Illinois inheritance statute: (1) promotion of legitimate family relationships, *id.* at 768; (2) establishment of an accurate and efficient method of disposing of intestate property, *id.* at 770; (3) the decedent easily could have provided for his illegitimate child by will, *id.* at 773; and (4) the statutory attempt to mirror the presumed intent of the decedent, who must be presumed to know the law and therefore to intend to exclude an illegitimate child from inheriting by taking no action to make a will or legitimate the child. *Id.* at 774.

383. Stenger, *supra* note 377, at 393.

384. See *supra* notes 364-366 and accompanying text.

385. Thus, the adopted child inherits from its adopting parents, see *supra* note 373 and accompanying text, but usually does not inherit from the biological parents who consented to the adoption.

386. The illegitimate, resulting from premarital or extramarital sex, at one time inherited from no one. See *supra* notes 376-77 and accompanying text.

387. "Intended parents" refers to the male and female who plan to serve as the child's societal father and mother.

388. *Human Embryo Transfer: Hearings Before the Subcomm. on Investigations and Oversight of the House Comm. on Science and Technology*, 98th Cong. 2d Sess. 167 (1985) (statement of Lori B. Andrews, research attorney, Am. Bar Foundation) [hereinafter cited as Andrews Statement].

389. See *infra* text accompanying notes 294-96 (discussing artificial insemination); 431-33 (discussing *in vitro* fertilization); 463 (discussing *in vivo* fertilization); and 492-93

biological parent to undergo adoption proceedings to become the child's legal parent,<sup>390</sup> as occurs, for example, with surrogate motherhood<sup>391</sup> seems absurd. Furthermore, by requiring adoption proceedings, the legal system is impliedly labeling the products of artificial reproduction "illegitimate," thus evoking all the negative connotations of that categorization. State legislatures should develop logical, rational, and consistent definitions of the legal relationships between the participants in and offspring of artificial reproduction. These definitions would then govern inheritance rights. An analysis of the technologies of reproduction alternatives, the traditional legal response to these alternatives, and public policy considerations provides a useful framework for determining the inheritance rights of the alternative reproduction products and participants.

### C. ARTIFICIAL REPRODUCTION USING THIRD PARTY DONORS: METHODS AND INHERITANCE

In examining the inheritance rights implicated by artificial reproduction, this section of the Special Project will treat separately the following methods: artificial insemination, *in vitro* fertilization, *in vivo* fertilization and surrogate motherhood. In the strictest medical sense, artificial insemination is actually a form of *in vivo* fertilization because artificial insemination is a type of fertilization that occurs within the body of a woman.<sup>392</sup> Similarly, surrogate motherhood is not a purely scientific classification. For legal purposes, the label surrogate motherhood denotes the combination of participants in which a woman carries a fertilized ovum, or zygote,<sup>393</sup> to term and relinquishes all parental rights. From a scientific perspective, however, the implanted zygote may have been fertilized by any of the various means of artificial reproduction known to modern medicine. Thus, medical classifications focus on the scientific procedure involved. By contrast, legal classifications for the purpose of determining inheritance rights must focus on the par-

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(discussing frozen embryos), see generally *supra* section III of this Special Project.

390. The law fails to provide that the biological father may become the legal father if this is what he intends. See generally, Andrews Statement, *supra* note 388, at 178-79.

391. See generally *supra* section III of this Special Project.

392. For a more thorough explanation of the relation between *in vivo* fertilization and artificial insemination, see *supra* notes 17-22 and accompanying text in section II of this Special Project.

393. For an explanation of the appropriate labels attached to the various stages of fetal development, see *supra* note 15.

ticipants involved.

## 1. Artificial Insemination

### (a) Background

Using artificial insemination, doctors inseminate a woman with the sperm of either her husband<sup>394</sup> or a third party donor.<sup>395</sup> The child's biological father, therefore, may be either the child's intended father<sup>396</sup> or the third party donor.<sup>397</sup> One survey indicates that husband infertility represents the major reason couples resort to artificial insemination.<sup>398</sup> Recent estimates show that artificial insemination annually accounts for ten to twenty thousand births in the United States.<sup>399</sup>

### (b) Legal Authority

Because artificial insemination is the oldest of the artificial reproduction techniques,<sup>400</sup> more cases,<sup>401</sup> statutes,<sup>402</sup> and attorney general opinions<sup>403</sup> have addressed artificial insemination than any of the other, newer techniques.

394. For simplicity of illustration, when discussing a "couple" this Special Project uses as a model a husband and wife. Of course, participants in the process may include unmarried women and unmarried men. Artificial reproduction methods also make it possible for male or female homosexuals to become "parents."

395. For an explanation of the artificial insemination procedure, see *supra* notes 17-19 and accompanying text.

396. "Intended father" refers to the man who intends to take custody of the child and become its legal father.

397. The following chart posits the two combinations possible with artificial insemination:

Sperm Egg  
 H W  
 T W (where T=third party donor)

Thus, the child results from the union of the wife's egg (W) with either the husband's sperm (H) or a third party—usually anonymous—donor's sperm (T).

398. Curie-Cohen, *supra* note 19. Other commonly cited reasons for resorting to artificial insemination include the following: preventing the transmission of genetic defects or diseases, a woman's wish to have a child without sexual contact with the father, and husband impotence. *Id.*; see also *supra* notes 20-22 and accompanying text.

399. *Id.* at 588 (arguing, however, that six to ten thousand annually represents a more realistic estimate).

400. W. FINEGOLD, ARTIFICIAL INSEMINATION 63 (1964); see also, Comment, *Artificial Human Reproduction: Legal Problems Presented by the Test Tube Baby*, 28 EMORY L. J. 1045, 1047 (1979) (claiming first human conception by means of artificial insemination occurred two hundred years ago).

401. See generally *supra* section III of this Special Project.

402. *Id.*

403. *Id.*

Early case law did not take a clear, uniform approach to artificial insemination.<sup>404</sup> In 1954 an Illinois court<sup>405</sup> found a woman guilty of adultery for undergoing the "artificial insemination by donor" (AID) process although her husband had consented to the procedure. The court then granted the husband's request for divorce on adultery grounds.<sup>406</sup> In 1963, however, a New York court<sup>407</sup> required a husband to provide child support payments because he consented to his wife's artificial insemination by a third party donor. The court, nonetheless, declared the child an illegitimate.<sup>408</sup> A 1968 California court<sup>409</sup> held that the husband of a woman artificially inseminated by an anonymous third party donor's sperm was the legal father of the resulting child. The court relied on the husband's consent to the artificial insemination.<sup>410</sup> Thus, a court for the first time declared the mother's husband, who had no biological relationship to the child, the child's legal father instead of making the biological father the legal father.<sup>411</sup> A New York court<sup>412</sup> broke new ground in 1973 by stating that a child conceived by consensual AID during a valid marriage is a legitimate child. In addition, the court held that the husband's consent was a condition precedent when the mother remarried and her new spouse wanted to adopt the child.<sup>413</sup> Thus, by 1973, courts had accepted the concept of AID, deemed the mother's husband the legal father, and found the child to be legitimate. The courts at this point, however, had not considered the child's inheritance rights.

Twenty-five state statutes declare that the husband of the artificially inseminated woman is the legal father if he consented to the artificial insemination.<sup>414</sup> Furthermore, twelve states exclude a

404. Cf. *infra* notes 405, 407, 409, and 412 and accompanying text.

405. *Doornbos v. Doornbos*, 23 U.S.L.W. 2308 (Ill. Super. Ct. 1954), *appeal dismissed on procedural grounds*, 12 Ill. App. 2d 473, 139 N.E.2d 844 (1956).

406. *Id.*

407. *Gursky v. Gursky*, 39 Misc. 2d 1083, 242 N.Y.S.2d 406 (N.Y. Sup. Ct. 1963).

408. *Id.* at 1088, 242 N.Y.S. 2d at 411.

409. *People v. Sorensen*, 68 Cal. 2d 280, 437 P.2d 495, 66 Cal. Rptr. 7 (1968).

410. *Id.* at 285, 437 P.2d at 499, 66 Cal. Rptr. at 11.

411. The *Sorenson* court appropriately dismissed as absurd any charge of adultery between the woman and doctor because the doctor may be a woman, or the husband himself may administer the insemination by a syringe. Charges of adultery between the woman and donor are equally absurd because at the time of insemination the donor may be a thousand miles away or may even be dead. *Id.* at 289, 437 P.2d at 501, 66 Cal. Rptr. at 13.

412. *In re Adoption of Anonymous*, 74 Misc. 2d 99, 345 N.Y.S. 2d 430 (N.Y. Sup. Ct. 1973).

413. *Id.* at 105, 345 N.Y.S.2d at 435-36.

414. See, ALASKA STAT. § 25.20.045 (1983); ARK. STAT. ANN. § 61-141(c) (1971); CAL. CIV. CODE § 7005(a) (West 1983); COLO. REV. STAT. § 19-6-106(1) (1978); CONN. GEN. STAT.



third party sperm donor from the list of the child's potential legal fathers.<sup>415</sup> These statutes, however, generally establish legal paternity for the purpose of child custody and support, rather than addressing the issue of the inheritance rights of a child created by artificial insemination.

At least two Attorney General Opinions have addressed issues concerning artificial insemination. A 1982 opinion by the Georgia Attorney General limits the performance of the artificial insemination procedure to licensed physicians.<sup>416</sup> The opinion rejected arguments that a licensed physician should be allowed to delegate such authority to an assistant or to other qualified health personnel.<sup>417</sup> A year later, the Ohio Attorney General issued an opinion restricting the activities of surrogate motherhood agencies that were not licensed as child-placing agencies by the State Department of Public Welfare.<sup>418</sup> The opinion specifically prohibited three activities: (1) soliciting potential surrogate mothers; (2) negotiating fees for the surrogate; and (3) arranging for payment to the surrogate.<sup>419</sup> As with early case law and existing statutory law, Attorney General Opinions have failed to address the inheritance issues associated with artificial insemination.

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ANN. § 45-69i (West 1981); FLA. STAT. ANN. § 742.11 (West Supp. 1986); GA. CODE ANN. § 74-101.1(a) (1981); ILL. ANN. STAT. ch. 40 § 1453(a) (Smith-Hurd Supp. 1985); KAN. STAT. ANN. § 23-129 (1981); LA. CIV. CODE ANN. art. 188 (West Supp. 1986); MD. EST. & TRUSTS CODE ANN. § 1-2069(b) (1974); MICH. COMP. LAWS ANN. §§ 333.2824(6), 700.111(2) (West 1980); MINN. STAT. ANN. § 257.56(1) (West 1982); MONT. CODE ANN. § 40-6-106(1) (1985); NEV. REV. STAT. § 126.061(1) (1983); N.Y. DOM. REL. LAW § 73 (McKinney 1977); N.C. GEN. STAT. § 49A-1 (1984); OKLA. STAT. ANN. tit. 10, § 552 (West Supp. 1985); OR. REV. STAT. § 109.243 (1981); TENN. CODE ANN. § 68-3-306 (1983); TEX. FAM. CODE ANN. § 12.03(a) (Vernon 1975); VA. CODE § 64.1-7.1 (1980); WASH. REV. CODE ANN. § 26.26.050 (West Supp. 1983-84); WIS. STAT. ANN. §§ 767.47(9), 891.40(1) (West 1981 & Supp. 1985); WYO. STAT. § 14-2-103(a) (1978), cited in Andrews Statement, *supra* note 45 at 11 n.44.

415. CAL. CIV. CODE § 7005(b) (West 1983); COLO. REV. STAT. § 19-6-106(2) (1978); CONN. GEN. STAT. ANN. § 45-69j (West 1981); ILL. ANN. STAT. ch. 40 § 1453(b) (Smith-Hurd Supp. 1985); MINN. STAT. ANN. § 257.56(2) (West 1982); MONT. CODE ANN. § 40-6-106(2) (1985); NEV. REV. STAT. § 126.061(2) (1983); OR. REV. STAT. § 109.239 (1981); TRX. FAM. CODE ANN. § 12.03(b) (Vernon 1975); WASH. REV. CODE ANN. § 26.26.050(2) (West Supp. 1983-84); WIS. STAT. ANN. § 891.40(2) (West Supp. 1985); WYO. STAT. § 14-2-103(b) (1978), cited in Andrews Statement, *supra* note 388 at 11 n.46.

416. 1982 Ga. Op. Att'y Gen. 187 (1982).

417. *Id.*

418. 83 Ohio Off. Att'y Gen. 001 (1983).

419. *Id.*

## (c) Inheritance Analysis

One court that considered the inheritance issue noted that "it has never been suggested that a sperm donor other than the husband is liable for child support in an artificial insemination case."<sup>420</sup> The novel issue is whether a child should have the right to inherit from a sperm donor other than the husband. When a woman is artificially inseminated with the sperm of someone other than her husband, state legislatures must clearly define the child's rights to inherit from its "legal" father and its "biological" father. The need for legislation is particularly important because artificial insemination inheritance statutes could provide a model for subsequent cases concerning *in vitro* fertilization and surrogate motherhood. Because use of *in vitro* fertilization, *in vivo* fertilization, surrogate motherhood, and storage of frozen embryos is more recent than use of artificial insemination, statistics and logic suggest that parties will litigate the inheritance rights of children born by artificial insemination before the rights of those children born by use of the other techniques.

Present legislative attempts to ensure that the anonymous donor avoids the status of legal father of the child,<sup>421</sup> as a practical matter, will prevent the child from inheriting from the sperm donor because the donor's identity is kept anonymous.<sup>422</sup> Doctors performing artificial insemination do not keep medical records on the donors.<sup>423</sup> Furthermore, a recent survey indicated that a high percentage of doctors conduct merely a cursory medical history in-

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420. *Pamela P. v. Frank S.*, 110 Misc. 2d 978, 981 n.5, 443 N.Y.S.2d 343, 345 n.5 (N.Y. Fam. Ct. 1981) (barring mother from receiving child support payments from nonhusband father when she deceived him into believing that she was taking birth control pills). The question raised herein, however, is whether the child is entitled to inheritance from the donor regardless of the donor's liability for support.

421. See *supra* note 415 and accompanying text.

422. The failure to keep medical records on the sperm donor in artificial insemination cases has serious consequences in addition to the child's inability to inherit from the sperm donor. First, the child cannot fulfill its psychological desire to learn about its biological father. Curie-Cohen, *supra* note 19 at 1303. Second, participants may be unaware of genetic defects transmitted by the donor's sperm. *Id.* at 1302. For these reasons, a Presidential Commission issued its conclusion that "a genetic history should be obtained on all potential sperm donors and, where appropriate, the results of genetic screening should be available to prospective recipients." J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, *LAW, SCIENCE AND MEDICINE* 1305 (1984) (quoting *SCREENING AND COUNSELING FOR GENETIC CONDITIONS* 70 (1983)). These consequences, although outside the scope of this Special Project, provide support for the argument that thorough medical histories of sperm donors should be obtained and retained. See generally Lorio, *In Vitro Fertilization and Embryo Transfer: Fertile Areas for Litigation*, 35 S.W.L.J. 973, 978-84 (1982).

423. Currie-Cohen, *supra* note 19 at 1301, 1303.

vestigation.<sup>424</sup> Reasons for not keeping medical records include: minimization of the emotional stress on the "parents," the donors, and the child; encouragement of potential donors by assuring them anonymity;<sup>425</sup> and legal protection of the donor.<sup>426</sup> To ensure uncertainty over the identity of the true biological father, some physicians inseminate the woman with the sperm of several men, making it virtually impossible to determine the biological father.<sup>427</sup> These justifications for maintaining anonymity of the donor notwithstanding, legislatures must consider and address specifically the inheritance issues implicated by artificial insemination.

In fashioning appropriate legislation, lawmakers should look to the three considerations that determine inheritance under existing intestate succession laws<sup>428</sup> - bloodline, support, and societal acceptance. These considerations indicate that when artificial insemination is the method of artificial reproduction used, the child can inherit from an inseminated woman who clearly qualifies as the legal mother. This result is appropriate even though societal acceptance of artificial insemination may not be as prevalent as acceptance of natural, or coital, reproduction.<sup>429</sup> When the sperm donor for artificial insemination is the husband of the inseminated woman, the donor, or biological father, is also the legal father. As a result, the child can inherit from him. The bloodline factor is satisfied because the biological father and the legal father are the same man. The support factor is satisfied because the biological father intends to take custody of and support the child. The societal acceptance factor may not be fully satisfied if society is more comfortable with natural reproduction than artificial reproduction. Society, however, is more likely to accept artificial insemination when the husband is the sperm donor.

When the sperm donor is an anonymous third party, the inheritance analysis becomes more difficult. The anonymous donor satisfies the bloodline factor because he is biologically related to the child, whereas the husband is not. The anonymous donor does not satisfy the support factor, however, because the husband in-

424. *Id.* at 1300. In fact, many physicians expect medical students and hospital residents to "screen" themselves before they donate sperm. *Id.*

425. *Id.*

426. In addition to encouraging potential donors, anonymity also protects the donor from legal involvement insubsequent determinations about the legitimacy and inheritance rights of children born through artificial insemination. *Id.* at 1303.

427. *Id.* at 1301-02.

428. *See supra* notes 384-86 and accompanying text.

429. *See supra* notes 9-11 and accompanying text in section II of this Special Project.



what inheritance rights, if any, the child should have from an anonymous donor.

(b) Legal Authority

In the United States, only two reported court cases discuss the *in vitro* fertilization question.<sup>434</sup> The first case, *Del Zio v. Manhattan's Columbia Presbyterian Medical Center*,<sup>435</sup> concerned a claim for intentional infliction of emotional distress by the first couple to attempt *in vitro* fertilization in the United States.<sup>436</sup> After a physician removed an egg from Mrs. Del Zio, fertilized the egg with Mr. Del Zio's sperm, and placed the combination inside an incubator, the chairman of defendant's Department of Obstetrics and Gynecology destroyed the embryo. The chairman's action prevented Mrs. Del Zio from giving birth to a biologically-related child of her own.<sup>437</sup> The jury concluded that the defendant's conduct was so extreme, outrageous, and shocking that it exceeded all reasonable bounds of decency and awarded Mrs. Del Zio fifty thousand dollars for her emotional distress.

The second *in vitro* fertilization case, *Smith v. Fahner*,<sup>438</sup> challenged the constitutionality<sup>439</sup> of the Illinois *in vitro* statute.<sup>440</sup> In response to the filing of *Smith*, the Illinois Attorney General issued an opinion<sup>441</sup> exonerating doctors from criminal liability unless the doctor wilfully endangers or injures the embryo.<sup>442</sup> The opinion also provided that termination of a defective embryo con-

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T	W	Father infertile, mother fertile but unable to conceive.
H	T	Mother infertile but able to carry child.
T	T	Both parents infertile, but mother able to carry child.

Wallis, *The New Origins of Life*, TIME, Sept. 10, 1984, at 46, 49 (diagram of various reproduction technique combinations).

434. See *infra* notes 435 and 438 and accompanying text.

435. No. 74-3558 (S.D.N.Y. filed April 12, 1978).

436. L. ANDREWS, *supra* note 5, at 155-57.

437. *Id.*

438. No. 82c 4324 (N.D. Ill., memorandum opinion February 4, 1983).

439. For general discussion concerning constitutional right to artificial reproduction, see L. ANDREWS, *supra*, note 5, 153-54 (1984); Flannery, Weisman, Lipsett & Braverman, *Test Tube Babies: Legal Issues Raised by In Vitro Fertilization*, 67 GEO. L.J. 1295, 1302-11 (1979); Lorio, *supra* note 422, at 1006-10; Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405 (1983); Smith & Iraola, *Sexuality, Privacy and the New Biology*, 67 MARQ. L. REV. 263, 277-85 (1984); Note, *In Defense of Surrogate Parenting: A Critical Analysis of the Recent Kentucky Experience*, 69 KY. L.J. 877, 917-30 (1980-81); Comment, *supra* note 400, at 1052-61.

440. ILL. ANN. STAT. ch. 38 § 81-26(7) (Smith-Hurd Supp. 1985).

441. L. ANDREWS, *supra* note 5, at 155.

442. *Id.*

stitutes lawful termination of a pregnancy.<sup>443</sup> These legal opinions, however, have not addressed the issue of the inheritance rights of children created by *in vitro* fertilization.

Because legislatures and administrative agencies<sup>444</sup> have been hesitant to deal with issues that the new techniques raise,<sup>445</sup> very little statutory law addresses *in vitro* fertilization,<sup>446</sup> and none of the statutes define the inheritance rights of children created by *in vitro* fertilization. For example, an Illinois statute declares the doctor performing the procedure the "custodian" of the child for purposes of an 1877 Child Abuse Act.<sup>447</sup> Under that Act, the doctor is criminally liable for endangering the life or health of the embryo.<sup>448</sup> A Pennsylvania statute, by contrast, simply requires quarterly reports to the Pennsylvania Department of Health summarizing the *in vitro* fertilization that a doctor conducts.<sup>449</sup> The Pennsylvania statute, therefore, implicitly condones the procedure, whereas the Illinois statute discourages use of the *in vitro* process.<sup>450</sup> Such statutes, which expressly address new reproductive technologies, are only the first step. Legislatures must begin to consider all consequences of these technologies, particularly the in-

443. *Id.*

444. For example, the Secretary of Health, Education, and Welfare (now Health and Human Services) never approved or disapproved a Vanderbilt University grant application to the National Institutes of Health for *in vitro* fertilization study and research. Although the Ethics Advisory Board of HEW recommended consideration of the application in May 1979, the Secretary never acted. Lorio, *supra* note 422 at 977-78.

445. A number of commentators have called for legislative action. See, e.g., Andrews Statement, *supra* note 388 at 13, 15; L. ANDREWS, *supra* note 5; Andrews, *supra* note 5, at 797-98; Smith & Iraola, *supra* note 439, at 290-91; Wadlington, *supra* note 6, at 482-86, 512-14; Note, *Artificial Conception: A Legislative Proposal*, 5 CARDOZO L. REV. 713, 735 (1984); Note, *The Legal Status of Artificial Insemination: A Need for Policy Formulation*, 19 DRAKE L. REV. 409, 436-40 (1970); Comment, *Artificial Insemination—A Model Statute*, 24 CLEV. ST. L. REV. 341, 351-54 (1975); Comment, *Surrogate Motherhood in California: Legislative Proposals*, 18 SAN DIEGO L. REV. 341 (1981); Comment, *New Reproductive Technologies: The Legal Problem and a Solution*, 49 TENN. L. REV. 303, 308 (1982); Comment, *supra* note 400, at 1064-71, 1076-79. *But see* Annas, *Fathers Anonymous: Beyond the Best Interests of the Sperm Donor*, 14 FAM. L.Q. 1, 12-13 (1980) (suggesting that development of professional standards is a more pressing need than legislation).

446. See, e.g., ILL. ANN. STAT. ch 38, § 81-26(7) (Smith-Hurd Supp. 1985) (doctor performing *in vitro* fertilization subject to criminal liability under 1877 Child Abuse Act); PA. STAT. ANN. tit. 18, § 3213(e) (Purdon 1983) (requiring quarterly reports by all persons conducting or researching *in vitro* fertilization).

447. L. ANDREWS, *supra* note 5, at 150. *But see supra* notes 438-42 and accompanying text (statute's effectiveness diminished as a result of attorney general's opinion in response to suit to declare statute unconstitutional).

448. L. ANDREWS, *supra* note 5, at 150.

449. PA. STAT. ANN. tit. 18, § 3213(e) (Purdon 1983).

450. L. ANDREWS, *supra* note 5, at 150.

heritance consequences.

Some existing state statutes, which legislatures did not intend to regulate *in vitro* fertilization, confuse the situation because of their possible applicability to this form of artificial reproduction. Several state statutes indirectly threaten continued use of the *in vitro* fertilization procedure by restricting research on embryos.<sup>451</sup> Because the embryo forms prior to implantation into the woman's uterus, the procedure arguably violates statutes that prohibit research endangering the life or health of embryos.<sup>452</sup> Fear of criminal prosecution discourages some doctors in states with tight restrictions on fetal research from performing *in vitro* fertilization at all.<sup>453</sup> Legislatures passed these statutes, however, unaware of *in vitro* fertilization.<sup>454</sup> The statutes represented a response to the legalization of abortion<sup>455</sup> and a concomitant attempt "to maintain

451. Fetal research statutes possibly affecting *in vitro* fertilization, embryo transfer, or embryo freezing (+ indicates that statute explicitly extends to research on embryos; indicates that the statute only covers research in conjunction with an abortion):

- + ARIZ. REV. STAT. ANN. § 36-2302 (Supp. 1982-83);
- + CAL. HEALTH & SAFETY CODE § 25956 (West 1984);
- + ILL. ANN. STAT. ch. 38 §§ 81-32, -32.1 (Smith-Hurd Supp. 1985);
- + IND. CODE ANN. § 35-1-58.5-6 (Burns 1985);
- + KY. REV. STAT. ANN. § 436.026 (1985);
- \* LA. REV. STAT. ANN. § 14:87.2 (West 1974);
- ME. REV. STAT. ANN. tit. 22 § 1593 (1980);
- \* MASS. GEN. LAWS ANN. ch. 112 § 12J (West 1983);
- \* MICH. COMP. LAWS ANN. §§ 333.2685 - .2692 (West 1980) (allows therapeutic research on embryo or fetus);
- \* MINN. STAT. ANN. §§ 145.421, .422 (West 1986);
- \* MO. ANN. STAT. § 188.037 (Vernon 1983);
- MONT. CODE ANN. § 50-20-108(3) (1985);
- + NEB. REV. STAT. §§ 28-342, -346 (1979);
- \* N.M. STAT. ANN. §§ 24-9A-1 to -6 (1981);
- \* N.D. CENT. CODE §§ 14-02.2-01 to -02 (1981);
- + OHIO REV. CODE ANN. § 2919.14 (Page 1982);
- + OKLA. STAT. ANN. tit. 63 § 1-735 (West 1984);
- + PA. CONS. STAT. ANN. tit. 18 § 3216 (Purdon 1983);
- \* R.I. GEN. LAWS §§ 11-54-1, -2 (Supp. 1985);
- S.D. CODIFIED LAWS ANN. § 34-23A-17 (1977);
- + TENN. CODE ANN. § 39-4-208 (1982);
- UTAH CODE ANN. § 76-7-310 (1978);
- + WYO. STAT. 35-6-115 (1977),

collected in L. ANDREWS, *supra* note 5, at 297-98 app. (updated as of March, 1986).

452. See generally L. ANDREWS, *supra* note 5, at 148-49 (discussing fetal research statutes).

453. *Id.* at 149.

454. *Id.* at 148.

455. *Cf.* *Roe v. Wade*, 410 U.S. 113 (1973).

respect for human dignity" by prohibiting research on embryos.<sup>456</sup> Indiscriminate application of this old legal framework to modern technology, therefore, has the unintended consequence of stifling progress in the artificial reproduction field.<sup>457</sup> Applying embryo research laws to a medical technological process that legislatures did not contemplate when passing these laws constitutes another compelling reason for legislation that directly addresses *in vitro* fertilization.

### (c) Inheritance Analysis

Under all four *in vitro* combinations<sup>458</sup> the three factor test, based on bloodline, support, and societal acceptance, strongly suggests that the child should inherit from the intended parents and not from the third party participant. In the first combination, the intended father's sperm fertilizes the intended mother's egg. Both intended parents are biologically related to the child and, thus, both intended parents satisfy the bloodline factor. The intended parents are also the only parties who intend to support the child. Because no third parties participate in this combination, no one else would be eligible to provide support. Finally, societal acceptance is uncertain. Some may consider the *in vitro* process unnatural, but this first combination is likely to be most acceptable to society because only the intended parents are involved.

In the second combination, a third party's sperm fertilizes the mother's egg. In the third combination, the intended father's sperm fertilizes a third party's egg. In both situations a doctor implants the embryo in the intended mother's uterus. These two approaches raise similar inheritance problems because only one of the intended parents participates. The child is related biologically to one of the intended parents, but also is related biologically to a third party donor. The bloodline factor, therefore, favors neither the intended parents nor the third party donor. The intended parents, however, plan to raise, support and care for the child, whereas the anonymous donor does not plan to do so. The support factor, therefore, favors the intended parents. Societal acceptance again is uncertain. Once the process has occurred, however, society would likely favor a legal framework that treats the child as the natural child of the intended parents. Inheritance rights would, of

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456. L. ANDREWS, *supra* note 5, at 149.

457. See *supra* notes 451-56 and accompanying text.

458. See *supra* note 433 and accompanying text.



course, accompany this status. The child that the second and third combinations produce, therefore, should inherit only from the intended parents.

In the fourth combination, a third party's sperm fertilizes a third party's egg. A doctor implants the embryo in the intended mother's uterus, and she carries the child full term. The bloodline factor does not favor the intended parents in this situation because neither of the intended parents bears a biological relationship to the child. Neither of the third party donors, however, intends to care for or support the child. Thus, the support factor favors the intended parents, who do plan to support the child. Societal acceptance may seem dispositive in this stalemate between the other two factors. American society's acceptance of the *in vitro* process involving two anonymous donors is difficult to predict. Society is most likely, however, to favor the intended parents. In the child's interests, society would seek to ensure that someone care for and provide for the child. The anonymity of the donors precludes the possibility of the child turning to them for support. The intended parents, on the other hand, will gladly care for the child. Furthermore, the intended parents' obligations to the child become more clear if the law entitles the child to inherit from them. In addition, society serves its own interests by having the child inherit from the intended parents because the child could rely on that inheritance rather than welfare programs if the intended parents die. In the final analysis, therefore, the child should inherit from the intended parents.

### 3. In Vivo Fertilization

#### (a) Background

*In vivo* fertilization involves the artificial insemination of a woman with the sperm of either an anonymous donor or the "intended father."<sup>459</sup> The *in vivo* process differs from *in vitro* in that *in vivo* fertilization occurs inside the uterus; *in vitro* occurs outside the uterus in a petri dish. Following conception inside the impregnated woman's uterus, the embryo is "flushed out"<sup>460</sup> and reimplanted into the uterus of the "intended mother."<sup>461</sup> Couples use the procedure when the wife has difficulty conceiving, but can

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459. See *supra* note 17 and accompanying text in section II of this Special Project.

460. Wallis, *supra* note 344, at 55.

461. *Id.*

carry and deliver the child safely.<sup>462</sup> Variations of the *in vivo* method exist as they do in other artificial reproduction techniques. For example, the "intended mother" could conceive the child, flush it out, and implant it in a surrogate mother.

The *in vivo* process is invaluable because it permits the wife to give birth to her husband's biological child if the husband is fertile and the third party "uterus donor" agrees to artificial insemination with the husband's sperm.<sup>463</sup> *In vivo* fertilization offers greater potential benefit than *in vitro* fertilization because women with no ovaries or inaccessible ovaries and women who do not wish to pass on a genetic defect can use the *in vivo* fertilization technique.<sup>464</sup> In effect, the *in vivo* process is simply a combination of artificial insemination<sup>465</sup> and partial surrogate motherhood.<sup>466</sup> This characterization will prove useful in analyzing the inheritance rights and responsibilities of each party.

### (b) Legal Authority

The *in vivo* fertilization process arguably violates statutes that prevent any research on an embryo<sup>467</sup> even more directly than the *in vitro* process.<sup>468</sup> In fact, the "flushing out" may constitute an "abortion" and fall within those embryo research statutes prohibiting research in conjunction with an abortion.<sup>469</sup> This result would be absurd because the purpose of *in vivo* fertilization, rather than

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462. *Id.*

463. See *supra* chart at note 433.

464. L. ANDREWS, *supra* note 5, at 252.

465. See *supra* notes 51-53 and accompanying text.

466. See *infra* notes 472-74 and accompanying text.

467. ARIZ. REV. STAT. ANN. § 36-2302 (Supp. 1982-83); FLA. STAT. ANN. §§ 82-436 to -441 (West Supp. 1983); IND. CODE § 35-1-58.5-6 (Burns 1985); LA. REV. STAT. ANN. § 14:87.2 (West 1974); ME. REV. STAT. ANN. tit. 22 § 1593 (1980); MASS. GEN. LAWS ANN. ch. 112 § 12J (West 1983); MICH. COMP. LAWS ANN. §§ 333.2685 to .2692 (West 1980 & Supp. 1985); MINN. STAT. ANN. § 145.421 (West 1986); MO. ANN. STAT. § 188.037 (Vernon 1983); MONT. CODE ANN. § 50-20-108 (1985); NEB. REV. STAT. §§ 28-342, -346 (1979); N.M. STAT. ANN. § 24-9A-3 (1981); N.D. CENT. CODE § 14-02.2-.01 to -.02 (Allen Smith 1981); OHIO REV. CODE ANN. § 2919.14 (Page 1982); OKLA. STAT. ANN. tit. 63 § 1-735 (West 1984); PA. STAT. ANN. tit. 18 § 3216 (Purdon 1983); R.I. GEN. LAWS § 11-54-1 and -2 (Supp. 1985); UTAH CODE ANN. § 76-7-310 (1978); and WYO. STAT. § 35-6-115 (1977). Cited in Andrews Statement, *supra* note 45, at 169 n.8. See also Andrews, *supra* note 5, 70 A.B.A. J. 50 (1984) (further analysis of the above cited laws).

468. L. ANDREWS, *supra* note 5, at 253.

469. ME. REV. STAT. ANN. tit. 22 § 1593 (West 1980); MASS. GEN. LAWS ANN. ch. 112 § 12J (a)III (West 1983); MICH. COMP. LAWS ANN. § 333.2690 (West 1980); NEB. REV. STAT. § 28-342 (1979); N.D. CENT. CODE § 14-02.2-02.2 (1981); R.I. GEN. LAWS § 11-54-1(e) (Supp. 1985); and WYO. STAT. § 35-6-115 (1977). Cited in Andrews Statement, *supra* note 388, at 269 n.9.

to terminate life, is to reimplant the embryo into the "mother" who intends to give birth to the child.<sup>470</sup>

### (c) Inheritance Analysis

The *in vivo* inheritance results should be nearly identical to those of the *in vitro* process because both involve a potential egg donor and potential sperm donor. *In vivo* fertilization differs from the *in vitro* procedure only in that the egg donor doubles as a uterus donor. The "intended mother" ultimately delivers the child as in the *in vitro* procedure. Even though conception occurs within the egg donor's womb, the resulting child should possess the same rights to inherit from the "intended parents" under *in vivo* fertilization as under *in vitro* fertilization.<sup>471</sup>

The three factor test produces the same results under both *in vivo* methods. Regardless of whether the intended father or a third party biologically fathers the child, the intended mother carries the child full term. As with *in vitro* fertilization involving one third party donor, the bloodline and support factors favor the intended parents in *in vivo* fertilization. The only distinction between the *in vitro* and *in vivo* procedures is that, in the *in vivo* procedure, the embryo is created in a third party's uterus rather than in a petri dish. Unless this distinction drastically erodes societal acceptance, which result seems unlikely, the same analysis discussed in the context of *in vitro* fertilization should apply in the *in vivo* situation. The child produced by means of *in vivo* fertilization, therefore, should inherit from the intended parents.

## 4. Surrogate Motherhood

### (a) Background

Surrogate motherhood highlights the possible combinations and variations of the other artificial reproduction techniques.<sup>472</sup> The surrogate mother carries the child full term and upon delivery

470. See *supra* note 460 and accompanying text.

471. See *supra* text following note 458.

472. The surrogate mother may be fertilized by artificial insemination, *in vitro* fertilization, *in vivo* fertilization, or natural reproduction. The participants may include the adopting husband, the adopting wife, anonymous sperm donors, and anonymous egg donors.

The following chart presents the wide variations possible in surrogate motherhood:

presents the child to the intended parents.<sup>473</sup> Under present practice, surrogates receive compensation upon their release of the child to the intended parents.<sup>474</sup> A separate Section of this Special Project addresses the legal complications arising out of the surrogate motherhood process.<sup>475</sup>

### (b) Legal Authority

Very little existing case law or legislation clarifies the legal consequences of surrogate parenting. As with *in vitro*<sup>476</sup> and *in vivo*<sup>477</sup> fertilization, courts often judge surrogate motherhood under statutes that should not apply to the new reproduction alternative. Two types of statutes illustrate this problem.

First, the contractual arrangements between the couples and the surrogates violate state statutes prohibiting the payment of money in return for a woman's consent to the adoption of her child.<sup>478</sup> Courts have held that this illegality voids the surrogate motherhood contract.<sup>479</sup> The legislatures, however, did not intend these statutes to govern surrogate motherhood, a process unknown

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Sperm	Egg	Fertilization medium	Gestation medium
H	T	artificial insemination	T
T	T	artificial insemination	T
H	W	<i>in vitro</i>	T
H	T	<i>in vitro</i>	T
T	W	<i>in vitro</i>	T
T	T	<i>in vitro</i>	T
H	T	<i>in vitro</i>	T

473. See generally *supra* section III of this Special Project.

474. See Handel, *supra* note 354, at 786 (estimating average surrogate fee at twelve thousand dollars plus medical expenses). See generally, Note, *supra* note 439, at 883 n.39.

475. See generally *supra* section III of this Special Project.

476. See *supra* notes 451-56 and accompanying text.

477. See *supra* notes 467-69 and accompanying text.

478. See, e.g., ALA. CODE § 26-10-8 (1977); ARIZ. REV. STAT. ANN. § 8-114.B (Supp. 1985); CAL. PENAL CODE § 273(a) (West 1970); COLO. REV. STAT. § 19-4-115 (1978); DEL. CODE ANN. tit. 13 § 928 (1981); FLA. STAT. ANN. § 63.212(1) (d) (West 1985); GA. CODE ANN. § 19-8-19 (Supp. 1984); IDAHO CODE § 18-1511 (1979); ILL. ANN. STAT. ch. 40 §§ 1526, 1701, 1702 (1981); IND. CODE ANN. § 35-46-1-9 (Burns 1985); IOWA CODE ANN. § 600.9(2) (West 1981); KY. REV. STAT. § 199-590(2) (Supp. 1984); MD. ANN. CODE art. 16 § 83 (1981); MASS. GEN. LAWS ANN. ch. 210 § 11A (West Supp. 1985); MICH. COMP. LAWS ANN. § 710.54 (West Supp. 1985); NEV. REV. STAT. § 127.290 (1986); N.J. STAT. ANN. § 9:3-54(a) (West Supp. 1983-84); N.Y. SOC. SERV. LAW § 374(6) (West 1983); N.C. GEN. STAT. § 48-37 (1984); OHIO REV. CODE ANN. § 3107.10(B) (Page 1980); S.D. CODIFIED LAWS ANN. § 25-6-4.2 (1984); TENN. CODE ANN. § 36-1-135 (1984); UTAH CODE ANN. § 76-7-203 (1978 & Supp. 1985); and WIS. STAT. ANN. § 946.716 (West 1982 & Supp. 1986). Cited in Andrews Statement, *supra* note 388, at 4 n.12.

479. See, e.g., 83 Op. Atty Gen. La. 869 (1983) (payment beyond "prenatal care and living expenses" violates statute prohibiting the sale of children).

when the legislatures adopted the statutes.<sup>480</sup> Second, several state statutes addressing artificial insemination inadvertently interfere with surrogate motherhood.<sup>481</sup> In twenty-two states,<sup>482</sup> the law deems the husband of a woman artificially inseminated by a third party donor's sperm with the husband's consent to be the legal father of the child.<sup>483</sup> These statutes, passed expressly to govern artificial insemination, interfere with continued development of medical technology by undermining the clear intent of the parties that the anonymous donor, rather than the surrogate's husband, become the child's legal father.<sup>484</sup> Other statutes expressly state that a non-husband donor shall not be the child's legal father,<sup>485</sup> thereby similarly subverting the intent of the parties.

Surrogate motherhood presents yet another legal quagmire which state legislatures must resolve through responsive, well-reasoned laws. The legislatures should look to the intent of the parties and seek a fair, just, and equitable solution.

### (c) Inheritance Analysis

A combination of the artificial insemination, *in vitro*, and *in vivo* alternatives results in ten variations<sup>486</sup> by which to fertilize

480. L. ANDREWS, *supra* note 5, at 226.

481. See *infra* notes 482 and 484.

482. ALASKA STAT. § 25.20.045 (1983); ARK. STAT. ANN. § 61-141 (1971); CAL. CIV. CODE § 7005 (West Supp. 1983); COLO. REV. STAT. § 19-6-106 (1978); CONN. GEN. STAT. § 45-69i (1981); FLA. STAT. ANN. § 742.11 (West Supp. 1986); GA. CODE ANN. § 19-7-21 (Supp. 1984); ILL. ANN. STAT. ch. 40 § 1452 (Smith-Hurd Supp. 1985); KAN. STAT. ANN. § 23-129 (1981); LA. CIV. CODE ANN. Art. 188 (West Supp. 1986); MD. EST. & TRUSTS CODE ANN. § 1-206(b) (1974); MICH. COMP. LAWS ANN. §§ 333.2824(6), 700.111 (West 1980); MINN. STAT. ANN. § 257.56 (West 1982); MONT. CODE ANN. § 40-6-106 (1985); NEV. REV. STAT. § 126.061(1) (1986); N.Y. DOM. REL. LAW § 73(1) (West 1977); N.C. GEN. STAT. § 49A-1 (1984); OKLA. STAT. ANN. tit.10, § 552 (West Supp. 1985); OR. REV. STAT. § 109.243, (1983); TENN. CODE ANN. § 68-3-306 (1983); TEX. FAM. CODE ANN. § 12.03(a) (Vernon 1975 & Supp. 1986); VA. CODE § 64.1-7.1 (1980 & Supp. 1985); WASH. REV. CODE ANN. § 26.26.050 (Supp. 1983-84); WIS. STAT. ANN. §§ 767.47(9), 891.40 (West 1981 & Supp. 1985); and WYO. STAT. § 14-2-103a (1978). Cited in Andrews Statement, *supra* note 388 at 11 n.44.

483. L. ANDREWS, *supra* note 5, at 226-27. See also Andrews Statement, *supra* note 388, at 175-77.

484. Andrews Statement, *supra* note 388, at 176.

485. CAL. CIV. CODE § 7005(b) (West 1983); COLO. REV. STAT. § 19-6-106(2) (1978); CONN. GEN. STAT. § 45-69j (1981); ILL. ANN. STAT. ch. 40 § 1453(b) (Smith-Hurd Supp. 1985); MINN. STAT. ANN. § 257.56(2) (West 1982); MONT. CODE ANN. § 40-6-106(2) (1981); NEV. REV. STAT. § 126.061(2) (1979); OR. REV. STAT. § 109.239(1) (1983); TEX. FAM. CODE ANN. § 12.03(b) (Vernon 1975 & Supp. 1986); WASH. REV. CODE ANN. § 26.26.050(2) (West Supp. 1983-84); WIS. STAT. ANN. § 891.40(2) (West 1985); WYO. STAT. § 14-2-103(b) (1978). Cited in Andrews Statement, *supra* note 388, at 11 n.46.

486. See *supra* note 472.

the egg that ultimately develops into the child the surrogate delivers. In seven<sup>487</sup> of the ten scenarios, at least one member of the intended couple bears a genetic relationship to the child. In these instances, the bloodline factor favors the intended parents. In the other three combinations,<sup>488</sup> the child possesses no biological relationship to either "parent." The various donors, however, do not intend to support the child. The support factor, which usually favors the intended parents, is negated when the surrogate offers to raise the child herself or with her mate. The societal acceptance factor may favor either the surrogate or intended parents. On one hand, society winces at the thought of taking a newly born child from the woman who carried the child for nine months, especially when the arrangement deprives the mother of the child against her wishes. The situations in which the child inherits the delivering mother's genes<sup>489</sup> exacerbate society's revulsion. On the other hand, denying the intended parents their long awaited child is equally reprehensible. The latter denial becomes intolerable if the child contains the genes of both of the intended parents.<sup>490</sup> This

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Sperm	Egg	Fertilization Medium	Gestation Medium
H	T	artificial insemination	T
H	W	<i>in vitro</i>	T
H	T	<i>in vitro</i>	T
T	W	<i>in vitro</i>	T
H	TA	<i>in vitro</i>	A
H	W	<i>in vivo</i> W	T
T	W	<i>in vivo</i> W	T

T = third party donor TA = anonymous third party donor

488.

Sperm	Egg	Fertilization Medium	Gestation Medium
T	T	artificial insemination	T
T	T	<i>in vitro</i>	T
T	TA	<i>in vitro</i>	T

T = third party donor TA = anonymous third party donor

489.

Sperm	Egg	Fertilization Medium	Gestation Medium
H	T	artificial insemination	T
T	T	artificial insemination	T
H	T	<i>in vitro</i>	T
T	T	<i>in vitro</i>	T

T = third party donor

490.

Sperm	Egg	Fertilization Medium	Gestation Medium
H	W	<i>in vitro</i>	T
H	W	<i>in vivo</i> W	T

conflict has led some critics to oppose the entire surrogate motherhood concept.<sup>491</sup>

Reasonable minds, undoubtedly, may differ. Nevertheless, given the goal of facilitating new reproduction possibilities, the intended parents, who intend from the outset to serve as the child's parents, must assume the role of legal parents. The law, therefore, should allow the surrogate mothered child to inherit from each of the intended parents through intestate succession or as a "child" under their respective wills. To reinforce the intended parents' commitment to the child, the law should allow the child to inherit from the couple at any time after conception. Although the law should favor the intended parents' relationship with the child, the child's best interests dictate that the death of both intended parents operate to place the surrogate in the position of legal mother. Although the suggestion contradicts the original intent of the parties, this result ensures that the child inherits from the surrogate and, more importantly, ensures the child's well-being in the event of a catastrophe. Finally, the surrogate may allow another couple to adopt the child. In that case the state's normal adoption procedures and legal consequences should apply.

#### D. FROZEN EMBRYOS: A SPECIAL DILEMMA

Although freezing of sperm and eggs occurred much earlier,<sup>492</sup> embryo freezing represents a very recent phenomenon.<sup>493</sup> Physicians often freeze embryos that are formed, but not used, during *in vitro* fertilization.<sup>494</sup> The frozen embryo procedure allows the woman to try again if the first implanatation proves unsuccessful.<sup>495</sup> Modern medicine's ability to freeze embryos greatly facilitates artificial reproduction, but portends potentially catastrophic repercussions for estate planning law. The medical technology of freezing embryos poses a special dilemma for estate planning because during the storage period the rights—and indeed the identities—of the participants are suspended indefinitely.<sup>496</sup> An estate could re-

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491. See Note, *supra* note 439, at 887-905 (analyzing Kentucky Attorney General opinion which "came down emphatically against" surrogate parenting).

492. Frozen sperm and eggs are useful in artificial insemination, *in vitro*, *in vivo*, and surrogate motherhood methods of fertilization. L. ANDREWS, *supra* note 5, at 256-58.

493. *Id.* See *supra* notes 378 & 379 and accompanying text for an explanation of the process of freezing embryos.

494. L. ANDREWS, *supra* note 5, at 256-58.

495. *Id.*

496. Another period of time in the artificial reproduction process indefinitely suspends the rights of all participants. When physicians fertilize ova in a petri dish, they allow the

main unsettled for years while a decedent's biologically related embryo remained frozen. Similarly, a planned settlement and distribution of an estate could be thrown into question upon the discovery of previously undiscovered frozen embryo "heir."

In the summer of 1984, the inheritance rights of frozen embryos received much attention when the world learned of the existence of two "orphaned" frozen embryos.<sup>497</sup> In 1981, Elsa Rios, a Los Angeles resident, attempted *in vitro* fertilization at the Queen Victoria Medical Center in Melbourne, Australia.<sup>498</sup> Physicians removed a number of eggs and fertilized them with anonymously donated sperm.<sup>499</sup> Doctors implanted some of the resulting embryos in Ms. Rios and froze two others.<sup>500</sup> The implantation failed to result in a pregnancy, but, before Ms. Rios returned to have the frozen embryos implanted, she and her husband died in a plane crash in Chili.<sup>501</sup> The Rios' respective wills contained no mention of the embryos, leaving an estimated one million dollar estate in limbo.<sup>502</sup> Questions immediately arose concerning the inheritance rights of the embryos,<sup>503</sup> and the moral, social, ethical, and legal obligations of the Medical Center.<sup>504</sup>

The law, unfortunately, provided no immediate answers. The Victoria state government requested a "committee of scholars,"<sup>505</sup> formed earlier to study the potential consequences of artificial reproduction technologies,<sup>506</sup> to recommend a proper course of action to take with respect to the embryos.<sup>507</sup> The committee proposed destruction of the embryos.<sup>508</sup> The upper house of the Victoria

morula to undergo division for several days before implantation. The more advanced early embryo has more likelihood of successful implantation. See *supra* notes 373-74 and accompanying text. Unlike the more lengthy storage of frozen embryos, this period of only two or three days is relatively insignificant for purposes of inheritance rights.

497. Wallis, *supra* note 1, at 68.

498. *Id.*

499. *Id.*

500. *Id.*

501. *Id.*

502. *Id.*

503. *Id.*

504. *Id.*; see also "A Legal, Moral, Social Nightmare" *TIME*, Sept. 10, 1984, at 55-56.

505. *Study Deals with Rights of Test-Tube Babies*, *Tennessean*, Sept. 5, 1984, at 7A.

506. *Id.*; see also, *TIME supra* note 504, at 68.

507. *Tennessean, supra* note 505.

508. *Legislation Permits Embryos' Adoption*, *Tennessean*, Oct. 24, 1984, at 1A, 3A. The committee also recommended abolition of surrogate motherhood because it is "too complicated legally," but the committee did recommend that the "social parents" become, by law, the legal parents. *Tennessean, supra* note 505.



state parliament responded to the ensuing public outrage<sup>509</sup> by adopting legislation allowing the hospital to thaw and implant the embryos into two of the thousands of volunteer surrogate mothers.<sup>510</sup> The legislation, however, applied only to those particular two frozen embryos.<sup>511</sup> Clearly, to facilitate estate planning any legislation must address the inheritance rights of all frozen embryos.

The particular reproductive technique chosen to bring the frozen embryo into the world as a child should dictate the child's inheritance rights. If the chosen techniques would otherwise favor inheritance from the intended parents,<sup>512</sup> the use of a frozen embryo should not vary that result. When the embryo's "intended parents" both die, however, the embryo's rights must cease vis-a-vis the intended parents. The chaos and uncertainty otherwise resulting in estate planning is intolerable. The couple's physician should have a duty to locate immediately a potential mother, surrogate or otherwise, and a couple seeking a child. The physician should thaw the embryo and implant it. At this point, the particular technique chosen again should govern the child's inheritance rights. The law should impute consent to such consequences by virtue of the intended parents participation in the frozen embryo procedure.

#### E. CONCLUSION

The law should protect children created through artificial reproduction technology by clearly defining their inheritance rights. Legislation would infuse predictability into the artificial reproduction techniques by ensuring that each participant in the new methods realizes the potential legal consequences. Increasing use of existing artificial reproduction methods creates mounting pressure for the estate planner to ensure that the estate distribution reflects the client's wishes. Furthermore, the complexity of the estate planner's task grows with each technological breakthrough in the artificial reproduction field. Legislators should adopt the analytical framework of applying the bloodline factor, the support factor, and the societal acceptance factor to the method of artificial reproduction to determine from whom the resulting child may inherit. Re-

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509. *Id.*

510. *Id.*

511. *Id.*

512. *See supra* text accompanying notes 429-30, text following note 115, and text following note 471.

ardless of the analysis adopted, however, the current chaotic situation demands that legislators respond adequately to rapidly advancing medical technology by passing legislation defining the inheritance rights of children created by artificial reproduction.

## V. State Regulation of the Physician in the Abortion Decision

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### A. INTRODUCTION

The decision of a woman to abort her pregnancy is a personal choice, but one that also implicates others. Few issues in the history of American law have created a furor equal to the controversy surrounding abortion. In addition to the important legal issues raised, questions of ethics, autonomy, and morality touch everyone and incite many. The abortion controversy arises from a conflict between two largely incompatible principles. One principle, now

constitutionally recognized,<sup>513</sup> is the autonomy of the woman and her right to make a private decision about her body and her pregnancy. The other principle, currently argued with great conviction, is the right of the unborn fetus to realize its potential "human" existence. Proponents of this principle seek state action overriding the woman's choice.

The pregnant woman does not make her abortion decision in a vacuum. The decision necessarily involves third parties. This Part focuses on the primary outside party: the woman's attending physician.<sup>514</sup> The physician's role in the abortion process has attained a constitutional status itself.<sup>515</sup> However, many opponents of abortion in state legislatures have concluded that if they cannot interfere directly with the woman's right to an abortion, regulation of the attending physician can serve the same purpose. Consequently, since the United States Supreme Court first recognized the woman's constitutional right to an abortion in *Roe v. Wade*, state legislatures have enacted a myriad of provisions regulating the physician and his relationship with the pregnant woman.<sup>516</sup> Subsequent Supreme Court decisions have largely invalidated such efforts.<sup>517</sup> New methods of interfering with the physician's role, and consequently with the woman's constitutional rights, however, are being

513. See *Roe v. Wade*, 410 U.S. 113 (1973).

514. This section characterizes the physician as the primary outside party because unless an abortion is self-induced, an increasingly rare occurrence now that abortion is legal, a physician or other medical personnel must perform every abortion. Not every pregnant woman will have a husband or living parents, although these are certainly important parties. States' attempts to give husbands or parents the right to notification of or consent to the woman's abortion are viewed in this section as attempts to regulate the physician's constitutionally protected rights in the abortion process. Accordingly, the physician is the most influential party, other than the woman herself, in the abortion decisionmaking process.

515. Although outside the scope of this section, one of the underlying issues in the regulation of the physician is the extent to which the woman's right to an abortion protects the individual performing the abortion. The abortion process inextricably intertwines the woman and her physician. The physician or individual performing an abortion, however, does not necessarily have standing to attack an abortion statute because it violates the woman's rights. Although serious standing problems arise, the physician's role as decisionmaker, nevertheless, has attained a constitutionally protected status. See *infra* note 385.

516. See, e.g., IDAHO CODE § 18-613 (1979); UTAH CODE ANN. § 76-7-303 (1978 & Supp. 1985); TENN. CODE ANN. § 39-4-202(f) (1978). See generally, Bryant, *State Legislation on Abortion After Roe v. Wade: Selected Constitutional Issues*, 2 AM. J.L. & MED. 101, 102-03 (1976-77); Note, *Implications of the Abortion Decision: Post Roe and Doe Litigation and Legislation*, 74 COLUM. L. REV. 237 (1974).

517. See, e.g., *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983) (striking down mandatory abortion information disclosure); *Colautti v. Franklin*, 439 U.S. 379 (1979) (striking down Pennsylvania's abortion statute that regulated physicians); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (striking down maternal consent requirements).

employed.<sup>518</sup>

This Part of the Special Project examines the validity of these new regulations within the context of *Roe* and its progeny.

Section B analyzes the development and resulting recognition of the woman's constitutional right to decide whether to terminate her pregnancy. Section C discusses the physician's role in the abortion decision by reviewing the framework set out in *Roe v. Wade*, discussing the physician's decisionmaking ability, examining the viability determination, and analyzing the maternal health determination. Section D focuses on states' attempts to regulate the physician indirectly by requiring consent or notification of the woman's spouse or parents. Section E applies the analysis of Section C to two cases recently heard by the Supreme Court. Section F concludes that the physician, rather than the states, should define viability in order to adequately protect the woman's right to decide whether to terminate her pregnancy.

## B. THE RIGHT TO AN ABORTION

### 1. *The Development of the Right*

With the adoption of the fourteenth amendment to the United States Constitution,<sup>519</sup> the states surrendered much of their authority to the federal government, including the federal courts.<sup>520</sup> Under the due process clause of the fourteenth amendment, federal courts attained the power to examine and invalidate state laws that interfere with a person's interest in life, liberty, or property.<sup>521</sup> The type of interest being interfered with generally determines the standard of review that the courts will apply.<sup>522</sup> If a state statute interferes with an interest expressly recognized in the Constitution, courts will subject the statute to a "strict scrutiny" standard and uphold the statute only if it is narrowly tailored to further a "compelling state interest."<sup>523</sup> If a state statute interferes with an interest that the Constitution does not recognize, courts will uphold the

518. See *infra* notes 373-457 and accompanying text.

519. The text of the fourteenth amendment reads in pertinent part: "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law. . . ." U.S. CONST. amend. XIV, § 1.

520. See generally J. NOWAK, R. ROTUNDA, & J. YOUNG, CONSTITUTIONAL LAW 414-24 (2d ed. 1983).

521. *Id.* at 416-17.

522. *Id.* at 418-19.

523. *Id.*

statute if it has a "rational basis."<sup>524</sup> Consequently, under the less strict rational basis test, courts generally will uphold a statute that interferes with a particular liberty interest that is not found in the Constitution.<sup>525</sup>

The Supreme Court has recognized interests that, although not specifically enumerated in the Constitution, are sufficiently implicit within the penumbra of the Constitution to deserve a protected status.<sup>526</sup> The Court has subsumed many of these interests under what is called the "right to privacy." In due process terms, the right to privacy means "a right to engage in certain highly personal activities."<sup>527</sup> A state statute that interferes with an individual's right to privacy is subject to strict scrutiny.

The Supreme Court recognized the right to procreative privacy in *Griswold v. Connecticut*.<sup>528</sup> In *Griswold* the Court invalidated a Connecticut anticontraception statute<sup>529</sup> because it interfered with a married individual's right to privacy.<sup>530</sup> Although the Court did not expressly state which provisions of the Constitution created the right,<sup>531</sup> the Court did hold that the right arose from the "penumbras" and "emanations" of the Bill of Rights.<sup>532</sup> Once the Supreme Court recognized that the right to privacy is constitutionally protected and decided that statutes infringing upon that right are subject to strict scrutiny, the Court's next task was to decide exactly what interests this general right subsumes. One such interest is a woman's right to choose an abortion.

524. *Id.* at 418; see *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955).

525. This two-tier approach of applying either a strict scrutiny or a rational basis test, although without explicit foundation in the Constitution, is necessary to implement constitutional protections in a rational way. The Constitution should afford citizens greater protection against state action affecting expressly enumerated freedoms than garden-variety liberty interests that are not explicitly mentioned, but remain protected under the due process clause. See generally, Gunther, *The Supreme Court 1971 Term—Forward: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972).

526. See *supra* notes 359-65 and accompanying text.

527. NOWAK, *supra* note 520, at 735.

528. 381 U.S. 479 (1965).

529. The Connecticut statute read in pertinent part: "Any person who uses any drug, medicinal article or instrument for the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned." CONN. GEN. STAT. ANN. § 53-32 (West 1958) (repealed 1971).

530. 381 U.S. at 483-84.

531. The Court found the right to privacy implicit in the Bill of Rights—specifically the first, third, fourth, fifth, and ninth amendments. 381 U.S. at 484.

532. The right to privacy "emanates" from several amendments. *Id.* The "penumbras" are enforceable against the states under the fourteenth amendment. *Id.* at 482. This zone of privacy encompasses the marriage relationship. *Id.* at 484-85.

## 2. *The Recognition of the Right*

In *Roe v. Wade*<sup>533</sup> the Supreme Court recognized that a woman's liberty interests under the fourteenth amendment include a right to be free from state interference with her decision to procure an abortion, except in certain instances. In so holding, the Court specifically identified the right to privacy as an aspect of the fourteenth amendment and held that the right to privacy "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."<sup>534</sup> Consequently, any state statute that unduly burdens this right will be subject to strict scrutiny.

Since *Roe*, many states have enacted statutes that regulate a woman's right to have an abortion.<sup>535</sup> Many of these statutes directly or indirectly regulate the attending physician, often subjecting him or her to severe criminal sanctions.<sup>536</sup> In an effort to limit the number of abortions, states have enacted legislation that interferes with the physician-patient relationship. These statutes may impose a mandatory process for review of the physician's decision,<sup>537</sup> dictate the information the physician is required to disclose to a pregnant woman,<sup>538</sup> prescribe the method of abortion used,<sup>539</sup> require consent of the woman's parents or spouse,<sup>540</sup> or require notification of the parents or spouse.<sup>541</sup> The role of the attending physician has become a pivotal issue in abortion litigation. Because these statutes also burden the woman's decision, they have been strictly scrutinized. The following Sections examine the validity of these regulations in light of *Roe* and its progeny and analyze two recent court of appeals decisions that the Supreme Court is now considering.

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533. 410 U.S. 113 (1973). *Roe* addressed a challenge by Jane Roe, an unmarried, pregnant woman, to the Texas criminal abortion laws. The Texas law made it a crime to administer or obtain an abortion unless necessary to save the mother's life. TEX. REV. CIV. STAT. ANN. arts. 4512.1-4, 4512.6 (Vernon 1976).

534. 410 U.S. at 153.

535. See *supra* note 515.

536. *Id.*

537. See *infra* notes 542-45 and accompanying text.

538. See *infra* notes 562-65 and 575-87 and accompanying text.

539. See *infra* notes 598-613 and 620-24 and accompanying text.

540. See *infra* notes 628-33 and 643-60 and accompanying text.

541. See *infra* notes 635-41 and 661-75 and accompanying text.

## C. THE ROLE OF THE PHYSICIAN IN THE ABORTION DECISION

1. *The Roe Framework*

In *Roe* the Supreme Court severely limited the power of a state to interfere with the abortion decision. Although the *Roe* Court held that the right to an abortion is a fundamental constitutional right, the Court also explicitly rejected the notion that the right is absolute.<sup>542</sup> State regulations that do not unduly burden a woman's procurement of an abortion are valid. State abortion regulations are not unduly burdensome if they serve a compelling state interest and are narrowly tied to the implementation of that interest.<sup>543</sup>

The Court in *Roe* identified two compelling state interests: the interest in the health of the mother and the interest in the potential life of the fetus.<sup>544</sup> Because first trimester abortions are generally safer than childbirth, the state interest in the mother's health does not become compelling until after the first trimester.<sup>545</sup> The state interest in the life of the fetus becomes compelling at the point of "viability."<sup>546</sup> Viability is defined as the point when the fetus "presumably has the capability of meaningful life outside the mother's womb."<sup>547</sup> The Court indicated that viability occurs approximately 24-28 weeks after conception.<sup>548</sup> Regulations proscribing abortion after viability are thus permissible except when an

542. 410 U.S. at 153.

543. *Id.* at 153, 155. For a thorough discussion of virtually all abortion cases in the federal courts through 1979, see L. WARDLE, *THE ABORTION PRIVACY DOCTRINE: A COMPENDIUM AND CRITIQUE OF FEDERAL ABORTION CASES* (1980).

544. 410 U.S. at 162-63.

545. *Id.* at 163.

546. The state interest in the fetus' potential life appears more important because when this interest becomes compelling—at viability—the state can fully regulate or even prohibit abortions except when the mother's health is endangered. Conversely, the state's interest in the woman's health, though arising at an earlier stage in the pregnancy—after the first trimester—carries with it a narrower scope of permissible state regulation.

Although theoretically the state could prohibit abortions for the sake of maternal health, the least restrictive alternative requirement (for statutes restricting fundamental rights) would lead to lesser restrictions. For example, the state might be able to dictate only the place or method of abortions as opposed to prohibiting abortions altogether.

547. 410 U.S. at 163. Notably, the Court refused to conclude that a fetus was a "person" within the meaning of the fourteenth amendment. *Id.* at 158. If the fetus were a person, an abortion would be murder. This refusal to define a fetus as a person within the fourteenth amendment does not preclude a finding that the state could still assert an interest in a potential person, that is, a viable fetus.

548. *Id.* at 160. For a discussion of the relation of medical technology to the definition of viability, see *supra* notes 152-63 and accompanying text.

abortion is necessary to protect the life or health of the mother.<sup>549</sup> The state, however, must narrowly tailor the regulations to implement the precise state interest at stake.<sup>550</sup>

In a summary of its holding, the Court delineated the framework of the *Roe* decision:

(a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.

(b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

(c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.<sup>551</sup>

After *Roe*, the physician becomes the pivotal outsider in the woman's constitutionally protected abortion decision. In particular, the physician's role is crucial in three distinct situations: the decision to abort, the determination of when viability occurs, and the determination of when the pregnancy endangers the mother's health. The following subsections consider the extent to which the state can interfere with these three determinations. Significantly, protection of the woman's right to an abortion has allowed the physician's role in making these determinations to assume constitutional dimensions.

## 2. *The Decision to Abort the Pregnancy*

The *Roe* framework leaves many important questions unanswered, including the question of who decides whether to terminate the pregnancy. The Court initially identified the decision of

549. *Id.* at 163-64.

550. *Id.* at 165.

551. *Id.* at 164-65. The Court's decision in *Roe* has been severely criticized. In his dissent, Justice Rehnquist argued that the woman's abortion decision was not a fundamental right. Consequently, the Court need only examine state interference with the decision according to the deferential rational basis test. *Id.* at 172-73.

Many commentators have greeted *Roe* with negative reactions. The main criticism of the decision is that it revives the substantive due process doctrine in which the Court substitutes its own opinion for that of the state legislatures. A leading observer has noted that "[w]hat is frightening about *Roe* is that this super-protected right is not inferable from the language of the Constitution." Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 *YALE L.J.* 920, 935-36 (1973); see also Morgan, *Roe v. Wade and the Lesson of the Pre-Roe Case Law*, 77 *MICH. L. REV.* 1724 (1979); but see Tribe, *The Supreme Court, 1972 Term, Forward: Toward a Model of Roles in the Due Process of Life and Law*, 87 *HARV. L. REV.* 1 (1973).



whether to abort as the woman's decision.<sup>552</sup> This determination is the necessary corollary of the determination that it is the woman's right of privacy that the Constitution protects. Other language in the *Roe* opinion, however, interjects the physician into the decisionmaking process: "Up to [viability], the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician."<sup>553</sup> The *Roe* decision, therefore, left unclear exactly whose decision the Constitution protected from state interference.

A related question that *Roe* left unanswered was to what extent state regulation that interfered with the physician's role in the decision to abort the pregnancy was permissible. Arguably, as long as the woman makes the abortion decision, and as long as the state does not hinder the woman's access to a physician, the state is complying with *Roe*.<sup>554</sup> Language in *Roe*, however, implies that the Constitution also protects the physician's role.<sup>555</sup> The strict holding of *Roe* is that state regulations must not unduly burden the woman's right to an abortion. Later cases, however, demonstrate that if regulations limiting the physician's freedom actually restrict the woman's access to an abortion, those restrictions are invalid.<sup>556</sup>

In the companion case to *Roe*, *Doe v. Bolton*,<sup>557</sup> the Court addressed several questions concerning permissible regulation of physicians. In *Doe* the Court examined a Georgia criminal abortion statute that required, among other things, that a hospital abortion committee approve the abortion procedure and that two other

552. 410 U.S. at 153. For additional indication that the woman is the party primarily concerned in the abortion decision, see the language in *Planned Parenthood v. Danforth*, 428 U.S. 52, 60 (1976).

553. 410 U.S. at 166.

554. The physician has no constitutional "right to abort." However, state legislation that interferes with the physician's role also interferes with the woman's ability to secure an abortion. Regulation of the physician thus indirectly interferes with the woman's rights. State regulation of the physician within this context, therefore, is impermissible.

555. See *Roe*, 410 U.S. at 166.

556. See cases cited *supra* note 517.

A physician would, of course, have standing to challenge an abortion statute placing criminal penalties on physicians. Typically, physicians challenge these statutes on grounds of vagueness. See, e.g., *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983) (statute so vague it provides insufficient notice). The question arises about how a physician can challenge an abortion statute on substantive *Roe* grounds. Allowing a physician to challenge such a statute would appear to violate the standing requirements that prohibit a plaintiff from asserting the rights of others. See *Warth v. Seldin*, 422 U.S. 490 (1975). In cases such as *Akron*, however, the Supreme Court has allowed the plaintiff physicians or abortion clinics to attack directly the merits of the abortion law.

557. 410 U.S. 179 (1973).

physicians confirm the attending physician's determination.<sup>558</sup> The Court held that these provisions were unconstitutional under *Roe* because they severely burdened the woman's privacy right and unduly interfered with the judgment of the attending physician.<sup>559</sup>

The Court's decision in *Roe* thus reaffirmed the crucial role of the physician in the abortion decision. Although the state has a compelling interest in the woman's health under *Roe*, the attending physician is in the best position to determine when an abortion is necessary. The Court enumerated those factors relevant to the patient's well-being—physical, emotional, psychological, familial, and age—that a physician could consider in exercising his medical judgment. The Court reasoned that consideration of these health-related factors allowed the attending physician room to make the best medical judgment.<sup>560</sup>

Thus, the *Roe* and *Doe* decisions essentially create a team approach to the abortion decision. The woman, in consultation with her attending physician, decides whether to abort the pregnancy. The state, with its interests in the life of the fetus and the health of the woman, seemingly is relegated to postviability regulation. Many states, however, have not accepted this interpretation and have enacted statutes regulating previability, as well as postviability, abortions.<sup>561</sup>

Informed consent provisions are among the many intricate post-*Roe* regulations that states have imposed on the abortion decision.<sup>562</sup> These provisions require the physician to inform the pregnant woman of various facts that the state legislature, rather than the physician, deems important.<sup>563</sup> Although some states' tort laws impose on all physicians a general duty to disclose,<sup>564</sup> the informed consent abortion statutes often require disclosure of information beyond that necessary to educate the woman. More fundamentally, the statutes intrude into the traditional domain of the

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558. See, GA. CODE ANN. § 26-1202(5) (1972) (repealed 1973). The Georgia statute was modeled after the MODEL PENAL CODE § 230.3 (Proposed Official Draft 1962) GA. CODE ANN. §§ 26-1201 to -03 (1972) (repealed 1973).

559. 410 U.S. at 197-98.

560. *Id.* at 192.

561. See *supra* note 516.

562. Typically such provisions are, in effect, tantamount to the informed consent required under the common law.

563. See *infra* notes 566-85 and accompanying text.

564. See, e.g., *Bang v. Charles T. Miller Hospital*, 251 Minn. 427, 88 N.W.2d 186 (1958); *Gray v. Grunnagle*, 423 Pa. 144, 223 A.2d 663 (1966); *Belcher v. Carter*, 13 Ohio App. 2d 113, 234 N.E.2d 311 (1967).

physician by removing his discretion to determine what information should be disclosed. Apparently, courts determine the dividing line between permissible and impermissible informed consent provisions by the effect the provision will have on the physician's discretion.<sup>565</sup>

In *Planned Parenthood v. Danforth*,<sup>566</sup> the Supreme Court upheld a Missouri abortion statute<sup>567</sup> that required, among other things, a written certification of the woman's consent to the abortion. Rejecting the contention that the statute imposed an extra burden on the woman, the Court reasoned that because the decision to abort is important and often stressful, it is desirable and imperative that the woman make the decision with full knowledge of its nature and consequences.<sup>568</sup> The state may constitutionally assure the woman's awareness of the decision and its significance by requiring her prior written approval.<sup>569</sup> The Court recognized that Missouri did not require the consent regulation for other types of surgery, yet determined that such selectivity was permissible because of the special nature of the abortion decision.<sup>570</sup>

A possible reading of *Danforth*—that states are relatively free to interject consent requirements into the physician-patient relationship—proves incorrect because the proper focus is on the extent of the burden that the consent requirement imposes. In *Roe* the Court held that it would impose strict judicial scrutiny only when a regulation “unduly burdens” the woman's decision.<sup>571</sup> Because the Court found the burden in *Danforth* relatively insubstantial, the Court employed the more deferential “rational basis” test.<sup>572</sup> The Court warned, however, that if a consent requirement, or any other abortion regulation, becomes “an undesired and uncomfortable straitjacket”<sup>573</sup> on the physician, the statute must survive strict scrutiny.<sup>574</sup>

This “straitjacket” of unduly restrictive consent requirements

565. See generally *infra* section VIII of this Special Project.

566. 428 U.S. 52 (1976).

567. House Bill 1211, 1974 Missouri Laws (*reprinted* at 428 U.S. at 84).

568. 428 U.S. at 67.

569. *Id.*

570. *Id.* at 65-67.

571. *Roe*, 410 U.S. at 156. See also, *Bellotti v. Baird*, 428 U.S. 132, 147 (1976) (an abortion regulation is unconstitutional if it unduly burdens a woman's right to seek an abortion).

572. *Maher v. Roe*, 432 U.S. 464, 478 (1977). See generally *WARDLE*, *supra* note 543, at 4.

573. 428 U.S. at 67 n.8.

574. *Id.*

appeared in *City of Akron v. Akron Center for Reproductive Health*,<sup>575</sup> in which an abortion clinic challenged a city ordinance requiring the attending physician to inform the woman of a number of facts, only some of which directly concerned her abortion.<sup>576</sup> The Court invalidated the ordinance and reiterated the overriding principle that the validity of a requirement such as informed consent depends on the state's interest in protecting the health of the pregnant woman.<sup>577</sup> Although *Danforth* had recognized the validity of general informed consent provisions, the *Akron* Court asserted that the physicians had the responsibility to ensure that they convey appropriate information to their patients based on their patients' particular circumstances.<sup>578</sup> Accordingly, a state regulation is impermissible if it becomes overly specific regarding the information a physician conveys.

One concern of the Court when evaluating informed consent requirements is the depth of intrusion into the physician's domain. The *Akron* Court did note that a state may require the physician to inform the patient about the physical and emotional implications of having an abortion.<sup>579</sup> Yet the state cannot impose obstacles in the physician's path by requiring him or her to convey a lengthy and inflexible list of information.<sup>580</sup> The Court, however, has provided little guidance beyond these general parameters. In practice these parameters will be difficult to apply consistently, especially when state statutes require detailed and specific disclosures that relate to the state's legitimate interest in maternal health.

The *Akron* Court also was concerned with the state's motivation for requiring disclosure of certain information. Although the state has an interest in ensuring that the woman make the abortion decision with full knowledge, this interest does "not justify abortion regulations *designed* to influence the woman's informed

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575. 462 U.S. 416 (1983).

576. *Id.* at 442. The statute required disclosure of "the status of her pregnancy, the development of her fetus, the date of possible viability, the physical and emotional complications that may result from an abortion, and the availability of agencies to provide her with assistance and information with respect to birth control, adoption, and childbirth." *Id.*

577. *Id.*

578. *Id.* at 443.

579. *Id.* at 445. "Consistent with its interest in ensuring informed consent, a State may require that a physician make certain that his patient understands the physical and emotional implications of having an abortion." *Id.*

580. *Id.*

choice between abortion or childbirth."<sup>581</sup> Thus, the *Akron* decision indicates that the Court will not uphold informed consent requirements, as well as other abortion regulations, if they either overly intrude into the physician's domain or seek to influence the woman to reconsider her abortion decision. The Court found another provision of the *Akron* statute, which required the attending physician to inform the woman of the risks of the particular abortion procedure<sup>582</sup> as well as any other information that he believes is relevant to her decision,<sup>583</sup> to be clearly related to the state's legitimate interests in requiring informed consent.<sup>584</sup> The Court struck down the provision, however, because it required the physician to personally inform the patient, rather than permitting his assistant to do it.<sup>585</sup>

### 3. *The Determination of Viability*

In *Roe* the Court identified "viability" as the point at which the state's interest in the fetus becomes compelling. The state's other legitimate interest, the health of the mother, becomes compelling at the beginning of the second trimester. Because these two interests have different justifications, they arise at different points in the pregnancy.<sup>586</sup>

The state's interest in a fetus becomes compelling at viability because at that point the fetus "presumably has the capability of meaningful life outside the mother's womb."<sup>587</sup> To protect this compelling interest, the state may regulate or even prohibit abortions, except when an abortion is necessary to preserve the life or health of the mother.<sup>588</sup> The establishment of viability as the operative point in abortion regulation has given rise to a host of legal questions. Two principal questions arise. First, when does viability

581. *Id.* at 443-44 (emphasis added).

582. For a discussion of the various abortion procedures and accompanying risks, see *infra* notes 639-56 and accompanying text.

583. *Id.* at 449; see *id.* at 446 for the full text of the provision.

584. *Id.* at 446.

585. A statute found not unduly burdensome would be subject to the more accommodating rational basis test.

586. The state's interest in the potential life of the fetus arises when the fetus is capable of life independent of the mother. The *Roe* Court identified this point as arising at 24-28 weeks. The state's interest in the health of the mother becomes compelling at the point when abortion is more dangerous to the mother than childbirth. This point occurs, according to the *Roe* Court, at approximately the end of the first trimester. See *supra* notes 544-49 and accompanying text.

587. 410 U.S. at 163.

588. *Id.* at 163-64.

occur? Second, who decides when viability occurs?

The Court's deference to the medical judgment of the attending physician indicates that the answers to these two questions essentially converge; viability occurs when the physician says so. Although the Court in *Roe* did not define the exact point at which viability occurs, the Court did provide limited guidance. The Court stated that the medical and scientific community considers a fetus viable if it is potentially capable of living outside the mother's womb, even with artificial aid.<sup>589</sup> The fetus must be capable of meaningful life. In a later opinion, the Court asserted that meaningful life means more than mere momentary survival.<sup>590</sup>

The Court reported that the medical community usually places viability at seven months, or 28 weeks, although viability may occur earlier, even at 24 weeks.<sup>591</sup> The Court's data, however, reflects the judgment of the medical community in 1973. As medical technology advances, the point of viability is pushed further back toward conception.<sup>592</sup> The Court's trimester approach thus becomes an outmoded concept as the viability determination is tied to advancing medical technology.<sup>593</sup> This realization strengthens the argument that each attending physician should make the viability determination. Because viability is a medical phenomenon, it changes constantly as technology advances. In addition, viability depends inevitably on the particular circumstances of each case. These factors are best known and weighed by the attending physician, thus compelling the conclusion that the attending physician should make the viability decision. The current situation,

589. *Id.* at 160; see also *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) (quoting *Roe*, 410 U.S. at 160).

590. See, *Colautti*, 439 U.S. at 387.

591. 410 U.S. at 160.

592. This dynamic notion of viability led Justice O'Connor, in her dissenting opinion in *City of Akron v. Akron Center For Reproductive Health*, 462 U.S. 416 (1983) to assert that:

The *Roe* framework . . . is clearly on a collision course with itself. As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health is moved further forward to actual childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception . . . .

. . . .

[Thus] that framework is clearly an unworkable means of balancing the fundamental right and the compelling state interests that are indisputably implicated.

*Id.* at 458-59 (O'Connor, J., dissenting).

593. See generally, Note, *Demise of the Trimester Approach?* *City of Akron v. Akron Center for Reproductive Health*, 23 J. FAM. L. 267 (1985).

however, creates the irony that the state can prosecute physicians for postviability abortions, but the physician is the party most capable of deciding when viability occurs. The Court has never recognized this irony although it has concluded that the physician should determine viability.

In *Roe* the Court did discuss the attending physician's decisionmaking role up to the point of the viability decision:

[This] decision vindicates the *right of the physician* to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to these points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.<sup>594</sup>

Although this passage implies that the physician plays the pivotal outside role in the abortion decision, the Court merely identified the physician as the person best qualified to make medical decisions about the pregnancy. By deferring to the physician's expertise only up to the point of viability, the Court stopped short of making the physician the determiner of viability.

In *Danforth* the Court filled this void left by *Roe* by clearly establishing the attending physician's role as the determiner of viability. Recognizing that viability is essentially a medical concept and may vary with each pregnancy, the Court stated the determination of whether a particular fetus is viable must be a matter for the judgment of the attending physician.<sup>595</sup> This assertion, which is clearly an expansion of *Roe*, could be construed as an additional limitation on state regulation. If the viability determination is solely that of the physician, then any state regulation attempting to define viability would be impermissible. The *Danforth* Court, however, did not go this far. Although the Court did leave the actual determination of viability to the physician, *Danforth* did not totally foreclose state legislation from defining viability.<sup>596</sup>

A dilemma remains after *Roe* and *Danforth*. If the state has a legitimate interest in protecting the life of a "viable" fetus, which the state clearly does under *Roe*, how can the state protect this

594. 410 U.S. at 165-66 (emphasis added).

595. *Danforth*, 428 U.S. at 64. The Court stated expressly that "it [was] not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period." *Id.*

596. The Court actually upheld the Missouri provision defining viability "as 'that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems.'" *Id.* at 63 (quoting § 2(2) of the Missouri abortion legislation, reprinted at 428 U.S. at 84).

interest if the state, on its own, cannot identify when viability occurs? Perhaps the answer lies in the Court's unexpressed conclusion that the state's interest is not nearly as great as the woman's interest. If the Court gives the state too much power to regulate the viability decision, the result may be that women are unable to exercise their right to an abortion. The threat of prosecution may deter a physician who is otherwise willing to perform an abortion on what he considers to be a nonviable fetus. Consequently, the state's binding determination concerning viability would penalize the woman.<sup>597</sup>

In *Colautti v. Franklin*<sup>598</sup> the Court attempted to clarify the scope of permissible postviability regulation, but actually confused the issue.<sup>599</sup> In *Colautti* the Court invalidated the Pennsylvania Abortion Control Act,<sup>600</sup> which placed broad restrictions on abortions and imposed criminal liability on noncomplying physicians.<sup>601</sup> The Pennsylvania legislature had seized upon the language in *Roe* which indicated that a state may prohibit abortions when the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid."<sup>602</sup> Based on this language, the legislature felt justified in imposing criminal liability on a physician who failed to use the statutorily prescribed abortion technique when the fetus was viable or when there was sufficient reason to believe that the fetus may be viable.<sup>603</sup> The Pennsylvania act, therefore, confronted the Court with the conflict it had created in *Roe* and *Danforth*—the state's power to protect its interest in the fetus through criminal legislation versus the physician's freedom to treat his patient as he

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597. A state is always free to prohibit abortions after viability. The question here is when viability occurs. Of course, the state need not enact any abortion legislation at all.

598. 439 U.S. 379 (1979).

599. See NOWAK, *supra* note 520, at 747-50.

600. PA. STAT. ANN., tit. 35, § 6605(a) (Purdon 1977) (repealed 1982).

601. The Act reads in pertinent part:

(a) Every person who performs or induces an abortion shall prior thereto have made a determination based on his experience, judgment or professional competence that the fetus is not viable, and if the determination is that the fetus is viable or if there is sufficient reason to believe that the fetus may be viable, shall exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

*Id.*

602. *Roe*, 410 U.S. at 160.

603. See *supra* note 601.



sees fit and the woman's right to receive unencumbered medical treatment.

The Court, after restating its earlier holdings concerning viability and noting that no decisions have upheld state attempts to stretch the time of viability in one direction or the other,<sup>604</sup> found the Pennsylvania statute impermissibly vague.<sup>605</sup> The Court focused on the section of the statute that required the physician to conform to a prescribed standard of care. Because the statute conditioned potential criminal liability on confusing and ambiguous criteria and did not give broad discretion to the attending physician, the Court concluded that the statute had a "chilling effect on the exercise of constitutional rights."<sup>606</sup> The *Colautti* Court found that the statute's sanctions for an abortion performed when there is sufficient reason to believe that the fetus may be viable were unjustified.<sup>607</sup> Because it was unclear whether the statute imposed a subjective or objective criterion, the provision regarding who may determine the fetus' potential viability was ambiguous.<sup>608</sup> Thus, the statute, as construed by the Court, improperly attempted to impose criminal liability without fault.<sup>609</sup>

The state argued, and the dissent agreed,<sup>610</sup> that no prosecution would occur under the statute when the physician made a

604. 439 U.S. at 389.

605. *Id.* at 390. ("We agree . . . that the viability-determination requirement of § 5(a) is ambiguous, and that its uncertainty is aggravated by the absence of a scienter requirement with respect to the finding of viability.")

606. *Id.* at 394. Interestingly, the Court makes reference to the physician's "constitutional rights." The Court, however, does not elaborate. Because the Court was speaking in the context of the lack of notice provided by the statute, the physician's due process rights are apparently the rights that are chilled. However, the use of "exercise" here implies that the Court is referring to the physician's abortion role because to speak of the exercise of the right to notice under a statute would seem odd. Consequently, apparently either a) the physician has a constitutionally recognized "right to abort" or b) the physician can somehow "exercise" the woman's right to an abortion. Neither proposition has been recognized explicitly and neither has any logical foundation. Yet one of the propositions must be true in order for the Court's statements in *Colautti* to have any meaning.

607. *Id.* at 391.

608. The provision was ambiguous about whether there must be "sufficient reason" from the perspective of the judgment, skill, and training of the attending physician, or whether there must be "sufficient reason" from from the perspective of a cross section of the medical community or a panel of experts. *Id.*

609. The Court noted that as a matter of due process, a criminal statute is void for vagueness when it fails to give a person of ordinary intelligence fair notice that the conduct contemplated is forbidden or when the statute is so indefinite that it encourages arbitrary and erratic convictions. *Id.* at 390.

610. *Id.* at 407-08 (White, J., dissenting).

mistake about whether or not a fetus was viable.<sup>611</sup> This admission by the state renders the majority's holding inconsistent. One can only conclude that the majority either did not believe the state's assertion—in which case the Court should have ordered abstention, thus allowing the state courts to interpret the statute<sup>612</sup>—or that the majority was consciously expanding the physician's role by prohibiting state regulation of a "potentially" viable fetus. Justice White commented in dissent that the Court appeared to be tacitly disavowing the "potential ability to live outside the mother's womb" component of viability described in *Roe*. Justice White viewed this attitude as an additional constitutionally unwarranted intrusion on the states' police powers.<sup>613</sup>

Although the *Colautti* Court purported to be merely restating the crucial role of the attending physician, the decision actually lessened the states' power to protect their recognized interest in a viable fetus and correspondingly increased the physician's power to decide whether to perform an abortion. The state apparently may not enumerate the elements making up the viability determination. What role the state can play remains unclear after *Colautti*. Some commentators, however, read *Colautti* as indicating that a state can write only a general statute prohibiting abortions after viability and hope that physicians will not abort a viable fetus.<sup>614</sup> If this reading is accurate, then the state's compelling interest in protecting a viable fetus is form without substance.

#### 4. *The Determination of Danger to Maternal Health*

In *Roe* the Court identified protection of the mother's health as a legitimate state interest.<sup>615</sup> The Court, however, created a con-

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611. *Id.* at 407.

612. Abstention is a judicially created doctrine that allows a federal court to remand a case to the state courts when an interpretation of an unclear state statute may avoid a constitutional issue. See *Railroad Commission v. Pullman Co.*, 312 U.S. 496 (1941). Generally, the plaintiff can reserve his federal questions in state court and have the federal court decide them if the case returns to federal court. See *England v. Louisiana State Board of Medical Examiners*, 375 U.S. 411 (1964). See generally, Field, *Abstention in Constitutional Cases: The Scope of the Pullman Abstention Doctrine*, 122 U. PA. L. REV. 1071 (1974).

613. 439 U.S. at 406-07 (White, J., dissenting).

614. See NOWAK, *supra* note 520, at 749.

615. Because first trimester abortions are safer than childbirth, the Court held that the Constitution virtually precludes states from regulating first trimester abortions. See Dellapenna, *The History of Abortion: Technology, Morality and Law*, 40 U. PRR. L. REV. 359, 413-14 (1979). The states may regulate first trimester abortions only if the regulations "have no significant impact on the woman's abortion right" and are "justified by important state health objectives." *Akron*, 462 U.S. at 430. After the first trimester, the state may regulate

flict by also identifying protection of the viable fetus as a legitimate interest. This conflict between fetal and maternal rights poses the question of defining the scope of permissible state regulation of abortion of a viable fetus when the mother's health is endangered. The Court answered this question by allowing an exception that permits an abortion of a viable fetus when the abortion is necessary to protect the life and health of the mother.<sup>616</sup>

In allowing this exception, however, the Court created another question: when is the mother's health in jeopardy, and who makes this decision? Although *Roe* left this question unanswered, the Court in *Doe* concluded that the attending physician should make the medical determination of maternal health in the light of all factors relevant to the patient's well-being.<sup>617</sup> This language effectively leaves the health determination to the physician and removes whatever state power might have been left after *Roe*. After *Doe*, if the physician determines that an abortion is necessary, even in the last week of pregnancy, the state apparently is precluded from intervening.<sup>618</sup>

In response to the latitude given to physicians after *Roe* and *Doe*, many states enacted regulations proscribing abortions of a viable fetus, or prescribing the required method of abortion, even though the pregnancy could result in harm to the mother. Typically these regulations merely forbid postviability abortions and impose criminal penalties.<sup>619</sup> Problems arise, however, when these provisions call for a trade-off between the health of the mother and the life of the fetus.

A "trade-off" conflict between the mother's health and the fetus' life was present in *Colautti* when the Pennsylvania statute required the physician to employ the abortion technique that provided for the greatest opportunity for fetal survival unless a different method would be necessary to preserve the life or health of the mother.<sup>620</sup> The plaintiffs attacked this provision because it

the abortion procedure only to the extent that the regulation reasonably relates to preserving and protecting the mother's health. *Id.*

616. 410 U.S. at 163-64.

617. *Doe*, 410 U.S. 179, 192 (1973).

618. See generally, Note, *Hospitalization Requirements for Second Trimester Abortions: For the Purpose of Health or Hindrance?*, 71 GEO. L. J. 991 (1983).

619. See, e.g., S.C. CODE ANN. § 44-41-20 (Law. Co-op. 1976); PA. STAT. ANN., tit. 35, § 6605(a) (Purdon 1977) (repealed 1982).

620. 439 U.S. 379, 397 (1979). The Pennsylvania statute required the physician to exercise that degree of professional skill, care and diligence to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique

prohibited the widely used saline amnio-infusion method of abortion.<sup>621</sup> Although saline solution is the method of abortion chosen most often by physicians because of the method's safety value, it is also nearly always fatal to the fetus.<sup>622</sup> The alternate abortion methods that were available under the statute increased the likelihood of fetal survival.<sup>623</sup> These methods, however, also increased the health problems for the mother.<sup>624</sup>

The Court found that the statute's failure to provide that the mother's health prevail over the fetus' survival rendered the statute unconstitutional. Because the statute only required a safer technique when it was "necessary" to protect the mother's health, with the implication that lack of a necessity was insufficient, the statute impermissibly burdened the mother's right and intruded into the physician's protected domain.<sup>625</sup> Because "necessary" is a vague guideline for the imposition of criminal sanctions, the statute gave the physician insufficient notice of his potential criminal liability. The Court concluded that the statute would ultimately hinder the woman in her effort to find a willing physician.<sup>626</sup>

After *Colautti* a state apparently cannot subject the physician to criminal penalties if the physician reasonably concludes an abortion is necessary to protect the life or health of the mother. Accordingly, any provision regulating postviability abortions must not overly intrude on the physician's ability to perform an abortion when he or she concludes it is necessary to protect the mother's health. The Court has yet to make clear exactly what type and degree of threat to maternal health gives rise to the exception.

The question also remains concerning how much of a trade-off between the mother's health and the fetus' survival is permissible.

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employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.

PA. STAT. ANN., tit. 35, § 6605(a)(Purdon 1977) (repealed 1982).

621. Saline abortion involves injecting a saline solution into the amniotic fluid which burns the fetus. Labor is then induced to expell the dead or injured fetus. *See infra* text following note 644.

622. 439 U.S. at 398.

623. *Id.* at 398-99.

624. *Id.* The Court noted that "it is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a 'trade-off' between the woman's health and additional percentage points of fetal survival." *Id.* at 400. The Court held only that when conflicting duties of this magnitude are concerned, a state must be more precise before it can subject a physician to possible criminal sanctions. *Id.* at 401.

625. *Id.*

626. *Id.*

Language in *Doe* indicates that the physician must make the health determination in light of *all* factors, including the woman's emotional well-being. Given this approach, the *Colautti* opinion leaves open the possibility that a physician could abort an eight-month fetus because childbirth might be too emotionally wrenching for the mother or because the mother might suffer temporary or minor medical complications. Seemingly, a relatively minor health problem should not defeat the state's interest in the fetus. Yet the question is more than just one of degree. Any statute that forces a trade-off between the woman and the fetus will invariably intrude into the recognized domain of the physician. The Court has not upheld any such intrusion. Consequently, with the maternal health determination, as well as with the viability determination, the ultimate decision is that of the physician rather than the state.

#### D. INDIRECT REGULATION OF THE PHYSICIAN: THIRD PARTY CONSENT OR NOTIFICATION STATUTES

Under *Roe* and its progeny, the abortion decision is primarily the concern of the woman in consultation with her physician. The physician's role itself has acquired constitutional protection, although this protection apparently arises from the woman's constitutional right of privacy.<sup>627</sup> In an attempt to regulate abortions, states have interfered with the physician by direct regulation of his practice. In a conceptually distinct, although practically similar, manner states also have interfered with the abortion process by interjecting various third parties. Typically such provisions require the physician either to notify a parent or spouse of the abortion or to obtain their consent before performing the abortion.

##### 1. *The Spouse as Third Party*

Although the male partner contributes equally to the pregnancy, his subsequent legal rights are minimal. The woman's autonomy and constitutional rights are not diminished when she and the father are married. Some states, in an attempt to hinder the woman's abortion decision, have attempted to interject the male into the decision process when he and the woman are married. These states require the physician either to notify the husband of the abortion or to obtain his consent, or both. Generally these at-

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627. See *supra* note 606.

tempts have failed, particularly when the states require consent.<sup>628</sup>

Arguably, the spouse has a real interest in the decision to abort. Besides the obvious emotional and familial ties, the state may legally obligate the male to support the child even though he may have desired that the mother procure an abortion. Similarly, he may fervently desire that the child be born and yet have no role in the decision to abort. Although these interests are strong, they do not justify state delegation of power to the spouse to defeat a woman's fundamental constitutional right.

### (a) Spousal Consent Statutes

In *Danforth*<sup>629</sup> the Supreme Court struck down a provision of the Missouri abortion statute<sup>630</sup> that required the spouse's prior written consent before a woman could have her pregnancy aborted. The State argued that the provision merely implemented its legitimate interest in the institution of marriage.<sup>631</sup> The Court held that the state may not constitutionally require spousal consent as a condition for abortion during the first trimester.<sup>632</sup> This conclusion is a logical corollary of *Roe*, which said that because the state has no authority to regulate or proscribe abortion during the first trimester when the decision belongs to the physician and the woman, the state cannot delegate that authority to any other person, even the spouse.<sup>633</sup> Consequently, the Court has established that states may not require spousal consent.

### (b) Spousal Notification Statutes

The question remains whether spousal notification statutes are constitutional. To date, only one lower court has considered the question. In *Schienberg v. Smith*<sup>634</sup> the United States Court of Appeals for the Fifth Circuit upheld a Florida spousal notification provision.<sup>635</sup> The State justified the requirement by emphasizing

628. See generally Note, *Spousal Notification: An Unconstitutional Limitation on a Woman's Right to Privacy in the Abortion Decision*, 12 HOFSTRA L. REV. 531 (1984).

629. 428 U.S. 52.

630. Section 3(3) of House Bill No. 1211, 1974 Missouri Laws reprinted at 428 U.S. at 85.

631. 428 U.S. at 68.

632. *Id.* at 69.

633. *Id.*

634. 659 F.2d 476 (5th Cir. 1981).

635. FLA. STAT. ANN. § 390.001(4)(b) (West 1981). The provision required "a married woman presently living with her spouse to notify her husband of her intent to terminate her pregnancy and to provide him with the opportunity to consult with her concerning the abor-

the state's interest in the marital relationship and the husband's interest in procreation.<sup>636</sup> The Fifth Circuit agreed, holding that the state's interest in marriage justifies the burden imposed on the woman's abortion decision. The court reached this decision by relying on "the basic values that underlie our society."<sup>637</sup> The court distinguished *Danforth*, which rejected a spousal consent statute.<sup>638</sup> The parties did not challenge a notification provision in *Danforth*, and, therefore, that case should not be cited as authority for the validity of notification provisions.

The Fifth Circuit found the state's interest in the marriage compelling, noting that the Supreme Court has traditionally recognized the crucial role of the marriage relationship in society. The court found that this interest justifies the burden it imposes on the woman. This conclusion, however, is unacceptable in light of Supreme Court decisions holding that state interference with first trimester abortions must be related to maternal health. Because the State's justification in *Schienberg* was its interest in marriage, not maternal health, the case arguably is wrongly decided.<sup>639</sup>

A notification statute may be permissible only if it does not "unduly burden" the woman's abortion decision. A statute that did not impose an undue burden would survive the rational basis test. Scenarios could arise, however, in which spousal notification will unduly burden the woman's decision to abort. As the district court in *Schienberg* noted,<sup>640</sup> spousal notification could result in physical and mental abuse of the woman. Given the traditionally dominant role of the husband, the male's opinion could well be outcome-determinative. This situation could severely burden the woman's constitutionally protected right to decide whether to terminate her pregnancy.<sup>641</sup>

tion procedure." 659 F.2d at 482.

636. 659 F.2d at 483.

637. *Id.* at 484 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977)).

638. 659 F.2d at 484-85.

639. For another commentator's conclusion that *Schienberg* was wrongly decided, see Werth, *Spousal Notification and the Right of Privacy*, 59 CHI.-[ ]KENT L. REV. 1129, 1145-50 (1984).

640. 482 F. Supp. 529 (S.D. Fla. 1979) *aff'd in part vacated in part* 659 F.2d 476 (5th Cir. 1981).

641. *Id.* at 538. The district court noted:

Specific instances where a woman might desire or choose not to communicate with her husband concerning an impending termination of pregnancy include:

- 1) where the husband is not the father of the fetus; for instance, where the fetus is the product of an extramarital affair;
- 2) where the wife has been a rape victim, has not disclosed the incident to her

## 2. *The Parent as Third Party*

### (a) Parental Consent Statutes

When the pregnant woman is an unmarried minor, her parents may have an interest in the decision whether or not to terminate her pregnancy. States have attempted to protect this parental interest by passing statutes requiring the parent's consent before the minor can have an abortion.<sup>642</sup>

*Roe* did not answer the question of whether the traditional legal differentiation between minors and adults extends to abortion law. Arguably, because abortion is a fundamental right and because minors enjoy the same constitutional protections as adults,<sup>643</sup> courts should fully protect minors from state interference. The Supreme Court, however, has not so held.

In *Danforth* the Court invalidated a Missouri parental consent provision. The Court held that a state cannot impose a *blanket* consent provision because this type of a provision constitutes a delegation of a power that the state does not possess.<sup>644</sup> The Court, however, acknowledged that a state's regulatory authority over children is broader than the state's authority over adults.<sup>645</sup> Although the state asserted a compelling interest in maintenance of the family unit as a justification for the blanket consent requirement, the Court responded that the statute's parental veto would not further that interest.<sup>646</sup> The Court found that the statute was

husband, and has subsequently become pregnant;

3) where the husband, because of strong religious or moral precepts, would strenuously object;

4) where the husband is seriously ill or emotionally unstable and is unable to participate in an abortion decision; and

5) where the woman is a "battered wife" and fears that discussion concerning an abortion may precipitate physical violence.

*Id.* (footnotes omitted).

The district court's list is not exhaustive. For example, a woman might choose not to communicate with her husband concerning an impending termination of pregnancy if the marriage was unstable and the wife was contemplating divorce.

642. See, e.g., LA. REV. STAT. ANN. § 40:12.35, 35.5 (West Supp. 1980) (requiring parental notice for all unmarried women under 18 years old); MINN. STAT. ANN. § 144.343.2(a) (West 1984) (requiring 48-hour parental notice); TENN. CODE ANN. § 39-4-202(f) (1982) (requiring parental notice for minors under 18 years of age).

643. See *Danforth*, 428 U.S. at 74. The *Danforth* Court applied the same reasoning to Missouri's spousal consent provision. See *supra* text accompanying notes 629-32.

644. 428 U.S. at 74.

645. *Id.* at 74-75.

646. *Id.* at 75. The Court stated:

It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate



overly broad and, therefore, unconstitutional.

In *Bellotti v. Baird (Bellotti II)*<sup>647</sup> the Court readdressed the issue of state parental consent statutes. The Court sustained a challenge to a Massachusetts law that regulated minors' access to abortions and attempted to define the permissible scope of such regulations. The Massachusetts statute required an unmarried pregnant minor under the age of eighteen to obtain the consent of both parents before she could obtain an abortion.<sup>648</sup> The Supreme Court first compared the constitutional rights of children to those of adults. The Court noted that although the Constitution protects children, the rights of children cannot be equated with those of adults.<sup>649</sup> The Court cited three reasons for this difference in treatment: (1) the peculiar vulnerability of the child; (2) the relative inability of the child to make a mature, informed decision; and (3) the importance of the parental role in the childbearing process.<sup>650</sup> The Court concluded that the state may adjust its legal system to take into account children's vulnerability<sup>651</sup> and recognized the need for states to defer to parental control.<sup>652</sup> The Court interjected a vague caveat to this holding: because of the unique nature of the minor's decision to obtain an abortion,<sup>653</sup> states must act with "particular sensitivity" when attempting to involve parents in the process.<sup>654</sup>

Turning its attention to the statute in question, the Court reiterated the *Danforth* requirement that states cannot impose blan-

the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.

*Id.*

647. 443 U.S. 622 (1979). In *Bellotti I*, 428 U.S. 132 (1976), the Court ordered the district court that had originally tried the case to abstain and send the case to the state courts for an interpretation of the statute. *Bellotti II* is the opinion of the case after it had worked its way back up to the Supreme Court.

648. *Id.* at 625.

649. *Id.* at 633-34.

650. *Id.* at 634.

651. *Id.* at 635.

652. *Id.* at 637-38.

653. *Id.* at 642. In distinguishing the abortion decision from other situations in which parental consent is required before the minor may act—for example, the decision to marry—the Court emphasized the "grave and indelible" consequences of unwanted motherhood and the impossibility of postponing the decision.

654. *Id.* at 642.

ket parental consent requirements in the first twelve weeks of pregnancy.<sup>655</sup> The Court chose not to forbid all consent requirements and held instead that the state must provide an alternative procedure to obtain authorization for the abortion.<sup>656</sup> The alternative procedure for obtaining authorization must ensure that an absolute veto power is unavailable to the parent.<sup>657</sup> The Court then delineated an alternative procedure in which a pregnant minor can obtain judicial approval for an abortion without requiring parental notification or consent. Judicial approval for the abortion must be given if the minor can show either that she is sufficiently mature and informed to make the decision or that the abortion is in her best interests.<sup>658</sup> The Court found that the Massachusetts statute fell short of this requirement. Although the statute provided an alternative procedure for obtaining authorization, the procedure was deficient because it permitted judicial approval to be withheld from a mature and competent minor, and because it required parental consultation or notification in each case.<sup>659</sup> By refusing to prohibit all requirements of parental consent, however, the Court in *Bellotti II* allowed the state to delegate authority to the parent that the state did not possess, and, thus, expanded the state's power to restrict teenage abortions.<sup>660</sup>

### (b) Parental Notification Statutes

In *H. L. v. Matheson*<sup>661</sup> the Court significantly extended the scope of state control over teen-age abortions by upholding the Utah parental notification statute. In *Matheson* a fifteen-year-old girl challenged the constitutionality of a Utah statute that required the physician to notify the parents or guardian of a minor upon whom an abortion was to be performed.<sup>662</sup> Although a majority of

655. *Id.* at 643.

656. *Id.*

657. *Id.*

658. *Id.* at 644.

659. *Id.* at 651.

660. *Danforth* expressly held that states cannot delegate a power that they do not possess. See *supra* text accompanying note 643. Because states, prior to *Bellotti II*, could not restrict immature minors' access to abortions, the result in *Bellotti II* was a clear expansion of state power.

661. 450 U.S. 398 (1980).

662. *Id.* at 400. UTAH CODE ANN. § 76-7-304 (1978) provides:

To enable the physician to exercise his best medical judgment [in considering a possible abortion] he shall:

(1) Consider all factors relevant to the well-being of the woman upon whom the abortion is to be performed included, but not limited to,

the Court could not agree on a rationale for upholding the law, a plurality found the statute imposed burdens that were sufficiently tailored to the state's legitimate interest in the welfare of the minor.<sup>663</sup>

Writing for the Court, Chief Justice Burger distinguished the Utah statute from the Massachusetts statute invalidated in *Bellotti II*.<sup>664</sup> Whereas the Massachusetts statute in *Bellotti II* had required parental consent for abortions performed on mature minors, the Utah statute required only parental notification. The Court quoted a concurring opinion in *Danforth* which stated that the state furthers a constitutionally permissible end when it encourages an unmarried minor to seek the help and advice of her parents in deciding whether to terminate her pregnancy.<sup>665</sup>

The Court also relied on language in earlier decisions recognizing the parents' constitutional right to direct the rearing of their children in their own household.<sup>666</sup> The *Bellotti II* Court's concern that parental consent could effectively preclude an abortion decision by a mature minor apparently is not present when the state only requires parental notification. To the contrary, the Court found that the Utah statute furthered the important state interests of family integrity and adolescent protection because the statute applied to immature and dependent minors.<sup>667</sup> The plurality, however, virtually ignored the extent of the burden that such a statute places on the minor's constitutional right to an abortion.

In his concurrence, Justice Powell, along with Justice Stewart, limited the effect of the Court's holding. Powell joined the Court's opinion "on the understanding that it leaves open the question whether [the statute] unconstitutionally burdens the right of a mature minor or a minor whose best interests would not be served by

- (a) Her physical, emotional and psychological health and safety,
- (b) Her age,
- (c) Her familial situation.

(2) *Notify, if possible, the parents or guardian of the woman upon whom the abortion is to be performed, if she is a minor or the husband of the woman, if she is married.*

(emphasis added)

663. Chief Justice Burger delivered the opinion of the Court, joined by Justices Stewart, White, Powell, and Rehnquist. Justices Powell, Stewart and Stevens filed concurrences. Justices Marshall, Brennan and Blackmun dissented.

664. See *supra* notes 647-60 and accompanying text.

665. 450 U.S. at 409-10 (quoting *Danforth*, 428 U.S. at 91 (Stewart, J., concurring)). See also *Bellotti II*, 443 U.S. at 657 (White, J., dissenting).

666. 450 U.S. at 410.

667. 450 U.S. at 411.

parental notification."<sup>668</sup>

Justice Stevens' concurrence examined the physician's role in the minor's abortion decision. Justice Stevens reasoned that the physician's medical judgment is to be respected, but even the most conscientious physician's interests in the overall welfare of a minor cannot be equated with those of most parents.<sup>669</sup> Concluding that the physician's opinion does not outweigh state and parental interests,<sup>670</sup> Justice Stevens upheld the state intervention in this case.

In dissent Justice Marshall emphasized the narrowness of the Court's holding because the Court had not examined the constitutionality of the statute as applied to mature minors.<sup>671</sup> Justice Marshall nevertheless chastised the plurality for ignoring the reality of teenage pregnancies. He reasoned that parental interference resulting from the state-imposed notification requirement will cause many minors to delay their abortion decisions until after the first trimester.<sup>672</sup> Consequently, these minors will incur greater health risks.<sup>673</sup> Other teenagers likely will attempt more radical alternatives such as illegal or self-induced abortions.<sup>674</sup> Consequently, Justice Marshall concluded that the statute impermissibly burdened the minor's fundamental right to choose, in consultation with her physician, whether to terminate her pregnancy.<sup>675</sup>

If the Court has accepted the notion that the Constitution entitles minors to less protection than adults, then a pregnant teenager's right to secure an abortion is seriously jeopardized. The result is curious because the state's interest in the family justifies statutes allowing *parents*, not states, to restrict the minor's right to have an abortion. In this sense, the state action is neutral. In reality, however, the state is successfully circumscribing the minor's rights. The Court has held firm to the principle that the state cannot require parental consent, and the concurrences emphasize *Matheson's* narrow ruling. The present mature-immature distinction in *Matheson* may prove workable, yet this case is one of the few Supreme Court decisions allowing state intrusion on the physi-

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668. *Id.* at 414 (Powell, J., concurring).

669. *Id.* at 420 n.8 (Stevens, J., concurring).

670. *Id.* at 419-20 (Stevens, J., concurring).

671. *Id.* at 425-26 (Marshall, J., dissenting). The Court had denied standing to the plaintiff in this class action to the extent that she purported to represent mature minors. *Id.* at 405-06.

672. *Id.* at 438.

673. *Id.* at 439.

674. *Id.*

675. *Id.* at 454.

cian-patient abortion decision. That the case allows states to interject others into the decision, rather than directly interfering itself, is of little practical consequence. The net result is an interference with a pregnant minor's exercise of her constitutional right to decide whether to terminate her pregnancy.

#### E. THE ROLE OF THE PHYSICIAN RE-EXAMINED: INFORMED CONSENT CASES PENDING BEFORE THE SUPREME COURT

Although existing case law insulates the physician fairly well from state intrusion, the Supreme Court, quite possibly, may expand the states' power to regulate abortion. During the 1985 October Term, the Court heard oral arguments<sup>676</sup> on appeal<sup>677</sup> of two recent court of appeals decisions that struck down provisions of informed consent abortion statutes. Because the holdings in both cases appear to comply with existing Supreme Court precedent, the Court's grant of certiorari may indicate that the Court is considering changing the law to allow for greater state intervention.<sup>678</sup>

In *Charles v. Daley*<sup>679</sup> the United States Court of Appeals for the Seventh Circuit struck down various provisions of the Illinois abortion law.<sup>680</sup> Precedent clearly warrants the holding, although an alternative resolution of the case was possible. Because the court struck the statute on grounds of vagueness, the Seventh Circuit could have abstained and remanded the case to the Illinois state courts for a determination of the state law.<sup>681</sup> The provisions at issue in *Daley* regulate the attending physician. The most important provisions impose a standard of care on physicians and their assistants who abort a fetus. According to the statute, the physician performing any abortion of a viable fetus<sup>682</sup> or a fetus

676. The Supreme Court held oral arguments for the cases on November 5, 1985.

677. The case names on appeal are *Diamond v. Charles*, 84-1379 and *Thornburgh v. American College of Obstetricians and Gynecologists*, 84-495.

678. The Court most likely would not grant certiorari and hear full oral arguments if it merely planned to affirm the cases. Because only four votes are required to hear the case, however, a majority of the Court may intend to affirm.

679. 749 F.2d 452 (7th Cir. 1984).

680. ILL. STAT. ANN. ch. 38, § 81-26 (Smitb-Hurd 1983) (amended 1984).

681. See *supra* note 612.

682. Section 6(1) of the Illinois law provided:

No person who intentionally terminates a pregnancy after the fetus is known to be viable shall intentionally fail to exercise that degree of professional skill, care and diligence to preserve the life and health of any fetus intended to be born and not aborted. Any physician or person assisting in such a pregnancy termination who shall intentionally fail to take such measures to encourage or to sustain the life of a fetus known to be viable, before or after birth, commits a Class 2 felony if the death of the viable fetus or

that is possibly viable,<sup>683</sup> must use the same standard of care that a physician would use in preserving the life and health of the fetus.

The Seventh Circuit struck down the provision regulating abortions of viable fetuses on grounds of vagueness. Because the statute did not specify who was to make the viability determination—the physician or his assistant—the statute was vague.<sup>684</sup> The provision was unconstitutionally vague because it prescribed criminal sanctions for physicians without adequately describing the prohibited conduct. This type of sanction hinders the physician because he is given insufficient notice of a possible violation that, in turn, significantly burdens a woman's right to terminate her pregnancy.<sup>685</sup>

The Seventh Circuit also invalidated the provision regulating abortions of a possibly viable fetus. Because the statute might induce a physician to refuse to perform an abortion for fear of criminal sanctions, the court held that the statute interfered with a woman's right to an abortion.<sup>686</sup> On a more fundamental level, the court rejected the state's proffered interest in enacting the statute—an interest in the viable fetus. Because the statute necessarily applied to previability fetuses, the statute exceeded the scope of the state's interest.<sup>687</sup>

A separate provision of the Illinois act required the physician to inform the patient of the abortion method being used and whether the procedure would result in fetal death.<sup>688</sup> Specifically, the statute required physicians who prescribe "abortifacients,"<sup>689</sup>

infant results from such failure.

ILL. STAT. ANN. ch. 38 § 81-26 (Smith-Hurd 1983) (amended 1984).

683. Section 6(4) provided:

No person who intentionally terminates a pregnancy shall intentionally fail to exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted when there exists, in the medical judgment of the physician performing the pregnancy termination based on the particular facts of the case before him, a possibility known to him of more than momentary survival of the fetus, apart from the body of the mother, with or without artificial support.

ILL. STAT. ANN. ch. 38, § 81-26 (Smith-Hurd 1983) (amended 1984).

684. 749 F.2d at 459-60.

685. *Id.* at 461.

686. *Id.* at 460-61.

687. *Id.* at 461.

688. ILL. STAT. ANN. ch. 38 §§ 81-22(7), 81-31(c) (Smith-Hurd 1983).

689. The statute defines "abortifacient" as any substance or device which is known to cause fetal death. *Id.* at ch. 38 § 81-22(7). This definition would include such devices as the intrauterine device (IUD) and DES ("morning after pill"). For a discussion of this issue, see

to inform the mother that these devices cause fetal death.<sup>690</sup> After reviewing the Supreme Court cases dealing with informed consent provisions, the Seventh Circuit found that the Illinois requirement impermissibly regulated the physician. Requiring the physician to disclose this information impermissibly intruded on the physician's medical discretion at a stage when the state's interest is not compelling.<sup>691</sup> The state's interest in the woman's health does not justify such a disclosure requirement because the state is, in essence, foisting on the woman the state's theory of fetal death.<sup>692</sup> Because neither recognized state interest is compelling, the regulation was impermissible.<sup>693</sup>

The Supreme Court's decision in *City of Akron v. Akron Center for Reproductive Health*,<sup>694</sup> clearly warranted this conclusion. Although in *Akron* the state required detailed information to be given, the information required in *Daley* was different only in degree, not in substance. The Court has consistently recognized the physician's need to retain control of his relationship with his patient.<sup>695</sup>

In *American College of Obstetricians and Gynecologists v. Thornburgh*,<sup>696</sup> the United States Court of Appeals for the Third Circuit struck down various provisions of Pennsylvania's abortion law that directly regulated the physician.<sup>697</sup> Although the court was deferential to the legislature, construing provisions narrowly to avoid constitutional infirmities and "overlooking what may reasonably be deemed to be a pervasive invalid intent,"<sup>698</sup> the court invalidated provisions requiring informed consent and the "trading-off" of the mother's health.

The statute's informed consent provision required that the physician convey five categories of information to the pregnant woman.<sup>699</sup> The Third Circuit noted that no Supreme Court opinion

text accompanying notes 139-40. See also Rust, "The Abortion Cases," 72 A.B.A. J. 50, 51 (Feb. 1, 1986).

690. ILL. STAT. ANN. ch. 38 §§ 81-22(7), 81-31(c).

691. 749 F.2d at 462.

692. *Id.* The problem rests in part upon a disputed definition of "fetal death," specifically whether abortifacient devices cause "death" similar to abortion. See Rust, *supra* note 689, at 51.

693. 749 F.2d at 462.

694. 462 U.S. 416 (1983).

695. See *supra* notes 542-626 and accompanying text.

696. 737 F.2d 283 (3rd Cir. 1984).

697. PA. STAT. ANN. tit. 18 §§ 3201-3220 (1983).

698. 737 F.2d at 292.

699. *Id.* at 295. These factors include the possible adverse physical and emotional side

has allowed states to require the types of information with such specificity as that imposed in the Pennsylvania statute.<sup>700</sup> The Third Circuit found two principal defects in the Pennsylvania provision. First, it improperly detailed the information to be conveyed to the patient, thereby impermissibly encroaching on the physician's medical judgment.<sup>701</sup> Second, the provision was improperly "designed to influence the woman's informed choice between abortion or childbirth."<sup>702</sup> The Supreme Court's opinion in *Akron* compels this result. Clearly the Pennsylvania statute is "designed not to inform the woman's consent but rather to persuade her to withhold it altogether."<sup>703</sup>

A separate provision of the Pennsylvania law requires that the abortion method used when the fetus is viable be the one most likely to result in the fetus being aborted alive.<sup>704</sup> The only exception to this requirement is when the abortion procedure would cause a "significantly greater" risk to the pregnant woman.<sup>705</sup> Relying on an earlier opinion in *Colautti v. Franklin*,<sup>706</sup> the court held the provision invalid because it required an impermissible trade-off between the mother's health and fetal survival.<sup>707</sup> The Third Circuit's conclusion is sound because the *Colautti* court clearly required that maternal health be the main factor when the state's interests in maternal health and fetal survival converge.<sup>708</sup>

*Daley and Thornburgh* present no substantial federal ques-

effects, the fetus' gestational age, the availability of benefits for prenatal and postnatal care, and the father's liability in child support. *Id.* See PA. STAT. ANN. tit. 18 § 3205(a)(1) (1983).

700. 737 F.2d at 295.

701. *Id.* at 296.

702. *Id.* (quoting *Akron*, 462 U.S. 416, 444 (1983)).

703. *Akron*, 462 U.S. 416, 444 (1983).

704. 737 F.2d at 300. See PA. STAT. ANN. tit. 18 § 3210(b) (1982).

705. 737 F.2d at 300. See PA. STAT. ANN. tit. 18 § 3210(b) (1982).

706. Taylor, High Court Hears Two Abortion Cases, N.Y. Times, Nov. 6, 1985, at 22, col. 4.

707. *Thornburgh* presents a problem with the "finality" rule. Under 28 U.S.C. § 1254(2), the Court will only hear an appeal from the final order of a lower court. Because the Third Circuit only considered portions of the statute, and remanded the rest to the district court, the plaintiffs are not appealing the whole case.

*Diamond* concerns a serious question of standing. Because the State of Illinois decided not to appeal the ruling, only a physician who has intervened below remains as an appellant. The physician, however, has not been prosecuted under the statute and does not even perform abortions. Consequently, he may be denied standing to challenge the statute. See Rust, *supra* note 689, at 52-53.

708. 439 U.S. 379 (1979). In *Colautti*, the Supreme Court invalidated an earlier version of the Pennsylvania statute because the statute did not clearly specify "that the woman's life and health must always prevail over the life and health of the fetus when they conflict." *Id.* at 400.



tions because the issues are governed by Supreme Court precedent. If the Court is predisposed to giving states more power to interfere in the abortion decision, then regulation of physicians is an effective approach. The Court has recognized various state interests as legitimate, yet the state is virtually powerless to protect these interests. Consequently, the Court could allow state intervention to effectuate state interests. For example, the Court could allow states to create medical panels to render ad hoc judgments of fetal viability; or it could allow states to specify the exact maternal health problems that give rise to the health exception. These results would require a new balancing between the states' interests and maternal rights.<sup>709</sup> Up to the present, the Burger Court has steadfastly protected the woman's abortion right created in *Roe*. One factor complicating any prediction of the Court's decision in these cases is the procedural posture in which they have reached the Court. Because the questioning at oral arguments primarily concerned jurisdictional questions,<sup>710</sup> the Court possibly may avoid totally the merits of each case.<sup>711</sup>

#### F. CONCLUSION

The role of the physician in the abortion decision represents a fundamental conflict in abortion law—a conflict between the desire to protect and implement the state's judicially recognized interest in maternal health and fetal viability and the woman's fundamental right to secure an abortion. The notion of viability is at the center of this conflict. Obviously, the states cannot be left to define viability because many states would define viability so broadly that abortions would be unattainable. Conversely, the states' most effective means of protecting a viable fetus—criminally punishing a physician who aborts it—is limited when the physician is the one who defines viability. The only effective way to protect the woman's constitutional right to privacy in deciding whether to terminate her pregnancy may be to guarantee her physician autonomy in the decisionmaking process by freeing him from all but the most

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709. 737 F.2d at 300.

710. *Id.* See *Colautti*, 439 U.S. at 379.

711. Because the Supreme Court refused to allow the Justice Department to argue orally in support of its brief that *Roe* be overturned, the Court, most likely, is not reconsidering *Roe*. Further evidence of the unlikelihood that the Supreme Court will significantly modify *Roe* may be found in the fact that the current Court expressly upheld *Roe* in the 1983 *Akron* decision.

general state regulations.<sup>712</sup>

## VI. Wrongful Pregnancy and Wrongful Conception

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### A. INTRODUCTION

“Wrongful pregnancy” and “wrongful conception” are labels attached to a cause of action alleging that but for a third party’s negligence, the plaintiff-parents would not have conceived or given birth to an unplanned yet healthy child.<sup>713</sup> Arguably, these labels apply to two different causes of action created by different factual circumstances.<sup>714</sup> In a strictly defined wrongful conception case, a negligent sterilization operation results in the conception of a fetus. The fetus, however, is never born because the mother either miscarries or has an abortion.<sup>715</sup> In a strictly defined wrongful pregnancy action, the child conceived after a negligent sterilization operation is born.<sup>716</sup> Courts, however, frequently use the terms

712. The author of this Section would like to thank Professor Thomas R. McCoy of Vanderbilt Law School for his invaluable advice.

713. See Collins, *An Overview & Analysis: Prenatal Torts, Preconception Torts, Wrongful Life, Wrongful Death, and Wrongful Birth: Time for a New Framework*, 22 J. FAM. L. 677, 690-91 (1984).

Although, in the narrowest sense, the term “wrongful birth” applies when the parents allege the health care provider’s negligence deprived them of the choice not to give birth to a defective infant, see *infra* notes 614-30 and accompanying text, wrongful birth broadly defined could also include situations normally labeled wrongful pregnancy or wrongful conception. *Id.* at n.65.

714. See *id.* at 690 nn. 63-64.

715. In medical terms, a miscarriage is a spontaneous abortion. See generally *supra* section II of this Special Project.

716. Damages computation is the only area in which the question of whether the unintentionally conceived child is born becomes relevant. Plaintiff parents in the theoretical wrongful conception case would not be able to recover the costs of rearing a child who was never born. Thus, the negligent conception case would not present the difficult issue of to what extent expenses of rearing such a child are recoverable—an issue on which courts split sharply. See *infra* notes 560-68 and accompanying text.

“wrongful conception” and “wrongful pregnancy” interchangeably.<sup>717</sup> For purposes of this Section, the term “wrongful pregnancy” will refer to those causes of action in which parents allege that a third party’s negligence resulted in the unplanned conception of a child, regardless of whether that child was carried to term.

Several features distinguish the wrongful pregnancy action from wrongful birth, wrongful life, and fetal wrongful death actions—the other prenatal torts. One such feature is the identity of the proper plaintiff. Although the fetus is the plaintiff in some prenatal torts,<sup>718</sup> wrongful pregnancy clearly is a parental cause of action.<sup>719</sup> A second distinguishing feature is that the infant in a wrongful pregnancy action is healthy and not defective.<sup>720</sup> A third distinction between wrongful pregnancy actions and other prenatal torts is the nature of the negligent act. Birth tort actions other than wrongful pregnancy allege negligent genetic testing or a failure to provide adequate genetic counseling, depriving parents of an informed choice of whether to conceive or, after conception, whether to abort a fetus.<sup>721</sup> In contrast, the gravamen of a wrongful pregnancy complaint is that the parents, who had already made a conscious decision not to conceive, tried to prevent pregnancy by obtaining professional health care, yet pregnancy occurred because the professional negligently provided that care.<sup>722</sup>

717. See, e.g., *Hershley v. Brown*, 655 S.W.2d 671, 673 n.1 (Mo. Ct. App. 1983) (wrongful conception synonymous with wrongful pregnancy); *Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 442, 314 S.E.2d 653, 654 (1984) (stating that “we will refer to wrongful pregnancy or wrongful conception actions as those brought by the parents of a child whose conception or birth was due to the negligence of a physician in performing a sterilization or abortion.”).

718. See generally *infra* section VIII of this Special Project.

719. See *University of Ariz. Health Sciences Center v. Super. Ct.*, 136 Ariz. 579, 581 n.1, 667 P.2d 1294, 1296 n.1 (1983) (stating that “wrongful pregnancy” is the usual label placed on “an action brought by the parents of a healthy, but unplanned child”). Cf. *Miller v. DuHart*, 637 S.W.2d 183 (Mo. Ct. App. 1982) (denying siblings of “wrongfully conceived” child a cause of action against doctor who performed negligent sterilization operation on their mother); *Aronoff v. Snider*, 292 So. 2d 418 (Fla. App. 1974) (denying siblings of child conceived after negligent vasectomy recovery for reduction in the proportional share of parental love, affection, and economic loss resulting from birth of the unwanted child).

720. See *University of Ariz. Health Sciences Center v. Super. Ct.*, 136 Ariz. at 581 n.1, 667 P.2d at 1296 n.1 (stating that “[a wrongful pregnancy] action is distinguished from a ‘wrongful birth’ claim brought by the parents of a child born with birth defects”).

721. See *infra* notes 614-30 and accompanying text. In a negligent genetic counseling case, the negligent act occurs *before* the parents make a conscious choice to conceive. Negligent genetic testing usually occurs after conception, and the harm inflicted on the parents is a deprivation of their opportunity to choose whether to abort an infant that the defendant erroneously has led them to believe is healthy.

722. See Comment, *Wrongful Pregnancy: Damages Recoverable for the Birth of a*

Not surprisingly, many wrongful pregnancy cases concern negligently performed sterilization operations such as tubal ligations<sup>723</sup> and vasectomies.<sup>724</sup> "Wrongful pregnancy," however, also applies to a great variety of other fact situations, including negligently performed abortions,<sup>725</sup> negligently filled birth control prescriptions,<sup>726</sup> failures to perform sterilization operations,<sup>727</sup> failures to reinsert contraceptive devices following medical examinations,<sup>728</sup> and other negligent conduct.<sup>729</sup> Additional confusion results from judicial mislabeling of the various birth torts<sup>730</sup> or failure to apply any label at all.<sup>731</sup>

*Normal, Healthy Child*, 7 AM. J. TRIAL ADVOC. 385, 385-86 (1984).

723. See, e.g., *Beardsley v. Wierdsma*, 650 P.2d 288 (Wyo. 1982); *Coleman v. Garrison*, 327 A.2d 757 (Del. Super. Ct. 1974), *aff'd*, 349 A.2d 8 (Del. 1975); *Flowers v. District of Columbia*, 478 A.2d 1073 (D.C. 1984); *Public Health Trust v. Brown*, 388 So. 2d 1084 (Fla. Dist. Ct. App. 1980); *Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 314 S.E.2d 653 (1984); *Cockrum v. Baumgartner*, 95 Ill. 2d 193, 447 N.E.2d 385 *cert. denied*, 464 U.S. 846 (1983); *Spoljaric v. Pangan*, — Ind. App. —, 466 N.E.2d 37 (1984); *Jones v. Malinowski*, 299 Md. 257, 473 A.2d 429 (1984); *McCullough v. Hutzel Hosp.*, 81 Mich. App. 545, 276 N.W.2d 569 (1979); *Miller v. DuHart*, 637 S.W.2d 183 (Mo. Ct. App. 1982); *Kingsbury v. Smith*, 122 N.H. 237, 442 A.2d 1003 (1982); *Bentacourt v. Gaylor*, 136 N.J. Super. 69, 344 A.2d 336 (N.J. Super. Ct. Law Div. 1975); *Mason v. Western Pa. Hosp.*, 499 Pa. 484, 453 A.2d 974 (1982).

724. See, e.g., *University of Ariz. Health Sciences Center v. Super. Ct.*, 136 Ariz. 579, 667 P.2d 1294 (1983); *Wilbur v. Kerr*, 275 Ark. 239, 628 S.W.2d 568 (1982); *Fassoulas v. Ramey*, 450 So. 2d 822 (Fla. 1984); *Aronoff v. Snider*, 292 So. 2d 418 (Fla. Dist. Ct. App. 1974); *Maggard v. McKelvey*, 627 S.W.2d 44 (Ky. Ct. App. 1981).

725. See *Wilczynski v. Goodman*, 73 Ill. App. 3d 51, 391 N.E.2d 479 (1979); *Nanke v. Napier*, 346 N.W.2d 520 (Iowa 1984); *Jean-Charles v. Planned Parenthood*, 99 A.D.2d 542, 471 N.Y.S.2d 622 (N.Y. App. Div. 1984).

726. See *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971).

727. See *Green v. Sudakin*, 81 Mich. App. 545, 265 N.W.2d 411 (1978). Cf. *Boone v. Mullendore*, 416 So. 2d 718 (Ala. 1982) (involving situation in which doctor told plaintiff that cyst removal operation had rendered her sterile; plaintiff consequently ceased using birth control pills and became pregnant).

728. See *Jackson v. Bumgardner*, 71 N.C. App. 107, 321 S.E.2d 541 (1984).

729. See, e.g., *J.P.M. v. Schmid Laboratories, Inc.*, 178 N.J. Super. 122, 428 A.2d 515 (N.J. Super. Ct. App. Div. 1981) (negligence/products liability action against condom manufacturer for wrongfully conceived child); *Roman v. City of New York*, 110 Misc. 2d 799, 442 N.Y.S.2d 945 (N.Y. Sup. Ct. 1981) (wrongful conception action based on alleged negligent misrepresentations contained in pamphlet that advised no contraceptives were needed following sterilization operation); *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 219 N.W.2d 242 (1974) (failure to diagnose pregnancy in timely manner precluded mother from option of terminating pregnancy).

730. See *Wilbur v. Kerr*, 275 Ark. 239, 628 S.W.2d 568 (1982) (action for damages resulting from unplanned healthy child characterized by court as action for "wrongful birth" or "wrongful conception").

731. See *Jackson v. Anderson*, 230 So. 2d 503 (Fla. Dist. Ct. App. 1970) (characterizing pregnancy following sterilization operation as breach of express warranty and negligence—no mention of wrongful pregnancy or wrongful conception). Likewise, a court may have labeled this action "medical malpractice," with no mention of the unique facts of the

Wrongful pregnancy actions have proliferated in recent years. Most state supreme courts addressing the issue in cases of first impression<sup>732</sup> have had little trouble in recognizing wrongful pregnancy as a valid cause of action despite policy arguments that this recognition would spawn fraudulent claims, that damage recoveries would be disproportionate to defendants' liability, and that the proximate cause link in these cases would be too weak.<sup>733</sup> At least one state supreme court, however, has flatly refused to recognize the wrongful pregnancy action.<sup>734</sup>

The broad acceptance of the wrongful pregnancy action stems in part from its similarity, in essence, to a medical malpractice action.<sup>735</sup> Thus, courts can readily identify and consider the traditional tort elements of duty, breach, proximate cause, and injury.<sup>736</sup> Other issues, however, have created more disparity among jurisdictions. Statute of limitations problems often arise in these cases; Section B of this Part addresses these problems and examines both legislative and judicial responses. The most controversial wrongful pregnancy questions arise in the area of damages. Section C addresses the damages issue. Section D concludes that attorneys must take care to identify wrongful pregnancy claims accurately and to comply with the relevant jurisdiction's statute of limita-

particular case. See *Green v. Sudakin*, 81 Mich. App. 545, 265 N.W.2d 411 (1978) (complaint labeled action as medical malpractice and breach of contract). Practitioners involved in what are herein described as wrongful pregnancy actions should research carefully what labels, if any, courts have applied to birth tort actions in the relevant jurisdiction and examine the factual circumstances that the labels have described. In light of the confusion surrounding these labels, plaintiffs' attorneys possibly should label their complaints medical malpractice actions to avoid having their cases dismissed on summary judgment by a judge who is hostile to a particular label.

732. See, e.g., *Wilbur v. Kerr*, 275 Ark. 239, 628 S.W.2d 568 (1982); *Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 314 S.E.2d 653 (1984); *Kingshury v. Smith*, 122 N.H. 237, 442 A.2d 1003 (1982).

733. In *Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 314 S.E.2d 653 (1984), the Georgia Supreme Court acknowledged these policy arguments, but noted that parties have raised them frequently regarding other tort claims and that the predicted problems have had satisfactory solutions under traditional tort theories. *Id.* at 442-43, 314 S.E.2d at 654.

734. See *Schork v. Huber*, 648 S.W.2d 861 (Ky. 1983). In rejecting a wrongful pregnancy action seeking costs of rearing a healthy child, the Kentucky Supreme Court used sweeping language regarding the various birth tort claims. "That a child can be considered as an injury offends fundamental concepts attached to human life . . . . The establishment of a cause of action based on the matter of wrongful conception, wrongful life or wrongful birth is clearly within the purview of the legislature only." *Id.* at 862-63.

735. E.g., *Weintraub v. Brown*, 98 A.D.2d 339, 341, 470 N.Y.S. 2d 634, 637 (N.Y. App. Div. 1983) (wrongful pregnancy claim is "brought under common-law negligence or medical malpractice principles").

736. E.g., *Beardsley v. Wierdsma*, 650 P.2d 288, 291 (Wyo. 1982) (wrongful pregnancy plaintiff must prove negligence, causation, and damages to prevail).

tions. Section D also urges courts to consider carefully the complex policy issues surrounding the damages question in adopting an approach that best serves the competing interests at stake.

## B. STATUTE OF LIMITATIONS ISSUES

A common problem in wrongful pregnancy cases is that the relevant statute of limitations may run before the plaintiff discovers the alleged negligence, especially when conception does not occur until several years after a negligent sterilization operation.<sup>737</sup> This barrier, which can also bar other medical malpractice claims,<sup>738</sup> generally arises in states with an "occurrence" statute of limitations. Under an "occurrence" statute, the statutory period begins to run when the negligent act occurs, regardless of when the negligence is discovered.<sup>739</sup> *Spoljaric v. Pangan*<sup>740</sup> illustrates how an occurrence statute of limitations affects a wrongful pregnancy case. In *Spoljaric* the parents of a child conceived nine months after a negligently performed tubal ligation filed their complaint more than two years after the operation. The Indiana Court of Appeals, noting that the Indiana statute of limitations for medical malpractice cases is an occurrence statute,<sup>741</sup> held the plaintiff's claim time-barred.<sup>742</sup>

Recognizing the potential injustice caused by occurrence statutes, some courts have found ways to allow plaintiffs recovery in spite of these statutes.<sup>743</sup> Legislatures, however, have restricted these judicial methods in response to arguments that the resulting increased malpractice awards will raise insurance premiums and ultimately have a detrimental effect on health care.<sup>744</sup> Many states have adopted a special medical malpractice statute of limitations

737. *E.g.*, *Harrison v. Schrader*, 569 S.W.2d 822 (Tenn. 1978) (claim for negligence in performance of sterilization where operation performed in 1972, but wife did not become pregnant until December 1975).

738. See PROSSER AND KEETON ON THE LAW OF TORTS, § 30 at 165 (W.P. Keeton, D. Dobbs, R. Keeton & D. Owen 5th ed. 1984) [hereinafter cited as PROSSER & KEETON].

739. PROSSER & KEETON, *supra* note 26 § 30 at 165.

740. \_\_\_ Ind. App. \_\_\_, 466 N.E.2d 37 (1984).

741. *Id.* at \_\_\_, 466 N.E.2d at 40.

742. *Id.* at \_\_\_, 466 N.E.2d at 45.

743. For a list of the devices courts have used to avoid the statute of limitations bar, see PROSSER & KEETON, *supra* note 738 § 30 at 166-68.

744. *Id.* See *Harrison v. Schrader*, 569 S.W.2d 822, 825, 826-27 (Tenn. 1978) (upholding medical malpractice statute of limitations as constitutional when measured against the rational basis test because legislature was concerned about high malpractice insurance premiums and resulting increase in health care costs as well as detrimental effect on medical profession).

with shorter time constraints than those applicable to other negligence actions.<sup>745</sup> Other states have passed "discovery" medical malpractice statutes of limitations under which the statutory period is tolled until the plaintiff discovers or should have discovered the negligence.<sup>746</sup> "Discovery" statutes, however, often contain a statute of repose that establishes an absolute time limit after which the plaintiff may not file an action, regardless of whether the injury has been discovered.<sup>747</sup>

Plaintiffs have used various theories in attempting to circumvent statutes of limitations that otherwise would bar their claims. A trilogy of recent Missouri appellate decisions illustrates these theories. In the earliest of these cases, *Miller v. DuHart*,<sup>748</sup> the parents and siblings of a child born three and one-half years after the mother had a tubal ligation brought suit. In an attempt to avoid the barrier imposed by the statute of limitations, the siblings, seeking damages for loss of parental society and financial support, argued that their claims were timely because of a statutory exception that tolled the running of the statute<sup>749</sup> in actions brought by children younger than ten years of age.<sup>750</sup> The court, however, found no cognizable legal basis for the siblings' action because "[i]t would be ludicrous to find that the defendants owed a duty to the appellant children to prevent the birth of their brother."<sup>751</sup> The *Miller* court next addressed the parents' wrongful pregnancy claims and held that, although the claims stated a cognizable cause of action, the two-year statute of limitations for medical malpractice barred the action.<sup>752</sup> The court rejected the plaintiffs' arguments that the general tort statute of limitations, which did not begin to run until the injury caused by the defendants' alleged negligence was ascer-

745. See, e.g., CAL. CIV. PROC. CODE § 340.5 (West 1982); FLA. STAT. ANN. § 95.11 (4)(b) (West 1982).

746. PROSSER & KEETON, *supra* note 738 § 30 at 166-67.

747. *Id.* § 30 at 167-68.

748. 637 S.W.2d 183 (Mo. Ct. App. 1982). The case was before the court on appeal by the plaintiffs of a state lower court order granting defendants' motion to dismiss on the ground that plaintiffs' claims were time-barred.

749. MO. REV. STAT. § 516.105 (West Supp. 1986).

750. *Miller*, 637 S.W.2d at 185. The statute tolling the running of the statute of limitations until the children reached age twelve. All the plaintiff children were under the age of ten.

751. *Id.* at 187. At least one other jurisdiction has rejected an action, presumably intended to avoid the bar of the statute of limitations, brought by siblings. See *Aronoff v. Snider*, 292 So. 2d 418 (Fla. Dist. Ct. App. 1974).

752. *Miller*, 637 S.W.2d at 188.

tainable,<sup>753</sup> governed the cause of action. The court held instead that wrongful pregnancy actions clearly are governed by the medical malpractice statute of limitations that began to run at "the date of the act of neglect complained of."<sup>754</sup> The court also found that the facts did not warrant application of the "continuing treatment" exception to the statute of limitations,<sup>755</sup> which tolls the statute while the plaintiff remains under the doctor's care.<sup>756</sup> Consequently, the *Miller* court thwarted both the siblings' and the parents' attempts to avoid the statute of limitations.

A year after *Miller*, the Missouri Court of Appeals faced another wrongful pregnancy action in *Hershley v. Brown*.<sup>757</sup> In *Hershley*, the plaintiffs alleged that the defendant doctor failed to perform the requested tubal ligation. The doctor inserted a tubal ring in the plaintiff to prevent conception, rather than cauterizing or removing portions of the plaintiff's fallopian tubes as agreed.<sup>758</sup> The court noted that the plaintiffs' claims would be barred by the statute of limitations unless the allegations fell under one of the recognized exceptions to that statute.<sup>759</sup> The first statutory exception applies when a foreign object is negligently introduced and permitted to remain in the body.<sup>760</sup> The court asserted that this "foreign objects" exception did not apply to the *Hershley* facts because in *Hershley* the doctor had intentionally inserted the tubal ring. The exception by its terms applies only when the object was unintentionally introduced into the body.<sup>761</sup> The court, however,

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753. *Id.*

754. *Id.* While rejecting plaintiffs' request that the court adopt a discovery rule, *id.* at 190, the court noted that, at the time of its decision, at least 13 state courts had adopted a discovery rule in cases concerning negligent sterilization operations. *Id.* at 188 n.2. The court cited *Laughlin v. Forgrave*, 432 S.W.2d 308 (Mo. 1968), in which the Missouri Supreme Court refused to adopt a discovery rule in another type of medical malpractice case, saying that adoption of such a rule is a legislative, not a judicial, function. *Id.* at 189.

755. The Missouri Supreme Court has held that the statute of limitations does not begin to run against a plaintiff until treatment by the defendant ceases. *Thatcher v. DeTar*, 351 Mo. 603, 173 S.W.2d 760 (1943).

756. *Miller*, 637 S.W.2d at 190. The court found that plaintiff had failed to allege any further treatment by the defendant following the sterilization operation and, thus, could not claim that the defendant's continued treatment effectively tolled the statute.

757. 655 S.W.2d 671 (Mo. Ct. App. 1983). The trial court granted defendant's motions to dismiss the case on grounds that plaintiff failed to state a claim upon which relief could be granted and that the claim was time-barred. The plaintiffs then appealed the case to the Missouri Court of Appeals.

758. *Id.* at 674.

759. Mo. REV. STAT. § 516.105 (West Supp. 1986).

760. *Id.*

761. *Hershley*, 655 S.W.2d at 675-76.



found that the plaintiff's action was governed by a second statutory exception that tolls the medical malpractice limitations period until the plaintiff discovers the negligence.<sup>762</sup> This exception, the "fraudulent concealment of medical malpractice" exception, applies whenever the patient fails to discover her injuries because the health care provider fraudulently conceals his negligence.<sup>763</sup> The court held that the doctor had committed a battery when he performed a surgical procedure other than the one the plaintiff requested.<sup>764</sup> The court found that the doctor fraudulently concealed this tort from the plaintiff because the doctor knew he had performed unauthorized surgery and, therefore, failure to inform constituted fraud.<sup>765</sup>

Missouri's most recent wrongful pregnancy decision appears to expand the scope of *Hershley*. In *Sanders v. Nouri*,<sup>766</sup> the court held that, as in *Hershley*, the "fraudulent concealment of medical malpractice" exception kept the plaintiff's claim alive despite the absence of any indication that the defendant doctor had committed a battery.<sup>767</sup> In *Sanders*, the Court held that because the defendant doctor knowingly had removed a smaller portion of the plaintiff's fallopian tubes than he had agreed, the plaintiff had sufficiently alleged a case of medical malpractice and fraudulent concealment thereof.<sup>768</sup> Thus, *Sanders* arguably widens the opening created by the *Hershley* decision and, consequently, expands the definition of the fraudulent concealment exception in Missouri. *Sanders* could provide wrongful pregnancy plaintiffs a means of hurdling the barrier imposed by the state's "occurrence" medical malpractice statute.

These cases merely illustrate various attempts by plaintiffs to avoid statutes of limitations and do not constitute an exhaustive list of plaintiffs' theories. Each jurisdiction will vary in its statutes, exceptions, and judicial interpretations, thereby requiring practitioners to conduct careful research according to the jurisdiction. This research will be difficult, however, in light of the probability

762. *Id.* at 676-77.

763. MO. REV. STAT. § 516.105 (West Supp. 1986).

764. *Hershley*, 655 S.W.2d at 676.

765. *Id.*

766. 688 S.W.2d 24 (Mo. Ct. App. 1985). The case was before the court on appeal by the plaintiffs. The trial court had dismissed the case as barred by the applicable statute of limitations.

767. *Id.* at 27. "That appellants have used the label battery rather than negligence is not fatal to their claim." *Id.*

768. *Id.*

that courts have dismissed many of their jurisdictions' wrongful pregnancy cases on summary judgment because the complaints were untimely filed.

### C. DAMAGES ISSUES

The availability of certain types of damages in wrongful pregnancy actions is well established. Most states agree that the plaintiff-mother in wrongful pregnancy actions may recover the traditional damages available in most medical malpractice suits.<sup>769</sup> These damages generally include physical and mental pain and suffering incurred during pregnancy and childbirth,<sup>770</sup> medical expenses incurred during pregnancy and delivery,<sup>771</sup> lost wages,<sup>772</sup> and, in the case of a negligent sterilization, either a refund for the cost of the original surgery<sup>773</sup> or the cost of the second operation.<sup>774</sup> Courts generally permit the plaintiff-father to recover for loss of

769. See *Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 314 S.E.2d 653 (1984). Noting that the "vast majority" of courts permit recovery of expenses of the unsuccessful medical procedure, pain and suffering, medical complications, costs of delivery, lost wages, and loss of consortium, the court said that these damages are similar to those in most medical malpractice cases and, thus, "represent no real deviation from traditional tort remedies." *Id.* at 443, 314 S.E.2d at 654.

770. *E.g.*, *Bushman v. Burns Clinic Medical Center*, 83 Mich. App. 453, 268 N.W.2d 683 (1978) (allowing plaintiff to recover for pain, suffering, and discomfort in wrongful pregnancy action); *accord Green v. Sudakin*, 81 Mich. App. 545, 265 N.W.2d 411 (1978) (awarding damages for mental anguish in wrongful pregnancy action despite general preclusion of these damages when the suit is brought as a breach of contract action; exception permitting these damages applied because subject matter of the contract was intensely personal); *Jean-Charles v. Planned Parenthood*, 99 A.D.2d 542, 471 N.Y.S.2d 622 (N.Y. App. Div. 1984) (limiting mother's recovery for pain, suffering, and mental distress to the extent distress resulted from actual or anticipated physical pain and suffering associated with pregnancy and childbirth).

771. *E.g.*, *Wilczynski v. Goodman*, 73 Ill. App.3d 51, 63, 391 N.E.2d 479, 488 (1979) (permitting recovery of hospital and medical expenses incurred in childbirth after physician negligently performed abortion, noting that to preclude recovery "would allow tortious conduct by a medical practitioner . . . to be totally uncompensable"); *cf.* *James G. v. Caserta*, 332 S.E.2d 872, 877 n.7 (W. Va. 1985) (stating that "if the parents chose to terminate the unplanned pregnancy, the costs of such an operation would also be recoverable").

772. *E.g.*, *Troppe v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971) (plaintiff who became pregnant because of negligently filled birth control prescription entitled, among other things, to lost wages during confinement). *But cf.* *Jean-Charles v. Planned Parenthood*, 99 A.D.2d 471, N.Y.S.2d 622 (N.Y. App. Div. 1984) (denying recovery for mother's future wages lost because obligation to raise child precludes ability to earn wages).

773. *E.g.*, *Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 314 S.E.2d 653 (1984) (allowing recovery of costs of ineffective sterilization procedure and noting that "[t]he vast majority of courts allow recovery of expenses for the unsuccessful medical procedure which led to conception or pregnancy").

774. *E.g.*, *Flowers v. District of Columbia*, 478 A.2d 1073 (D.C. 1984) (permitting recovery for cost of future tubal ligation when first operation unsuccessful).

consortium.<sup>775</sup>

In contrast to this unanimity on traditional malpractice damages, the states split sharply on whether and to what extent parents also may recover the costs associated with rearing the unplanned child to the age of majority.<sup>776</sup> At present, courts take three distinct positions on this issue. A minority of states follow the "full recovery" position, which allows parents to recover all the costs of rearing the unplanned child. The majority of states reject the full recovery position in favor of one of two alternatives. Some "strict rule" jurisdictions preclude recovery for any rearing costs. Others strike a middle ground and adopt a "benefits rule," permitting recovery for the economic rearing costs offset by the value of the emotional benefits the parents derive from the child. The following cases illustrate the policy considerations underlying these positions.

### 1. *The Full Recovery Rule*

Under general principles of tort law, a tortfeasor is liable for all foreseeable harm his negligence proximately causes.<sup>777</sup> Certainly, parents will incur foreseeable economic burdens because of the birth of an unplanned child.<sup>778</sup> The full recovery rule recognizes both the foreseeability and the proximate causal connection between these burdens and the negligent act. According to this rule a negligent health care provider should be liable for *all* the costs of rearing the unplanned child.<sup>779</sup>

The court in *Custodio v. Bauer*<sup>780</sup> first articulated the full recovery rule. In *Custodio* the California Court of Appeals stated that a defendant doctor's negligence would entitle the plaintiffs to recover *all* damages proximately caused thereby.<sup>781</sup> The *Custodio*

775. *E.g.*, *Kingsbury v. Smith*, 122 N.H. 237, 442 A.2d 1003 (1982).

776. Clearly, in the strictly defined "wrongful conception" case, in which the unplanned fetus' birth is prevented by abortion or miscarriage, the plaintiff parents' recovery is limited to the traditional medical malpractice damages. The issue of rearing costs will not arise in such a case. These cases, therefore, are less controversial and probably more likely to be settled out of court. *See supra* note 714.

777. PROSSER & KEETON, *supra* note 738, § 42 at 273.

778. In *Maggard v. McKelvey*, 627 S.W.2d 44 (Ky. Ct. App. 1981), the court stated that to hold that the costs of rearing the plaintiff's child were not foreseeable consequences of the defendant doctor's negligence "would defy logic and be contrary to the concept of causation in tort." *Id.* at 47. The court held, however, that public policy precluded recovery. *Id.* at 48.

779. *See Custodio v. Bauer*, 251 Cal. App. 2d 303, 59 Cal. Rptr. 463 (Cal. Ct. App. 1967).

780. *Id.*

781. *Id.* at 324, 59 Cal. Rptr. at 476-77.

court, however, did not determine the size of the damages award in that particular case<sup>782</sup> and subsequent California decisions have backed away from the full recovery rule in favor of the benefits test rule.<sup>783</sup>

An Ohio Supreme Court case, *Bowman v. Davis*,<sup>784</sup> appears to follow the *Custodio* decision. In *Bowman*, the plaintiff gave birth to twins following a negligent tubal ligation performed by the defendant-doctor. Appealing the jury's \$450,000 verdict, the defendant argued that public policy and the plaintiff's signature on a consent form barred the plaintiff's recovery of damages.<sup>785</sup> The court rejected the public policy argument, noting that the choice not to procreate enjoys constitutional protection.<sup>786</sup> The court also held that the consent form did not bar the plaintiff's claim because the form applied only when a patient whose sterilization was effective attempted to show she was unaware of the operation's permanent effect.<sup>787</sup> Many courts cite *Bowman* for the proposition that Ohio has adopted the full recovery rule<sup>788</sup> because the Ohio Supreme Court's ruling effectively affirmed the trial court's jury instructions to award all damages "which are reasonably certain to exist now or in the future as the proximate result of defendant's liability."<sup>789</sup> A careful reading of *Bowman*, however, reveals that the decision did not adopt definitively the full recovery theory. First, the court's remarks regarding recovery for all foreseeable consequences were dicta; the holding rested on the public policy and consent form issues.<sup>790</sup> A second reason for reading *Bowman* narrowly is found in a footnote to the case. The court stated that the defendants had not raised the issue of whether recovery in a wrongful pregnancy action should be limited to the expenses of pregnancy only and

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782. *Id.* at 325-26, 59 Cal. Rptr. at 477-78.

783. *See* *Morris v. Frudenberg*, 135 Cal. App. 3d 23, 185 Cal. Rptr. 76 (Cal. Ct. App. 1982); *Stills v. Gratton*, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (Cal. Ct. App. 1976).

784. 48 Ohio St.2d 41, 356 N.E.2d 496 (1976).

785. *Id.* at 43-44, 356 N.E.2d at 498.

786. *Id.* at 46, 356 N.E.2d at 499.

787. *Id.* at 44-45, 356 N.E.2d at 498.

788. *See, e.g.,* *Nanke v. Napier*, 346 N.W.2d 520, 522 (Iowa 1984); *Jackson v. Bumgardner*, 71 N.C. App. 107, 321 S.E.2d 541, 545 (1984).

789. 48 Ohio St.2d at 43, 356 N.E.2d at 498. The Ohio Supreme Court's opinion states: "For this court to endorse a policy that makes physicians liable for the foreseeable consequences of all negligently performed operations *except* those involving sterilization would constitute an impermissible infringement of a fundamental right." *Id.* at 46, 356 N.E.2d at 499.

790. *Id.* at 44-46, 356 N.E.2d at 498-99.

that the court, therefore, was not deciding that issue.<sup>791</sup> Thus, whether any jurisdiction actually has adopted and still applies the full recovery rule remains highly questionable.<sup>792</sup>

## 2. The Strict Rule

The majority of state courts<sup>793</sup> recognizing wrongful pregnancy have held that public policy concerns absolutely preclude parental recovery of the costs associated with rearing unplanned children.<sup>794</sup> The policy reason most commonly cited in support of the strict rule is that the birth of a healthy infant, even if unplanned, can never be considered an injury.<sup>795</sup> Courts generally buttress this broad statement with the argument that, as a matter of law, the value of being a parent outweighs any of its costs.<sup>796</sup> Strict rule courts disclaim reliance on sentimentality.<sup>797</sup> In addition to finding no injury, many courts argue that if a court imposes orthodox tort law rules permitting recovery for all foreseeable damages in wrongful pregnancy actions, the court likewise must impose other tort principles, including the duty to mitigate damages and the avoida-

791. *Id.* at 44 n.1, 356 N.E.2d at 498 n.1.

792. In a recent case, *Byrd v. Wesley Medical Center*, 699 P.2d 459, 462 (Kan. 1985), the Kansas Supreme Court also concluded that the *Bowman* court had not actually adopted the full recovery rule.

793. Cases that apply the strict rule include *Wilbur v. Kerr*, 275 Ark. 239, 628 S.W.2d 568 (1982); *Flowers v. District of Columbia*, 478 A.2d 1073 (D.C. 1982); *Cockrum v. Baumgartner*, 95 Ill.2d 193, 447 N.E.2d 479 *cert. denied*, 464 U.S. 846 (1983); *Wilczynski v. Goodman*, 73 Ill. App.3d 51, 391 N.E.2d 479 (1979); *Nanke v. Napier*, 346 N.W.2d 520 (Iowa 1984); *Schork v. Huber*, 648 S.W. 2d 861 (Ky. 1983); *Maggard v. McKelvey*, 627 S.W.2d 44 (Ky. Ct. App. 1981); *Kingsbury v. Smith*, 129 N.H. 237, 442 A.2d 1003 (1982); *J.P.M. v. Schmid Laboratories, Inc.*, 178 N.J. Super. 122, 428 A.2d 515 (N.J. Super. Ct. App. Div. 1981); *Jean-Charles v. Planned Parenthood Assoc., Inc.*, 99 A.D.2d 542, 471 N.Y.S.2d 622 (N.Y. App. Div. 1984); *Weintraub v. Brown*, 98 A.D.2d 339, 470 N.Y.S.2d 634 (N.Y. App. Div. 1983); *Sala v. Tomlinson*, 73 A.D.2d 724, 422 N.Y.S.2d 506 (N.Y. App. Div. 1979); *Mason v. Western Pa. Hosp.*, 499 Pa. 484, 453 A.2d 974 (1982); *James G. v. Caserta*, 332 S.E.2d 872 (W.Va. Ct. App. 1985); *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 219 N.W.2d 242 (1974); *Beardsley v. Wierdsma*, 650 P.2d 288 (Wyo. 1982).

794. See *Collins*, *supra* note 713, at 698.

795. *Public Health Trust v. Brown*, 388 So.2d 1084, 1085 (Fla. Dist. Ct. App. 1980) (“[A] parent cannot be said to have been damaged by the birth and rearing of a normal, healthy child.”).

796. See *id.* at 1085-86. To illustrate the principle that the benefits of parenthood outweigh the burdens as a matter of law, courts have stated that “the validity of the principle may be tested by asking any parent the purchase price for that particular youngster.” *Id.* at 1086.

797. *E.g.*, *Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 443, 314 S.E.2d 653, 655 (1984) (stating that “[t]his is not to say that we may lapse into sentimentality or embrace a maudlin picture of home and family”).

ble consequences rule.<sup>798</sup> Under this theory, the parents' failure to procure an abortion or place the unwanted child for adoption could preclude recovery for rearing costs because the parents failed to mitigate or avoid the damages created by the defendants' negligence.<sup>799</sup>

The "emotional bastard"<sup>800</sup> argument is another policy reason often cited by strict rule courts. Courts using this argument seek to protect the unplanned child from the emotional harm they believe could result if he should later learn of his parents' attempt to make another individual pay for his upbringing.<sup>801</sup> Courts also cite the policy of avoiding interference with the family relationship, and the problems such interference potentially could cause, as another reason for precluding recovery of rearing costs.<sup>802</sup> Likewise, some courts have stated that permitting parents to recover all economic damages, while allowing them to retain all benefits of parenthood, makes the defendant-doctor a "surrogate parent."<sup>803</sup> At least one court has held that allowing recovery for both wrongful death and wrongful pregnancy is too contradictory to be permitted.<sup>804</sup> Courts also cite many of the standard public policy arguments, frequently used to preclude recovery in other torts, to support decisions denying recovery of rearing costs. These standard public policy arguments include speculativeness of damages,<sup>805</sup> lack of foreseeability,<sup>806</sup> disproportionality of damages to the negligent conduct,<sup>807</sup> creation of a windfall for the plaintiffs,<sup>808</sup> encouragement of fraudulent claims,<sup>809</sup> and deferral to the legislature.<sup>810</sup>

798. See *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 519, 219 N.W.2d 242, 245 (1974).

799. *E.g.*, *Wilbur v. Kerr*, 275 Ark. 239, 628 S.W.2d 568, 570 (Ark. 1982); *Flowers v. District of Columbia*, 478 A.2d 1073, 1076 (D.C. 1982).

800. *Wilbur*, 275 Ark. at 244, 628 S.W.2d at 571.

801. See *id.*

802. *E.g. Flowers*, 478 A.2d at 1077 (citing a fear that permitting parents to hold a third party financially responsible for their child could destabilize families).

803. *E.g.*, *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 518, 219 N.W.2d 242, 244-45 (1974) (stating that to hold "[e]very child's smile . . . is to remain with the mother and father . . . [and] every financial cost . . . would be shifted to the physician . . . [would] create a new category of surrogate parent.").

804. *Byrd v. Wesley Medical Center*, 237 Kan. 215, —, 699 P.2d 459, 468 (1985) ("We recognize wrongful death actions because of the great value we place on human life. Conversely, we cannot recognize actions for . . . wrongful conception . . .").

805. *E.g.*, *James G. v. Caserta*, 332 S.E.2d 872 (W. Va. 1985).

806. *E.g.*, *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 219 N.W.2d 242 (1974).

807. *Id.*

808. *E.g.*, *Kingsbury v. Smith*, 122 N.H. 237, 243, 442 A.2d 1003, 1006 (1982).

809. *E.g.*, *Rieck v. Medical Protective Co.*, 64 Wis. 2d 514, 219 N.W.2d 242 (1974). The

The strict rule's denial of any rearing costs has provoked sharp criticism. The strongest arguments center on the rule's conclusion that a healthy child is no injury. Critics contend that courts reaching this conclusion are imposing personal value judgments favoring having children while ignoring the realities of the burdens on unwilling parents.<sup>811</sup> Critics also contend that the strict rule underestimates the jury's ability to award appropriate damages, noting that juries are required to evaluate intangible factors in many other areas of tort law.<sup>812</sup> Critics refute claims that recovery of rearing costs will encourage fraudulent claims and disproportionate liability by noting that the same claim has been made in other tort cases.<sup>813</sup> Despite such criticisms, however, the strict rule remains in force in many jurisdictions.<sup>814</sup>

### 3. *The Benefits Test Rule*

A third approach to damages recovery in wrongful pregnancy actions permits plaintiffs to recover the costs of rearing their un-

particular facts of the *Rieck* case may well support the notion that fraudulent claims will increase if courts permit recovery for rearing costs because *Rieck* addressed an untimely diagnosis of pregnancy that deprived parents of the choice to abort. Unlike the *Rieck* case, cases of negligent sterilization operations present little chance of fraudulent claims because the parents' intent to prevent further pregnancies is clear. A recent New York Supreme Court decision, however, appears to have opened the door for recovery in cases just like *Rieck*. In the March, 1985 case of *Samuels v. Weiss* (reported in 71 A.B.A.J. 102 June, 1985) Justice Ascione labeled a woman's complaint "wrongful diagnosis" and permitted her to recover for emotional harm after her doctor's diagnosis of pregnancy came too late for her to obtain an abortion.

810. *E.g.*, *Schork v. Huber*, 648 S.W.2d 861 (Ky. 1983).

811. *E.g.*, *University of Ariz. Health Sciences Center v. Superior Ct.*, 136 Ariz. 579, 667 P.2d 1294 (1983). Discussing *Public Health Trust's* statement of "universally shared emotion and sentiment," the Arizona Supreme Court stated: "[W]e believe that the strict rule . . . ignores logical consideration . . . [W]e must recognize . . . that there are cases where the birth of an unplanned child can cause serious emotional or economic problems to the parents." *Id.* at 584, 667 P.2d at 1299.

812. *See* *Coleman v. Garrison*, 327 A.2d 757 (Del. Super. Ct. 1974), *aff'd* 349 A.2d 8 (Del. 1975); *Jones v. Malinowski*, 299 Md. 257, 473 A.2d 429 (1984).

813. *See* *University of Ariz. Health Sciences Center v. Super. Ct.*, 136 Ariz. 579, 583, 667 P.2d 1294, 1298 (1983) ("[T]his is . . . the hue and cry in many tort cases and in essence is no more than the fear that some tort cases will be decided badly.").

814. For cases expressly adopting the strict rule, see cases cited *supra* notes 793-96, 798-801. *See also* *Cockrum v. Baumgartner*, 95 Ill. 2d 193, 447 N.E.2d 385 (1983); *Wilczynski v. Goodman*, 73 Ill. App. 3d 51, 391 N.E.2d 479 (1979); *Nanke v. Napier*, 346 N.W.2d 520 (Iowa 1984); *Maggard v. McKelvey*, 627 S.W.2d 44 (Ky. Ct. App. 1981); *J.P.M. v. Schmid Laboratories, Inc.*, 178 N.J. Super. 122, 428 A.2d 515 (N.J. Super. Ct. App. Div. 1981); *Jean-Charles v. Planned Assoc., Inc.*, 99 A.D.2d 542, 471 N.Y.S.2d 622 (N.Y. App. Div. 1984); *Weintrauh v. Brown*, 98 A.D.2d 339, 470 N.Y.S.2d 634 (N.Y. App. Div. 1983); *Sala v. Tomlinson*, 73 A.D.2d 724, 422 N.Y.S.2d 506 (N.Y. App. Div. 1979); *Mason v. Western Pa. Hosp.*, 499 Pa. 484, 453 A.2d 974 (1982); *Beardsley v. Wierdsma*, 650 P.2d 288 (Wyo. 1982).

planned child to the age of majority, reduced by the value of the emotional benefits plaintiffs will receive in their role as parents.<sup>815</sup> Courts adopting this rule generally state that in doing so, they simply are applying "settled common-law principles."<sup>816</sup> These courts expressly reject the contention of strict rule courts that the benefits of a healthy baby always outweigh the burdens, noting that the extent of benefits and burdens will turn on the unique facts and circumstances of each case.<sup>817</sup> For this reason, benefits test jurisdictions leave damages computation to the jury,<sup>818</sup> arguing that the risk of speculativeness is no greater in wrongful pregnancy actions than in any other area of tort law.<sup>819</sup> Several courts that recognize the benefits test rule have stated that in computing damages the jury should consider the parents' preconception reasons for desiring to avoid the birth.<sup>820</sup> These courts regard the parents' reasons as "the most telling evidence of whether or to what extent the birth of the child actually injured the parents."<sup>821</sup> Consequently, parents who sought to avoid conception because of fears of genetic defects or threats to the mother's health are not likely to be able to show greater burdens than benefits if their fears prove to have been unfounded. Conversely, if economic factors motivated the choice to avoid conception, the burdens of the unplanned child's birth might outweigh the benefits.

Courts adopting the benefits test approach uniformly have stated that the plaintiff has no obligation to mitigate damages by either aborting the child or placing it for adoption.<sup>822</sup> In response to the argument that mitigation is required, one court stated that

815. See *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971).

816. *Id.* at 245, 187 N.W.2d 511, 513. See also *University of Ariz. Health Sciences Center v. Super. Ct.*, 136 Ariz. 579, 586, 667 P.2d 1294, 1301 (1983) (no reason not to apply "ordinary damage rules" to wrongful pregnancy cases).

817. See *Jones v. Malinowski*, 299 Md. 257, 269, 473 A.2d 429, 435 (1984) (rejecting proposition that as a matter of law that no legally valid claim could exist for the expenses of rearing unplanned child); *University of Ariz. Health Sciences Center v. Super. Ct.*, 136 Ariz. 579, 585, 667 P.2d 1294, 1300 (1983); see also *Coleman v. Garrison*, 281 A.2d 616 (Del. Super. Ct. 1971), *dismissed* 298 A.2d 320 (Del. 1972) ("[I]t cannot be said as a matter of law that a healthy child always confers a benefit greater than the expense of his birth and support . . . . Otherwise, all married couples would have children.").

818. 136 Ariz. at 585, 667 P.2d at 1300.

819. *Id.*

820. See *id.*; see also *Jones v. Malinowski*, 299 Md. 257, 473 A.2d 429 (1984).

821. *University of Ariz. Health Sciences Center v. Super. Ct.* 136 Ariz. 579, 585, 667 P.2d 1294, 1300 (1983).

822. *Id.*; see also *Morris v. Frudenberg*, 135 Cal. App. 3d. 23, 185 Cal. Repr. 76 (1982); *Ochs v. Borrelli*, 187 Conn. 253, 445 A.2d 883 (1982); *Jones v. Malinowski*, 299 Md. 257, 473 A.2d 429 (1984); *Troppi v. Scarf*, 31 Mich. App. 240, 187 N.W.2d 511 (1971).



imposing such a duty on the injured plaintiff ignores the difference between the avoidance of conception and the disposition of the human organism after conception.<sup>823</sup> The court further asserted that the defendant does not have the right to insist that the victim of his negligence be willing to abort or place a child for adoption.<sup>824</sup> Other courts addressing the issue have stated that the plaintiff's duty is only to mitigate damages through reasonable means and that abortion and adoption are not reasonable means of mitigation.<sup>825</sup>

Critics of the benefits test raise several objections. Some argue that the test requires parents to show that they do not want their child in order to increase their recovery.<sup>826</sup> Other critics of the benefits test argue that it seeks to weigh two different interests—love and companionship versus economics.<sup>827</sup> Critics also state that the benefits test could harm the child emotionally and might require speculative damages computation.<sup>828</sup>

#### D. CONCLUSION

In light of the inevitable time delay between a negligent sterilization operation and the resulting pregnancy, practitioners representing wrongful pregnancy plaintiffs much pay special attention to their jurisdiction's statute of limitations. Similarly, because a jurisdiction may or may not expressly recognize wrongful pregnancy as a cause of action, attorneys should pay particular attention to the label attached to allegations that a third party's negligence resulted in the conception or birth of unplanned yet healthy child. Regardless of the factual circumstances, wrongful pregnancy is really nothing more than a traditional medical malpractice action with an additional twist in damages computation on the question of whether to require the tortfeasor to bear the costs of raising the product of his negligence. This issue involves complex policy considerations that courts must weigh carefully.<sup>829</sup>

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823. *Troppe v. Scarf*, 31 Mich. App. 240, 257, 187 N.W.2d 511, 519 (1971).

824. *Id.*

825. *E.g.*, *Morris v. Frudenberg*, 135 Cal. App. 3d 23, 185 Cal. Rptr. 76 (1982).

826. *See Wilbur v. Kerr*, 275 Ark. 239, 243, 628 S.W.2d 568, 571 (1982) (rule requires parents to "demonstrat[e] they do not want the child in order to get a greater reward. If they admit the child is a welcome addition . . . they may get nothing.").

827. *See Fulton-DeKalb Hosp. Auth. v. Graves*, 252 Ga. 441, 444, 314 S.E.2d 653, 655 (1984).

828. *See Byrd v. Wesley Medical Center*, 237 Kan. 215, 699 P.2d 459 (1985), and authorities cited therein.

829. For additional information on policies and theories in wrongful pregnancy cases,

Despite the rule that a tortfeasor should be liable for all damages proximately caused by his negligence, courts generally have rejected the full recovery approach that embodies this rule. Because courts have not used this approach to decide a case, and because a majority of jurisdictions have adopted the antithetical strict rule, the full recovery approach merits discussion only on a theoretical basis. The strict rule approach, precluding all recovery, appears to be an overly-simplistic judicial response to a very complex area. This position is based on an inherent distrust of the jury's ability to compute a complex damages award and ignores the judge's ability to reduce an excessive award. The strict rule approach also allows a tortfeasor to escape paying any damages. The benefits test, permitting recovery for some portion of rearing costs has the advantage of holding the tortfeasor responsible for damages while recognizing the mitigating factors of the benefits of child-rearing. Even this modified rule, however, likely will result in jury awards that could lead to increased health care insurance premiums, which could raise the costs of medical care for all of society. Increased premiums also may discourage talented persons from entering the medical profession, ultimately decreasing the quality of health care available. In light of so many competing policy concerns, no easy answers yet emerge to the controversial problems of the wrongful pregnancy action.

## VII. Wrongful Birth

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see generally Note, *Judicial Limitations on Damages Recoverable for the Wrongful Birth of a Healthy Infant*, 68 VA. L. REV. 1311 (1982); Comment, *Wrongful Pregnancy: Damages Recoverable for the Birth of a Normal, Healthy Child*, 7 AM. J. TRIAL ADVOC. 385 (1985); Comment, *Recovery of Childrearing Expenses in Wrongful Birth Cases: A Motivational Analysis*, 32 EMORY L.J. 1167 (1983).

## A. INTRODUCTION

Wrongful birth is an action in which a health care provider breaches a duty "to impart information or perform medical procedures with due care," and that breach is a proximate cause of the birth of a defective child.<sup>830</sup> Like wrongful pregnancy, the action is frequently mislabeled.<sup>831</sup> Despite the lack of longstanding judicial precedent in the area,<sup>832</sup> courts have developed several distinct elements that characterize the wrongful birth action. This tort is generally a parental cause of action—parents seek recovery for harm inflicted on them.<sup>833</sup> Furthermore, the label "wrongful birth" applies only when the infant is defective.<sup>834</sup> The most significant characteristic of wrongful birth is the conduct alleged to be negligent. The crux of the wrongful birth action is a negligent deprivation of choice.<sup>835</sup> The plaintiff parents do not allege that the defendant caused their infant's abnormality. Rather, the parents allege that the health care provider's negligence deprived them of the information necessary to make an informed choice of whether to conceive or to continue a pregnancy. Had such information been presented to them, the parents allege, they would not have had the child. In sum, the parents allege that but for the health care provider's negligence, the child would not have been born.<sup>836</sup>

This Part examines the fundamental features of the wrongful birth cause of action. Section B discusses typical fact situations that give rise to a wrongful birth claim. Section C considers the elements of the wrongful birth tort—duty, breach, proximate cause, and injury—that distinguish this tort from other medical

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830. *Harbeson v. Parke-Davis, Inc.*, 98 Wash.2d 460, 467, 656 P.2d 483, 488 (1983).

831. See *supra* note 725 and accompanying text; see also *Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807 (N.Y. 1978) (exemplifying misapplication of label "wrongful life" to parental cause of action that was "wrongful birth").

832. The wrongful birth action, by definition, can arise only in the context of advanced medical knowledge and technology in which doctors can detect prenatal defects or test genetic carriers. The absence of this knowledge and technology prior to the 1970s explains why this area of tort law is recent. As technology and medical science continue to advance in the area of prenatal care and genetic testing, the number of wrongful birth actions will also increase. See *Harbeson v. Parke-Davis*, 98 Wash.2d 460, 472, 656 P.2d 483, 491 (1983).

833. *E.g.*, *DiNatale v. Lieberman*, 409 So. 2d 512, n.1 (Fla. Dist. Ct. App. 1982) (describing wrongful birth as "the parent's" cause of action for the expenses of caring for the defective child"). But see *infra* note 853 (discussing cases allowing the child to bring the cause of action).

834. In the case of a healthy but unplanned child, the cause of action is "wrongful pregnancy." See *supra* note 713 and accompanying text.

835. See *Collins, supra* note 713 at 690-91 n.65.

836. See *id.*

malpractice claims. Section D addresses the damages issue. Section E concludes that attorneys who frame their allegations properly will find courts receptive to claims of wrongful birth.

## B. TYPICAL CASES

The factual circumstances giving rise to a wrongful birth action generally involve negligent genetic testing or negligent genetic counseling. In a typical negligent genetic testing case,<sup>837</sup> the parents, aware that they may be carriers of a genetic disease or aware that other circumstances increase the probability of a defective child,<sup>838</sup> seek professional genetic tests on themselves or the fetus. The health care provider's failure to use due care in performing or interpreting the results of these tests deprives the parents of the opportunity to choose to avoid the birth of a defective child.<sup>839</sup> The underlying rationale in negligent genetic testing cases is that the parents have relied to their detriment on the negligent information the defendant provided. *Naccash v. Burger*<sup>840</sup> illustrates the typical wrongful birth action resulting from negligent genetic testing. In *Naccash* an expectant father had a blood test performed to ensure that he was not a carrier of Tay-Sachs<sup>841</sup> disease because, as the expectant mother testified at trial, "[t]here is nothing on this earth that would have made [us] have a baby with Tay-Sachs disease."<sup>842</sup> After the defendant assured the plaintiff-parents that the father did not carry this disease, the expectant mother decided to have the baby. Later, after the infant was diagnosed as having Tay-Sachs, the plaintiffs discovered that defendant had confused the husband's blood sample with the sample of a noncarrier.<sup>843</sup> The court permitted the wrongful birth action, noting that the errone-

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837. *E.g.*, *Naccash v. Burger*, 223 Va. 406, 290 S.E.2d 825 (1982).

838. *See supra* notes 731-58 and accompanying text.

839. *E.g.* *Becker v. Schwartz*, 46 N.Y.2d 401, 407, 386 N.E.2d 807, 811 (N.Y. 1978) ("It is not contended that the defendant physicians' treatment . . . caused the abnormalities in [plaintiffs'] infants . . . , but only that had plaintiffs been properly advised by defendants of the risks of abnormality, their infants would never have been born.").

840. 223 Va. 406, 290 S.E.2d 825 (1982). The case was before the Virginia Supreme Court on appeal by the defendant doctor.

841. *Id.* at 410, 290 S.E.2d at 827. "Tay-Sachs disease is a fatal, progressive, degenerative disease of the nervous system which occurs primarily in Jewish infants of Eastern European ancestry. A diseased child appears normal at birth, but at four to six months of age, the child's central nervous system begins to degenerate, and he suffers eventual blindness, deafness, paralysis, seizures, and mental retardation. His life expectancy is two to four years." *Goldberg v. Ruskin*, 128 Ill. App. 3d 1029, 1031, 471 N.E.2d 530, 532, n.2 (1984).

842. *Naccash*, 223 Va. at 411, 290 S.E.2d at 828.

843. *Id.* at 410-11, 290 S.E.2d at 827.

ous test results deprived the plaintiffs of the chance to decide whether to terminate the pregnancy.<sup>844</sup> Other negligent genetic testing cases have produced similar results.<sup>845</sup>

Many wrongful birth actions concern allegations of negligent genetic counseling.<sup>846</sup> Plaintiffs often allege negligent genetic counseling when the defendant fails to inform them of an increased probability of a deformed child and of tests that could determine if such deformities were present.<sup>847</sup> In an early wrongful birth case, *Becker v. Schwartz*,<sup>848</sup> a New York court permitted the parents of a child born with Down's Syndrome<sup>849</sup> to recover from the doctor who negligently failed to inform them that the mother's age increased the probability of this defect and that an amniocentesis test could detect the defect. Other wrongful birth actions arise from the doctor's failure to diagnose a genetic disease in the parents' first child in time to permit the parents to avoid the risk of producing a second defective child.<sup>850</sup> For example, in *Schroeder v. Perkel*<sup>851</sup> a New Jersey court permitted the parents of two children born with cystic fibrosis<sup>852</sup> to recover from the doctor who had treated the first child but had failed to diagnose the child's disease in time to permit the parents to avoid the birth of a second child.

844. *Id.* at 414, 290 S.E.2d at 830.

845. *E.g.*, *Gildiner v. Thomas Jefferson Univ. Hosp.*, 451 F. Supp. 692 (E.D. Pa. 1978) (negligent interpretation of amniocentesis test to determine if fetus afflicted with Tay-Sachs); *Nelson v. Krusen*, 678 S.W.2d 918 (Tex. 1984) (negligent interpretation of tests performed on mother to determine if she was carrier of Duchenne muscular dystrophy).

846. *See, e.g.*, *Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (N.Y. 1978); *Berman v. Allan*, 80 N.J. 421, 404 A.2d 8 (1979).

847. *Id.*

848. 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978). *See also* *Berman v. Allan*, 80 N.J. 421, 404 A.2d 8 (1979); *cf.* *Goldberg v. Ruskin*, 128 Ill. App.3d 1029, 471 N.E.2d 530 (1984) (permitting recovery after defendants failed to inform expectant Jewish parents of higher probability of Tay-Sachs disease in Jewish population and to recommend amniocentesis test); *Johnson v. Yeshiva Univ.*, 42 N.Y.2d 818, 820, 364 N.E.2d 1340, 1341 (1977) (holding failure to perform amniocentesis on pregnant mother who later gave birth to child with cri-du-chat syndrome stated no cause of action because doctor's failure was "permissible exercise of medical judgment and not a departure from then accepted medical practice").

849. Down's Syndrome is a form of mental retardation that results in a variety of physical abnormalities. This syndrome is caused by the presence of an extra chromosome. *See* *Becker v. Schwartz*, 46 N.Y.2d 401, 406 n.1, 386 N.E.2d 807, 808 n.1, 413 N.Y.S.2d 895, 896 n.1 (1978).

850. *See* *Schroeder v. Perkel*, 87 N.J. 53, 432 A.2d 834 (1981); *cf.* *Turpin v. Sortini*, 31 Cal.3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982) (permitting child with hereditary deafness to recover from doctor who failed to detect the deafness in her older sister).

851. 87 N.J. 53, 432 A.2d 834 (1981).

852. Cystic fibrosis is a genetic disease that results in chronic respiratory problems. Victims usually die in their late teen years. *Id.* at 58, 432 A.2d at 836.

Courts have also permitted wrongful birth actions when physicians negligently misrepresent the inheritability of a genetic disease,<sup>853</sup> negligently misrepresent the probability of birth defects arising from prescription drugs,<sup>854</sup> fail to correctly diagnose in an expectant mother an illness known to be associated with birth defects,<sup>855</sup> or negligently perform sterilization operations or abortions requested by the parents to avoid birth of a defective child.<sup>856</sup>

### C. ELEMENTS OF TORTS IN WRONGFUL BIRTH ACTION

Courts have recognized the validity of wrongful birth claims despite policy arguments to the contrary.<sup>857</sup> Most courts have few theoretical problems with the action because they see it as a mere extension of traditional tort law to new factual circumstances.<sup>858</sup> However, because of the unusual twists in traditional tort principles resulting from these circumstances an examination of the elements of duty, breach, proximate cause, and injury is helpful in understanding the wrongful birth claim.

#### 1. *Duty and Breach*

The initial question in a wrongful birth action is what duty, if any, the health care provider owes parents who affirmatively seek specific medical advice regarding a genetic disease. Courts readily conclude that the health care provider owes the parents a duty of

853. *Park v. Chessin*, 46 N.Y.2d 401, 386 N.E.2d 807 (N.Y. 1978) (parents were told incorrectly that chances of having second child with polycystic kidney disease were "practically nil").

854. *Harheson v. Parke-Davis, Inc.*, 98 Wash.2d 460, 656 P.2d 483 (1983) (diabetic mother told prescription drug could cause cleft palate and temporary hirsutism, but drug actually caused severe birth defect of fetal hydantoin syndrome).

855. This failure to diagnose commonly occurs when an expectant mother has contracted rubella, which causes severe defects, and the doctor negligently misdiagnoses the illness. See *Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984); *Eisbrenner v. Stanley*, 106 Mich. App. 357, 308 N.W.2d 209 (1981); *Prochanik v. Cillo*, 97 N.J. 339, 478 A.2d 755 (1984); *Jacobs v. Theimer*, 519 S.W.2d 846 (Tex. 1975); *Dumer v. St. Michael's Hosp.*, 69 Wis.2d 766, 233 N.W.2d 372 (1975).

856. *Speck v. Finegold*, 497 Pa. 77, 439 A.2d 110 (1981). In these circumstances the plaintiff parents might also have a claim for wrongful pregnancy. See *supra* notes 713-729 and accompanying text.

857. See *Azzolino v. Dingfelder*, No. 718 PAB4, slip. op. (N.C. Dec. 10, 1985) (refusing to recognize wrongful birth as valid cause of action).

858. See *Speck v. Finegold*, 497 Pa. 77, 83, 439 A.2d 110, 113 (1981); see also *Naccash v. Burger*, 223 Va. 406, 413, 290 S.E.2d 825, 827 (1982) ("Only a novel twist in the medical setting differentiates the present situation [a wrongful pregnancy case] from the ordinary malpractice action.").

reasonable care.<sup>859</sup> In *Naccash v. Burger*,<sup>860</sup> for example, the court held that when the plaintiffs presented themselves to the defendant for Tay-Sachs testing, the defendant owed the plaintiff-parents a duty of reasonable care in performing the tests and also had a duty to give "reasonably accurate information" regarding the test results so that the parents could make an informed decision whether to abort the child.<sup>861</sup> Similarly, in *Park v. Chessin*,<sup>862</sup> the court permitted parents to recover after they had specifically inquired about the risks of having a second child with polycystic kidney disease. The court stated that the physician's duty to the plaintiff-parents was merely an extension of the classic tort duty "that one may not speak without prudence or due care when one had a duty to speak, knows that the other party intends to rely on what is imparted, and does, in fact, so rely to his detriment."<sup>863</sup>

Absent a specific inquiry by the prospective parents, however, the scope of the doctor's duty becomes a more complex question. Defendants often urge courts to limit a physician's duty to instances in which the parents ask questions and request specific care.<sup>864</sup> Courts have rejected this suggestion, however, and instead have imposed on physicians an affirmative duty to disclose facts relevant to the parents' decision to avoid the birth. Some courts base this affirmative duty to disclose on the theory that, because of the physician-patient relationship, the doctor has a duty to advise the patient in accordance with correct medical practice.<sup>865</sup>

Other courts similarly have found an affirmative duty of disclosure, but on the theory that parents have a right not to have a defective child and that, consequently, physicians have a duty to assist parents in exercising that right.<sup>866</sup> Under this theory, the parents' constitutionally protected right to obtain an abortion creates the physician's duty.<sup>867</sup> This right, coupled with medical science's increased ability to predict the occurrence of defects attrib-

859. *E.g.*, *Becker v. Schwartz*, 46 N.Y.2d 401, 412, 413 N.Y.S.2d 895,386 N.E.2d 807, 813 (N.Y. 1978) ("There can be no dispute . . . that plaintiffs have alleged the existence of a duty flowing from defendants to themselves and that the breach of that duty was the proximate cause of the birth . . .").

860. 223 Va. 406, 290 S.E.2d 825 (1982).

861. *See id.* at 414, 290 S.E.2d at 829.

862. 60 A.D.2d 80, 400 N.Y.S.2d 110 (N.Y. App. Div. 1977), *aff'd* 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (N.Y. 1978).

863. *Id.* at 86, 400 N.Y.S.2d at 113.

864. *Goldberg v. Ruskin*, 128 Ill. App. 3d 1029, 1039, 471 N.E.2d 530, 537 (1984).

865. *Id.*

866. *Harbeson v. Parke-Davis, Inc.*, 98 Wash. 2d 460, 472, 656 P.2d 483, 491 (1983).

867. *See Roe v. Wade*, 410 U.S. 113 (1973).

utable to genetic disorders, imposes the duty of affirmative disclosure on the physician.<sup>868</sup> Once courts have determined that the physician owes the plaintiff a duty of care, a breach of that duty occurs when the physician negligently fails to provide parents with information material to the parents' decision of whether to avoid the birth.<sup>869</sup>

## 2. *Proximate Cause and Injury*

To bring a cause of action in tort, the plaintiff must show the defendant's negligence proximately caused his or her injury.<sup>870</sup> In the context of a wrongful birth action, the plaintiff claims that the defendant's negligence proximately caused the birth of a defective child in the following manner: the physician's negligence deprived plaintiffs of the information necessary for their decision whether to avoid the birth of the defective child; the plaintiffs allege that, had they known their child would be defective, they would have avoided the birth through abortion or sterilization; thus, the plaintiffs allege that but for the physician's failure to provide them with relevant information, the defective child would not have been born.<sup>871</sup>

In *Eisbrenner v. Stanley*<sup>872</sup> a Michigan court addressed a common defense physicians raise in wrongful birth cases and discussed the proximate cause element of the action. The defendant-doctor had argued that the plaintiffs had not shown proximate cause because the physician's allegedly negligent conduct had not caused the child's birth defects and because no one could have prevented the defects. In response, the Michigan Court of Appeals stated that this argument misconstrued the plaintiffs' theory. The plaintiffs did not claim that the defendant's conduct caused the defects. Rather, the parents claimed that because the defendant breached his duty to render proper medical treatment, they were deprived of information that would have led them to terminate the pregnancy.

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868. See *Blake v. Cruz*, 108 Idaho 253, 256, 698 P.2d 315, 318-19 (1984); *Harbeson v. Parke-Davis, Inc.*, 98 Wash.2d 460, 472, 656 P.2d 483, 491 (1983).

869. The court will find a breach of this duty when the physician failed "to conform to the appropriate standard of skill, care or learning." *Harbeson v. Parke-Davis, Inc.*, 98 Wash.2d 460, 473, 656 P.2d 483, 492 (1983). Cf. *Johnson v. Yeshiva Univ.*, 42 N.Y.2d 818, 364 N.E.2d 1340 (N.Y. 1977) (defendant's failure to perform amniocentesis test on mother who later gave birth to cri-du-chat child held to be "no more than a permissible exercise of medical judgment and not a departure from then accepted medical practice.").

870. PROSSER & KEETON, *supra* note 738 6 § 30 at 165.

871. *E.g.*, *Schroeder v. Perkel*, 87 N.J. 53, 60-61, 432 A.2d 834, 837 (1981).

872. 106 Mich. App. 357, 308 N.W.2d 209 (1981).



The child was born and lived as a result of the defendant's negligence. Thus, according to the court, the plaintiffs properly alleged proximate cause.<sup>873</sup>

The injury complained of in a wrongful birth action is the birth of a deformed child.<sup>874</sup> Recognition of the injury is closely tied to the other elements of the action. The Washington Supreme Court has stated that an inevitable by-product of recognizing a parental right to avoid giving birth to a defective child is a recognition that the birth of a defective child is an actionable injury.<sup>875</sup> The Idaho Supreme Court has added that establishing proximate cause and injury in the wrongful birth action will present no problem as long as the plaintiffs show that had the physician *not* been negligent, they would have aborted their child or avoided conceiving it in the first place.<sup>876</sup>

#### D. DAMAGES

Although every state that has considered a wrongful birth claim has recognized the validity of the action,<sup>877</sup> courts do not agree on the types of damages that plaintiffs may recover. The majority of jurisdictions recognizing the action permit parents to recover, at a minimum, the extraordinary medical costs needed to raise the defective child.<sup>878</sup> The rationale behind extraordinary medical expense awards is that, while the plaintiffs intended to have a child, the defendant deprived them of their choice to avoid

873. *Id.* at 366, 308 N.W.2d at 213.

874. *E.g.*, *Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984). *Contra* *Azzolino v. Dingfelder*, No. 718PA84, slip. op. at 11 (N.C. Dec. 10, 1985). In *Azzolino* the North Carolina Supreme Court held that "claims for relief for wrongful birth of defective children shall not be recognized in this jurisdiction absent a clear mandate by the legislature." The court refused to recognize this claim because, in its view, the tort element of injury was absent. It criticized other jurisdictions that recognized the actions as "tak[ing] a step into *entirely untraditional analysis* by holding that the existence of a human life can constitute an injury cognizable at law." *Id.* at 12. The court admitted, however, that it was adopting "a view contrary to . . . a strong trend among other jurisdictions." *Id.* at 11.

The dissent argued that the majority opinion misconstrued the nature of the injury by characterizing it as the child's existence, when the real injury to the parents was the deprivation of their choice to make an informed choice. *Id.* at 22, (Exum, J., dissenting).

875. *See Harbeson v. Parke-Davis, Inc.*, 98 Wash.2d 460, 473, 656 P.2d 483, 492 (1983).

876. *See Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984).

877. Recognition "that society has a vested interest in . . . preventing birth defects, and in requiring that wrongdoers [compensate their victims] . . . has led to unanimous acceptance by the courts of wrongful birth as a claim for relief." *Blake v. Cruz*, 108 Idaho 253, 257, 698 P.2d 315, 319 (1984).

878. *E.g.*, *Harbeson v. Parke-Davis*, 98 Wash. 2d 460, 656 P.2d 483 (1983).

the birth of a *defective* child.<sup>879</sup> Under general tort principles, the defendant must put the plaintiff in as good a position as he or she would have been in had it not been for the defendant's negligence.<sup>880</sup> Applying this principle to a wrongful birth cause of action, the court in *Harbeson v. Parke-Davis* stated that the plaintiff-parents should recover the expenses associated with the delivery and rearing of their infant that would not have arisen had the child been normal.<sup>881</sup> Parents may not recover, however, for loss of consortium, pain and suffering incurred in childbirth, and wages lost during pregnancy because these losses would have occurred in any pregnancy, regardless of whether the child was defective.<sup>882</sup> Several jurisdictions expressly have permitted recovery of extraordinary medical expenses for the life of the child, rather than just to the age of majority, after noting that statutes bind parents to support an adult unable to support himself.<sup>883</sup> Other jurisdictions have permitted recovery of extraordinary medical expenses by the child himself in cases in which the statute of limitations may bar a parental cause of action but not an action brought by certain minor children.<sup>884</sup>

A minority approach precludes parents from recovering extraordinary medical expenses, but permits them to recover for the emotional damage they have suffered because of the birth of a de-

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879. *Id.*

880. PROSSER & KEETON, *supra* note 738 § 85 at 608.

881. 98 Wash.2d 460, 479, 656 P.2d 483, 495 (1983).

882. *Moore v. Lucas*, 405 So.2d 1022, 1026 (Fla. Dist. Ct. App. 1981) (damages for physical pain and suffering and mental anguish not recoverable because mother "wanted to become pregnant . . . and the pregnancy and delivery in connection with [her deformed child] were no more difficult or painful than if he had been normal"). *But see Park v. Chesin*, 60 A.D.2d 80, 400 N.Y.S.2d 110 (N.Y.App. Div. 1977), *aff'd* 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (N.Y. 1978) (recovery for loss of mother's services permitted).

883. *E.g.*, *Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984); *James G. v. Caserta*, 332 S.E.2d 872 (W. Va. 1985).

884. *See Procanik v. Cillo*, 97 N.J. 339, 478 A.2d 755 (1984) (infant plaintiff permitted recovery when parents' claim for these expenses would be barred by statute of limitations).

While statute of limitations issues theoretically may arise in wrongful birth actions, *see Anderson v. Wagner*, 61 Ill. App.3d 822, 378 N.E.2d 805 (1978) (parents' medical malpractice case for failure to diagnose rubella during pregnancy resulting in birth defects to child barred by statute of limitations); *Nelson v. Kriser*, 678 S.W.2d 918 (Tex. 1984) (reversing statute of limitations bar in a wrongful birth action), the lack of case law in this area indicates these issues arise less frequently in wrongful birth actions than they do in wrongful pregnancy cases. One possible explanation is that because many inherited birth defects appear at an early age, parents are likely to discover they have a wrongful birth action soon after their infant is born, but several years may pass between a negligent sterilization operation and the conception of a child whose birth forms the basis of a wrongful pregnancy action.

fective child.<sup>885</sup> In *Berman v. Allen*<sup>886</sup> a North Carolina court allowed recovery of damages for mental and emotional distress, but held that the parents of a Down's Syndrome child could not recover for her medical expenses. The court stated that permitting the parents to retain all the benefits of the child's love while "saddling defendants with the enormous expenses attendant upon her rearing" would be a disproportionate remedy.<sup>887</sup>

Several jurisdictions have allowed wrongful birth plaintiffs to recover both extraordinary medical expenses and emotional distress damages.<sup>888</sup> At least one jurisdiction permitting this dual recovery, however, requires that the emotional distress award be offset by the benefits of parenthood that the plaintiffs will receive.<sup>889</sup> Other jurisdictions have stated that dual recovery is impermissible because the plaintiffs failed to meet the state's common law requirements for negligent infliction of emotional distress.<sup>890</sup> As the area of wrongful birth continues to receive judicial attention, further damages issues are certain to develop.<sup>891</sup>

#### E. CONCLUSION

Courts have had little difficulty recognizing wrongful birth as a cause of action. The traditional tort elements of duty, breach, proximate cause, and damages are easily discernable in this cause of action. Practitioners contemplating a wrongful birth action must take careful steps to ensure that the court recognizes that the complaint alleges the deprivation of an opportunity for parents to choose to avoid the birth of a deformed child—not that the physician caused the defect. Damages allowable in wrongful birth claims will depend on the jurisdiction's approach to the issues of extraordinary medical costs and emotional distress.

885. At least two courts have permitted the defective child to recover for wrongful birth; see *supra* note 853.

886. 71 N.C. App. 289, 322 S.E.2d 567 (1984).

887. *Id.* at \_\_\_\_, 322 S.E.2d at 581.

888. See *Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984); *Naccash v. Burger*, 223 Va. 406, 290 S.E.2d 825 (1982); *Harbeson v. Parke-Davis, Inc.*, 98 Wash.2d 460, 656 P.2d 483 (1983).

889. *Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984).

890. *E.g.*, *Moore v. Lucas*, 405 So.2d 1022 (Fla. Dist. Ct. App. 1981) (claim for emotional distress stricken because of failure to meet impact doctrine); *cf.* *Goldberg v. Ruskin*, 128 Ill. App.3d 1029, 471 N.E.2d 530 (1984) (remanding case to permit parents to show physical injury or illness in effort to recover for negligent infliction of emotional distress).

891. See generally, Capron, *Tort Liability in Genetic Counseling*, 79 COLUM. L. REV. 618 (1979); Note, *Father & Mother Know Best: Defining the Liability of Physicians for Inadequate Genetic Counseling*, 87 YALE L.J. 1488 (1978).

Wrongful birth will likely be an expanding area of tort law in the coming decades. This continued expansion is contingent, however, upon two factors: (1) the continued expansion of medical technology's ability to detect genetic carriers and genetically imperfect fetuses and (2) the future direction of the United States Supreme Court's *Roe v. Wade* decision.<sup>892</sup> The wrongful birth action is permitted on the parents' right to choose whether to continue a pregnancy. If the Supreme Court should curtail or abolish the right to an abortion, wrongful birth would be a valid action only in instances when parents, as genetic carriers, could be tested prior to conception.

## VIII. Wrongful Life

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### A. INTRODUCTION

Advances in medical technology, including amniocentesis<sup>893</sup> and various methods of genetic testing,<sup>894</sup> have greatly increased the amount and sophistication of information available to adults engaged in family planning. The technical nature of this medical capability to predict inheritable birth defects and diseases has in-

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892. 410 U.S. 113 (1973). For a discussion of *Roe v. Wade* and its progeny, see *generally infra* section V of this Special Project.

893. For an explanation of the amniocentesis method of detecting genetic disease, see *supra* notes 55-56 and accompanying text. Two other methods that allow early sampling of fetal cells are discussed *supra* notes 57-62 and accompanying text.

894. For a discussion of testing for genetic disease, see *supra* notes 46-54 and accompanying text.

creasingly involved the expertise of physicians in family planning decisions. Consequently, new professional legal duties have arisen. When negligently performed genetic testing and counseling about the risk of birth defects results in a misinformed or uninformed decision to have a child who is later born with predictable abnormalities, many courts have recognized a "wrongful birth" cause of action on behalf of the mother.<sup>895</sup> These wrongful birth actions assert that the mother is damaged by her reliance on the erroneous advice of the defendant-physician.<sup>896</sup>

Courts have been much more reluctant, however, to recognize the impaired child's claim for wrongful life in similar situations of negligent testing and counseling.<sup>897</sup> The gravamen of a wrongful life claim is that the plaintiff is damaged by her very existence and would not have been born but for the defendant's negligence.<sup>898</sup> The claim essentially asserts that the defendant breached a duty owed directly or inuring derivatively to the plaintiff-child by not informing the parents of the risk of predictable abnormalities. Because the parents were thereby deprived of information that would have convinced them to decide against having the child, this

895. See, *Speck v. Finegold*, 497 Pa. 77, 439 A.2d 110 (1981); *Eisbrenner v. Stanley*, 106 Mich. App. 357, 308 N.W.2d 209 (1981). For a more thorough discussion of wrongful birth, see *supra* section VII of this Special Project.

896. The physician may render advice prior to conception. More commonly the physician's consultation with the prospective parents occurs after conception with a view toward aborting the pregnancy if there are significant risks of birth defects. In this latter situation, any damage resulting from the physician's negligence is contingent on the woman's right to have an abortion. Absent a right to have an abortion, the physician's erroneous advice would not deprive the prospective mother of information necessary to make an informed choice because she would have no legal right to choose between abortion and child bearing. Consequently, the constitutional right to have an abortion, established by *Roe v. Wade*, 410 U.S. 113 (1973), has had a major impact on the development of wrongful birth cases.

897. To date, the decisions recognizing wrongful life claims have limited that cause of action to cases concerning erroneous information about the risks of birth defects or disease. See, e.g., cases cited *infra* notes 911-14. Wrongful life claims have failed in fact situations not involving faulty testing and counseling. For example, in *Zepeda v. Zepeda*, 41 Ill. App. 2d 240, 190 N.E.2d 849 (1963), *cert. denied*, 379 U.S. 945 (1964), a healthy, illegitimate child unsuccessfully sued his father for damages resulting from his illegitimacy. Other unsuccessful claims have arisen from improperly performed sterilization, see, e.g., *Stribling v. de-Quevedo*, 288 Pa. Super. 436, 432 A.2d 239 (1980); *Elliott v. Brown*, 361 So. 2d 546 (Ala. 1978), or improperly performed abortion, see, e.g., *Speck v. Finegold*, 497 Pa. 77, 439 A.2d 110 (1981), which usually resulted in the birth of a healthy but unplanned child. See, e.g., *Beardsley v. Wierdsma*, 650 P.2d 288 (Wyo. 1982). No court has admitted that a life may be wrongful absent some physical affliction, and currently prevailing case law suggests that courts will uniformly reject any future wrongful life claims by healthy children.

898. See *Dumer v. St. Michael's Hosp.*, 69 Wis. 2d 766, 771-72, 233 N.W.2d 372, 375 (1975).

breach is the proximate cause of the child's birth<sup>899</sup> and the resulting injury of life in an impaired state.<sup>900</sup>

Currently, the highest court in thirteen states refuse to recognize a cause of action for wrongful life.<sup>901</sup> Appellate courts in three other states<sup>902</sup> and federal district courts applying the law of two other states<sup>903</sup> have dismissed wrongful life claims. In sum, eigh-

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899. In this context the physician's breach of duty is not the proximate cause of afflictions to what would otherwise be a healthy child. See Note, *Wrongful Life: A Modern Claim Which Conforms to the Traditional Tort Framework*, 20 WM. & MARY L. REV. 125, 137 (1978). "The impaired child plaintiff in a wrongful life claim never had the opportunity to be born healthy." *Id.* at 144.

This statement is true in most but not all wrongful life cases. Stated more accurately from the time of the alleged breach of duty, the impaired child did not have the chance to be born healthy. See generally *Harbeson v. Parke-Davis, Inc.*, 98 Wash. 2d 460, 656 P.2d 483 (1983).

900. No court has allowed a child to assert a wrongful life claim against her parents. Arguably, if an afflicted child's life can be wrongful because of the physician's negligence, then that life could be wrongful because of the parents' negligence. Realistically, some prospective parents may have a child with defects after a physician properly has informed them of the risks of defects. In that case, the child would have the same afflictions for which a negligent physician would have been liable according to the wrongful life theory. The child, however, would have no available recovery from her parents because a woman's right to abort during the first trimester of pregnancy is absolute. See *Roe v. Wade*, 410 U.S. 113, 163 (1973). Regardless of the mother's constitutional rights, any other ruling would have a staggeringly adverse impact on familial relationships and implicitly would encourage abortion to avoid parental liability. See *Turpin v. Sortini*, 31 Cal. 3d 220, 228, 643 P.2d 954, 959, 182 Cal. Rptr. 337, 342 (1982). Parents under the specter of a lawsuit could not act entirely in the child's best interest. Preserving unencumbered parental freedom of choice is a more desirable social result for all parties than is parental liability. But see *Curlender v. Bio-Science Laboratories*, 106 Cal. App. 3d 811, 829, 165 Cal. Rptr. 477, 488 (1980) (partially overruled in *Turpin v. Sortini*) (if properly informed parents make a conscious choice to have a seriously impaired infant, "we see no sound public policy which should protect those parents from being answerable for the pain, suffering and misery which they have wrought upon their offspring"). In response to *Curlender*, the California legislature enacted a statute expressly prohibiting this type of suit. See, CAL. CIV. CODE § 43.6 (West 1982).

901. *Elliott v. Brown*, 361 So. 2d 546 (Ala. 1978); *Coleman v. Garrison*, 349 A.2d 8 (Del. 1975) (parent's claim treated as one for wrongful life); *Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984); *Bruggeman v. Schimke*, 718 P.2d 635 (Kan. 1986); *Schork v. Huber*, 648 S.W.2d 861 (Ky. 1983) (wrongful life discussed though facts did not present the issue); *Smith v. Cote*, Available on LEXIS Aug. 3, 1986, No. 85-015 (N.H. 1986); *Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); *Azzolino v. Dingfelder*, 315 N.C. 103, 337 S.E.2d 528 (1985); *Speck v. Fmegold*, 497 Pa. 77, 439 A.2d 110 (1981) (affirming by three to three decision lower court's dismissal of claim); *Nelson v. Krusen*, 678 S.W.2d 918 (Tex. 1984); *James G. v. Caserta*, 332 S.E.2d 872 (W. Va. 1985); *Dumer v. St. Michael's Hosp.*, 69 Wis. 2d 766, 233 N.W.2d 372 (1975); *Beardsley v. Wierdsma*, 650 P.2d 288 (Wyo. 1982). Cf. *Payton v. Abbott Labs*, 386 Mass. 540, 437 N.E.2d 171 (1982) (daughters who would not have been born but for ingestion of DES could not recover).

902. *Moores v. Lucas*, 405 So. 2d 1022 (Fla. Dist. Ct. App. 1981). *Eisbrenner v. Stanley*, 106 Mich. App. 351, 308 N.W.2d 209 (1981); *Miller v. Duhart*, 637 S.W.2d 183 (Mo. App. 1982).

903. *White v. United States*, 510 F. Supp. 146 (D. Kan. 1981) (applying Georgia law);

teen jurisdictions have reported decisions denying recovery to plaintiffs alleging that their existence constituted a culpable injury.<sup>904</sup>

Courts have rejected wrongful life claims for various policy reasons. Some courts maintain that allowing a wrongful life cause of action implies that nonlife is preferable to life in an impaired state, an unacceptable disavowal of the sanctity and worth of all human life.<sup>905</sup> Other courts consider the tort beyond judicial administrability.<sup>906</sup> These courts reason that the compensatory nature of tort law would require courts to compare the harm of an impaired life with nonexistence when measuring damages.<sup>907</sup> Because man is incapable of making this comparison, these courts believe that they should not allow the claim absent legislative enactment.<sup>908</sup> In addition to policy reasons, some courts have rejected wrongful life claims because the plaintiffs failed to establish a duty, breach, or injury—the fundamental elements of a tort claim.<sup>909</sup> These courts have applied a standard negligence formula

Phillips v. United States, 508 F. Supp. 537 (D. S.C. 1980) (applying South Carolina law).

904. These statistics include claims asserted by healthy child plaintiffs. Some courts that have confronted claims by healthy children, however, used sweeping language which indicates that a life would not be wrongful under any circumstances, including severely impaired life. See *Elliott v. Brown*, 361 So. 2d 546 (Ala. 1978). But see *Beardsley v. Wierdsma*, 650 P.2d 288 (Wyo. 1982) (addressing only healthy child's claim and withholding judgment on the validity of impaired children's claims).

905. See *Elliott v. Brown*, 361 So. 2d 546, 548 (Ala. 1978) ("a legal right not to be born is alien to the public policy of this State to protect and preserve human life"); see also *Phillips v. United States*, 508 F. Supp. 537 (D. S.C. 1980).

906. See, e.g., *Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978) (discussing physician's failure to advise plaintiffs of the increased risk of Down's Syndrome in children born to women over 35 and of the availability of amniocentesis test); *Dumer v. St. Michael's Hosp.*, 69 Wis. 2d 766, 233 N.W.2d 372 (1975) (discussing physician's alleged misdiagnosis of reubella as a rash on pregnant woman).

907. See *Dumer v. St. Michael's Hosp.*, 69 Wis. 2d at 771, 231 N.W.2d at 375-76.

908. A statute would be in derogation of the common law in those states that have judicially rejected wrongful life claims. A statute recognizing wrongful life claims might remove the conceptual difficulty of assessing damages by stating what components would be allowable.

909. See *Nelson v. Krusen*, 678 S.W.2d 918 (Tex. 1984). In *Nelson* a physician allegedly rendered erroneous advice that a pregnant woman was not a carrier of Duchenne muscular dystrophy. The court found it impossible to decide rationally whether the plaintiff had been damaged. *Id.* at 925. The concurrence further stated:

Courts examining "wrongful life" suits have had difficulty with virtually every element of the cause of action—the nature of the duty, if any, owed to an unborn child under these circumstances, the concomitant question of breach, and the issue of proximate cause in a situation where both the child's life and his or her defective condition are due to the same negligent act.

*Id.* at 928-29 (Robison, J., concurring).

and have concluded that wrongful life does not fit into the traditional tort framework.

Judicial recognition of a wrongful life tort is a fairly recent phenomenon. Prior to 1982, only three decisions had allowed claims for wrongful life, and higher courts subsequently overruled or modified all of these decisions.<sup>910</sup> Since 1982, however, the Supreme Courts of California,<sup>911</sup> Washington,<sup>912</sup> and New Jersey<sup>913</sup> have recognized wrongful life claims. Two state courts of appeals also have recognized causes of action for wrongful life.<sup>914</sup> These five opinions do not represent a trend toward uniform acceptance of wrongful life claims; seven state courts have rejected these claims since 1982.<sup>915</sup> Nevertheless, these five decisions represent significant steps toward allowing impaired children to assert claims for wrongful life and lay a foundation for future wrongful life actions.

Section B of this Part discusses five recent opinions that have recognized a wrongful life cause of action and evaluates these courts' analytical approaches to the elements of the claim—duty, causation, injury and damages. Section C examines the merits and flaws of these opinions and suggests a better-reasoned analytical approach to wrongful life cases. Section D concludes that a well-reasoned approach to wrongful life claims, with a proper assessment of injury and damages, will enable courts to provide just compensation for the children who suffer the consequences of the medical community's negligence in prenatal care.

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910. *Parke v. Chessin*, 60 A.D.2d 80, 400 N.Y.S.2d 110 (1977), *modified sub nom. Becker v. Schwartz*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); *Becker v. Schwartz*, 60 A.D.2d 587, 400 N.Y.S.2d 119 (1977), *modified*, 46 N.Y.2d 401, 386 N.E.2d 807, 413 N.Y.S.2d 895 (1978); *Curlender v. Bio-Science Lab.*, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980), *partially overruled in Turpin v. Sortini*, 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982).

911. *Turpin v. Sortini*, 31 Cal.3d at 228, 643 P.2d at 959, 182 Cal. Rptr. at 342.

912. *Harbeson v. Parke-Davis, Inc.*, 98 Wash. 2d 460, 656 P.2d 483 (1983).

913. *Procanik v. Cillo*, 97 N.J. 339, 478 A.2d 755 (1984).

914. *Continental Casualty Co. v. Empire Casualty Co.*, No. 83 CAT 139 (Colo. Ct. App. June 27, 1985); *Siemieniec v. Lutheran Gen. Hosp.* 134 Ill. App. 3d 823, 480 N.E.2d 1227 (1985).

915. See *Blake v. Cruz*, 108 Idaho 253, 698 P.2d 315 (1984); *Bruggeman v. Schimke*, 718 P.2d 635 (Kan. 1986); *Schork v. Huber*, 648 S.W.2d 861 (Ky. 1983); *Smith v. Cote*, available on LEXIS Aug. 3, 1986, No. 85-015 (N.H. 1986); *Azzolino v. Dingfelder*, 315 N.C. 103, 337 S.E. 2d 528 (1985); *Nelson v. Krusen*, 678 S.W.2d 918 (Tex. 1984); *James G. v. Caserta*, 332 S.E.2d 872 (W. Va. 1985).



B. PRINCIPAL CASES RECOGNIZING A WRONGFUL LIFE CAUSE OF ACTION

1. State Supreme Court Decisions

(a) *Turpin v. Sortini*

In *Turpin v. Sortini*<sup>916</sup> the California Supreme Court considered a deaf child's claim for general and special damages resulting from a hearing specialist's erroneous diagnosis. The plaintiff's parents consulted the defendant about the suspected hearing problems of their infant child, Hope. The parents alleged that after the specialist incorrectly diagnosed Hope's hearing as being within normal limits, they conceived Joy, the plaintiff.<sup>917</sup> Another specialist subsequently informed the parents of Hope's deafness and of the reasonable probability that any of their future children would inherit the hearing defect.<sup>918</sup> The parents alleged that had they known of the hereditary deafness, they would not have conceived Joy, who suffered from the same disease.<sup>919</sup> The court concluded that if Joy sustained her burden of proof on remand, she could recover the extraordinary expenses occasioned by the hereditary ailment.<sup>920</sup>

The *Turpin* court did not analyze the elements of duty, breach, and causation because the defendant did not challenge these aspects of the claim on appeal.<sup>921</sup> Addressing the injury element, the court discussed *Curlender v. Bio-Science Labs, Inc.*,<sup>922</sup> a California court of appeals decision that recognized a claim for wrongful life. The *Curlender* court refused to recognize a right not to be born and, therefore, rejected the state of nonlife as the proper reference for establishing an injury. Instead, the *Curlender* court found the child's condition at birth to be the proper point of reference.<sup>923</sup> The *Turpin* court, however, reasoned that finding that the injury is the child's impaired condition implies that the child

916. 31 Cal. 3d 220, 643 P.2d 954, 182 Cal. Rptr. 337 (1982). The trial court had dismissed the child's cause of action on demurrer.

917. *Id.* at 224, 643 P.2d at 956, 182 Cal. Rptr. at 339.

918. *Id.*

919. *Id.*

920. *Id.* at 238, 643 P.2d at 965, 182 Cal. Rptr. at 348. The court did not provide guidelines for determining these extraordinary expenses, apparently leaving the details of the assessment to the trial court if it found liability.

921. *Id.* at 230, 643 P.2d at 960, 182 Cal. Rptr. at 343.

922. 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980).

923. *Turpin*, 31 Cal. 3d at 231, 643 P.2d at 960, 182 Cal. Rptr. at 343 (citing *Curlender*, 106 Cal. App. 3d at 828-29, 165 Cal. Rptr. at 488).

would have been healthy but for the tortfeasor's negligence.<sup>924</sup> The court dismissed the *Curlender* reasoning as inapplicable by noting that the child in the instant wrongful life claim never had a chance to be healthy.<sup>925</sup> The *Turpin* court stated that establishing injury in a wrongful life claim necessarily requires comparison of life in an impaired state with no life at all.<sup>926</sup> The court thus rejected one of the primary justifications for denying wrongful life claims—the notion that life is always better than nonlife as a matter of law.<sup>927</sup> In rejecting that notion the court found support in statutory<sup>928</sup> and case law<sup>929</sup> acknowledging the rights of terminally ill persons to refuse life sustaining procedures.<sup>930</sup>

The court next considered whether a fact finder could determine that nonlife was preferable to life in the instant case. Acknowledging that such a jury finding would be unlikely, the court nevertheless stated that the plaintiff could claim special damages if the "defendant's negligence was in fact a proximate cause of the child's present and continuing need for such special, extraordinary medical care and training."<sup>931</sup> By defining the injury in this manner, the court implicitly found the injury to be the child's impaired state, although the court had rejected explicitly that definition earlier in the opinion.<sup>932</sup> Achieving the same result as the *Curlender* court, the *Turpin* court held the defendant liable for failure to diagnose a hereditary condition that could not have been prevented.

Turning to the issue of damages, the court first considered whether to award general damages. Relying on the landmark decision *Gleitman v. Cosgrove*,<sup>933</sup> the court stated that calculation of

924. 31 Cal. 3d at 231, 643 P.2d at 961, 182 Cal. Rptr. at 344.

925. *Id.*

926. *Id.* at 232, 633 P.2d at 961, 182 Cal. Rptr. at 344.

927. *Id.* at 233, 633 P.2d at 962, 182 Cal. Rptr. at 345.

928. The court cited CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1986).

929. The court cited *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). In that case, the court considered a request for authority to discontinue extraordinary procedures sustaining the life of a drug overdose victim who suffered irreversible brain damage and who survived in a vegetative state. The *Quinlan* court noted the right of privacy found in the penumbra of the guarantees of the Bill of Rights. "Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." *Id.* at 40, 355 A.2d at 663.

930. *Turpin*, 31 Cal. 3d at 233, 633 P.2d at 962, 182 Cal. Rptr. at 345.

931. *Id.* at 238, 643 P.2d at 965, 182 Cal. Rptr. at 348.

932. See *supra* text accompanying note 904.

933. 49 N.J. 22, 227 A.2d 689 (1967). *Gleitman* was the first state supreme court case analyzing a wrongful life claim by an impaired child. Many later decisions relied on the reasoning of *Gleitman* in rejecting the claim.

general damages requires comparing the plaintiff's pain and suffering to no existence at all, an assessment of which man is incapable.<sup>934</sup> This problematic comparison, however, served as the court's essential basis for establishing the injury element of the claim.<sup>935</sup> The *Turpin* court thus suggested that, for purposes of finding a tort injury, life in an impaired state may be worse than nonlife, but that a court cannot determine the extent of the difference to assess damages. Although the court considered general damages incalculable, the court found the special expenses attendant to the plaintiff's deafness "readily ascertainable" and concluded that these expenses were the proper measure of damages.<sup>936</sup> The court, however, did not explain why the problematic comparison of impaired life and nonlife did not affect the award of special damages. In this respect, the award of special damages is arbitrary even if, as the court suggested, those figures are readily ascertainable.

The precedent that *Turpin* established is clearer than the reasoning behind the holding. In California, a child-plaintiff may assert a cause of action for wrongful life. Physicians have the duty, although not clearly delineated in *Turpin*, to inform potential parents of discoverable hereditary defects that their child might have at birth. If the defendant's breach of this duty deprives the parents of information that would have led them to decide against having the child, causation is established. Courts actually are defining the injury in terms of damages, which consist of the special costs associated with the defect during the plaintiff's life.

*Turpin* is significant not only because it was the first state supreme court decision that recognized a claim for wrongful life, but also because this decision established in California that the basis for liability is linked not to the severity of a birth defect, but to its predictability. Moreover, *Turpin* attacked, albeit inconsistently, the premise that life is always better than nonlife. Finally, *Turpin* provided an administrable measure of damages that proved attractive to future courts.<sup>937</sup>

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934. *Turpin*, 31 Cal. 3d at 235, 643 P.2d at 963, 182 Cal. Rptr. at 346.

935. See *supra* text accompanying note 906.

936. 31 Cal. 3d at 238, 643 P.2d at 965, 182 Cal. Rptr. at 348.

937. See, e.g., *Procanik v. Cillo*, 97 N.J. 339, 478 A.2d 755 (1984); *Harbeson v. Parke-Davis*, 98 Wash. 2d 460, 656 P.2d 483 (1983).

(b) *Harbeson v. Parke-Davis, Inc.*

In *Harbeson v. Parke-Davis, Inc.*<sup>938</sup> the defendant-physicians had prescribed Dilantin, an anticonvulsant drug, to the plaintiffs' mother to control her epileptic seizures.<sup>939</sup> Although the plaintiffs' parents inquired about the risks associated with pregnancy while on the drug, the defendants did not research the issue or inform the parents about the known correlation between Dilantin and birth defects.<sup>940</sup> The children-plaintiffs were born with fetal hydantoin syndrome, which is characterized by several physical and developmental abnormalities.<sup>941</sup> The parents testified that they would not have had the children-plaintiffs had the defendants informed them of the risks associated with Dilantin.<sup>942</sup>

Relying on *Turpin*, the Washington Supreme Court observed that allowing a wrongful birth action by parents while denying recovery to impaired children would be anomalous.<sup>943</sup> The court noted that the parents' recovery did not include care for the children after the age of majority, although the children's need for special medical care and training would continue throughout their lives.<sup>944</sup> The court preferred to place the burden of these continuing special medical care and training costs on those who caused them.<sup>945</sup> For these reasons, the Washington court recognized the wrongful life cause of action.<sup>946</sup>

Addressing the elements of this cause of action, the court imposed on the defendants a duty to inform prospective parents of the risks that the defendants should have discovered, given the standard of care in the profession.<sup>947</sup> In this case, the defendants' failure to alert the plaintiffs' parents to the effects of Dilantin on

938. 98 Wash. 2d 460, 656 P.2d 483 (1983).

939. *Id.* at 462, 656 P.2d at 486.

940. *Id.* at 463, 656 P.2d at 487.

941. The plaintiffs had "mild to moderate growth deficiencies, mild to moderate developmental retardation, wide-set eyes, lateral ptosis (drooping eyelids), hypoplasia of the fingers, small nails, low-set hairline, broad nasal ridge, and other physical and developmental defects." *Id.* at 463, 656 P.2d at 486.

942. The district court made fact findings and certified to the Washington Supreme Court the question whether the plaintiffs could maintain a claim for wrongful life.

943. 98 Wash. 2d at 479, 656 P.2d at 495 (quoting *Turpin v. Sortini*, 31 Cal. 3d 220, 238, 643 P.2d 954, 965, 182 Cal. Rptr. 337, 348 (1982)).

944. *Id.*

945. *Id.*

946. *Id.*

947. *Id.* at 480-82, 656 P.2d at 495-96. The district court held that the physicians breached this standard by failing to conduct a literature search of the effects of Dilantin on pregnancy. *Id.* at 483, 656 P.2d at 497.

pregnancy foreseeably endangered the plaintiffs' health.<sup>948</sup> Having established the defendants' breach of this duty, proof that the plaintiffs would not have been born but for the defendants' negligence established causation.<sup>949</sup> Considering the issue of injury, the *Harbeson* court recognized prior courts' difficulty with establishing this element of the claim. The court nonetheless concluded that an injury exists "to the extent that [the minor plaintiffs] require special medical treatment and training beyond that required by children not afflicted with fetal hydantoin syndrome."<sup>950</sup> The Washington Supreme Court, therefore, defined injury in terms of damages, much like the California Supreme Court did in *Turpin*.<sup>951</sup> The court denied recovery of general damages because the court considered the difference between impaired life and nonlife impossible to calculate.<sup>952</sup> Like *Turpin*, *Harbeson* does not explain why the impossibility of this calculation precludes recovery of general damages for pain and suffering, yet does not affect a determination of special damages. The *Harbeson* court, however, did render an administrable decision that served two objectives: to deter malpractice and to ease the burdens of the impaired plaintiff.

(c) *Procanik v. Cillo*

In *Procanik v. Cillo*<sup>953</sup> the New Jersey Supreme Court overruled the landmark decision of *Gleitman v. Cosgrove*,<sup>954</sup> which had refused to recognize a cause of action for wrongful life. In *Procanik* the plaintiff's mother consulted the defendant during the first trimester of pregnancy to determine whether she had contracted rubella.<sup>955</sup> Erroneously assured that she had not contracted the disease, the plaintiff's mother allowed her pregnancy to continue,

948. *Id.* at 480, 656 P.2d at 496.

949. *Id.*

950. *Id.* at 483, 656 P.2d at 497.

951. See *supra* notes 904-10 and accompanying text.

952. *Id.* at 480, 656 P.2d at 496. One commentator has concluded that for this reason the court should not have found an injury. Recent Development, *Washington Recognizing Wrongful Birth and Wrongful Life—A Critical Analysis—Harbeson v. Parke-Davis, Inc.*, 58 WASH. L. REV. 649, 676 (1983). "Existing principles should not be stretched beyond recognition in order to allow recovery in specific cases. If a claim does not fit within accepted tort principles, there should be no recovery unless the tort principles are changed by the legislature." *Id.*

953. 97 N.J. 339, 478 A.2d 755 (1984).

954. 49 N.J. 22, 227 A.2d 589 (1967). See *supra* note 933.

955. *Id.* at 343, 478 A.2d at 758. Because the case presented an appeal from a granted motion to dismiss, the court accepted as true plaintiff's allegation regarding the consultation. *Id.*

eventually giving birth to the infant-plaintiff who suffered from congenital rubella syndrome.<sup>956</sup> A proper evaluation by the defendant during pregnancy would have revealed the mother's disease and the corresponding likelihood of the child's afflictions.<sup>957</sup> The defendant's error thus deprived the plaintiff's parents of information necessary to make an informed choice about terminating the pregnancy.<sup>958</sup>

In considering whether to recognize a wrongful life cause of action, the court admitted the logical problems inherent in a wrongful life claim, such as recognizing the child's standing and injury. The court, however, concluded that "[l]aw is more than an exercise in logic, and logical analysis, although essential to a system of ordered justice, should not become an instrument of injustice."<sup>959</sup> The court noted that this case served as a good example of potential injustice because, although New Jersey recognized a parental cause of action for wrongful birth, the statute of limitations had run on the parents' claim.<sup>960</sup> Concerned that the child may have had no other prospects for recovery, the court, therefore, concluded that if the plaintiff sustained the burden of persuasion, he could recover the "extraordinary medical expenses attributable to his affliction."<sup>961</sup>

The court stated its findings on duty, breach, and causation with little elaboration.<sup>962</sup> Addressing the issues of injury and damages, the *Procanik* court, like the *Turpin* and *Harbeson* courts, made the analytical leap from injury to damages without explanation.<sup>963</sup> Confining recovery to special damages, the court stated that "the ultimate decision is a policy choice summoning the most sensitive and careful judgment."<sup>964</sup> The court asserted that the two

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956. The child's multiple birth defects included eye lesions, heart disease, and auditory defects. *Id.* at 344, 478 A.2d at 758.

957. *Id.* at 343, 478 A.2d at 758.

958. *Id.* at 348-49, 478 A.2d at 760.

959. *Id.* at 351, 478 A.2d at 762.

960. *Id.* at 352, 478 A.2d at 762.

961. *Id.* at 342-43, 418 A.2d at 757. The court asked: Must the child "forego medical treatment for his blindness, deafness, and retardation? We think not." *Id.* at 352, 478 A.2d at 762.

962. The court merely stated: "The defendant doctors do not deny they owed a duty to the infant plaintiff, and we find such a duty exists . . . [W]e assume, furthermore, that the defendant doctors were negligent in treating the mother [and] that their negligence deprived the parents of the choice of terminating the pregnancy . . ." *Id.* at 348-49, 478 A.2d at 760.

963. *See id.* at 353-54, 478 A.2d at 763.

964. *Id.* at 354, 478 A.2d at 763.

policy objectives of tort law—compensating injury and deterring future wrongdoing—both require a more ascertainable and predictable measure of damages than is possible in the highly speculative determination of whether nonlife may be preferable to a plaintiff's impaired life.<sup>965</sup> The court found that damages measured by the cost of extraordinary care provides both a predictable, ascertainable means of compensating the plaintiff and a "sufficient sting" to deter future malpractice.<sup>966</sup> Thus, the court arguably defined the tort in traditional negligence terms, but the decision ultimately relied on policy grounds. In this respect, the *Procanik* court's rationale had a different emphasis from *Turpin* and *Harbeson*, although the result was the same.

In a separate opinion, Justice Handler concurred in the award of special damages, but dissented from the court's denial of general damages.<sup>967</sup> Justice Handler saw no reason to deny general damages and suggested alternative methods of assessment, including comparing the benefits of an impaired life with its burdens,<sup>968</sup> compensating for diminished parenthood,<sup>969</sup> and compensating for impaired childhood.<sup>970</sup> More importantly, Justice Handler, unlike the majority, openly addressed the element of injury and the formulas for compensation.<sup>971</sup> He argued that the infant's injury does not necessitate either a preference for nonlife over life or an irrational comparison of the two.<sup>972</sup> Rather, the injury consists of the consequences of depriving the parents of their right to determine on the child's behalf whether he should have been born.<sup>973</sup>

By characterizing the injury in this manner, Justice Handler solved two analytical problems. First, he removed the calculation

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965. *Id.*

966. *Id.*

967. *Id.* at 368, 478 A.2d at 764-72. (Handler, J., concurring). Justice Schreiber dissented from the award of special damages and would have denied recovery entirely. He viewed the award as compensation for the defects, which implied that the defendants had caused the defects. Because the physicians did not cause the defects, Justice Schreiber considered holding the physicians liable unjust. *Id.* at 370-71, 478 A.2d at 772-73 (Schreiber, J., dissenting).

968. *Id.* at 368, 478 A.2d at 771. See *infra* notes 1011-14 and accompanying text.

969. 97 N.J. at 368, 478 A.2d at 771 (Handler, J., concurring). Parents who are kept ignorant of a child's defective state until his birth are, according to Justice Handler, less fit to assume parental responsibilities than they otherwise would be. Thus, this element of damages includes both emotional and psychological harm. See *id.* at 358-59, 478 A.2d at 766-68.

970. *Id.* at 368, 478 A.2d at 771.

971. *Id.* at 356-69, 478 A.2d at 764-772.

972. *Id.* at 358, 478 A.2d at 765.

973. *Id.* at 364, 478 A.2d at 769.

of life versus nonlife from a finding of injury. Thus, a court could define the four elements of the tort in a principled manner. The court could make the life-nonlife calculation, if at all, when assessing damages. Any difficulty in assessing damages would not be a bar to recovery.<sup>974</sup> Second, by emphasizing the parents' fundamental right of choice, his approach avoids a judicial determination that nonlife is preferable to life, because the parents, not the court, make the choice. Justice Handler's policy was simply to protect the child's right to have his parents sufficiently informed to act in his best interest.<sup>975</sup>

## 2. State Appellate Court Decisions

### (a) *Siemieniec v. Lutheran General Hospital*

In addition to the preceding state supreme court decisions, intermediate courts in Illinois and Colorado have recognized claims for wrongful life in *Siemieniec v. Lutheran General Hospital*,<sup>976</sup> and *Continental Casualty Co. v. Empire Casualty Co.*,<sup>977</sup> respectively. The Illinois Court of Appeals, in *Siemieniec v. Lutheran General Hospital*,<sup>978</sup> allowed a child-plaintiff's claim<sup>979</sup> for extraordinary expenses attendant to hemophilia<sup>980</sup> after he reached the age of majority. The complaint alleged that the defendant-physician erroneously informed the plaintiff's mother that the risk that her child would be born a hemophiliac was very low.<sup>981</sup> The plaintiff's mother claimed that she would have terminated her pregnancy if the results of tests determining the likelihood of hemophilia in her offspring had been positive.<sup>982</sup> Relying on the inac-

974. *Id.* at 368, 478 A.2d at 771.

975. *Id.* at 365, 478 A.2d at 769.

976. 134 Ill. App. 3d 823, 480 N.E.2d 1227 (1985).

977. No. 83CAO139 (Colo. Ct. App. June 27, 1985) (available Oct. 20, 1985, on LEXIS, States library, Colo. file).

978. 134 Ill. App. 3d 823, 480 N.E.2d 1227 (1985).

979. The court stated that the claim was not one for wrongful life, *Id.* at \_\_\_\_, 480 N.E.2d at 1235, but that the semantic description of the claim was without significance. The fact situation in *Siemieniec* paralleled those of the previously discussed wrongful life cases.

980. Hemophilia is a hereditary blood clotting disorder that primarily affects males. The deficiency or inactivity of coagulation factors needed for blood clotting causes the disorder, which occurs in different levels of severity. *Id.* at 825 n.1, 480 N.E.2d at 1229 n.1.

981. The lower court submitted certified questions to the Appellate Court of Illinois, First District, Second Division. One question was whether the child had a cause of action for extraordinary medical expenses during his age of majority. The court considered the pertinent alleged facts to be true for purposes of analysis. *Id.* at \_\_\_\_, 480 N.E.2d at 1228.

982. Plaintiff's mother apparently made this allegation to establish a prima facie showing of causation. In a wrongful life suit, the plaintiff must show that, but for the de-



curate information, she decided to have the child.

The court summarily disposed of previous decisions that had denied recovery on similar facts, stating that those "decisions often reflect[ed] the now discarded rationale of the New Jersey Supreme Court in *Gleitman* . . . that it could not weigh the value of an impaired life against no life at all."<sup>983</sup> The Illinois court indicated that it would not preclude recovery because of the impaired life versus nonlife dilemma. In this case, however, the plaintiff sought only specific damages for the extraordinary expenses relating to hemophilia and, therefore, the problematic comparison of impaired life with nonlife was unnecessary.<sup>984</sup> According to the court, only a claim for general damages would require that assessment, and such a claim was not before the court.<sup>985</sup> The Illinois court thus used the same argument asserted in previous cases—special damages, unlike general damages for pain and suffering, are readily ascertainable and, therefore, allowable. The court did not define the plaintiff's injury and then measure damages; rather, the court ascertained the damages figures and then found an injury.<sup>986</sup> Thus, the *Siemieniec* court, like the court in *Turpin*, allowed a cause of action for a plaintiff who faced costly physical problems, but who could conceivably lead a full, productive life.

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defendant's erroneous information or lack of information, the plaintiff would not have been born. The *Siemieniec* court noted two types of hemophilia, factor VIII and factor IX. The plaintiff was born with factor IX hemophilia, for which no reliable test existed. Thus, the physician was allegedly negligent in failing to apprise plaintiff's mother of the risk of factor IX hemophilia, for which he could not test. Plaintiff's mother alleged she would have aborted the pregnancy if tests for hemophilia had been "positive." *Id.* at \_\_\_\_, 480 N.E.2d at 1228. Would she have aborted, however, if informed of the risk of factor IX hemophilia? The court failed to address this question although it appears crucial to a prima facie showing of causation.

Plaintiff's mother obviously wanted to have a healthy child, but a fact finder must determine the degree of risk she was willing to assume. Because courts use a subjective test to analyze the element of causation in a wrongful life case, the fact finder must determine what the prospective mother would have decided had she been properly informed. In the instant case, the mother's testimony would likely have been the only available evidence on the issue of causation. Unless her testimony was not credible, the plaintiff could probably establish causation in a conclusory fashion. The foregoing analysis illustrates the inherent difficulty of defending against this element of the tort.

983. *Id.* at \_\_\_\_, 480 N.E.2d at 1233.

984. *Id.* at \_\_\_\_, 480 N.E.2d at 1235.

985. *Id.*

986. The court noted that "the damage here is both certain and readily measurable." *Id.* (quoting *Turpin v. Sortini*, 31 Cal. 3d 220, 238-39, 643 P.2d 954, 965, 182 Cal. Rptr. 337, 348 (1985)). The court then stated that "[i]f, as alleged, defendants' negligence was in fact a proximate cause of the child's present and continuing need for such special, extraordinary medical care and training, we believe . . . defendants [should be held] liable for the cost of such care." *Id.*

(b) *Continental Casualty Co. v. Empire Casualty Co.*

In *Continental Casualty Co. v. Empire Casualty Co.*<sup>987</sup> the Colorado Court of Appeals reviewed a trial court's finding that a physician was liable on four counts of negligence.<sup>988</sup> The physician had mistyped the plaintiff's mother's blood type during her first pregnancy;<sup>989</sup> proper testing would have revealed the RH incompatibility of the parents' blood types. This incompatibility posed a significant risk to their later offspring.<sup>990</sup> In cases of RH incompatibility, administering a drug to the mother within seventy-two hours after giving birth prevents her future offspring from being exposed to the devastating consequences of blood sensitization.<sup>991</sup> Because the physician did not discover the RH incompatibility and render appropriate treatment following plaintiff's mother's first two pregnancies,<sup>992</sup> her third child, the plaintiff, suffered a stroke either *in utero* or shortly after birth.<sup>993</sup> Furthermore, because the physician incorrectly advised the mother before her third pregnancy that she still could have normal children, the physician deprived her of information that would have affected her decision to have the third child.<sup>994</sup>

The appellate court limited its review to deciding whether a wrongful life claim was legally cognizable.<sup>995</sup> Holding that wrongful life was a proper claim, the court determined that the trial court's findings of fact supported the imposition of liability in this case.<sup>996</sup> Applying basic tort principles,<sup>997</sup> the court found that the physi-

987. No. 83CAO139 (Colo. Ct. App. June 27, 1985) (available Oct. 20, 1985, on LEXIS, States library, Colo. file).

988. The four counts were (1) mistyping plaintiff's mother's blood in July 1972; (2) failing to retype her blood in March 1974 during her second pregnancy; (3) failing to investigate the stillbirth of her second child in 1974; and (4) subsequently advising the parents affirmatively that they could have normal children in the future. *Id.*

989. *Id.*

990. "[The child plaintiff] suffered from a hemolytic disease known as erythroblastosis fatalis." *Id.*

991. *Id.* For an explanation of the process in which a mother develops antibodies that attack fetal cells, see *supra* notes 99-104 and accompanying text.

992. The mother's second child was stillborn. *Id.*

993. *Id.*

994. *Id.*

995. *Id.*

996. *Id.*

997. The court cited § 311 of The Restatement (Second) of Torts, which reads as follows:

Negligent Misrepresentation Involving Risk of Physical Harm

- (1) One who negligently gives false information to another is subject to liability for physical harm caused by action taken by the other in reasonable reliance upon such

cian's duty to inform the parents of potential deformities inured to the child as a foreseeable victim of the physician's actions or omissions.<sup>998</sup> Failure to inform the plaintiff's parents constituted a breach of duty, and the plaintiff established causation when the parents showed that they would have prevented the plaintiff's birth if they had been properly informed.<sup>999</sup> The court did not require the plaintiff to show that nonlife is preferable to life, but the court's reasoning logically suggests that this showing is necessary to establish injury.

Noting that previous courts had refused to find an injury because public policy dictates a universal preference for life,<sup>1000</sup> the *Continental Casualty* court was "unwilling to say as a matter of law that life, even with the most severe and debilitating of impairments, is always preferable to non-existence."<sup>1001</sup> The court acknowledged that the recent trend was for courts to allow only special damages. The court, however, expressed no view on the limited damages rule because the issue was not raised on appeal.<sup>1002</sup> Thus, the Colorado court's decision arguably was more internally consistent than the previous decisions. Those earlier decisions had suggested that life may not always be preferable to nonlife, but had refused to allow general damages because that comparison was unmeasurable.

Although similar to *Harbeson* in some respects, *Continental Casualty* presented the unusual situation of a defendant being liable to the child under two different theories. First, the defendant was liable in a standard malpractice claim for the preventable stroke that he proximately caused.<sup>1003</sup> Second, the defendant was liable in a wrongful life claim because he deprived the parents of information necessary to their decision whether to have the child. This dual liability, however, would not result in a greater award of

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information, where such harm results

(a) to the other, or

(b) to such third persons as the actor should expect to be put in peril by the action taken.

(2) Such negligence may consist of failure to exercise reasonable care

(a) in ascertaining the accuracy of the information, or

(b) in the manner in which it is communicated.

RESTATEMENT (SECOND) OF TORTS § 311 (1965).

998. *Continental Casualty*, No. 83CAO139.

999. *Id.*

1000. *See, e.g., cases cited supra note 905.*

1001. *Continental Casualty*, No. 83CAO139.

1002. *Id.*

1003. *Id.*

damages unless the harm caused by one tort was different from that caused by the other. Therefore, the result may be an award of the same amount that would have been recoverable under only a standard malpractice action, which presumably would include the computation of extraordinary expenses. Although a dual liability claim produces the same result as a single liability claim, the incidence of dual claims for wrongful life and standard malpractice may increase because positing more than one theory may increase the chances of recovery.

### C. ANALYSIS

The concept of a wrongful life tort has existed for only twenty years and only recently has found some judicial favor. The foregoing decisions that have recognized wrongful life claims represent a radical departure from the pre-1982 judicial consensus rejecting claims of wrongful life. Moreover, the *Turpin* and *Siemieniec* courts allowed claims for deaf and hemophiliac plaintiffs, suggesting that a birth defect or disease need not be completely debilitating for a court to allow recovery. All five courts employed a result-oriented approach to establish an administrable system of recovery for plaintiffs. Unfortunately, the courts achieved this result at the expense of sound legal analysis. Law should not be a servant of logic,<sup>1004</sup> but too much departure from logic weakens the public's confidence in the judiciary. If courts continue to "define" wrongful life as they do currently, and if courts continue to allow recovery, they should define the plaintiff's injury more precisely. Moreover, courts must relate the definition of injury to the relief allowed. The following analysis highlights some of the merits and some of the flaws in the current reasoning and suggests a more principled approach to these issues.

Comparing the elements of duty and injury in a wrongful life claim to those of a conventional malpractice claim is helpful. Wrongful life is a category of malpractice that has evolved from the doctrine of informed consent. In recent years, courts have acknowledged a physician's preconception or prenatal duty to subsequently born children.<sup>1005</sup> Prevention of future birth defects depends on proper information gathered through case histories,

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1004. See *supra* text accompanying note 959.

1005. See generally Collins, *An Overview and Analysis: Prenatal Torts, Preconception Torts, Wrongful Life, Wrongful Death, and Wrongful Birth: Time for a New Framework*, 22 J. FAM. L. 677 (1983-84).

genetic testing, amniocentesis, or physical examination of the prospective mother. Public policy, therefore, dictates that physicians owe future children a duty to provide adequate information to prospective parents according to the standards of the profession. The physician cannot ensure that prospective parents will use this information wisely or follow his advice, but fulfilling this duty to inform the prospective parents better enables them to act in the best interest of the child. Whether the duty is owed directly or inures derivatively to the child, the boundaries of the duty are the same in the context of informing the prospective parents. The courts recognizing wrongful life claims have concluded that this duty to the child, which had been established in the standard malpractice context, should also apply to a defendant in a claim for wrongful life.<sup>1006</sup> Breach of the defendant's duty to inform causes the injury—the child's impaired state—because the parents, equipped with proper information, could have prevented the child's impaired condition. This approach to the duty element is a sound mode of analysis.

The issue of injury and damages in wrongful life claims are more problematic. The wrongful life cases discussed in Section B established the extraordinary expenses associated with a plaintiff's abnormalities as the proper measure of injury and damages. The primary reason for focusing on extraordinary expenses was that courts are capable of calculating these expenses and reaching an ascertainable figure.<sup>1007</sup> That a court may ascertain this figure does not explain, however, why calculable extraordinary expenses should be the measure of a defined injury. In addition to the fact that the extraordinary expenses formula provides an administrable means of awarding recoveries to handicapped plaintiffs, the courts may have chosen this amount as the measure of damages because a parent in a wrongful birth action can recover extraordinary expenses throughout the child's minority. These courts were troubled by the unsettling proposition that parents could recover extraordinary expenses for wrongful birth while a child could recover nothing.<sup>1008</sup> This discrepancy, however, does not logically suggest that a child has suffered an injury in a wrongful life case. Rather, this

1006. See, e.g., *Harbeson v. Parke-Davis, Inc.*, 98 Wash. 2d 460, 476, 656 P.2d 483, 493 (1983); *Turpin v. Sortini*, 31 Cal. 3d 220, 230, 643 P.2d 954, 960, 182 Cal. Rptr. 337, 343 (1982).

1007. See, e.g., *supra* text accompanying notes 936 and 966.

1008. See *supra* text accompanying note 51; see also *Turpin v. Sortini*, 31 Cal. 3d at 238, 643 P.2d at 965, 182 Cal. Rptr. at 348.

concern indicates that recovery for extraordinary expenses in a wrongful birth claim should not be a windfall to the parents, but should be preserved for the child's benefit. Thus, any perceived anomaly in denying recovery for the child is related to the inadequacy of a blanket award in a wrongful birth claim, not the proper legal definition of an injury.

Courts should reject this illogical approach and develop a more precise, discreet definition of the injury in wrongful life claims. Traditional tort principles can frame this definition. As a general rule, the compensatory purpose of tort law is to place the plaintiff in the position she would have been in but for the tortfeasor's negligence.<sup>1009</sup> A compensable injury exists if the fact finder determines that the plaintiff is in a worse position after the alleged tort.<sup>1010</sup> From the plaintiff's perspective in a wrongful life suit, the consequences of the defendant's negligence are the change from nonexistence to life—with all of the benefits and burdens that accompany the plaintiff's life. In the wrongful life context, therefore, courts must assign values to nonexistence, the burdens of life, and the benefits of life.

Because a preference for nonexistence is unfathomable, courts have balked at assigning any value to nonexistence. Courts could, however, assign nonexistence a value of zero because it is neither a positive or negative position; it is nothing.<sup>1011</sup> Consequently, courts would not measure nonexistence in assessing damages,<sup>1012</sup> but, starting with the plaintiff's birth, would compare the benefits and burdens of the plaintiff's life in an impaired state. If the burdens exceed the benefits, then the plaintiff has been injured and tort

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1009. See W. PROSSER, J. WADE, & V. SCHWARTZ, *CASES AND MATERIALS ON TORTS* 537 (7th ed. 1982).

1010. *Cf. id.*

1011. A finding that life is worse than nonlife means that "the balance between happiness and misery in life is negative, or positive, but that finding is not literally a comparison of a person's condition with the condition of not-being, as in the latter state there is neither happiness nor misery whatsoever." Tedeschi, *On Tort Liability for "Wrongful Life,"* 1 ISRAEL L. REV. 513, 530 (1966).

1012. In another context, the law has not necessitated an evaluation of anything beyond the victim's life. Survival statutes allow the estate of a deceased tort victim to recover ascertainable damages on the victim's behalf. Generally, the judiciary determines damages according to traditional tort principles. No state requires a metaphysical assessment of the benefit or burdens beyond death, nor does any state allow the prospect of this assessment to diminish or increase recovery. The law considers only what can be empirically known through human experience. If the law does not allow the question of a hypothetical benefit or burden resulting from death to affect recovery, the law need not preclude recovery when the unknown areas exist prior to, rather than after, life.

law, therefore, entitles her to recovery.<sup>1013</sup>

Courts could determine the burdens by using traditional concepts of damages, including an assessment of pain and suffering. Measuring the benefits of life in an impaired state may seem irrational. Courts, however, routinely place pecuniary value on the burdens of pain, suffering, and mental distress and have established administrable patterns of awards for these burdens.<sup>1014</sup> Courts could develop a similar pattern regarding the benefits of life in an impaired state. Moreover, if a court allows a wrongful life claim, refusing to account for the benefits of life essentially makes the defendant liable for the impaired child's deformities. Wrongful life claims, however, assert that the defendant proximately caused the plaintiff's life, not the plaintiff's defects.

The administrability of basing awards on extraordinary expenses is appealing, but assessment of the benefits and burdens of the plaintiff's life more closely relates to the injury that the plaintiff alleged and, therefore, the relief that the plaintiff seeks in a wrongful life claim. Furthermore, defining injury as the amount by which the burden of an impaired life exceeds its benefits properly distinguishes wrongful life claims from other malpractice claims. Finally, this approach inherently ensures that recovery would depend on the severity of the defects. Wrongful life claims would be successful only in cases of extremely impaired plaintiffs.

In addition to establishing a more rational approach to determining the elements of a wrongful life claim and to assessing a proper damages award, courts must consider the policy implications of these decisions. The courts that have allowed wrongful life claims have thus far declined to state expressly that nonexistence is preferable to life in an impaired condition, but the reasoning inherent in allowing a wrongful life claim suggests this conclusion. Explaining the tort through more clearly articulated principles

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1013. See Cohen & Chessen, *The Continuing Judicial Development of the Theory of "Wrongful Life,"* 4 AM. J.L. & MED. 211, 227 (1978).

In some situations, the plaintiff can be said to benefit from the defendant's tort. The Restatement (Second) of Torts states:

When the defendant's tortious conduct has caused harm to the plaintiff or to his property and in so doing has conferred a special benefit to the interest of the plaintiff that was harmed, the value of the benefit conferred is considered in mitigation of damages, to the extent that this is equitable.

RESTATEMENT (SECOND) OF TORTS § 920 (1979) (emphasis added). Thus, if the fact finder determines that the benefits of impaired life exceed the burdens, no recovery would inure to the plaintiff. In this situation, the defendant could not counterclaim for the excess benefits because allowing him to recover for his own negligence would be inequitable.

1014. See Cohen & Chessen, *supra* note 1013, at 227.

does not dispose of the far-reaching policy concerns that recognition of the claim presents. Some courts may consider a determination that life's burdens exceed its benefits tantamount to sanctioning suicide, but making an objective determination for purposes of tort recovery need not go so far. The moral propriety of affirming all life can coexist with an understanding that certain life may impose intolerable burdens. In the final analysis, although courts should consider the logical implications of their rulings, practical experience indicates that explicit judicial recognition of the view that life in an impaired state is worse than nonlife for purposes of tort recovery is unlikely. As the current trend suggests, courts inclined to recognize claims for wrongful life do not necessarily feel constrained by logic.

#### D. CONCLUSION

Wrongful life, a concept that failed in the courts for almost twenty years, has finally gained recognition as a viable tort claim for children who suffer the consequences of the medical community's negligent prenatal care and counseling. Courts that have recognized this cause of action have rejected the notion that life, even in a seriously impaired state, is always preferable to nonexistence. These courts have developed an administrable approach to providing remedies that accommodate the child-plaintiff's impairments. Unfortunately, courts have reached these commendable results in result oriented opinions that are analytically unsound. Proper determination of whether and how much a court should allow a plaintiff to recover in a wrongful life claim requires a well-reasoned approach to each element of the tort and to the damages issue. Particularly, courts should be careful to define the injury as the plaintiff's life, with all of its benefits and burdens. Courts should then assess those benefits and burdens and, if the burdens outweigh the benefits, award damages accordingly. This approach, with a more accurate characterization of injury and a more precise correlation of injury and damages, best serves the goals of tort law by providing plaintiffs just compensation for their injuries and by holding defendants responsible for the consequences of their negligence.

## IX. Wrongful Death and the Unborn

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A. INTRODUCTION

The expansion of fetal rights in tort law<sup>1015</sup> has prompted judicial consideration of recovery for fetal death under state wrongful death statutes.<sup>1016</sup> Wrongful death statutes provide for monetary awards to designated beneficiaries when the decedent dies because of a tortfeasor's intentional negligent act.<sup>1017</sup> With respect to recov-

1015. See generally Collins, *supra* note 1005 (wrongful life section) (surveying and analyzing the development of tortfeasors' liability). See also sections VI, VII, and VIII of the Special Project.

1016. State legislatures initially patterned their wrongful death statutes after Lord Campbell's Act (Fatal Accidents Act), 1846, 9 & 10 Vict., ch. 93, which compensated families of persons killed in accidents. The Act read, in part, as follows:

WHEREAS no Action at Law is now maintainable against a Person who by his wrongful Act, Neglect, or Default may have caused the Death of another Person, and it is often times right and expedient that the Wrongdoer in such Case should be answerable in Damages for the Injury so caused by him: Be it therefore enacted by the Queen's most Excellent Majesty, by and with the Advice and Consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the Authority of the same, That whensoever the Death of a Person shall be caused by wrongful Act, Neglect, or Default, and the Act, Neglect, or Default is such as would (if Death had not ensued) have entitled the Party injured to maintain an Action and recover Damages in respect thereof, then and in every such Case the Person who would have been liable if Death had not ensued shall be liable to an Action for Damages, notwithstanding the Death of the Person injured, and although the Death shall have been caused under such Circumstances as amount in Law to Felony.

*Id.* This Act statutorily overruled *Baker v. Bolton*, 170 Eng. Rep. 1033 (K.B. 1808), which had held that death is not a civil injury. *Id.* The *Baker* decision, although substantively superceded by statute in both the United Kingdom (excluding Scotland) and the United States, continues to support the proposition that no common law remedy for wrongful death has ever existed. *But see infra* note 1040 (discussing *Moragne v. States Marine Lines, Inc.*, 398 U.S. 375 (1970), in which Justice Harlan cast doubt on that theory). In the United States, every state except Massachusetts recognizes wrongful death as an exclusively statutory remedy. See *Gaudette v. Webb*, 362 Mass. 60, 71, 284 N.E. 2d 222, 229 (1972).

1017. See, e.g., MD. CTS. & JUD. PROC. CODE ANN. § 3-902 (1984). ("An action may be maintained against a person whose wrongful act causes the death of another.")

Wrongful death statutes must be distinguished from survival statutes. Survival statutes allow a victim's estate to enforce a victim's right to sue because that right "survives" his death. See, e.g., ME. REV. STAT. ANN. tit. 18-A, §3-817(a)(1981); MODEL SURVIVAL AND DEATH

ery for fetal death, the relevant inquiry is whether a fetus is a "person" within the meaning of the state's wrongful death statute. If the fetus is a person under the statute, and the defendant proximately caused the decedent's death, the designated beneficiaries—usually the parents of the unborn child—may recover to the extent allowed by statute.<sup>1018</sup> Courts that have allowed recovery generally have held that only a "viable"<sup>1019</sup> fetus has an independent status as a person for purposes of wrongful death statutes.<sup>1020</sup>

Section B of this Part briefly traces the development of prenatal tort theories, theories which culminated in recovery for the tortious death of the unborn. Section C examines the reasoning of courts that refuse to acknowledge a cause of action for fetal death under a wrongful death statute and then considers other decisions allowing recovery. Section D delineates various components of damages that courts have allowed. Section E argues that recovery should be available for the wrongful death of the unborn and that conception, rather than viability, is the appropriate point for determining personhood for purposes of wrongful death recovery. Section F concludes that allowing recovery for wrongful death occurring at any point after conception best serves the policies underlying wrongful death statutes and the goals of tort law.

## B. DEVELOPING THE CONCEPT OF WRONGFUL DEATH OF THE UNBORN

In a wrongful death action the plaintiffs must show that the decedent, had he lived, could have maintained a cause of action against the tortfeasor.<sup>1021</sup> Consequently, as long as courts refuse to

ACT § 2 (1979). Wrongful death statutes, on the other hand, grant the victim's surviving relatives a separate cause of action. The award recovered under each type of statute generally goes to the same parties, but the recoverable damages may differ. For example, the decedent's pain and suffering is a proper element of damages under a survival statute; loss of services to a spouse is a proper element of damages under a wrongful death statute.

1018. State statutes generally designate proper plaintiffs in a wrongful death action. *See, e.g.*, MO. ANN. STAT. § 537.080 (Vernon Supp. 1986) (favoring (1) the spouse, children, father, or mother of the deceased, natural or adoptive; (2) the brother or sister of the deceased or their descendants; or, if no one available in the first two groups, (3) a plaintiff ad litem). The parents of a deceased unborn child would have the initial right to sue under most statutes.

1019. A fetus is "viable" when its life can be sustained apart from its mother. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1455 (26th ed. 1985).

1020. *See, e.g.*, *Summerfield v. Superior Court*, 144 Ariz. 467, 698 P.2d 712 (1985); *Volk v. Baldazo*, 103 Idaho 570, 651 P.2d 11 (1982).

1021. *See infra* text accompanying note 1052.

recognize suits by plaintiffs who survived injuries inflicted *in utero*, no action for prenatal death resulting from such injuries can lie under a wrongful death statute. In *Dietrich v. Inhabitants of Northampton*<sup>1022</sup> Justice Holmes denied recovery for the wrongful death of a child who died shortly after birth because of injuries suffered *in utero*.<sup>1023</sup> Justice Holmes held that recovery under the statute did not include injuries to the unborn child because the child was a part of its mother, but that the mother could recover damages for the injuries in her own suit.<sup>1024</sup> Sixty years later the court in *Bonbrest v. Kotz*<sup>1025</sup> departed from *Dietrich* by denying summary judgment to a physician who allegedly injured the plaintiff while removing her from her mother's womb.<sup>1026</sup> The court distinguished *Dietrich* on the ground that the instant plaintiff was viable at the time of the alleged injury and, therefore, had an independent status to sue.<sup>1027</sup> The decision in *Bonbrest* initiated uniform recognition of a right to recovery for prenatal torts occurring after the point of viability when the victim survives birth.<sup>1028</sup> Furthermore, many courts allow recovery for surviving victims when the tort occurs after conception but prior to the point of viability.<sup>1029</sup>

Once courts established recovery for surviving victims of prenatal torts, the next logical step was to consider an action for wrongful death when the victim died *in utero*. The Minnesota Supreme Court, in *Verkennes v. Corniea*, was the first court to ac-

1022. 138 Mass. 14 (1884).

1023. The injury occurred during the fifth month of pregnancy, when the child's mother slipped and fell on defendant's highway. *Id.* at 14.

1024. *Id.* at 17. Justice Holmes noted that "no case, so far as we know, has ever decided that, if the infant survived, it could maintain an action for injuries received by it while in its mother's womb." *Id.* at 15.

1025. 65 F. Supp. 138 (D. D.C. 1946).

1026. *Id.* at 139.

1027. *Id.* at 140. The court made the distinction because the plaintiff was, in fact, viable at the time of the alleged injury. The court, however, indicated that viability was not necessarily a prerequisite to recovery. The court stated that "[i]ndeed, apart from viability, a non-viable fetus is not a part of its mother." *Id.* "By the eighth week the embryo or foetus, as we now call it, is an unmistakable human being, even though it is still only three-quarters of an inch long." *Id.* at 11 (quoting G. CORNER, OURSELVES UNBORN: AN EMBRYOLOGIST'S ESSAY ON MAN (1944)). Later courts, however, have clung to the viability distinction, which is still necessary for recovery in most jurisdictions. *See, e.g.,* Werling v. Sandy, 17 Ohio St. 3d 45, 476 N.E.2d 1053 (1985); TENN. CODE ANN. § 20-5-106 (1980).

1028. *See* Collins, *supra* note 1005 (wrongful life section), at 679-80.

1029. *See, e.g.,* Wolfe v. Isbell, 291 Ala. 327, 280 So. 2d 758 (1973); Sinkler v. Kneale, 401 Pa. 267, 164 A.2d 93 (1960). Few courts, however, allow recovery when defendant has breached a duty prior to conception. *See, e.g.,* Renslow v. Mennonite Hosp., 67 Ill. 2d 348, 367 N.E.2d 1250 (1977).

knowledge that recovery was available in these circumstances.<sup>1030</sup> The plaintiff alleged that the defendants failed to attend to his wife's needs after labor had commenced and that this neglect caused his child to be stillborn.<sup>1031</sup> Relying on the viability distinction enunciated in *Bonbrest*, the Minnesota court found that an action for wrongful death lies when the wrongful act of another destroys a life capable of independent existence.<sup>1032</sup>

Currently, courts disagree over whether a fetus is a person within the meaning of a particular wrongful death statute.<sup>1033</sup> A decided and increasing majority holds that a fetus is a person and that recovery is available.<sup>1034</sup> In addition, South Dakota and Tennessee have explicitly amended their survival statutes to include recovery for the death of an "unborn child" and of a "viable fetus," respectively.<sup>1035</sup> In sum, thirty-seven jurisdictions allow recovery under existing statutes for the wrongful death of a viable fetus.<sup>1036</sup> A few of these jurisdictions indicate that viability is not a

1030. 229 Minn. 365, 38 N.W.2d 838 (1949).

1031. *Id.* at 366-67, 38 N.W.2d at 839.

1032. *Id.* at 370-71, 38 N.W.2d at 841.

1033. Compare *Summerfield v. Superior Court*, 144 Ariz. 467, 698 P.2d 712 (1985) (fetus is a person) with *Kuhnke v. Fisher*, \_\_\_ Mont. \_\_\_, 683 P.2d 916 (1984) (fetus is not a person).

1034. See *infra* note 1036 and accompanying text.

1035. S.D. CODIFIED LAWS ANN. § 21-5-1 (1985); TENN. CODE ANN. § 20-5-106 (6)(b) (1980). For an explanation of the distinction between survival statutes and wrongful death statutes, see *supra* note 1017.

1036. See *Simmons v. Howard University*, 323 F. Supp. 529 (D. D.C. 1971); *Eich v. Town of Gulf Shores*, 293 Ala. 95, 300 So.2d 354 (1974); *Summerfield v. Superior Court*, 144 Ariz. 467, 698 P.2d 712 (1985); *Hatala v. Markiewicz*, 26 Conn. Supp. 358, 224 A.2d 406 (Conn. Super. Ct. 1966); *Worgan v. Greggo & Ferrara, Inc.*, 50 Del. 258, 128 A.2d 557 (1956); *Porter v. Lassiter*, 91 Ga. App. 712, 87 S.E.2d 100 (1955); *Volk v. Baldazo*, 103 Idaho 570, 651 P.2d 11 (1982); *Chrisafogeorgis v. Brandenburg*, 55 Ill. 2d 368, 304 N.E.2d 88 (1973); *Britt v. Sears*, 150 Ind. App. 487, 277 N.E.2d 20 (1971); *Dunn v. Rose Way, Inc.*, 333 N.W.2d 830 (Iowa 1983) (interpreting rule of civil procedure); *Hale v. Manion*, 189 Kan. 143, 368 P.2d 1 (1962); *Mitchell v. Couch*, 285 S.W.2d 901 (Ky. 1955); *Danos v. St. Pierre*, 383 So. 2d 1019 (La. Ct. App. 1980); *State ex rel. Oldham v. Sherman*, 234 Md. 179, 198 A.2d 71 (1964); *Mone v. Greyhound Lines, Inc.*, 368 Mass. 354, 331 N.E.2d 916 (1975); *O'Neil v. Morse*, 385 Mich. 130, 188 N.W.2d 785 (1971); *Verkennes v. Corniea*, 229 Minn. 365, 38 N.W.2d 838 (1949); *Rainey v. Horn*, 221 Miss. 269, 72 So.2d 434 (1954); *O'Grady v. Brown*, 654 S.W.2d 904 (Mo. 1983); *White v. Yup*, 85 Nev. 527, 458 P.2d 617 (1969); *Poliquin v. MacDonald*, 101 N.H. 104, 135 A.2d 249 (1957); *Salazar v. St. Vincent Hosp.*, 95 N.M. 150, 619 P.2d 826 (1980); *Hopkins v. McBane*, 359 N.W.2d 862 (N.D. 1984); *Werling v. Sandy*, 17 Ohio St. 3d 45, 476 N.E.2d 1053 (1985); *Evans v. Olson*, 550 P.2d 924 (Okla. 1976); *Libbee v. Permanente Clinic*, 268 Or. 258, 518 P.2d 636 (1974); *Amadio v. Levin*, \_\_\_ Pa. \_\_\_, 501 A.2d 1085 (1985); *Presley v. Newport Hosp.*, 117 R.I. 177, 365 A.2d 748 (1976); *Fowler v. Woodward*, 244 S.C. 608, 138 S.E.2d 42 (1964); *Witty v. American Gen. Capital Distrib., Inc.*, 697 S.W.2d 636 (Tex. Ct. App. 1985); *Nelson v. Peterson*, 542 P.2d 1075 (Utah 1975); *Vaillancourt v. Medical Center Hosp.*, 139 Vt. 138, 425 A.2d 92 (1980); *Moen v. Hanson*, 85

prerequisite to a cause of action.<sup>1037</sup> Ten jurisdictions, however, hold that a fetus is not a person within the meaning of the particular statute, and thus deny recovery.<sup>1038</sup> Section C discusses the reasoning behind this split in authority.

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Wash. 2d 597, 537 P.2d 266 (1975); *Baldwin v. Butcher*, 155 W. Va. 431, 184 S.E.2d 428 (1971); *Kwaterski v. State Farm Mut. Auto. Ins. Co.*, 34 Wis. 2d 14, 148 N.W.2d 107 (1967).

Relevant statutory provisions include ALA. CODE § 6-5-410 (1975); ARIZ. REV. STAT. ANN. § 12-611 (1982); CONN. GEN. STAT. ANN. § 52-555 (West Supp. 1985); DEL. CODE ANN. tit. 10, § 3704 (1974 & Supp. 1984); D.C. CODE ANN. § 16-2701 (1981); GA. CODE ANN. § 3-505 (1975); IDAHO CODE § 5-311 (Supp. 1985); ILL. ANN. STAT. ch. 70, § 1 (Smith-Hurd 1959); IND. CODE ANN. § 34-1-1-2 (Burns Supp. 1985); IOWA R. CIV. P. 8; KAN. STAT. ANN. § 60-1901 (1983); KY. CONST. § 241; LA. CIV. CODE ANN. art. 2315 (West Supp. 1985); MD. CTS. & JUD. PROC. CODE ANN. § 3-902 (1984); MASS. GEN. LAWS ANN. ch. 229, § 2 (West 1985); MICH. COMP. LAWS ANN. § 600.2922 (West Supp. 1985); MINN. STAT. ANN. § 573.02 (West Supp. 1985); MISS. CODE ANN. § 11-7-13 (Supp. 1985); MO. ANN. STAT. § 537.080 (Vernon Supp. 1986); NEV. REV. STAT. § 41-2-1 (1978); N.H. REV. STAT. ANN. § 556:7 (1974); N.M. STAT. ANN. § 41-2-21 (1978); N.D. CENT. CODE § 32-21-01 (Supp. 1985); OHIO REV. CODE ANN. § 2125.01 (Page Supp. 1984); OKLA. STAT. ANN. tit. 12, § 1053 (West Supp. 1985); OR. REV. STAT. § 30.020 (1985); PA. STAT. ANN. tit. 12, § 1601 (Pardon 1982); R.I. GEN. LAWS § 10-7-1 (1985); S.C. CODE ANN. § 15-51-10 (Law. Co-op. 1976); S.D. CODIFIED LAWS ANN. § 21-5-1 (1985); TENN. CODE ANN. § 20-5-106 (1980); TEX. CIV. PRAC. & REMEDIES CODE § 71.002 (Vernon 1986); UTAH CODE ANN. § 78-11-12 (1977); VT. STAT. ANN. tit. 14, § 1491 (1974); WASH. REV. CODE ANN. § 4.24.010 (Supp. 1986); W. VA. CODE § 55-7-5 (1981); WIS. STAT. ANN. § 895.03 (West 1983).

1037. See *Porter v. Lassiter*, 91 Ga. App. 712, 87 S.E.2d 100 (1955) (fetus must be "quick" at time of injury); *Danos v. St. Pierre*, 383 So.2d 1019 (La. Ct. App. 1980) (conception); *Amadio v. Levin*, \_\_\_ Pa. \_\_\_, 501 A.2d 1085 (1985) (conception); *Presley v. Newport Hosp.*, 117 R.I. 177, 365 A.2d 748 (1976) (viability not a factor); S. D. CODIFIED LAWS ANN. § 21-5-1 (1985) (unborn child).

1038. *Mace v. Jung*, 210 F. Supp. 706 (D.C. Alaska 1962) (holding no cause of action for wrongful death of nonviable fetus); *Justus v. Atchison*, 19 Cal. 3d 564, 139 Cal. Rptr. 97, 565 P.2d 122 (1977); *Hernandez v. Garwood*, 390 So.2d 357 (Fla. 1980); *Kuhnke v. Fisher*, \_\_\_ Mont. \_\_\_, 683 P.2d 916 (1984); *Smith v. Columbus Community Hosp., Inc.*, 222 Neb. 776, 387 N.W.2d 490 (1986); *Graf v. Taggart*, 43 N.J. 303, 204 A.2d 140 (1964); *Endresz v. Friedberg*, 24 N.Y.2d 478, 248 N.E.2d 901, 301 N.Y.S.2d 65 (1969); *Didonato v. Wortman*, available on LEXIS Aug. 3, 1986 No. 8526SC1015 (N.C. Ct. App. 1986); *Lawrence v. Craven Tire Co.*, 210 Va. 138, 169 S.E.2d 440 (1969); *Estate of Baby Foy v. Morningstar Resort, Inc.*, 635 F.Supp. 741 (D.C. Virgin Islands 1986).

Relevant statutory provisions include ALASKA STAT. § 09.55.580 (1985); CAL. CIV. PROC. CODE § 377 (West 1986); FLA. STAT. ANN. § 768.19 (West 1985); MONT. CODE ANN. § 27-1-512 (1985); NEB. REV. STAT. § 30-809 (1979); N.J. STAT. ANN. § 2A:31-1 (West 1982); N.Y. EST. POWERS & TRUSTS LAW § 5-4.1 (McKinney Supp. 1986); N.C. GEN. STAT. § 28A-18-a (1984); VA. CODE § 8.01-50 (1984).

Five states have no reported decisions on the matter. Statutes creating a cause of action for wrongful death in those states include ARK. STAT. ANN. § 27-906 (1979); COLO. REV. STAT. § 13-21-202 (1973 and Supp. 1984); HAWAII REV. STAT. § 663-3 (1976); ME. REV. STAT. ANN. tit. 18-A, § 2-804 (1981 and Supp. 1985); see also WYO. CONST. art. 9, § 4.

### C. ANALYTICAL APPROACHES TO WRONGFUL DEATH OF THE UNBORN

#### 1. Rationale for Denying Recovery

Statutory construction and findings of legislative intent have led some courts to deny recovery for the wrongful death of a viable fetus. In *Justus v. Atchison*<sup>1039</sup> the California Supreme Court affirmed the dismissal of claims against physicians for the wrongful death of viable unborn children. The court acknowledged the policy arguments articulated by the parties, but stated that the legislature had the sole authority to create law in this area.<sup>1040</sup> The court, therefore, refused to allow recovery when the terms of the statute did not clearly manifest an intent to allow recovery.<sup>1041</sup> According to the court, the legislature's express recognition of the rights of the unborn for limited purposes excluded, by negative implication, any right of recovery for the death of the unborn.<sup>1042</sup> Finally, the court noted that although the legislature had amended the statute several times, the statute still did not include any reference to the unborn.<sup>1043</sup> In sum, the *Justus* court found legislative preemption of the area of wrongful death and then inferred, from legislative silence, affirmative legislative intent to deny recovery for the death of a fetus.<sup>1044</sup>

The Florida Supreme Court also interpreted legislative silence

1039. 19 Cal. 3d 564, 565 P.2d 122, 139 Cal. Rptr. 97 (1977).

1040. *Id.* at 574, 565 P.2d at 123, 139 Cal. Rptr. at 103. The court distinguished Justice Harlan's opinion in *Moragne v. States Marine Lines, Inc.*, 398 U.S. 375 (1970). In *Moragne* Justice Harlan postulated that even if legislative action had created recovery for wrongful death, that remedy was so pervasive that over time it had become a part of the common law. Accepting this argument, the judiciary can supplement existing statutory regulation of wrongful death. In the context of fetal death, this concept of a common law aspect of wrongful death would force courts to consider the policy arguments for and against recovery instead of reluctantly expanding the definition of "person" within a given statute. See generally Note, *Wrongful Death and the Stillborn Fetus: A Common Law Solution to a Statutory Dilemma*, 43 U. Prrt. L. Rev. 819 (1982).

1041. *Justus*, 19 Cal. 3d at 580, 565 P.2d at 132, 139 Cal. Rptr. at 107.

1042. *Id.* at 579, 565 P.2d at 132, 139 Cal. Rptr. at 107.

1043. *Id.*

1044. Justice Tobriner concurred in the result, but disagreed with the majority's reasoning. He could not discern an affirmative legislative intent to preclude judicial development of wrongful death principles because wrongful death theory had evolved to become a part of the common law. He would, however, have rejected the plaintiff's claim for policy reasons. *Id.* at 586-87, 565 P.2d at 136-137, 139 Cal. Rptr. at 111-12 (Tobriner, J., concurring). Justice Tobriner concluded: "[W]e should not recognize a new cause of action for the wrongful death of a fetus, a wholly intangible injury to plaintiffs for which any monetary recovery can provide no real compensation . . ." *Id.* at 586, 565 P.2d at 136, 139 Cal. Rptr. at 111 (citation omitted).

as an intent to deny recovery, although following somewhat different reasoning. In light of judicial decisions allowing recovery to surviving victims of prenatal torts, the court in *Stern v. Miller*<sup>1045</sup> considered the reasons for allowing recovery for the tortious death of the unborn to be compelling.<sup>1046</sup> The court, nonetheless, construed legislative intent to require a different result. In a previous decision, *Stokes v. Liberty Mutual Insurance Co.*,<sup>1047</sup> the Florida court stated that a child must be born alive before an action lies for wrongful death.<sup>1048</sup> After *Stokes*, but prior to *Stern*, the legislature had amended the wrongful death statute, but did not redefine the word "person" to include a fetus.<sup>1049</sup> The *Stern* court concluded that it could interpret the legislature's continued use of the same definition only as approval of the *Stokes* decision.<sup>1050</sup> The Florida court, therefore, refused to overrule its previous holding denying recovery.

In addition to inferring legislative intent, courts have employed other means of statutory construction to deny recovery. The Virginia Supreme Court addressed the issue of recovery for the wrongful death of the unborn in *Lawrence v. Craven Tire Co.*<sup>1051</sup> The court noted that because a cause of action under the wrongful death statute is derivative, the decedent must have been entitled to sue had he not died.<sup>1052</sup> The court narrowly interpreted this requirement to mean that the decedent must have had a vested right to sue at the time of the commission of the tort.<sup>1053</sup> Because an unborn child could not have a vested right to sue, the parents' right to recover under the wrongful death act did not

1045. 348 So. 2d 303 (Fla. 1977).

1046. *Id.* at 306. The court reasoned as follows:

A viable fetus is a human being, capable of independent existence outside the womb; a human life is therefore destroyed when a viable fetus is killed; it is wholly irrational to allow liability to depend on whether death from fatal injuries occurs just before or just after birth; it is absurd to allow recovery for prenatal injuries unless they are so severe as to cause death; such a situation favors the wrongdoer who causes death over the one who merely causes injuries, and so enables the tortfeasor to foreclose his own liability.

*Id.*

1047. 213 So.2d 695 (Fla. 1968).

1048. *Id.* at 700.

1049. 348 So. 2d at 307.

1050. *Id.*

1051. 210 Va. 138, 169 S.E.2d 440 (1969).

1052. *Id.* at 140, 169 S.E.2d at 441. All states have a similar requirement.

1053. *Id.* The court stated: "If plaintiff's decedent had no right, at time of death, to maintain an action for personal injuries, then the right to maintain the present action could not be transmitted to her personal representative." *Id.*

vest.<sup>1054</sup> The court, therefore, found that the statute, by its very terms, precluded recovery for the death of a fetus.<sup>1055</sup>

By requiring that the decedent must have had a right to sue at the time of the tort, the *Craven* court read into the statute a timing requirement that arguably did not exist. The court could have determined that an unborn child would have had a right to sue for prenatal injuries if it had survived birth. This finding would have satisfied the derivative requirement of the statute. Nonetheless, even if the court had not employed this statutory construction as a rationale, the court would have denied recovery because the court suggested that a fetus was not a person under the statute.<sup>1056</sup>

In *Endresz v. Friedberg*<sup>1057</sup> the New York Court of Appeals summarily concluded that the legislature did not intend to allow recovery for the wrongful death of a fetus.<sup>1058</sup> Moreover, the court looked beyond legislative intent and articulated policy reasons for denying recovery. The court discussed policy rationales in an effort to harmonize its holding with *Woods v. Lancet*,<sup>1059</sup> a case in which the court had allowed recovery for tortious prenatal injuries for a victim born alive. Comparing the two situations, the *Endresz* court noted that the deceased fetus did not face impaired mental or physical health as did the surviving injured fetus.<sup>1060</sup> Furthermore, the mother could recover adequate damages for injuries to her person in the case of a tortiously inflicted stillbirth;<sup>1061</sup> any additional recovery for the death of the fetus, therefore, would be essentially punitive in character.<sup>1062</sup> The court also stated that the inherent problems of proving causation and establishing damages militate against allowing a cause of action.<sup>1063</sup> For these reasons, the court refused to extend the *Woods* holding to encompass recovery for the wrongful death of a fetus.

## 2. Rationale for Allowing Recovery

A shrinking minority of states follow the reasoning of the preceding decisions and deny recovery for the wrongful death of an

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1054. *Id.*

1055. *Id.* at 142, 169 S.E.2d at 442.

1056. *Id.* at 140-42, 169 S.E.2d at 441-42.

1057. 24 N.Y.2d 478, 248 N.E.2d 901, 301 N.Y.S.2d 65 (1969).

1058. *Id.* at 486, 248 N.E.2d at 905, 301 N.Y.S.2d at 71.

1059. 303 N.Y. 349, 102 N.E.2d 691 (1951).

1060. *Endresz*, 24 N.Y.2d at 483, 248 N.E.2d at 903, 301 N.Y.S.2d at 69.

1061. *Id.* at 484, 248 N.E.2d at 904, 301 N.Y.2d at 69.

1062. *Id.*

1063. *Id.*



unborn child.<sup>1064</sup> Predictably, increasing recognition of the right to recover has followed the expansion of liability for torts committed prior to birth. Legislative preemption arguments<sup>1065</sup> have not precluded most courts from reaching the policy considerations attendant to prenatal wrongful death claims. Considering both the pros and the cons of allowing recovery, most courts have concluded that the arguments favoring recovery are more persuasive. Representative decisions from the Supreme Courts of Idaho, Arizona, and Alabama elucidate the policy considerations for allowing recovery.

In *Volk v. Baldazo*,<sup>1066</sup> the plaintiffs appealed from a partial summary judgment denying recovery for the wrongful death of a viable unborn child. The plaintiffs alleged that the defendants had negligently struck an automobile driven by Mrs. Volk, who was then nine months pregnant and who delivered a stillborn child eleven hours after the accident.<sup>1067</sup> The Idaho Supreme Court determined that the plaintiffs' complaint stated a valid claim.<sup>1068</sup> The court found wrongful death statutes to derogate the common law rule that upon death an injured person's cause of action ceased to exist.<sup>1069</sup> Consequently, the court stated that it should construe liberally the statute to effect the legislature's intent to compensate designated survivors and deter wrongful conduct.<sup>1070</sup> The court held that allowing recovery for the wrongful death of a viable unborn fetus promotes these objectives.<sup>1071</sup> To conclude otherwise would mean holding a defendant liable for injuries to a fetus subsequently born alive while immunizing the defendant from suit if he killed a fetus.<sup>1072</sup> This result would subvert the legislature's intent in passing the wrongful death statute.<sup>1073</sup> The court, therefore, furthered legislative policy by allowing the plaintiffs' claim.

In *Summerfield v. Superior Court*,<sup>1074</sup> the Arizona Supreme

1064. These states are California, Florida, Montana, Nebraska, New Jersey, New York, North Carolina, and Virginia. See cases cited *supra* note 1038.

1065. The phrase "legislative preemption argument" refers to the position that state legislatures have the sole authority to create law in the area of wrongful death and that courts, therefore, are "preempted" from the field of wrongful death. See *supra* text accompanying note 1040.

1066. 103 Idaho 570, 651 P.2d 11 (1982).

1067. *Id.* at 571, 651 P.2d at 12.

1068. *Id.*

1069. *Id.* at 573, 651 P.2d at 14.

1070. *Id.* at 574, 651 P.2d at 15.

1071. *Id.*

1072. *Id.*

1073. *Id.*

1074. 144 Ariz. 467, 698 P.2d 712 (1985).

Court overruled an earlier decision, *Kilmer v. Hicks*,<sup>1075</sup> that had denied recovery for the wrongful death of a viable fetus. Cognizant of legislative preemption arguments, the court argued that a cause of action for wrongful death had common law attributes.<sup>1076</sup> The court found that although the legislature may have thought it was creating a new cause of action, the wording of the statute required judicial application of common law principles. For example, the statute allowed "such damages as [are] fair and just" and required consideration of "mitigating and aggravating circumstances."<sup>1077</sup> Because the statute called for a more active judicial role than mere statutory construction, the court did not confine its analysis of wrongful death to a strict interpretation of the word "person" in the statute. Rather, the court interpreted the word in light of legislative goals. Like the *Volk* court, the Arizona Supreme Court in *Summerfield* sought to promote the two legislative objectives of compensating survivors and deterring wrongful conduct.<sup>1078</sup>

The defendants in *Summerfield* argued that interpreting the word "person" to include a fetus would contravene the principles of *Roe v. Wade*,<sup>1079</sup> which held that a fetus was not a person for fourteenth amendment purposes. The Arizona court responded that a word could have different meanings in different contexts.<sup>1080</sup> *Roe* held that a mother's right to privacy in the first trimester of pregnancy outweighed any rights of the fetus, but the decision did not address whether a tortfeasor may terminate the life of a viable fetus against the mother's will.<sup>1081</sup> Moreover, the Arizona court

1075. 22 Ariz. App. 552, 529 P.2d 706 (1974).

1076. 144 Ariz. at 473-74, 698 P.2d at 718-19. The court found these attributes in the long history of judicial precedent interpreting the wrongful death statutes. Cf. *supra* note 1040 (discussing Justice Harlan's theory of the common-law aspect of wrongful death).

1077. ARIZ. REV. STAT. ANN. § 12-613 (1982).

1078. 144 Ariz. at 476, 698 P.2d at 721.

1079. 410 U.S. 113 (1973).

1080. 144 Ariz. at 478, 698 P.2d at 723.

1081. See *id.* The divergent policies behind *Roe* and the wrongful death statutes may account for the different meanings of the word "person" in these different contexts. The mother's right to privacy under *Roe* and the survivors' right to recovery for wrongful death, nevertheless, conflict if a state allows recovery at any time following conception. Suppose, for example, that a pregnant woman aborts her pregnancy in the second month. *Roe* protects her right to do so. Suppose further that the father of a not-yet-viable fetus wants to sue for the wrongful death of his unborn child. The courts cannot accommodate the interests of both parties in this situation. As one commentator has stated:

If the woman's right to abortion and the fetus' right to be free from tortious injury are both accepted as socially desirable, then it may be necessary to accept some inconsistency and conclude that prenatal life will be protected against intentional or negligent interference, *absent* some compelling countervailing interest on the part of another.

noted that its holding was consistent with *Roe* to the extent that *Roe* recognized a state's interest in protecting a fetus after viability.<sup>1082</sup> The court, after disposing of the defendants' constitutional arguments and stating its interpretation of legislative policy, concluded that the plaintiffs could recover under the wrongful death act.<sup>1083</sup>

The Alabama Supreme Court allowed recovery for the wrongful death of a fetus in *Eich v. Town of Gulf Shores*.<sup>1084</sup> In contrast to other courts that had allowed recovery, the *Eich* court did not consider the wrongful death statute to be compensatory.<sup>1085</sup> Instead, the court declared that the purpose of the statute was to preserve human life. The statute accomplished this objective by punishing wrongful conduct resulting in death.<sup>1086</sup> With this view of the legislative purpose, the court felt compelled to allow recovery for the wrongful death of a viable fetus. The court posited a hypothetical situation of twins fatally injured during pregnancy, with one born alive before its death and the other stillborn.<sup>1087</sup> The court deplored the thought of allowing recovery for the death of the twin born alive and simultaneously denying recovery for the death of the stillborn twin.<sup>1088</sup> Because the legislature designed the statute to punish the tortfeasor, the court was unwilling to permit him to escape liability in either case. Consistent with this analysis, the court allowed the mother to recover for her child's death.<sup>1089</sup>

These cases illustrate that courts that are inclined to allow recovery for the wrongful death of viable fetus focus on the remedial and deterrent policy objectives of the statutes. The remedial objective is to provide compensation to survivors of a deceased tort victim. The deterrent objective is to protect and preserve life by deterring future wrongdoing. Prompted by these policy considerations, courts allowing recovery find support for their holdings in the common law recognition of liability for injuries incurred *in utero*. Moreover, the *Summerfield* court implied that,

Kader, *The Law of Tortious Prenatal Death Since Roe v. Wade*, 45 Mo. L. Rev. 639, 660 (1980).

1082. *Summerfield*, 144 Ariz. at 478, 698 P.2d at 723.

1083. *Id.* at 479, 698 P.2d at 724.

1084. 293 Ala. 95, 300 So. 2d 354 (1974).

1085. See *supra* text accompanying notes 1062, 1070, and 1078 (discussing other courts' emphasis on compensatory goals).

1086. 293 Ala. at 99, 300 So. 2d at 357.

1087. *Id.*

1088. *Id.*

1089. *Id.*

vis-à-vis the legislature, judicial authority is growing in the area of wrongful death because of the common law attributes of the cause of action. When these considerations—compensation, deterrence, and judicial authority—are weighed against strained statutory construction and legislative preemption arguments, no compelling reasons remain to deny recovery.

#### D. DAMAGES

The specific damages recoverable in actions for wrongful death vary depending on the applicable state statute. Some statutes allow recovery for such components as past and future lost support and services, loss of companionship, mental pain and suffering, and funeral expenses.<sup>1090</sup> Other statutes leave the issue of damages to judicial discretion by simply allowing an award that would be "just."<sup>1091</sup>

Some courts in jurisdictions purportedly limiting awards to pecuniary harm have interpreted pecuniary loss broadly to include "[c]ounsel, guidance, aid, advice, comfort, assistance, and protection which the child would have given had she lived."<sup>1092</sup> Future

1090. *E.g.*, FLA. STAT. ANN. § 768.21 (West Supp. 1986). The Florida statute provides in part:

All potential beneficiaries of a recovery for wrongful death, including the decedent's estate, shall be identified in the complaint, and their relationships to the decedent shall be alleged. Damages may be awarded as follows:

(1) Each survivor may recover the value of lost support and services from the date of the decedent's injury to his death, with interest, the future loss of support and services from the date of death and reduced to present value. In evaluating loss of support and services, the survivor's relationship to the decedent, the amount of the decedent's probable net income available for distribution to the particular survivor, and the replacement value of the decedent's services to the survivor may be considered. In computing the duration of future losses, the joint life expectancies of the survivor and the decedent and the period of minority, in the case of healthy minor children, may be considered.

(2) The surviving spouse may also recover for loss of the decedent's companionship and protection and for mental pain and suffering from the date of injury.

(3) Minor children of the decedent may also recover for lost parental companionship, instruction, and guidance and for mental pain and suffering from the date of injury.

(4) Each parent of a deceased minor child may also recover for mental pain and suffering from the date of injury.

(5) Medical or funeral expenses due to the decedent's injury or death may be recovered by a survivor who has paid them.

*Id.*

1091. *E.g.*, CAL. CIV. PROC. CODE § 377 (West 1986). The California statute provides: "In every action under this section, such damages may be given as under all the circumstances of the case, may be just . . ." *Id.*

1092. *See Pehrson v. Kistner*, 301 Minn. 299, 301, 222 N.W.2d 334, 336 (1974).

earning power is a significant element of damages<sup>1093</sup> and distinguishes wrongful death claims from other claims that allow a mother to recover medical and burial expenses.<sup>1094</sup> The Kentucky Supreme Court in *Rice v. Rizk*,<sup>1095</sup> demonstrated the importance of future earnings by reversing and remanding that case for a new trial because the jury failed to award damages for future earning power.<sup>1096</sup> The court also declared that the child is presumed to have had some earning capacity; proof of the infant's earning power is not a prerequisite to recovery.<sup>1097</sup>

Wrongful death statutes generally do not allow damages for the mental distress suffered by survivors. *Panagopoulous v. Martin*,<sup>1098</sup> however, held that recovery up to \$10,000 was allowable under West Virginia law without a showing of pecuniary loss.<sup>1099</sup> Consequently, the court considered appropriate an award for the sorrow, distress, and bereavement experienced by relatives of the deceased unborn child.<sup>1100</sup>

Further generalization about allowable damages is difficult because of the number of differing statutes and their interpretations. Once a court determines that a fetus is a person within the meaning of the particular statute, allowable components of damages should be determined according to the precedent set by other wrongful death cases not concerning the unborn. An attorney claiming damages must consult the applicable state statute and its judicial interpretation to determine what damages are recoverable in his or her jurisdiction.

#### E. ANALYSIS

Wrongful death statutes represent a legislative response to the anomalous situation that occurred when a tort resulted in the victim's death. The tortfeasor faced no civil liability<sup>1101</sup> and no one was compensated for the loss because the victim, ordinarily the

1093. Demonstrating the significance of the earning power component, the Illinois Supreme Court in *Jones v. Karraker*, 98 Ill. 2d 487, 457 N.E.2d 23 (1983), affirmed an award of \$125,000 for the wrongful death of a viable fetus.

1094. See *Endresz v. Friedberg*, 24 N.Y.2d 478, 248 N.E.2d 901, 301 N.Y.S.2d 65 (1969).

1095. 453 S.W.2d 732 (Ky. 1970).

1096. *Id.* at 735.

1097. *Id.*

1098. 295 F. Supp. 220 (S.D. W. Va. 1969).

1099. *Id.* at 226-27.

1100. *Id.* at 227.

1101. See *supra* note 1016.

plaintiff, was dead. Thus, the two fundamental goals of tort law, deterrence and compensation, were thwarted in the most egregious cases. Legislatures rectified this situation by granting a cause of action to the victim's beneficiaries through wrongful death statutes. As courts began to recognize torts against the unborn,<sup>1102</sup> however, another anomaly arose—a tortfeasor was held responsible if the victim survived the tort and was born, but escaped liability if the victim did not survive. Given this development, the courts responded most appropriately by allowing recovery under wrongful death statutes for the death of a fetus.<sup>1103</sup> Logic, fairness, and tort law policies mandated this response.

Unfortunately, logic, fairness, and tort policy did not prevail in every respect when courts began to apply wrongful death statutes to cases concerning the unborn. In determining personhood for the purpose of wrongful death statutes, the arbitrariness of fixing birth as the point of personhood was readily apparent because of the similarity of human status immediately before and after birth.<sup>1104</sup> Courts, therefore, chose viability, rather than birth, as the determinative feature of a "person" under wrongful death statutes. Viability, however, ultimately replaced one arbitrary distinction with another.<sup>1105</sup> Allowing recovery when death occurs one

1102. See *supra* text accompanying notes 1027-29.

1103. See generally Collins, *supra* note 1005 (wrongful life section). Beginning with *Bonbrest v. Kotz* a rapid series of cases "brought about a rather spectacular reversal of the no-duty rule. The child, if he is born alive, is now permitted in every jurisdiction to maintain an action for the consequences of prenatal injuries, and if he dies of such injuries after birth an action will lie for his wrongful death." PROSSER AND KEETON ON THE LAW OF TORTS § 55, at 368 (W. Keeton 5th ed. 1984).

1104. See *Scott v. Kopp*, 494 Pa. 487, 431 A.2d 959 (1981), *overruled in* *Amadio v. Levin*, \_\_\_ Pa. \_\_\_, 501 A.2d 1085 (1985), in which the court admitted the arbitrariness of the distinction, but maintained the live birth requirement. According to the court, "the requirement of live birth is in some sense an arbitrary requirement, but the line must be drawn somewhere, and wherever it is drawn, it will be the subject of argument and criticism." *Id.* at 491, 431 A.2d at 961.

1105. Comment, *Wrongful Death of the Fetus: Viability is Not a Viable Distinction*, 8 U. PUGET SOUND L. REV. 103 (1984). According to the commentator "[b]irth and viability are equally arbitrary lines for courts to use in deciding whether to allow recovery for the wrongful death of a fetus." *Id.* at 115. See *Presley v. Newport Hosp.*, 117 R.I. 177, 365 A.2d 748 (1976). The Rhode Island Supreme Court stated:

[L]ogic does not permit the insistence on viability as the line of demarcation between those for whom an action will lie and those who are without rights under the statute . . . . If we profess allegiance to reason, it would be seditious to adopt so arbitrary and uncertain a concept as viability as a dividing line between those persons who shall enjoy the protection of our remedial laws and those who shall become, for most intents and purposes, nonentities.

*Id.* at 187-88, 365 A.2d at 753-54.

minute after birth but denying recovery when death occurs one minute prior to birth is inequitable. Similarly, allowing recovery for death occurring one minute after viability, assuming such a determination could be made,<sup>1106</sup> and denying recovery for death occurring a short time earlier is equally unfair. The tortfeasor may have committed the same wrongful act causing the survivors to experience equal loss in both situations. Deterrence and compensation should not turn on the fortuity of the precise stage of fetal development at the time death occurs.

In light of these considerations and the difficulty in establishing viability, conception is a more logical point of reference for determining when a person exists for purposes of wrongful death recovery.<sup>1107</sup> Opponents of a conception standard may argue that it will produce unjust awards because, regardless of tortious conduct, the probability of prenatal death is greater before rather than after the viability stage.<sup>1108</sup> Miscarriage may occur early in pregnancy for a number of reasons. The prospective parents in these cases arguably will obtain a windfall if they recover damages for a child that would not have survived much longer after the tortious act and never would have been born. This argument is unconvincing. All wrongful death cases require courts to speculate on how long the victim may have lived had the tort never occurred. This uncertainty, however, does not preclude recovery. Rather, courts take the uncertainty into account when assessing damages. Courts should take the same approach when the victim is unborn. The possibility of prenatal death absent the tort should be considered in assessing damages, but should not preclude recovery altogether.

1106. The determination of viability is ordinarily a question of fact, but how are jurors to ascertain the point in time at which a fetus could survive outside its mother? See Comment, *Torts—The Right of Recovery for the Tortious Death of the Unborn*, 27 How. L.J. 1649, 1662 (1984) (“The determination of viability by medical standards is both complex and difficult to diagnose. It may differ with each pregnancy.”).

1107. “[T]he requirement of viability will be scrapped as courts begin to accept the notion that a child is an entity, or a ‘person’ from the moment of conception, and that as such it is entitled to be protected as is every other person.” S. SPEISER, 1 RECOVERY FOR WRONGFUL DEATH § 4:38, at 564 (2d ed. 1975).

Fixing conception as the point at which the unborn acquire personhood for purposes of wrongful death recovery, however, presents a conflict with the constitutional analysis of personhood in *Roe v. Wade*, 410 U.S. 113 (1973). See *supra* notes 1079-81 and accompanying text for a discussion of this problem.

1108. “It is difficult to state an absolute occurrence rate for spontaneous abortion . . . . [Statistics] indicate a total [spontaneous] abortion rate of 27 percent, with most occurring in the first few weeks of gestation and a marked decrease after the 12th week.” S. ROMNEY, M. GRAY, A. LITTLE, J. MERRILL, E. QUILLIGAN & R. STANDER, *GYNECOLOGY AND OBSTETRICS* 570 (2d ed. 1981).

Although some courts allowing recovery for prenatal wrongful death have acknowledged problems with the viability standard,<sup>1109</sup> very few have departed from it. Only two courts have held that conception is the proper standard.<sup>1110</sup> Establishing conception as the critical point would avoid the problem of determining the point of viability and would advance in a consistent and logical manner the goals of deterring wrongful conduct and compensating survivors for their loss.

## F. CONCLUSION

A decided majority of courts now allow recovery for tortious death of the unborn by allowing actions under wrongful death statutes. This development was a logical progression from the recognition of other causes of action for prenatal torts. More importantly, recovery under wrongful death statutes provides a means of holding defendants liable, thereby deterring future wrongdoing and compensating the victim's beneficiaries for the loss. To best serve these goals of deterrence and compensation, however, recovery should not depend on a fortuitous circumstance such as the stage of fetal development at the moment death occurs. A developing life exists from the time of conception and courts have recognized that the parents suffer a compensable loss when that fetus is tortiously killed before birth. The tort and the loss are the same regardless of the viability of the fetus. Conception, therefore, should be the only prerequisite to finding a "person" whose death is compensable under a wrongful death statute. This approach will accommodate the underlying purposes of wrongful death statutes and promote traditional tort law policies in the developing arena of rights of the unborn.

# X. Baby Doe: The Controversy Surrounding Withholding Treatment From Severely Defective Newborns

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1109. See, e.g., *Werling v. Sandy*, 17 Ohio St. 3d 45, 476 N.E.2d 1053 (1985); *Presley v. Newport Hosp.*, 117 R.I. 177, 365 A.2d 748 (1976).

1110. See *Amadio v. Levin*, \_\_\_ Pa. \_\_\_, 501 A.2d 1085 (1985); *Presley v. Newport Hosp.*, 117 R.I. 177, 365 A.2d 748 (1976); see also, *Danos v. St. Pierre*, 383 So. 2d 1019 (La. Ct. App. 1980) (Lottinger, J., concurring).



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A. INTRODUCTION

Recent medical advances in neonatal care have enabled physicians to sustain the fragile lives of infants born prematurely<sup>1111</sup> or with congenital defects.<sup>1112</sup> Only a decade ago, most of these newborns would have died within days or weeks of birth.<sup>1113</sup> The

1111. Approximately seven percent of all infants born in the United States each year weigh less than 2500 grams (5.5 lbs.) and are classified as low birth weight (LBW). Improvement among the smallest of these infants—those weighing from 1000-1500 grams—has been especially dramatic, with the neonatal mortality rate dropping from 50% to 20% in the past 25 years. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 197 (1983) [hereinafter cited as PRESIDENT'S COMMISSION.]

1112. Congenital defects are morphologic abnormalities of internal or external organs arising before birth that have actual or potential clinical significance. 1 J. WYNGAARDEN & L. SMITH, *CECIL TEXTBOOK OF MEDICINE* 22 (1982), noted in PRESIDENT'S COMMISSION at 201. About four percent of the infants born in the United States are afflicted with one or more readily detectable congenital defects. PRESIDENT'S COMMISSION, *supra* note 1111, at 201.

1113. Between 1970 and 1980 the death rate among infants in the first 28 days of life—the neonatal period—was reduced by almost 50%. This decline represents the greatest proportional decrease in neonatal mortality since national birth statistics first were gathered in 1915. PRESIDENT'S COMMISSION, *supra* note 1111, at 197. Most of this decline is the result of improved survival rates of low birth weight infants, rather than a decline in the proportion of high risk births. See Kwang-Sun Lee, *Neonatal Mortality: An Analysis of the Recent Improvement in the United States*, 70 AM. J. PUB. HEALTH 15 (1980), noted in PRESIDENT'S COMMISSION at 197.

continually increasing ability of medical technology to prolong the lives<sup>1114</sup> of severely defective<sup>1115</sup> infants has magnified the profound moral and legal dilemma faced by parents and physicians who must decide in which cases, if any, life-sustaining treatment may be withheld from a critically ill newborn.<sup>1116</sup> Physicians and parents must consider not only whether they *can* treat a particular defect, but also whether they *should* treat the defective newborn.<sup>1117</sup>

Medical and legal commentators began debating the ethics of withholding or withdrawing life-sustaining treatment from severely defective newborns in the early 1970's.<sup>1118</sup> Several cases of selective

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1114. Although physicians frequently are successful in increasing the *length* of a defective infant's life, they often are unable to increase the *quality* of the newborn's life. In many cases, the surviving infant enjoys no interaction whatsoever with his environment. See Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213, 246-55 (1975) (discussing whether the potential *quality* of an infant's life is a valid consideration in treatment decisions).

1115. A "severely defective newborn" may be defined as one who is "not likely to survive without surgical and medical intervention and whose prognosis, even assuming this intervention, may be poor in terms of cognitive life and minimal functioning." Ellis, *Letting Defective Babies Die: Who Decides?*, 7 AM. J. LAW & MED. 393, 394 (1983), quoted in Comment, *Baby Doe Decisions: Modern Society's Sins of Omission*, 63 NEB. L. REV. 888, 899 n.46 (1984) [hereinafter cited as Comment, *Baby Doe Decisions*].

1116. See Note, *The HHS' Final Rule on Health Care for Handicapped Infants: Equal Protection Not Guaranteed*, 11 J. LEGIS. 269, 271 n.11 (1984) [hereinafter cited as Note, *The HHS' Final Rule*]. Physicians must make treatment decisions based on a wide variety of congenital abnormalities as well as low birth weights. Ethical debates, however, have focused on two general categories of critically ill newborns: infants born with neural tube defects (NTD) and infants born with permanent handicaps accompanied by life-threatening, surgically correctable lesions. The first category of cases involves NTD cases, which include anencephaly (partial or entire absence of the brain) and meningomyelocele, commonly called spina bifida (abnormally developed brain and spinal cord). Treatment decisions in NTD cases involve procedures that possibly will extend a child's life, but in no way will correct the defect. The second category of cases involves infants with correctable life-threatening defects combined with irremediable physical handicaps that are not life-threatening. These handicaps include Down's Syndrome and mental retardation. PRESIDENT'S COMMISSION, *supra* note 1111, at 202. For a discussion of the scientific aspects of Down's Syndrome, see *supra* notes 47-56 and accompanying text.

1117. Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890, 892 (1973).

1118. Members of the medical profession have debated the ethics of withholding treatment from defective newborns for as long as medical technology has made treatment possible. The debate was accelerated, however, by a 1973 medical journal article that publicly discussed the Yale-New Haven Hospital's treatment policies resulting in the death of 43 newborns due to non-treatment during a 30-month period. See Duff & Campbell, *supra* note 1117, at 892; see also Gustafson, *Mongolism, Parental Desires, and the Right to Life*, 16 PERSP. BIO. & MED. 517 (1973); Horan, *Euthanasia, Medical Treatment and the Mongoloid Child: Death as a Treatment of Choice?*, 27 BAYLOR L. REV. 76 (1975); Jonsen, *Critical Issues in Newborn Intensive Care: A Conference Report and Policy Proposal*, 55 PEDIATRICS 756 (1975); Lorber, *Selective Treatment of Myelomeningocele: To Treat or Not to Treat*, 53

nontreatment that recently received widespread media coverage<sup>1119</sup> accelerated this debate. These widely publicized cases generated intense debate throughout the nation, particularly among members of the medical<sup>1120</sup> and legal<sup>1121</sup> professions, parents of similarly afflicted infants,<sup>1122</sup> and other commentators concerned with the rights of handicapped newborns.<sup>1123</sup>

## B. INITIAL RECOGNITION OF THE CONTROVERSY

### 1. Birth of Bloomington "Baby Doe"

The "Baby Doe"<sup>1124</sup> situation in Bloomington, Indiana, on April 9, 1982, was the first nontreatment case to receive extensive

PEDIATRICS 307 (1974); Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202 (1973).

1119. See *infra* notes 1140 and 1174.

1120. For a selection of pre- and post-Baby Doe medical commentaries, see Howell & Shannon, *Pediatricians' Attitudes Affecting Decisionmaking in Defective Newborns*, 60 PEDIATRICS 197 (1977); Koop, *Ethical & Surgical Considerations in the Care of the Newborn with Congenital Abnormalities*, in *INFANTICIDE AND THE HANDICAPPED NEWBORN* 89 (D. Horan & M. Delahoyde eds. 1982); noted in Note, *The HHS' Final Rule*, *supra* note 1116, at 270 n.6; Murray, *The Final Anticlimactic Rule on Baby Doe*, HASTINGS CENTER REP. 5 (June 1985); Paris & Fletcher, *Infant Doe Regulations and the Absolute Requirement to Use Nourishment and Fluids for the Dying Infant*, 11 LAW, MED. & HEALTH CARE 210 (1983); Robertson & Fost, *Passive Euthanasia of Defective Newborn Infants: Legal Considerations*, 88 J. PEDIATRICS 883 (1976); Singer, *Sanctity of Life or Quality of Life?*, 72 PEDIATRICS 28 (1983); Strong, *The Tiniest Newborns*, 13 HASTINGS CENTER REP. 14 (1983).

1121. For a selection of recent legal commentaries, see Blumstein & Smith, *Baby Doe: Public Judgments or Private Choices? A Jurisdictional Approach*, NEW PERSP., Fall 1984, at 14; Longino, *Withholding Treatment from Defective Newborns: Who Decides and On What Criteria?*, 31 KAN. L. REV. 377 (1983); Shapiro, *Medical Treatment of Defective Newborns: An Answer to the "Baby Doe" Dilemma*, 20 HARV. J. ON LEGIS. 137 (1983); Shatten & Chabon, *Decision-Making and the Right to Refuse Lifesaving Treatment for Defective Newborns*, 3 J. LEGAL MED. 59 (1982); Note, *The HHS' Final Rule*, *supra* note 1116; Comment, *Baby Doe Decisions*, *supra* note 1115, at 88; Special Project, *Baby Doe: Problems and Legislative Proposals—Legislative Workshop*, 4 ARIZ. ST. L.J. 601 (1984); Comment, *Defective Newborns: Inconsistent Application of Legal Principle Emphasized by the Infant Doe Case*, 14 TEX. TECH. L. REV. 569 (1983).

1122. R. STINSON & P. STINSON, *THE LONG DYING OF BABY ANDREW* (1983) (views of the parents of a severely defective newborn) cited in Note, *The HHS' Final Rule*, *supra* note 1116, at 270 n.7; Brant & McNulty, *Treating Defective Newborns: The Ethical Dilemma*, 10 HUMAN RIGHTS, Fall 1982, at 34 (discussing *In re McNulty* from a parental perspective).

1123. Members of other professions also were active in the debate. For a debate of the issues surrounding the controversy, see *INFANTICIDE AND THE VALUE OF LIFE* (M. Kohl ed. 1978) (ethicist); P. RAMSEY, *ETHICS AT THE EDGES OF LIFE: MEDICAL AND LEGAL INTERSECTIONS* (1978) (ethicist); B. WEIR, *SELECTIVE TREATMENT OF HANDICAPPED NEWBORNS* (1984) (clergy). Additional articles include McCarthy, *Treating Defective Newborns: Who Judges Extraordinary Means?*, 62 HOSP. PROG. 45 (1981) (clergy) cited in Note, *The HHS' Final Rule*, *supra* note 1116, at 270 n.7; Paris, *Terminating Treatment for Newborns: A Theological Perspective*, 10 LAW, MED. & HEALTH CARE 120 (1982) (ethicist).

1124. The media labeled the unnamed Bloomington infant "Baby Doe" or "Infant

media coverage.<sup>1125</sup> Baby Doe suffered from two separate birth defects—Down's Syndrome<sup>1126</sup> and an esophageal atresia with associated tracheoesophageal fistula,<sup>1127</sup> a congenital defect that often accompanies Down's Syndrome.<sup>1128</sup> Baby Doe's parents considered various recommended treatment alternatives,<sup>1129</sup> but decided not to authorize a routine surgical procedure to correct the esophageal defect.<sup>1130</sup> Rather, the parents opted to provide the infant with medication sufficient only to keep him relatively comfortable and pain free until his inevitable death from pneumonia or starvation.<sup>1131</sup>

Hospital officials sought judicial guidance and reported the

Doe." The term "Baby Doe" currently is used to refer to many similarly situated newborns. Because the court sealed the official records of this case in accordance with Indiana law, only limited facts and findings are available. See Note, *The HHS' Final Rule, supra* note 1116, at 271 n.12.

1125. Pearl, *Baby Jane and Infant Doe: Treatment of Newborns with Birth Defects*, 16 *URB. LAW.* 701 (1984).

1126. Down's Syndrome results when an infant receives an extra chromosome from its parents. See *supra* text accompanying and following note 70. Down's Syndrome occurs approximately once in every 700 live births. Although children afflicted with Down's Syndrome are mentally retarded, many can hold simple jobs and live fairly normal lives. PRESIDENT'S COMMISSION, *supra* note 1111, at 202-03. For additional information on Down's Syndrome, see W. NYHAN AND E. EDELSON, *THE HEREDITY FACTOR* 128-29 (1976); W. NYHAN & N. SAKATI, *GENETIC AND MALFORMATION SYNDROMES IN CLINICAL MEDICINE* 117-23 (1976), cited in PRESIDENT'S COMMISSION, *supra* note 1111, at 202 n.23.

1127. An esophageal atresia is a blockage of the esophagus and a tracheoesophageal fistula is a separation between the esophagus and stomach. The defects prevented Baby Doe from eating or breathing normally. Physicians can repair the condition by using a surgical procedure that is "typically successful." PRESIDENT'S COMMISSION, *supra* note 1111, at 203. Conflicting opinions reported Baby Doe's chance for survival from "probably successful" to a "50-50 chance of success" to a "minimal chance of surviving the operation." See Comment, *Baby Doe Decisions, supra* note 1115, at 890 n.4.

1128. A majority of Down's Syndrome victims require no extraordinary care at birth. A few, however, are born with life-threatening, surgically correctable defects. The two most common defects that accompany Down's Syndrome are gastrointestinal blockage and congenital heart defects. PRESIDENT'S COMMISSION *supra* note 1111, at 203. Baby Doe's esophageal defect was a form of gastro-intestinal blockage.

1129. Two Bloomington pediatricians, including the Doe family pediatrician, recommended immediate transfer of the infant to another hospital for corrective surgery. The attending obstetrician, however, recommended the nonsurgical treatment procedures that the parents ultimately followed. Comment, *Baby Doe Decisions, supra* note 1115, at 890.

1130. *Id.* Some people refer to the withholding of life-sustaining treatment from a defective newborn as "passive" or "involuntary" euthanasia or "dystanasia." A voluntary withdrawal of treatment is known as "mercy killing" or "euthanasia." The primary difference between "dystanasia" and "euthanasia" is that, in the first case, treatment is never administered, and in the second case, existing treatment is affirmatively withdrawn or removed. *Id.* at 890 n.6 (citing Robertson, *supra* note 1114, at 214 n.6).

1131. Comment, *Baby Doe Decisions, supra* note 1115, at 890.

parents' nontreatment decision to county prosecutors.<sup>1132</sup> The Monroe County, Indiana, Circuit Court upheld the parents' decision and noted that "after having been informed of the opinions of two sets of physicians," the infant's parents had the right to select "a medically recommended course of treatment" for Baby Doe.<sup>1133</sup> Unsatisfied with the circuit court's ruling, the Monroe County Prosecutor filed an emergency petition with the local juvenile court.<sup>1134</sup> On April 13, the *referee pro tem* of the Monroe County Juvenile Court reasoned that the county had failed to establish that the parents' refusal to supply Baby Doe with necessary food and medical attention severely impaired his physical and mental condition.<sup>1135</sup> The court, therefore, denied the prosecutor's emergency petition.<sup>1136</sup> On April 14, the prosecutor made an unsuccessful attempt to appeal both the circuit and juvenile courts' rulings to the Indiana Supreme Court.<sup>1137</sup> On April 15, Baby Doe, receiving neither nutritional sustenance nor corrective surgery, died at age six days before attorneys could perfect an appeal to the United States Supreme Court.<sup>1138</sup>

## 2. Federal Response to Baby Doe:

### "Baby Doe" Regulations

Baby Doe's death received nationwide coverage in the popular press<sup>1139</sup> and forced the decision to withhold life-sustaining treat-

1132. *Id.* at 891.

1133. The circuit court's decision is set forth in *Treatments of Infants Born with Handicapping Conditions, Hearing Before the Subcomm. on Select Education of the House Comm. on Education and Labor, 97th Cong., 2d Sess. 73 (1982)*. See Pearl, *supra* note 1125, at 703.

1134. Comment, *Baby Doe Decisions, supra* note 1115, at 891.

1135. *Id.*

1136. *Indiana ex rel Infant Doe v. Monroe Cir. Ct., No. 482-5140 (Ind. Apr. 16, 1982), cert. denied, 464 U.S. 961 (1982), cited in Comment, Baby Doe Decisions, supra* note 1115, at 891 n.12.

1137. The Indiana Supreme Court upheld the rulings of both the Morgan County Circuit Court and Juvenile Court by recognizing the parents' right to decide to withhold corrective surgery. See Comment, *Baby Doe Decisions, supra* note 1115, at 891, n.12.

1138. According to the *New York Times*, Apr. 15, 1982, at D21, col. 5, Baby Doe died only hours before Justice Stevens of the United States Supreme Court was to hear a stay of the Indiana Supreme Court's ruling. *Id.*

1139. For examples of public response to infant Doe's death, see Trafford, *Doctor's Dilemma: Treat or Let Die?*, U.S. NEWS & WORLD REP., Dec. 6, 1982, at 58; Wallis, *The Stormy Legacy of Baby Doe: Should the Government Try to Save Severely Afflicted Infants?*, TIME, Sept. 26, 1982, at 58; Wash. Post, May 19, 1982, at A21, col. 4; N.Y. Times, Apr. 27, 1982, at A22, col. 1; N.Y. Times, Apr. 17, 1982, at A6, col. 2; Wash. Post, Apr. 17, 1982, at A1, col. 5; N.Y. Times, Apr. 15, 1982, at D21, col. 5.

ment from severely defective newborns out of the privacy of the medical profession and into the arena of public concern.<sup>1140</sup> President Reagan immediately issued a memorandum<sup>1141</sup> to the United States Attorney General and to Richard Schweiker, the Secretary of Health and Human Services (HHS); the memorandum emphasized that federal law prohibits discrimination, including the withholding of medically indicated treatment, on the basis of a handicap.<sup>1142</sup> Prompted by President Reagan's memorandum, the Department of Health and Human Services issued a notice entitled "Discriminating Against the Handicapped by Withholding Treatment or Nourishment; Notice to Health Care Providers."<sup>1143</sup> The notice emphasized the applicability of section 504 of the Rehabilitation Act of 1973<sup>1144</sup> to treatment decisions concerning severely defective newborns.<sup>1145</sup> Section 504 prohibits recipients of federal

1140. The overall public response to Baby Doe's death was one of outrage. Predictably, the child's death enraged human rights groups, handicapped rights groups, and right-to-life groups who believe that life should be maintained at all costs. In addition, many individuals and groups who maintain that certain circumstances do justify nontreatment argued that the "conservative" course of treatment employed in this case was unjustified. Mathieu, *The Baby Doe Controversy*, 4 ARIZ. ST. L.J. 605 (1984). These groups argued that the circumstances that justify nontreatment were not present in Baby Doe's case because the infant's underlying permanent defect of Down's Syndrome was not a severe disability that would render surgery to correct his life-threatening defect futile. *Id.*

1141. Baby Doe died on April 15, 1982. *See supra* text accompanying note 1138. President Reagan issued the memorandum on April 30, 1982. 49 Fed. Reg. 1,622 (1984).

1142. *See* Pearl, *supra* note 1125, at 703. The President's memorandum does not appear in the Weekly Compilation of Presidential Documents, but is reprinted in the Department of HHS Final Rule, Procedures and Guidelines Relating to Health Care for Handicapped Infants, 49 Fed. Reg. 1,622-23 (1984). *Id.* at 703 n.10.

1143. 47 Fed. Reg. 26,027 (1982). HHS issued the notice on May 18, 1982.

1144. 29 U.S.C. § 794 (1983). Section 504 of the Rehabilitation Act states that "[n]o otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

1145. Although HHS previously had not applied § 504 to treatment decisions concerning defective newborns, HHS maintained that the implementing regulations of § 504 (45 C.F.R. 84.61) indicate that the section is applicable to health care and that conditions such as Down's Syndrome or spina bifida properly are considered handicaps within the meaning of § 504 (45 C.F.R. 84.3(j)). 47 Fed. Reg. 26,027 (1982). The Notice alerted hospitals that it is unlawful under section 504:

for a recipient of Federal financial assistance to withhold from a handicapped infant nutritional sustenance or medical or surgical treatment required to correct a life-threatening condition, if:

- (1) The withholding is based on the fact that the infant is handicapped; and
- (2) The handicap does not render the treatment or nutritional sustenance medically contraindicated.

*Id.* The Notice also stated that failure to comply with the regulations would result in the termination of federal financial assistance. *Id.*

financial assistance from discriminating against the handicapped.<sup>1146</sup>

Approximately one year later, HHS issued regulations entitled the "Interim Final Rule,"<sup>1147</sup> which the Department designed to enforce the prohibitions stated in the preceding "Notice to Health Care Providers."<sup>1148</sup> These short-lived regulations commonly were called "Baby Doe Regulations." Promulgated under section 504,<sup>1149</sup> these regulations required any recipient of federal financial assistance providing health care to infants to post "in a conspicuous place in each delivery ward, each maternity ward, each pediatric ward, and each nursery, including each intensive care nursery, the following notice: **DISCRIMINATORY FAILURE TO FEED AND CARE FOR HANDICAPPED INFANTS IN THIS FACILITY IS PROHIBITED BY FEDERAL LAW.**"<sup>1150</sup> The Baby Doe Regulations also required each poster to include: (1) a statement noting the applicability of section 504 to the treatment of handicapped newborns, and (2) a statement instructing any citizen having knowledge of a severely defective newborn being denied food or customary medical care on the basis of a handicap to contact HHS through its toll-free Handicapped Infant Hotline<sup>1151</sup> in Washington, D.C. HHS issued the regulations without the benefit of public comment, as required by the Administrative Procedures Act (APA),<sup>1152</sup> and the regulations were soon challenged because of this failure to follow the APA's prescribed procedure for promulgating regulations.

1146. *See supra* note 1144.

1147. Nondiscrimination on the Basis of Handicap: Interim Final Rule, 48 Fed. Reg. 9630 (1983) ("The purpose of the interim final rule is to acquire timely information concerning violations of section 504 that are directed against handicapped infants and to *save the life of the infant.*") (emphasis in original).

1148. *See supra* note 1145 for the text of the Notice to Health Care Providers.

1149. 48 Fed. Reg. 9630 (1983).

1150. *Id.* at 9631.

1151. *Id.* The Hotline was available 24 hours a day, and the Department of Health and Human Services guaranteed that callers' names would remain confidential. *Id.* at 9632.

1152. Congress enacted the Administrative Procedures Act, 5 U.S.C. § 551 (1982), to eliminate arbitrary bureaucratic actions taken without consideration of and notice to persons affected. The Act generally requires a 30-day public comment period unless the promulgating agency can justify why a particular notice provision should be waived. 5 U.S.C. § 553(b), (d) (1982).

3. *Challenge to the Baby Doe Regulations:*  
*American Academy of Pediatrics v. Heckler*

The Baby Doe Regulations evoked intense emotional responses—both favorable and unfavorable—from organizations and individuals concerned with the rights of the handicapped and with the medical care of severely defective infants.<sup>1153</sup> Within several weeks of the publication of the Baby Doe Regulations, the American Academy of Pediatrics, the National Association of Children's Hospitals and Related Institutions, and the Children's Hospital National Medical Center filed suit against the Reagan Administration's new Secretary of Health and Human Services, Margaret Heckler, challenging the validity of the rules.<sup>1154</sup> On April 14, 1983, the United States District Court for the District of Columbia invalidated the Interim Final Rule,<sup>1155</sup> asserting that the regulations were (1) arbitrary and capricious,<sup>1156</sup> and (2) promulgated in violation of the Administrative Procedures Act's public notice requirement.<sup>1157</sup> By invalidating the Interim Final Rule on a procedural ground,<sup>1158</sup> the district court failed to resolve the basic question of whether HHS had exceeded its authority under section 504 by

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1153. Mathieu, *supra* note 1140, at 607. Traditionally, decisions to withhold or withdraw life-sustaining treatment from critically ill newborns have been made within the privacy of the physician-patient relationship, without intervention by governmental authorities. Groups opposing the Interim Final Rule argued that the regulations placed a "novel and far-reaching" burden upon the physician and parents' decisionmaking process. Conversely, organizations supporting the regulations argued that governmental interference was essential to insure proper decisions, particularly in borderline cases when parental decisions may reflect wholly irrelevant economic and familial considerations. *American Academy of Pediatrics v. Heckler*, 561 F. Supp. 395, 396-97 (D.D.C. 1983).

1154. Mathieu, *supra* note 1140, at 607. Thirteen organizations and individuals filed briefs as *amici curiae* supporting either the plaintiffs' or defendants' position. Plaintiffs attacked the regulations as: (1) arbitrary and capricious regulations; (2) promulgated in violation of the public comment requirement of the Administrative Procedures Act and without a justification for waiving the requirement; (3) exceeding the scope of the Department's statutory authority granted by § 504; and (4) an unjustified intrusion into the family-physician relationship and other confidential relationships protected by the Constitution. 561 F. Supp. at 396.

1155. 561 F. Supp. at 403.

1156. *Id.* at 399. The court applied a "test of rationality" to the regulations and concluded that haste and inexperience resulted in agency action based on inadequate consideration that was virtually meaningless beyond its intrinsic *in terrorem* effect. *Id.* at 399-400.

1157. The court rejected the Secretary's argument that the rule was either "interpretive" or "procedural" and therefore not subject to the notice requirements of the APA. The court also rejected the Secretary's argument that the requirements should have been waived to protect life from imminent harm. *Id.* at 401.

1158. *Id.*



promulgating regulations in the area of neonatal medical care.<sup>1159</sup> The district court's opinion also failed to decide whether the regulations, if properly promulgated, imposed an unconstitutional intrusion upon the privileged physician-patient relationship or the constitutionally protected familial right to privacy.<sup>1160</sup>

#### 4. Federal Response to Heckler

After the district court invalidated the Interim Final Rule in *Heckler*, HHS quickly issued "Proposed Rules"<sup>1161</sup> that were almost identical to their invalidated predecessors.<sup>1162</sup> In addition to restating the requirements of the Interim Final Rule, the Proposed Rules required state child-protective service agencies to establish and maintain procedures which would insure that the agency exercised its complete authority under state law to prevent the medical neglect of severely defective infants.<sup>1163</sup> Unlike the original regula-

1159. Although invalidating the regulations on procedural grounds, the court did discuss the propriety of the Department of HHS' regulation under the authority of § 504. The court conceded that some infants born with physical and mental defects may fit within § 504's broad definition of a handicapped individual. The court could not say with certainty that § 504 does not authorize some regulation of the types of medical care provided to handicapped newborns. The court also noted that the application of § 504 to treatment decisions was unprecedented because, as far as the court could determine, no congressional committee or member of the House or Senate had ever suggested that § 504 would apply to medical treatment of defective newborn infants or establish standards for preserving a particular quality of life. *Id.* at 400-02. The court concluded that the question of whether § 504 authorizes federal intervention in decisions regarding treatment of handicapped newborns should await the actual application of the statute to particular circumstances. In conclusion, the court suggested that Congress should take action to clarify the scope of § 504. *Id.* at 402.

1160. The court noted that if it interpreted § 504 to minimize or eliminate the role of a severely defective infant's parents in the treatment decision, the provision's application might infringe upon the parents' right to familial privacy similar to the privacy rights recognized in *Roe v. Wade*, 410 U.S. 113, 152-53 (1973), and *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965). 561 F. Supp. at 403.

1161. Mathieu, *supra* note 1140, at 611. The Department issued the regulations less than three months after the *Heckler* decision. The regulations officially were entitled *Non-discrimination on the Bases of Handicaps Relating to Health Care for Handicapped Infants: Proposed Rules*, 48 Fed. Reg. 30,846 (1983) [hereinafter cited as *Proposed Rules*].

1162. For a detailed comparison of the Interim Final Rule and the Proposed Rules, see *Note, The HHS' Final Rule*, *supra* note 1116, at 276-77.

1163. *Id.* at 277. The Proposed Rules, in a section to be codified at 45 C.F.R. § 84.61(2)(e), provided that:

Within 60 days of the effective date of this subsection [October 9, 1985], each recipient state child protective services agency shall establish and maintain written methods of administration and procedures to assure that the agency utilizes its full authority pursuant to State law to prevent instances of medical neglect of handicapped infants. These methods of administration and procedures shall include:

(1) A requirement that health care providers report immediately to the State agency suspected cases of medical neglect of handicapped infants;

tions, the Proposed Rules contained a sixty-day period for public comment and specifically solicited public responses to nine relevant issues.<sup>1164</sup> The Proposed Rules also contained a supplementary information section that stated the history of the regulation and HHS' reasons for promulgating the Proposed Rules.<sup>1165</sup>

During the sixty-day comment period, HHS received over 16,000 responses,<sup>1166</sup> an overwhelming majority of which supported the Proposed Rules.<sup>1167</sup> Physicians, hospital officials, and medical associations, however, voiced as much criticism to the Proposed Rules as they had to the Interim Final Rules.<sup>1168</sup> The American Academy of Pediatrics expressed its dissatisfaction by submitting to HHS a detailed alternative to the Proposed Rules, suggesting, among other things, that HHS require hospitals to establish and maintain infant care review boards<sup>1169</sup> as a condition to participat-

(2) A method by which the agency can receive reports of suspected medical neglect of handicapped infants from health care providers, other individuals, and the Department on a timely basis;

(3) Immediate review of reports of suspected medical neglect of handicapped infants and, where appropriate, onsite investigation of such reports;

(4) Provision of child protective services to medically neglected handicapped infants, including, when appropriate, seeking a timely court order to compel the provision of necessary nourishment and medical treatment; and

(5) Immediate notification to the Department's Office for Civil Rights of each report of suspected medical neglect of a handicapped infant, the steps taken by the agency to investigate such report, and the agency's disposition of such report.

48 Fed. Reg. 30,851 (1983) (to be codified at 45 C.F.R. § 84.61 (2)(e)(1)-(5)) (proposed July 5, 1983).

1164. See Proposed Rules, 48 Fed. Reg. at 30,850-51. Some of the specific issues raised included self-evaluations by health-providing institutions, and mandatory internal review committees.

1165. The Department included the supplementary information section to defend the rules against charges that HHS enacted the Proposed Rules, like the Interim Final Rules, in an arbitrary and capricious manner in violation of the Administrative Procedures Act, 5 U.S.C. § 706(2)(A) (1982). See Proposed Rules, *supra* note 1161, at 30,846-47.

1166. Note, *The HHS' Final Rule*, *supra* note 1116, at 277. The Department received 16,739 responses, 16,331 of which supported the Proposed Rules. See *Nondiscrimination on the Basis of Handicap; Procedures and Guidelines Relating to Health Care for Handicapped Infants: Final Rules*, 49 Fed. Reg. 1622, 1623 (1984) (to be codified at 46 C.F.R. § 86.55) [hereinafter cited as Final Rules].

1167. For a breakdown of specific groups' support or opposition percentages by occupation, see Final Rules, *supra* note 1166, at 1623.

1168. See, e.g., *Baby Doe Needs No Big Brother*, N.Y. Times, July 26, 1983, at 20, col. 1, cited in Note, *The HHS' Final Rule*, *supra* note 1116, at 277 n.58 (discussing the medical profession's unfavorable response to the proposed rules).

1169. Note, *The HHS' Final Rules*, *supra* note 1116, at 277. The alternate proposal that the American Academy of Pediatrics submitted suggested that the committees be composed of a hospital administrator, a representative of a disability group, a lay community member, a practicing member of the hospital's medical staff, and a practicing nurse. The proposal suggested also that the Infant Care Review Committees (ICRCs) assume responsi-

ing in the federally funded Medicare program.<sup>1170</sup> The American Medical Association (AMA), along with several related organizations,<sup>1171</sup> supported the concept of infant care review boards, but only on a voluntary basis.<sup>1172</sup> Additionally, the AMA opposed *all* federal intervention into treatment decisions, including federally mandated infant care review committees.<sup>1173</sup>

### C. THE CONTROVERSY REVISITED

#### 1. Birth of "Baby Jane Doe"

While HHS was evaluating the public response to the Proposed Rules and the American Academy of Pediatrics' alternative proposal, a second parental decision to withhold treatment from a severely defective newborn caught the attention of the popular press.<sup>1174</sup> "Baby Jane Doe"<sup>1175</sup> was born on October 11, 1983, in Port Jefferson, New York, with multiple birth defects including myelomeningocele (commonly called spina bifida),<sup>1176</sup> microcephaly,<sup>1177</sup> hydrocephalus,<sup>1178</sup> and a malformed brain stem. "Baby

bility for developing hospital policies and guidelines for the management of specific types of diagnoses, monitoring adherence to policies through retrospective record review, and reviewing specific cases when nontreatment is being considered. Under the alternative proposal, an ICRC would be responsible for alerting state child protective agencies whenever the committee disagreed with either the parents' or the physicians' decision to withhold or withdraw life-sustaining treatment from a severely defective newborn. Final Rules, *supra* note 1166, at 1623.

1170. Note, *The HHS' Final Rule*, *supra* note 1116, at 277.

1171. These organizations included the Catholic Health Association, the Federation of American Hospitals, the American College of Hospital Administrators, the American College of Physicians, and the American Nurses Association. Final Rules, *supra* note 1166, at 1624.

1172. Note, *The HHS' Final Rule*, *supra* note 1116, at 277.

1173. The AMA refused to support federal intervention in treatment decisions concerning seriously ill newborns, and commented that the attention which the government's action generated should provide a continued stimulus to develop procedures dealing with this sensitive area without the unwarranted intrusion of the federal government. Final Rules, *supra* note 1166, at 1624.

1174. See generally *The Case of Baby Jane Doe*, NEWSWEEK, Nov. 14, 1983, at 45-46; *Whose Lives Are They Anyway?*, TIME, Nov. 14, 1983; Wash. Post, Nov. 18, 1983, at A1, col. 3, cited in Note, *The HHS' Final Rule*, *supra* note 1116, at 271 n.15.

1175. The news media quickly nicknamed the infant "Baby Jane Doe" because of her parents' desire for anonymity.

1176. Spina bifida is a congenital defect characterized by an abnormal development of the osseous spine. See Robertson, *supra* note 1114, at 213 n.6. The PRESIDENT'S COMMISSION, noted that vigorous surgical, medical and rehabilitative therapies have improved drastically the prognosis of infants afflicted with spina bifida. Today, many individuals born with spina bifida can lead relatively normal, independent lives. PRESIDENT'S COMMISSION *supra* note 1111, at 202.

1177. Microcephaly is characterized by an abnormally small head circumference and increased pressure in the cranial cavity. Weber v. Stony Brook Hosp., 95 A.D.2d 587, 588,

Jane" also suffered other congenital abnormalities, including a "weak face," bilateral upper extremity spasticity, and a thumb formed entirely within her right hand.<sup>1179</sup> The infant was transferred immediately to the University Hospital, State of New York at Stony Brook<sup>1180</sup> for emergency surgery to correct both her spina bifida and hydrocephalus.<sup>1181</sup> After consulting several neurological experts, nurses, religious advisors, and a social worker, Baby Jane's parents refused to consent to the proposed surgical procedures.<sup>1182</sup> The parents instead decided to implement a "conservative" course of medical treatment,<sup>1183</sup> consisting of a nutritious diet, ingestion of antibiotics, and medical dressing of the infant's exposed spinal sac to encourage the closing of skin over the opening.<sup>1184</sup> The hospital, lacking the legal authority to perform the surgical procedures without parental consent, complied with the parents' choice of treatment.<sup>1185</sup>

On October 16, 1983, a Vermont attorney petitioned the Su-

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467 N.Y.S.2d 1186 (N.Y. 1983).

1178. Hydrocephalus is characterized by an excess of free fluid around the brain that results in a marked enlargement of the head. *Id.*

Because of the combination of microcephaly and hydrocephalus, an extremely high probability existed that Baby Jane Doe would have been so severely retarded that she never could have interacted with her environment or with other people. *United States v. University Hosp., State Univ. of N.Y. at Stony Brook*, 729 F.2d 144, 146 (2d Cir. 1984).

1179. *Id.*

1180. The remainder of this Section will refer to the University Hospital, State of New York as the "Stony Brook Hospital."

1181. 729 F.2d at 146. In the proposed surgical procedures, the doctors first would excise a sac of fluid and nerve endings from the infant's spinal column malformation and close the spinal opening. *Id.* Then the doctors would implant a pump into the infant's head to drain excess fluid from around the brain and to relieve pressure in the cranial cavity. *Id.* These two corrective procedures possibly would have prolonged Baby Jane's life, but would not have eliminated any of her physical disabilities or lessened the extent of her mental retardation. *Id.*

1182. *Id.*

1183. The treatment that the parents chose in this case differed significantly from the complete withdrawal of medical treatment and nutritional sustenance that occurred in the "Baby Doe" controversy. The New York Supreme Court, Appellate Division noted that the parents' choice of medical treatment did not place the infant in imminent danger of death. 95 A.D.2d at 589, 467 N.Y.S.2d at 686. The court recognized that surgical procedures possibly would reduce the risk of infection, but also found advantages in the conservative treatment. Although the mortality rate is higher when doctors use conservative medical treatment, the court noted that in this particular case the surgical procedures also entailed great risk to the infant. *Id.* The surgery could have deprived the infant of the little function remaining in her legs, and would have resulted in recurring urinary tract and kidney infections, skin infections, and edemas of the limbs. *Id.*

1184. See *University Hospital*, 729 F.2d at 146.

1185. See *United States v. University Hosp., State Univ. of N.Y. at Stony Brook*, 575 F. Supp. 607, 614 (E.D.N.Y. 1983).

preme Court of the State of New York, Suffolk County, seeking the appointment of a guardian *ad litem* for Baby Jane. The attorney also sought an order compelling the Stony Brook Hospital to perform the corrective surgical procedures.<sup>1186</sup> The court appointed a guardian *ad litem* for Baby Jane.<sup>1187</sup> On October 19 and 20 the court conducted an evidentiary hearing in which it determined that Baby Jane needed immediate surgical procedures to preserve her life.<sup>1188</sup> The court, therefore, ordered corrective surgery.<sup>1189</sup> On October 21, the New York Supreme Court, Appellate Division, reversed the lower court's ruling and concluded that the parents' choice of conservative treatment, rather than surgery, was well within accepted medical standards. Consequently, the court refused to disturb the parents' decision.<sup>1190</sup> The New York Court of Appeals affirmed the appellate division's holding on a procedural basis. The court of appeals concluded that the trial court had abused its discretion by allowing the case to proceed because the petitioner, having no disclosed relationship to the Does, had filed suit in the court directly, rather than through a state child-protective service agency as required by New York law.<sup>1191</sup> The court of appeals did not dispute the appellate division's finding that the parents had acted reasonably and in the child's best interest.<sup>1192</sup> Instead, the court of appeals indirectly affirmed the appellate division's reasoning by concluding that the circumstances of the case did not justify the court's intervention in the treatment process.<sup>1193</sup>

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1186. *University Hospital*, 729 F.2d at 146. The attorney was not related to Baby Jane Doe. *Id.*

1187. *Id.*

1188. *Id.*

1189. *Id.* at 147.

1190. *See Weber*, 95 A.D.2d at 589, 467 N.Y.S.2d at 686.

1191. *Weber*, 60 N.Y.2d at 211-21, 456 N.E.2d at 1188. New York law requires concerned citizens to contact the State Department of Social Services, which has primary responsibility for initiating child neglect proceedings, rather than petitioning the court system directly. N.Y. FAM. CT. ACT § 1011 (McKinney, 1983).

1192. The court viewed the parents' decision as a choice between reasonable medical alternatives, rather than a conscious decision to withhold treatment. *See Weber*, 95 A.D.2d at 589, 467 N.Y.S.2d at 687.

1193. The court of appeals recognized that occasions might arise when a court appropriately could intervene in the treatment process, but noted that Baby Jane Doe's case did not present circumstances justifying intervention. *Weber*, 60 N.Y.2d at 213, 456 N.E.2d at 1188.

2. *Federal Response to "Baby Jane Doe":*  
 United States v. University Hospital

Before the state courts resolved the battles concerning Baby Jane Doe's medical treatment,<sup>1194</sup> an undisclosed private citizen alerted HHS that the Stony Brook Hospital was withholding life-sustaining treatment from Baby Jane on the basis of her congenital defects.<sup>1195</sup> The Department referred the complaint to the New York State Child Protection Services,<sup>1196</sup> which concluded that Baby Jane's treatment presented no cause for state intervention.<sup>1197</sup> In addition to referring the complaint to the New York state agency, the Department secured copies of Baby Jane Doe's medical records through October 19, which were contained in the records of related state court proceedings.<sup>1198</sup> Department officials examined the records and uncovered no evidence that the hospital was denying Baby Jane medical treatment because of her handicaps.<sup>1199</sup> The Department, however, repeatedly demanded access to Baby Jane Doe's current medical records, which were in the hospital's possession.<sup>1200</sup> Stony Brook Hospital complied with the parents' request and refused to allow Department officials and federal investigators access to the confidential records.<sup>1201</sup>

Following Stony Brook Hospital's refusal to disclose the requested information, HHS commenced legal action to secure the

1194. For a discussion of related cases in New York state courts, see *supra* notes 1174-93 and accompanying text.

1195. *University Hospital*, 729 F.2d at 147.

1196. *Id.*; *University Hospital*, 575 F. Supp. at 611. The New York State Child Protection Service is approved under the Federal Child Abuse Prevention and Treatment Act. The Service is responsible for investigating alleged instances of child abuse, mistreatment, and neglect. *Id.*

1197. *Id.*

1198. *University Hospital*, 729 F.2d at 147. The Surgeon General of the United States reviewed the courts' medical records and concluded that a review of the infant's current medical records was necessary. The Surgeon General noted that:

[a]n appropriate determination concerning whether the current care of Infant Jane Doe is within the bounds of legitimate medical judgment, rather than based solely on a handicapping condition which is not a medical contraindication to surgical treatment, cannot be made without immediate access to, and careful review of, current medical records and other sources of information within the possession and control of the hospital.

*Id.*

1199. See *University Hospital*, 575 F. Supp. at 614.

1200. *University Hospital*, 729 F.2d at 147. For the Department's explanation of why it needed the records, see *supra* note 88.

1201. Stony Brook Hospital also based its refusal to release the records on serious concerns regarding the Department's jurisdiction and the procedures the Department employed in initiating the inquiry. *University Hospital*, 729 F.2d at 148.

remaining records.<sup>1202</sup> The government claimed access to the records under the implementing regulations<sup>1203</sup> of section 504.<sup>1204</sup> In *University Hospital*, the Department claimed a legal right to Baby Jane Doe's records<sup>1205</sup> to determine whether Stony Brook Hospital, as a recipient of federal funds, was discriminating against the infant by withholding treatment on the basis of her handicaps.<sup>1206</sup>

The district court rejected HHS' argument and granted summary judgment for the defendants, Stony Brook Hospital and Baby Jane Doe's parents.<sup>1207</sup> The court concluded that the infant's parents had made a reasonable choice between alternative medical treatments and that the hospital had not discriminated against Baby Jane Doe in violation of section 504.<sup>1208</sup> Thus, HHS had no valid claim to the records.<sup>1209</sup>

The district court's opinion, however, failed to resolve the dispute over whether HHS had exceeded its authority under section

1202. HHS commenced its action through the Department of Justice. Remaining anonymous, the infant's parents intervened as defendants in the suit. See *University Hospital*, 575 F. Supp. at 609.

1203. See 45 C.F.R. § 84.61 (1985).

1204. See *id.* § 80.6(c).

1205. The implementing regulations require each recipient of federal financial assistance to grant a Department official or other designated person access to all books, records, and other relevant information that the Department might find necessary to determine whether a recipient is discriminating against a handicapped individual in violation of § 504. *University Hospital*, 729 F.2d at 147-48.

Generally, an administrative agency is entitled to access to all information that is "not plainly incompetent or irrelevant" to the lawful purpose of the agency in the discharge of its duties. *Endicott Johnson Corp. v. Perkins*, 317 U.S. 501, 509 (1943). The power of an administrative agency, however, to conduct investigations and subpoena records is not unlimited. *University Hospital*, 575 F. Supp. at 614.

1206. *University Hospital*, 729 F.2d at 149.

1207. *University Hospital*, 575 F. Supp. at 616.

1208. The court expressly rejected defendants' claims that (1) the doctrine of laches barred the suit, (2) New York's physician-patient privilege barred access to Baby Jane Doe's records, and (3) medicare and medicaid do not constitute "federal financial assistance" within the meaning of § 504. *Id.* at 611-12, 615; see also Note, *The HHS' Final Rule*, *supra* note 1116, at 272 n.24. The court noted that defendants' physician-patient privilege argument was wholly without merit, and commented that

[i]t would be highly paradoxical if an individual's right to privacy could be asserted by that individual's parent or guardian, purportedly acting in that individual's own best interests, for the purpose of precluding an inquiry into the question of whether the parent or guardian was in fact acting in the individual's best interests.

*University Hospital*, 575 F. Supp. at 615-16.

1209. The court generalized that "if a recipient of federal financial assistance is clearly not violating [§ 504] by discriminating against handicapped persons, the Department of Health and Human Services may not obtain access to the records of such recipient pursuant to 45 C.F.R. §§ 80.6(c) and 84.61." *Id.* at 614.

504 by attempting to regulate treatment of severely defective newborns.<sup>1210</sup> The opinion focused on the particular facts of the Baby Jane Doe controversy and stressed that governmental intervention into Baby Jane's treatment was unwarranted because her parents' decision was reasonable and was based on adequate "consideration of the medical options available and on genuine concern for the best interests of their child."<sup>1211</sup> The opinion left open the possibility that governmental intervention into medical treatment, under the authority of section 504, might be appropriate when parental decisions are unreasonable or contrary to the best interests of the defective newborn.<sup>1212</sup> HHS appealed the district court's decision to the United States Court of Appeals for the Second Circuit.<sup>1213</sup>

### 3. *The Department of Health and Human Services' Final Rules*

On January 21, 1984, after the Second Circuit had heard *University Hospital*,<sup>1214</sup> but before it had issued an opinion, HHS published its "Final Rules"<sup>1215</sup> concerning governmental intervention into treatment decisions affecting severely defective newborns. With the Final Rules, which differ substantially from their predecessors,<sup>1216</sup> the Department hoped to replace the heated controversy surrounding the Proposed Rules and the Interim Final Rule with a "spirit of cooperation" between the federal government, the medical profession, private advocacy groups, and state governments.<sup>1217</sup> The Department promulgated the Final Rules under the authority of section 504.<sup>1218</sup> The Final Rules, like their predecessors, require hospitals to post warning notices that list a toll-free

1210. See *id.* at 616.

1211. *Id.* at 615.

1212. The court noted the possibility that § 504 does authorize challenges by the federal government to *unreasonable* choices of medical treatment for handicapped infants. *Id.* at 616.

1213. See *University Hospital*, 729 F.2d at 149.

1214. See *Id.*

1215. See FINAL RULES *supra* note 1166.

1216. For a discussion of the Interim Final Rule and the Proposed Rules, see *supra* notes 1147-73 and accompanying text.

1217. Compare 49 Fed. Reg. 1,622 (1984) with 48 Fed. Reg. 9,630 and 30,846 (1983). Seeking to promote the "cooperative spirit" of the regulations, HHS adopted a portion of the widely accepted *Principles of Treatment of Disabled Infants* as a general guideline for compliance with the Final Rules. 49 Fed. Reg. 1,652 (*codified* at 45 C.F.R. § 84.55(f)(1)(ii)(B)).

1218. 49 Fed. Reg. 1622 (1983).



hotline for reporting suspected cases of nontreatment based on handicaps.<sup>1219</sup> The Final Rule's notice requirements, however, are less intrusive than the previous regulations' requirements. The notice has a new heading,<sup>1220</sup> a smaller mandatory minimum size,<sup>1221</sup> and modified areas of display.<sup>1222</sup> Like the Proposed Rules, the Fi-

1219. Note, *The HHS' Final Rule, supra* note 1116, at 276-77. Under the Final Rules hospitals can choose to post either Notice A or Notice B, depending on the hospital's policy on nontreatment of severely defective newborns. Notice A, the preferred notice, reads in part:

**PRINCIPLES OF TREATMENT OF DISABLED INFANTS**

It is the policy of this hospital, consistent with Federal law, that, nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments.

This Federal law, section 504 of the Rehabilitation Act of 1973, prohibits discrimination on the basis of handicap in programs or activities receiving Federal financial assistance. For further information or to report suspected noncompliance, call:

[Identify designated hospital contact point and telephone number] or

[Identify appropriate child protective services agency and telephone number] or

U.S. Department of Health and Human Services (HHS): 800-368-1019 (Toll-free; available 24 hours a day; TDD capability).

The identity of callers will be held confidential. Retaliation by this hospital against any person for providing information about possible noncompliance is prohibited by this hospital and by Federal regulations.

49 Fed. Reg. 1,651. A health care provider may post Notice A only if it has a policy consistent with the one stated in the notice; if it has a procedure for reviewing treatment deliberations and decisions to which the notice applies; and if it has a consistent policy regarding the identity of callers. *Id.* Otherwise, the health care provider must display Notice B, which states:

**PRINCIPLES OF TREATMENT OF DISABLED INFANTS**

Federal law prohibits discrimination on the basis of handicap. Under this law, nourishment and medically beneficial treatment (as determined with respect for reasonable medical judgments) should not be withheld from handicapped infants solely on the basis of their present or anticipated mental or physical impairments.

This Federal law, section 504 of the Rehabilitation Act of 1973, applies to programs or activities receiving Federal financial assistance. For further information, or to report suspected noncompliance, call:

[Identify appropriate child protective services agency and telephone] or

U.S. Department of Health and Human Services: 800-368-1019 (Toll-free; available 24 hours a day; TDD capability).

The identity of callers will be held confidential. Federal regulations prohibit retaliation by this hospital against any person who provides information about possible violations.

*Id.*

1220. Note, *the HHS' Final Rule, supra* note 1116, at 278. The new heading, PRINCIPLES OF TREATMENT OF DISABLED INFANTS, replaces the warning, DISCRIMINATORY FAILURE TO FEED AND CARE FOR HANDICAPPED INFANTS IN THIS FACILITY IS PROHIBITED BY FEDERAL LAW. Compare 49 Fed. Reg. 1,651 with 48 Fed. Reg. 30,851.

1221. The required minimum size under the Final Rules is 5" x 7", as opposed to 8½" x 11" in the Proposed Rules and 17" x 14" in the interim Final Rule.

1222. Note, *The HHS' Final Rule, supra* note 1116, at 278. The Final Rules require

nal Rules require state child-protection agencies to establish and maintain written procedures designed to ensure that the agency fully exercises its authority under state law to prevent instances of unlawful medical neglect of handicapped newborns.<sup>1223</sup> The Final Rules, however, differ from their predecessors in a significant way. The Final Rules place the major burden of enforcing the regulations on state governments and hospitals, rather than on HHS and its federal investigators.<sup>1224</sup>

The penalties for violating HHS' Final Rules are relatively lenient. The only possible repercussion from a proven violation is that the state's child-protection agency will be subject to withdrawal of federal financial assistance under the Child Abuse Prevention and Treatment Act.<sup>1225</sup> The Final Rules neither threaten criminal prosecution nor authorize civil actions as penalties for violations of the requirements.<sup>1226</sup> The Final Rules also eliminate the federal investigation teams, nicknamed "Baby Doe Squads," that members of the medical profession violently opposed.<sup>1227</sup> Hospitals need not report suspicions of medical neglect to the designated state child-protection agency until after hospital officials reviewed the case and determined that the parents' treatment decision warrants state agency intervention.<sup>1228</sup> Furthermore, state agencies must report the disposition of cases concerning suspected medical neglect only on a "timely" basis,<sup>1229</sup> rather than "immediately" as the Proposed Rules required.<sup>1230</sup>

The Final Rules encourage, but do not require,<sup>1231</sup> hospitals to

hospitals to post notices in locations where nurses and other medical professionals who provide health care will see them. The hospitals need not place the notices where the parents of infant patients will see them. 46 C.F.R. § 84.55(b)(2).

1223. See 45 C.F.R. § 84.55(c) (1985); see also Note, *The HHS' Final Rule*, *supra* note 1116, at 278.

1224. See Note, *The HHS' Final Rule*, *supra* note 1116, at 278. The Proposed Rules advocated a "vigorous federal role in enforcing the protections of section 504." See Proposed Rules, *supra* note 1161.

1225. Murray, *supra* note 1120, at 6.

1226. *Id.*

1227. See Special Project, *supra* note 1121, at 607, 611, 614; see also Taub, *Withholding Treatment from Defective Newborns*, HASTINGS CENTER REP. 5 (Aug. 1982).

1228. Note, *The HHS' Final Rule*, *supra* note 1116, at 278.

1229. *Id.*

1230. *Id.* The Proposed Rules required that the state agencies maintain procedures for "[i]mmediate notification to the Department of each report of suspected medical neglect of a handicapped infant, the steps taken by the agency to investigate such report, and the agency's final disposition of such report." Proposed Rules, *supra* note 1161, at 30,851.

1231. "While the Department recognizes the value of ICRC's [(Infant Care Review Committees)] in assuring appropriate medical care to infants, such committees are not re-

establish and maintain Infant Care Review Committees (ICRCs).<sup>1232</sup> In the Final Rules, the Department states that the purpose of an ICRC is to assist health care providers in developing standards, policies, and procedures concerning the treatment of handicapped infants in general, and to advise physicians and parents in specific instances when nontreatment is contemplated.<sup>1233</sup> The Final Rules recommend that hospital ICRCs be composed of individuals representing a broad spectrum of perspectives and a wide variety of professions,<sup>1234</sup> but the Final Rules do not prescribe either mandatory membership requirements or functional duties.<sup>1235</sup>

The "Principles of Treatment of Disabled Infants" were announced on November 29, 1983. The Principles were developed through the combined efforts of several prominent medical and disability groups, including the American Academy of Pediatrics, the National Association of Children's Hospitals and Related Institutions, the Association for Retarded Citizens, the Down's Syndrome Congress, and the Spina Bifida Association of America.<sup>1236</sup> The Principles read in part:

It is ethically and legally justified to withhold medical or surgical procedures which are clearly futile and will only prolong the act of dying. However, supportive care should be provided, including sustenance as medically indicated and relief of pain and suffering. In cases where it is uncertain whether medical treatment will be beneficial, a person's disability must not be the basis for a decision to withhold treatment. . . . When doubt exists at any time about whether to treat, a presumption always should be in favor of treatment.<sup>1237</sup>

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quired by this section." 45 C.F.R. § 84.55(a) (1985).

1232. *Id.*

1233. Note, *The HHS' Final Rule*, *supra* note 1116, at 286. The President's Commission for the Study of Medicine and Biomedical and Behavioral Research encourages the use of ICRCs. *Id.* at 279 n.77. The commission noted that a review committee can serve a wide variety of functions including the following:

First, it can verify that the best information available is being used. Second, it can confirm the propriety of a decision that providers and parents have reached or confirm that the range of discretion accorded to the parents is appropriate. Third, it can resolve disputes among those involved in a decision, if necessary, by siding with one party or another in a dispute. Finally it can refer cases to public agencies (child protection services, probate courts, or prosecuting attorneys) when appropriate.

49 Fed. Reg. 1,622, 1,623 (1984) (quoting PRESIDENT'S COMMISSION, *supra* note 1111, at 227).

1234. 45 C.F.R. § 84.55(a) (1985). The rules suggest that an ICRC's membership should include a physician, a nurse, an advocate or handicapped persons' rights, a hospital administrator, and an attorney. *Id.* § 84.55(f)(2).

1235. The Department noted that the Federal government should not mandate ICRCs because these review boards, being "largely untried," are not demonstrably effective enough to justify making them mandatory for 7000 hospitals nationwide. 49 Fed. Reg. at 1,624.

1236. *Id.* at 1,622.

1237. *Id.*

The Principles also state that the actual or anticipated quality of an individual's life should not determine decisions concerning medical care.<sup>1238</sup>

On February 23, 1984, only ten days after the Department's Final Rules became effective, the Second Circuit issued its opinion in *United States v. University Hospital*.<sup>1239</sup> The Second Circuit upheld the district court's grant of summary judgment in favor of Baby Jane Doe's parents and Stony Brook Hospital.<sup>1240</sup> Unlike the lower court, the Second Circuit conducted an extensive examination of the legislative history of the Rehabilitation Act of 1973 and HHS' regulations under the Act.<sup>1241</sup> In particular, the Second Circuit sought to determine whether Congress intended section 504 to authorize HHS to conduct investigations into treatment decisions concerning severely defective newborns.<sup>1242</sup> The court focused on the legislative history of the Act<sup>1243</sup> and concluded that "Congress never contemplated that section 504 of the Rehabilitation Act would apply to treatment decisions involving defective newborn infants" when Congress enacted the statute in 1973, amended it in 1974, or at any subsequent time.<sup>1244</sup> The court based its decision on the absence of a "clear congressional directive"<sup>1245</sup> and supported the District of Columbia district court's conclusion in *American Academy of Pediatrics v. Heckler*<sup>1246</sup> that any intervention of a federal agency into medical treatment decisions should reflect cau-

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1238. *Id.*

1239. 729 F.2d 144 (2d Cir. 1984).

1240. *Id.* at 146.

1241. In analyzing the case, the Second Circuit assumed that the hospital was a recipient of federal financial assistance within the meaning of § 504 and that the "program or activity" to which the state applies, if at all, is the entire hospital. The Second Circuit then noted that the predecessor to HHS—the Department of Health, Education and Welfare (HEW)—had solicited comments on specific issues before issuing a new set of regulations under § 504. One of these specific issues was whether the regulations should contain provisions regulating institutionalized patients' rights to receive or refuse treatment. After evaluating comments, HEW determined that § 504 did not give the Department authority to regulate medical treatment. *Id.* at 152.

1242. *Id.* at 150.

1243. *Id.* at 157-61. The court concluded that the application of § 504 to medical treatment of handicapped infants was dramatically different in kind, as well as degree, from the applications of § 504 that Congress discussed in the legislative history. *Id.* at 161. For a recent commentary criticizing the court's examination of § 504's legislative history see Gerry, *The Civil Rights of Handicapped Infants: An Oklahoma "Experiment"*, 1 ISSUES L. & MED. 15. 47-55 (1985).

1244. 729 F.2d at 161.

1245. *Id.*

1246. 561 F. Supp. 395 (D.D.C. 1983).

tion and sensitivity.<sup>1247</sup> The Second Circuit thus noted that until Congress has clarified the Department's authority under section 504, a court would be unwarranted in exercising its judicial power to approve the Department's intervention into decisions affecting the medical treatment of severely defective newborns.<sup>1248</sup>

In *American Hospital Association v. Heckler*<sup>1249</sup> a federal district court invalidated the HHS Final Rules under section 504 of the Rehabilitation Act of 1973.<sup>1250</sup> In an unreported opinion, the Second Circuit subsequently affirmed the district court's decision.<sup>1251</sup> Both courts regarded the Second Circuit's decision in *United States v. University Hospital*<sup>1252</sup> as controlling. The district court noted that "in light of *University Hospital*," the regulations are "invalid, unlawful and must be set aside pursuant to the Administrative Procedures Act, 5 U.S.C. §706(2)(c), because promulgated without statutory authority."<sup>1253</sup> In June, 1985, the United States Supreme Court granted HHS' petition for writ of certiorari to review the case.<sup>1254</sup> On January 15, 1986, the Supreme Court heard oral arguments in the case<sup>1255</sup> but has not yet issued a decision.

#### 4. Congressional Response to University Hospital

In *University Hospital* the Second Circuit expressed the need for a congressional statement to clarify whether HHS exceeded its authority under section 504 by attempting to investigate and regulate the medical treatment of severely defective newborns.<sup>1256</sup> Although Congress maintained a "neutral position"<sup>1257</sup> in the controversy surrounding section 504, Congress indirectly responded to the Second Circuit's plea by passing the Child Abuse Amendments

1247. 729 F.2d at 161 (citing *Heckler*, 561 F. Supp. at 403). The Second Circuit concluded that under these circumstances Congress, rather than an executive agency, should first weigh the competing interests at stake. Until Congress has spoken, approval of this type of agency investigation would be an unwarranted exercise of judicial power. *Id.*

1248. *Id.*

1249. 585 F. Supp. 541 (S.D.N.Y. 1984).

1250. *Id.* at 542.

1251. *American Hosp. Assoc. v. Heckler*, No. 84-6211 (2d Cir. 1984).

1252. 729 F.2d 144 (2d Cir. 1984).

1253. 585 F. Supp. at 542.

1254. *Heckler v. American Hosp. Assoc.*, No. 84-1529, *cert. granted sub nom. Bowen v. American Hosp. Assoc.*, 105 S. Ct. 3475 (1985).

1255. *N.Y. Times*, Jan. 16, 1986, at B7, col. 2.

1256. 729 F.2d at 161.

1257. See *infra* notes 1272-74 and accompanying text.

of 1984.<sup>1258</sup> The Amendments retained HHS' previously granted authority to regulate the withdrawal of "medically indicated treatment"<sup>1259</sup> from handicapped newborns<sup>1260</sup> and, therefore, eliminated much of the controversy surrounding the Department's regulation under section 504.<sup>1261</sup>

Enacted in September of 1984, the Amendments expanded the definition of child abuse under the Child Abuse Prevention and Treatment Act of 1974<sup>1262</sup> to include the withholding of medically indicated treatment from defective newborns.<sup>1263</sup> The Amendments defined "withholding medically indicated treatment" as "the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgments will be most likely to be effective in ameliorating or correcting all such conditions . . ."<sup>1264</sup> Recognizing that in certain circumstances life-sustaining efforts will be futile, the Amendments specifically exempted nontreatment in three categories of cases from the definition of child abuse.<sup>1265</sup>

The Child Abuse Prevention and Treatment Act authorizes grants to qualifying states to aid in implementing state programs to prevent and treat child abuse and neglect.<sup>1266</sup> The Amendments

1258. Child Abuse Amendments of 1984, 42 U.S.C.A. § 5101-5106, 5116-5116g (West Supp. 1985).

1259. See *infra* notes 1263-65 and accompanying text.

1260. 42 U.S.C. § 5103(a)(1) (1982).

1261. HHS continued its efforts to establish the validity of the Final Rules promulgated under the Rehabilitation Act. See *infra* notes 1333-36 and accompanying text.

1262. Child Abuse Prevention and Treatment and Adoption Reform Act, 42 U.S.C.A. §§ 5101-5116 (West Supp. 1985). President signed the Act into law in 1974. Under the Act, the National Center on Child Abuse and Neglect makes grants to states for use in implementing child abuse and neglect prevention and treatment programs; funds the activities of nonprofit organizations relating to the prevention, identification, and treatment of child abuse and neglect; and assists states and communities in implementing child abuse and neglect programs.

1263. 42 U.S.C.A. § 5103(b)(2)(k)(3).

1264. *Id.*

1265. *Id.* The term "withholding of medically indicated treatment" does not include: the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's or physicians' reasonable medical judgment, (A) the infant is chronically and irreversibly comatose; (B) the provision of such treatment would (i) merely prolong dying, (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or (iii) otherwise be futile in terms of the survival of the infant; or (C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

*Id.*

1266. The fifty states, the District of Columbia, Puerto Rico, the Virgin Islands, the

require states, as a condition for participating in the state grant program,<sup>1267</sup> to implement programs or procedures designed to prevent instances of medical neglect, including the withholding of medically indicated treatment from severely defective newborns with life-threatening conditions.<sup>1268</sup> To implement the legislation's

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Commonwealth of the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands are eligible to apply for state grants. Fifty-one of the fifty-seven eligible jurisdictions meet the requirements of the Act and the regulations. These jurisdictions currently receive state funds. See Final rules, 50 Fed. Reg. at 14,878.

Each state currently has a statute that includes the failure to provide needed medical attention within the state's definition of neglect for the purposes of the state's child abuse statute. See ALA. CODE § 24-16-1(2) (Supp. 1985); ALASKA STAT. § 47.17.070(5) (1985); ARIZ. REV. STAT. ANN. § 36-2281 (Supp. 1984); ARK. STAT. ANN. § 42-807(c) (Supp. 1983); CAL. PENAL CODE § 11165(c) (West Supp. 1986); COLO. REV. STAT. § 19-1-103(20) (d) (1978); CONN. GEN. STAT. ANN. § 46b-120(b) (West Supp. 1984); DEL. CODE ANN. tit. 31, § 301(3) (1985); D.C. CODE ANN. § 16-2301(9)(B) (1981); FLA. STAT. ANN. § 39.01(27) (West Supp. 1985); GA. CODE ANN. § 15.11-2(8)(A) (Supp. 1982); HAWAII REV. STAT. § 350-1(1) (Supp. 1984); IDAHO CODE § 16-1602(n)(1) (1979 & Supp. 1985); ILL. REV. STAT. ch. 37, § 702-4(1) (Smith-Hurd Supp. 1985); IND. CODE ANN. § 31-6-4-3(a)(1) & (f) (Burns Supp. 1985); IOWA CODE ANN. § 232.2(6)(e) (West 1985); KAN. STAT. ANN. § 38-802(g)(1) (1981); KY. STAT. ANN. § 208.020(1)(d) (1982 & Supp. 1984); LA. STAT. REV. ANN. § 40.1299.36.1 (West Supp. 1986); ME. REV. STAT. ANN. tit. 22, § 4002(6)(B) (Supp. 1986); MD. FAM. LAW CODE. § 5-701(g)(2) (1984); MASS. GEN. LAWS ANN. ch. 119, § 51A (West Supp. 1985); MICH. COMP. LAWS ANN. § 722.622(d) (West Supp. 1985); MINN. STAT. ANN. § 626.556(2)(c) (West Supp. 1986); MISS. CODE ANN. § 43-21-105(l)(i) (1985); MO. ANN. STAT. § 210.110(5) (Vernon 1983 & Supp. 1986); MONT. CODE ANN. § 41-3-102(3)(c) (1985); NEB. REV. STAT. § 28-710-(3)(a) (1977); NEV. REV. STAT. § 200.5011(3) (1983); N.H. REV. STAT. ANN. § 169-C:3 XIX(b) (Supp. 1985); N.J. STAT. ANN. § 9:6-8.21(c)(4)(a) (West 1976 & Supp. 1985); N.M. STAT. ANN. § 30-6-1(A)(2) (1984); N.Y. SOC. SERV. LAW § 371.4-a(i)(A) (McKinney 1983); N.C. GEN. STAT. § 7A-517(21) (1981 & Supp. 1985); N.D. CENT. CODE § 27-20-02-5(a) (1974 & Supp. 1985); OHIO REV. CODE ANN. § 2151.03(C) (Page 1976); OKLA. STAT. ANN. tit. 21, § 845(B)(1) (West Supp. 1985); OR. REV. STAT. § 418.740(1)(e) (1986); PA. STAT. ANN. tit. 11, § 2203 (Purdon Supp. 1985); R.I. GEN. LAWS § 40-11-2d (1984 & Supp. 1985); S.C. CODE ANN. § 20-7-490(C)(3) (Law. Co-op. 1985); S.D. COMP. LAWS ANN. § 26-8-6(4) (1984); TENN. CODE ANN. § 37-1-102(10)(D) (Supp. 1985); TEX. FAM. CODE ANN. § 12.04(3) (Vernon 1975); UTAH CODE ANN. § 78-3a-2(17)(c) (Supp. 1985); VT. SUPP. ANN. tit. 33, § 682(3)(c) (Supp. 1985); VA. CODE § 16.1-228(A)(1) (1984 & Supp. 1985); WASH. REV. CODE ANN. § 26.44.020(12) (Supp. 1985); W. VA. CODE ANN. § 49-1-3(g)(1)(A) (Supp. 1985); WIS. STAT. ANN. § 48.981(1)(d) (West Supp. 1985); WYO. STAT. § 14-6-201(a)(xvi)(C) (1985); cited in Bopp & Balch, *The Child Abuse Amendments of 1984 and their Implementing Regulations: A Summary*, 1 ISSUES L. & MED. 92, 102 n.57 (1985).

1267. 42 U.S.C. § 5103(b)(2)(k); Bopp & Balch, *supra* note 1266, at 101.

1268. The Amendments require that these programs or procedures provide for:

(i) coordination and consultation with individuals designated by and within appropriate health-care facilities, (ii) prompt notification by individuals designated by and within appropriate health care facilities of cases of suspected medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), and (iii) authority, under State law, for the State child protective service system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, as may be necessary to prevent the withholding of medically indicated treatment from disabled infants with

requirements, Congress instructed HHS to develop and publish proposed regulations within 90 days<sup>1269</sup> and, after evaluating public comments, to publish final rules within 180 days of the Amendment's effective date.<sup>1270</sup> The Amendments also directed the Department to follow a similar procedure in issuing model guidelines designed to encourage hospitals to establish Infant Care Review Committees.<sup>1271</sup>

The authority Congress granted HHS under the Child Abuse Amendments of 1984 closely resembles the authority that the Department claimed, and the Second Circuit rejected, under the Rehabilitation Act of 1973. Although aware of the controversy surrounding the Department's prior intervention into medical treatment decisions, Congress took a neutral position and refused to clarify the scope of the Department's authority under section 504.<sup>1272</sup> The only reference Congress made to the Department's previous regulations was in a rule of statutory construction, which stated that "[n]o provision of the Act or any amendment made by this Act is intended to affect any right or protection under section 504 of the Rehabilitation Act of 1973."<sup>1273</sup> The ultimate determina-

life-threatening conditions.

42 U.S.C. § 5103(b)(2)(k). To aid qualifying states in establishing and maintaining the required programs, the Amendments authorize the Secretary of HHS to make additional grants to state agencies. See 49 Fed. Reg. 48,160 (1984) (to be codified at 45 C.F.R. § 1340.15) (proposed Dec. 10, 1981), 42 U.S.C. § 5103(c)(A).

1269. 42 U.S.C. § 5103 note.

1270. *Id.*

1271. *Id.* The Amendments require the Secretary of HHS to publish interim model guidelines

to encourage the establishment within health-care facilities of committees which would serve the purposes of educating hospital personnel and families of disabled infants with life-threatening conditions, recommending institutional policies and guidelines concerning the withholding of medically indicated treatment . . . from such infants, and offering counsel and review in cases involving disabled infants with life-threatening conditions.

*Id.* The Amendments also require the Secretary to solicit and evaluate public comments and issue model guidelines within 180 days of the enactment of the amendments (Oct. 9, 1984). *Id.*

Complying with the required procedures, the Department issued *Services and Treatment for Disabled Infants; Model Guidelines for Health Care Providers To Establish Infant Care Review Committees*, 50 Fed. Reg. 14,893 (1985). The model guidelines encourage the establishment of infant care review committees within hospitals that provide health care to infants. The guidelines are purely advisory and are consistent with the Department's rulemaking authority granted by the Child Abuse Amendments. *Id.*

1272. The legislative history of the Child Abuse Amendments reflects a deliberate attempt by Congress to maintain a policy of neutrality regarding the Department's authority under section 504. See Final Rules, *supra* note 1266, at 14,885.

1273. 42 U.S.C.A. § 5101 note (1984) (codified as a note to 42 U.S.C. § 5101).



tion of the scope of the Department's authority under section 504, therefore, depends on the Supreme Court's resolution of *Bowen v. American Hospital Association*.<sup>1274</sup>

5. *Department's Proposed Rules Issues under the Child Abuse Amendments of 1984*

On December 10, 1984, HHS issued the "Notice of Proposed Rulemaking" required by the Child Abuse Amendments of 1984.<sup>1275</sup> The Notice solicited public comments to the proposed regulations that the Department designed to enforce the newly enacted section 4(b)(2)(k) of the Child Abuse Prevention and Treatment Act.<sup>1276</sup> The Proposed Rules defined "medical neglect" to include the "withholding of medically indicated treatment from a disabled infant with a life-threatening condition."<sup>1277</sup> The rules also attempt to regulate the withdrawal of treatment from severely defective newborns.<sup>1278</sup> After soliciting and evaluating public comments on the Proposed Rules, the Department issued its most recent regulations under the authority of the Child Abuse Amendments of 1984.<sup>1279</sup> The final rules do not differ radically from the Proposed Rules. The final rules, however, do recognize and place greater emphasis on the delicate balance between the need to effectively protect the rights of disabled infants and the need to avoid unreasonable governmental intervention into treatment decisions.<sup>1280</sup>

Although an "overwhelming majority"<sup>1281</sup> of the more than 16,000 comments to the Proposed Rules indicated support, the Department revised the rules because of criticisms from individuals involved in the political compromise that resulted in the 1984 Amendments.<sup>1282</sup> On the one hand, critics of the Proposed Rules,

1274. See *supra* notes 1249-55 and accompanying text.

1275. 49 Fed. Reg. 48,160 (1984) (to be codified at 45 C.F.R. § 1340.15) (proposed Dec. 10, 1984).

1276. *Id.*

1277. *Id.* at 48,166.

1278. *Id.* at 48,166-67.

1279. Final Rules, *supra* note 1266, at 14,878. The Department's ultimate regulation under the Child Abuse Amendment is entitled the Final Rule. To avoid confusion between this final rule and the Final Rules that the Department promulgated under § 504, all references to the "final rules" in this section will refer to those published pursuant to the Child Abuse Amendments unless otherwise indicated.

1280. *Id.* at 14,879. The Department noted that its principal objective was to achieve the desired balance. *Id.*

1281. *Id.*; see *supra* note 1166.

1282. 49 Fed. Reg. 14,879.

including medical associations whose support was essential to the legislative compromise, argued that the careful balance achieved in the statute was distorted by the inclusion of an inflexible list of binding definitions that counterproductively constrained the exercise of reasonable medical judgment in response to the innumerable problems in intensive care nurseries.<sup>1283</sup> These associations threatened to withdraw their support for the legislation unless the final rules sufficiently reflected the deference to medical judgment that the compromise included.<sup>1284</sup>

On the other hand, over 115,000 individuals sent letters in support of assuring medically indicated treatment to disabled infants with life-threatening conditions.<sup>1285</sup> Many of these individuals urged continued emphasis on the final rules' requirement that medical treatment decisions not be based on subjective opinions about the potential quality of a defective infant's life.<sup>1286</sup> The Department gave particular consideration to a letter from the six principal sponsors<sup>1287</sup> of the "compromise amendment," which later became the pertinent provisions of the Child Abuse Amendments of 1984.<sup>1288</sup> The letter urged the Department to consider carefully the numerous requests that it delete the clarifying definitions and also urged the Department to avoid using the word "imminent" in describing the anticipated time of death.<sup>1289</sup> The principal sponsors also encouraged the Department to emphasize more clearly that the use of infant care review committees is not mandatory<sup>1290</sup> and to avoid using examples of specific medical diagnoses that readers might interpret as prescribing federally estab-

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1283. *Id.*

1284. *Id.*

1285. *Id.*

1286. *Id.*; see *infra* note 1328 for a discussion of the quality-of-life-approach to medical decisionmaking. A number of the commentators also endorsed the "clarifying definitions" included in the proposed rule, arguing that the interpretations were a proper supplement to the statutory definition. Final Rules, *supra* note 1266, at 14,879.

1287. Senators Hatch, Denton, Cranston, Nickles, Dodd, and Kassenbaum sponsored the amendment. *Id.*

1288. *Id.*

1289. The principal sponsors noted that:

In the negotiations leading to the final language, there was much discussion about whether or not to include the word "imminent" in the statutory definition. It became apparent that "imminent" would create undue confusion both because it was ambiguous and because the expected time of death cannot be predicted with precision. A decision was made, therefore, not to include "imminent," and we urge that it be dropped from the regulations as well.

*Id.*

1290. *Id.*

lished medical standards for treating specific cases.<sup>1291</sup>

After considering the public comments, the Department issued a final rule designed to reaffirm the Department's objective of preserving the careful balance accomplished in the 1984 Amendments "between the need for an effective program and the need to prevent unreasonable governmental intervention."<sup>1292</sup> The final rules adopted the definitions of "medical neglect"<sup>1293</sup> and "withholding of medically indicated treatment"<sup>1294</sup> without change from the Proposed Rules. The rules also define "infant"<sup>1295</sup> and "reasonable medical judgment"<sup>1296</sup> as the terms apply to the definition of withholding medically indicated treatment. The remaining sections of the rule establish minimum requirements that state child-protection programs must meet to qualify for participation in the state grant program under the Child Abuse Prevention and Treatment Act.<sup>1297</sup> The Department relocated the clarifying definitions that the medical profession strongly opposed to an appendix of the final rules and reclassified the definitions as interpretive guidelines.<sup>1298</sup> The rules also emphasize the importance of the treating physician's or physicians' reasonable medical judgment to treatment de-

1291. *Id.*

1292. *Id.*

1293. The final rules state that the term "'medical neglect' includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition." 45 C.F.R. § 1340.15 (1985).

1294. See *supra* note 1265 and accompanying text for the complete definition of "withholding of medically indicated treatment."

1295. The rules adopt the definition of "infant" from the Joint Explanatory Statement of the Principal Sponsors of the Amendments.

The term "infant" is defined as:

an infant less than one year of age. The reference to less than one year of age shall not be construed to imply that treatment should be changed or discontinued when an infant reaches one year of age, or to affect or limit any existing protections available under State laws regarding medical neglect of children over one year of age. In addition to their applicability to infants less than one year of age, the standards set forth in paragraph (b)(2) of this section should be consulted thoroughly in the evaluation of any issue of medical neglect involving an infant older than one year of age who has been continuously hospitalized since birth, who was born extremely prematurely, or who has a long-term disability.

45 C.F.R. § 1340.15(b)(3)(i) (1985); see also H. Conf. Rep. No. 1038, 98th Cong., 2d Sess. 41, reprinted in 1984 U.S. CODE CONG. & AD. NEWS 2947, 2970.

1296. The term "reasonable medical judgment" is defined as a "medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." 45 C.F.R. § 1340.15(b)(3)(ii) (1985).

1297. *Id.* § 1340.15(c)-(d).

1298. *Id.* § 1340.15 app.

cisions.<sup>1299</sup> The final rules reflect the suggestions of the principal sponsors by eliminating the use of specific examples of medical treatment and the word "imminent" and by stressing that infant care review committees are not mandatory.<sup>1300</sup> Finally, the rules satisfy the concerns of right-to-life organizations by stating that quality-of-life considerations may not be employed in the decision-making process.<sup>1301</sup> Accordingly, the latest Baby Doe regulations satisfy organizations representing a wide variety of perspectives.<sup>1302</sup>

The final rules represent a successful political compromise, which commentators and the Department of HHS agree will have a minimal effect on actual treatment decisions.<sup>1303</sup> Both right-to-life organizations supporting federal intervention into treatment decisions and medical associations that disapprove of any federal involvement claimed victory with respect to the final rules;<sup>1304</sup> each side of the controversy received a portion of what it wanted without making any major concessions.<sup>1305</sup>

#### 6. *Analysis of the Impact of the Final Rules on Actual Practice*

Although the final rules have eliminated much of the controversy surrounding federal intervention into the treatment of severely defective newborns, many argue that the rules will have little or no effect on current medical practices.<sup>1306</sup> One factor that contributes to the minimal impact of the rules is the penalty prescribed for violations.<sup>1307</sup> The final rules authorize no civil actions and threaten no criminal violations;<sup>1308</sup> hospitals, doctors, and parents face no liability under the rules even for the most blatant violation. The maximum penalty that the rules prescribe is the with-

1299. See Murray, *supra* note 1120, at 9.

1300. Final rules, *supra* note 1266, at 14,880.

1301. 45 C.F.R. § 1340 app. (1985). The regulations do not allow decisions based on opinions about the future "quality-of-life" of a retarded or disabled person. *Id.*

1302. See Murray, *supra* note 1120, at 6. The Department stressed that it did not intend the guidelines either to be binding rules of law or to prejudice the exercise of reasonable medical judgment. Final rules, *supra* note 1266, at 14,880.

1303. Murray, *supra* note 1120, at 8-9. The Department admitted that these rules will play only a minor role in the larger context of medical care for infants. Final rules, *supra* note 1266, at 14,886.

1304. For specific examples of both a medical association's and a right-to-life group's claim to victory, see Murray, *supra* note 1120, at 6-7.

1305. *Id.* at 9.

1306. See *id.*; see also Bopp & Balch, *supra* note 1266, at 119.

1307. Murray, *supra* note 1120, at 8.

1308. *Id.*; see Final rules, *supra* note 1266, at 14,887.

drawal of federal financial assistance to state child-protection agencies under the state grant program of the Child Abuse Prevention and Treatment Act.<sup>1309</sup> The requirements of the rules, like the maximum penalty, directly affect only state child protection services.<sup>1310</sup> The regulations' indirect effect on hospitals, physicians, and parents is wholly dependent on any additional requirements a state agency may choose to enact.<sup>1311</sup>

Although the final rules will not affect directly persons making treatment decisions, the regulations may help answer several widely debated questions. Three major questions remain in the Baby Doe controversy: (1) When, if ever, should life-sustaining treatment be withheld from a defective newborn?; (2) Who should decide whether life-sustaining treatment should be withheld in a particular case?; and (3) What criteria should the decisionmaker use in determining whether life-sustaining treatment should be withheld under specific circumstances?

The final rules address the question of when, if ever, medical treatment may be withheld from a defective newborn.<sup>1312</sup> The final rules offer three overlapping categories of cases in which extraordinary life-sustaining treatment procedures may be withheld.<sup>1313</sup> The regulations, however, unequivocally require that certain ordinary treatment procedures—including appropriate nutrition, hydration and medication—be given to all infants regardless of their condition or prognosis.<sup>1314</sup> One case in which life-sustaining treatment, other than appropriate nutrition, hydration and medication, may be withheld is when a physician, using reasonable medical judgment, determines that the treatment would be virtually futile.<sup>1315</sup>

1309. Final Rules, *supra* note 1266, at 14,887. One commentator remarked on the relatively mild penalties that the Final Rules impose:

Given the enormous fuss, one might imagine that physicians and hospital administrators would be summarily executed if they violated the rule. Hardly. The only direct consequence of a proven violation of the new regulation would be that the State's [child protection service] could be ruled ineligible for the relatively few federal dollars available under the Child Abuse Prevention and Treatment Act.

Murray, *supra* note 10, at 9.

1310. See Murray, *supra* note 1120, at 9.

1311. *Id.* Although the rule requires state child-protection services to establish certain procedures and programs, the effectiveness of such state regulations will vary greatly. Potentially, the legislation will not affect hospitals in the six jurisdictions that do not qualify for the federal state grant program under the Child Abuse Act at all.

1312. Final Rules, *supra* note 1266, at 14, 887-91.

1313. See *supra* notes 1264-65 and accompanying text.

1314. 45 C.F.R. § 1340.15(b)(2); see also Bopp & Balch, *supra* note 1266, at 108.

1315. 45 C.F.R. § 1340.15(b)(2)(iii).

The latest regulations define "virtually futile"<sup>1316</sup> as highly unlikely to prevent "death in the near future"<sup>1317</sup> as opposed to "imminent death."<sup>1318</sup> Physicians apparently have the option of withholding treatment when an infant might live for weeks or months with no prospect of relief or survival.<sup>1319</sup>

The final rules also address the question of who decides whether treatment should be withheld.<sup>1320</sup> Recognizing the constitutionally protected right of parents to control their children's upbringing,<sup>1321</sup> the final rules provide that, except in highly unusual circumstances, the infant's parents or guardians should decide whether to provide or to withhold medically indicated treatment.<sup>1322</sup> The rules also provide that the parents' decision must be followed unless inconsistent with the guidelines currently set out in the final rules.<sup>1323</sup> The rules provide that parents should base their decision on the advice, recommendations, and reasonable medical judgment of their physician.<sup>1324</sup>

The final rules also address which criteria the parents should use in making a treatment decision.<sup>1325</sup> Commentators have proposed a number of different criteria for treatment decisions, in-

1316. The definition of "virtually futile" in the final rules is contained in the appendix under the interpretative guidelines. 45 C.F.R. § 1340 app.

1317. Because of strong opposition from the six principal sponsors, the final rules define "virtually futile" as treatment "highly unlikely to prevent death in *the near future*." *Id.* (emphasis added). The rules explain the decision to adopt "in the near future" rather than "imminent" for purposes of the interpretative guidelines.

1318. "Imminent" was not adopted in the interpretative guidelines to the final rules to "assure no deviation from" the legislature's resolution "that 'imminent' would create undue confusion both because it was ambiguous and because the expected time of death cannot be predicted with precision." Final Rules, *supra* note 1266, at 14,880.

1319. Murray, *supra* note 1120, at 8.

1320. Final Rules, *supra* note 1266, at 14,880.

1321. The following cases have upheld as constitutional the rights of parents to make certain decisions for their children. Wisconsin v. Yoder, 406 U.S. 205 (1972) (right to determine children's upbringing); Prince v. Massachusetts, 321 U.S. 158 (1944) (right to circumscribe child's religious literature, but no right to expose community or child to communicable disease, ill health, or death); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (right to direct children's education); Meyer v. Nebraska, 262 U.S. 390 (1923) (right to raise child); *In re Green* (Child Div. Milwaukee County Ct., Wis. 1966) (right to choose to withhold novel or especially risky treatment for child), *reprinted in CRIME AND DELINQUENCY* 377 (1966). *Contra Custody of a Minor*, 393 N.E.2d 836 (1979) (child given "customary" treatment for leukemia over the objections of the parents); *In re Pogue*, No. M-18-74 (Super. Ct. D.C. Nov. 1, 1974) (blood transfusion ordered for child over religious objections of parents), *cited in Special Project*, *supra* note 1121, at 608 n.10.

1322. Final Rules, *supra* note 1266, at 14,880.

1323. *Id.*

1324. *Id.*

1325. See Murray, *supra* note 1120, at 7.

cluding the ordinary/extraordinary approach,<sup>1326</sup> the medical feasibility approach,<sup>1327</sup> the quality-of-life approach,<sup>1328</sup> and the jurisdictional approach.<sup>1329</sup> The final rules adopt an approach that narrows the discretion of parents and physicians to deny treatment.<sup>1330</sup> The final rules' "best interests of the infant" approach<sup>1331</sup> forbids parents from basing their decision on subjective predictions of the future "quality-of-life" of a retarded or disabled infant.<sup>1332</sup>

#### D. CONCLUSION

HHS continues litigation to establish its authority to regulate the treatment of defective newborns under section 504 of the Rehabilitation Act of 1973.<sup>1333</sup> The Department may be continuing litigation as a matter of principle, although the Department easily could have abandoned its attempts to regulate under section 504 and promulgated all regulations under the Child Abuse Amendments.<sup>1334</sup> Department officials, however, chose to continue pursuit of a dual regulatory system and await final determination of the

1326. For a discussion of the "ordinary v. extraordinary means" approach to infant care, see Robertson, *supra* note 1114, at 235-37. See also Longino, *supra* note 1121, at 397 ("This approach is founded upon the notion that heroic treatment measures should not have to be employed to preserve the life of a defective newborn.")

1327. For discussion of the medical feasibility approach, see Longino, *supra* note 1121, at 398-99; Shaw, *Dilemmas of "Informed Consent" in Children*, 289 NEW ENG. J. MED. 885, 889 (1973) (The medical feasibility standard focuses on the current medical condition of the infant and the feasibility of the treatment); Comment, *Withholding Treatment from Defective Newborns: Substituted Judgment, Informed Consent, and the Quinlan Decision*, 13 GONZ. L. REV. 781 (1978).

1328. The quality-of-life approach often is proposed to justify termination of a defective newborn's treatment. This standard is based on predictions of the infant's future potential if treated. Longino, *supra* note 1121, at 395-97; Robertson, *supra* note 1114, at 252. The final rules expressly reject the quality of life approach. 45 C.F.R. § 1340 app. (1985).

1329. The jurisdictional approach prefers the private choice by parents and physicians as opposed to judgments by courts or legislatures. Public intervention should displace parents' decisionmaking autonomy only if the parents cannot decide or if their decision does not reflect a legitimate choice among alternatives. See Blumstein & Smith, *supra* note 1121, at 19.

1330. Murray, *supra* note 1120, at 7.

1331. The "best interests of the child" approach is consistent with the standard applied in child custody and neglect cases. The approach simply requires "that the child's welfare is given priority over every other interest involved." Comment, *Baby Doe Decisions*, *supra* note 1115, at 924.

1332. 45 C.F.R. § 1340 app. (1985).

1333. "The Department's goal in pursuing, through litigation, reinstatement of the section 504-based authority, is to clear the way for action to forge" an effective interrelationship between the Child Abuse Amendments of 1984 and the section 504-based rule. Final rules, *supra* note 156, at 14,885, (comparing the two regulatory frameworks).

1334. *Id.*

scope of section 504 by the Supreme Court.<sup>1335</sup> The Supreme Court should uphold HHS' authority to regulate under section 504 in order to fill current gaps in the Department's authority under the Child Abuse Amendments of 1984.<sup>1336</sup> Commentators have elaborated on several gaps in the regulatory framework of the Child Abuse Amendments.<sup>1337</sup> First, states that choose not to participate in the federal grant program are not bound by the regulations.<sup>1338</sup> Consequently, compliance with the amendments is an option for states, rather than a requirement. Second, the Child Abuse Amendments give state protection agencies the *exclusive* right to file suit on behalf of a disabled infant.<sup>1339</sup> Neither parents, physicians, nor governmental officials are authorized to file such an action.<sup>1340</sup> Third, the amendments provide no remedy to an infant who is killed or debilitated as the result of medical neglect.<sup>1341</sup> The sole remedy under the Child Abuse Amendments is the withdrawal of grants to state agencies.<sup>1342</sup> Finally, the Amendments exclusively address medical neglect on a case-by-case basis and are ineffective against institutionally adopted policies that discriminate against defective newborns.<sup>1343</sup>

The dual system of regulation under both section 504 and the Child Abuse Amendments contemplated by HHS effectively would fill these gaps and eliminate the deficiencies of regulating solely under the Child Abuse Amendments.<sup>1344</sup> The Supreme Court should, therefore, uphold the Department's authority to regulate under section 504 in order to adequately protect disabled infants in need of medical treatment. HHS' final regulations under section 504<sup>1345</sup> and under the Child Abuse Amendments<sup>1346</sup> could work together to "substantially enhance the protection afforded disabled

1335. See *supra* notes 1239-55 and accompanying text.

1336. See Bopp & Balch, *supra* note 1266, at 130.

1337. See *id.* The commentators also list several accomplishments of the regulations. First, the commentators note that food and water must always be provided. Second, "quality of life" considerations may not be used in medical treatment decisions. Third, child protective services are now *required* to investigate cases of suspected medical neglect. *Id.* at 129.

1338. *Id.* at 130.

1339. *Id.*

1340. *Id.*

1341. *Id.*

1342. See *supra* notes 1306-10 and accompanying text.

1343. See Bopp & Balch, *supra* note 1266, at 130.

1344. *Id.*

1345. See *supra* notes 1214-35 and accompanying text.

1346. See *supra* notes 1292-1332 and accompanying text.



infants . . . .”<sup>1347</sup>

## XI. Maternal Rights Versus Fetal Rights

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### A. INTRODUCTION

Philosophers, physicians, and legal scholars have examined the potential conflict between the rights of the fetus and the rights of its mother. These groups have disagreed over the proper resolution of this conflict, and the disagreement has not been a function of discipline. Some commentators who evaluate this issue resolve all decisions in favor of the woman.<sup>1348</sup> Others, equally decidedly, insist that the rights of the fetus should prevail.<sup>1349</sup> The scholarly

1347. See Bopp & Balch, *supra* note 1266, at 130.

1348. See, e.g., Ruddick & Wilcox, *Operating on the Fetus*, 12 HASTINGS CENTER REP., 10, 14 (1982) (woman is primary obstetrical patient in maternal/fetal conflict); Annas, *Forced Cesareans: The Most Unkindest Cut of All*, 12 HASTINGS CENTER REP. 16, 45 (1982) (woman’s choice should be honored).

1349. See, e.g., Feinberg, *Wrongful Conception and the Right Not to be Harmed*, 8 HARV. J.L. & PUB. POL’Y 57 (1985) (the abrogation of duty to care for fetus invokes liability of pregnant woman); Shaw, *Conditional Prospective Rights of the Fetus*, 5 J. LEGAL MED. 63 (1984) (fetal rights override maternal rights).

debates explore the complexity of these issues, but the courts, in the few cases decided, tend to employ simplistic analyses to favor fetal over maternal rights. Little of the depth of scholarly discussion appears in these opinions. Instead, courts rely on the worn machinery of custody battles and other parent-child conflicts to guide decisions concerning recent scientific advances<sup>1350</sup> that make the issue of fetal rights so complex and puzzling.

Traditionally, Anglo-American law generally recognizes a distinction between duties imposed by law and responsibilities imposed by moral and ethical considerations. Consequently, one individual typically is not required to take risks or bear burdens for the sake of another.<sup>1351</sup> For example, parents are not required by law to donate organs to their children<sup>1352</sup> or to rescue them if they are in danger. Relying on this tradition, some commentators conclude that a woman may refuse fetal therapy.<sup>1353</sup> Other commentators maintain that new medical technology, which potentially increases the chance for healthy children, transforms the moral duty of promoting the well-being of children into a legal duty with all its rights and liabilities.<sup>1354</sup> This new focus on protecting the fetus evokes restrictions on the autonomy of the pregnant woman for the benefit of the fetus she carries. As medical technology continues to advance and the possibility to improve the quality of life for the fetus increases, the imposition of restrictions on pregnant women becomes more likely and, in some instances, already has occurred. Imposing restrictions raises more than the potential to produce healthier children or to improve physical appearance; these impositions implicate the fundamental principle of maternal choice.

This Part of the Special Project addresses areas of the law in which a right is pitted against a right: maternal rights of procreation and privacy versus fetal rights to be born physically and mentally healthy or to be born at all. The purpose of this Part is to evaluate trends and offer solutions to these difficult problems. Section B discusses maternal rights, and Section C examines fetal

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1350. See generally *supra* section II of this Special Project.

1351. W. KEETON, PROSSER & KEETON ON TORTS § 56 at 375 (5th ed. 1984).

1352. See Annas, *supra* note 1348 at 17; but see Mathieu, *Respecting Liberty and Preventing Harm: Limits of State Intervention in Prenatal Care*, 8 HARV. J.L. & PUB. POL'Y 19, 44 (1985). Mathieu argues that legal precedent exists for compelling parents to undergo invasive medical procedures for the sake of their children. *Id.*

1353. See, e.g., Annas, *supra* note 1348; Fletcher, *The Fetus as Patient: Ethical Issues*, 246 J.A.M.A. 772 (1981).

1354. See generally Feinberg, *supra* note 1349; Mathieu, *supra* note 1352; Robertson, *The Right to Procreate and in Utero Fetal Therapy*, 3 J. LEGAL MED. 333 (1982).

rights. Section D focuses on the three arenas in which conflict occurs: the courtroom, the hospital and the workplace. Section E concludes that a free society cannot tolerate unnecessary intrusions into a woman's rights to privacy and bodily integrity. Because legal mechanisms are currently poised to allow further and more frequent intrusions into these rights, the legal system must take care to prevent erosion of fundamental maternal rights.

## B. MATERNAL RIGHTS

The term "maternal rights" encompasses several legal concepts. These rights are not mutually exclusive. Instead, maternal rights overlap and intertwine to form a backdrop against which concepts of fetal rights must be viewed. One basis of the potential conflict between maternal and fetal rights stems from the mother's rights to privacy and bodily integrity. The right to privacy protects a woman's decisions to have a child.<sup>1355</sup> Although the constitution contains no explicit guarantees of privacy, the United States Supreme Court has recognized privacy interests in decisions regarding contraception,<sup>1356</sup> procreation,<sup>1357</sup> childrearing, and education.<sup>1358</sup> The Court also has established a woman's right to have an abortion prior to the third trimester of pregnancy, at which point the fetus has the "capability of meaningful life outside the mother's womb."<sup>1359</sup> Thus, a woman's right to privacy with respect to her own body is broad enough to encompass her decision whether to terminate her pregnancy<sup>1360</sup> until the third trimester when state regulations may protect potential life.<sup>1361</sup>

A pregnant woman's medical decisions may affect her own life as well as the life of her fetus. The Supreme Court, however, has not established guidelines to govern all potential situations of conflict between a woman's right to bodily integrity and the interest of

1355. See *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); *Roe v. Wade*, 410 U.S. 113 (1973). For the Supreme Court's views of the federal aspects of the right of privacy, see Annot., 43 A.L.R.2d 871, §§ 4 & 5 (1976 & Supp. 1985).

1356. See *Carey v. Population Services Int'l*, 431 U.S. 678, 684-86 (1977).

1357. See *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

1358. See *Wisconsin v. Yoder*, 406 U.S. 205, 213-15, 232 (1972) ("primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition"); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-36 (1925).

1359. *Roe*, 410 U.S. at 163. For a thorough discussion of the *Roe* decision, see *supra* notes 542-51 and accompanying text.

1360. 410 U.S. at 153.

1361. *Id.* at 154. The abortion decision is discussed *supra* at notes 542-51 and accompanying text.

her fetus. The *Roe* Court issued guidelines for one potential area of conflict and concluded that in light of present medical knowledge a state's interest in regulating abortion becomes compelling only after the fetus is viable.<sup>1362</sup> The Court has yet to address other medical aspects of pregnancy that may be affected by the constantly changing level of medical knowledge. For example, the Court has not considered the constitutional status of a woman's decision of whether to have a vaginal delivery or caesarean section. Arguably, the interests inherent in this decision have been afforded constitutional protection in that childbirth<sup>1363</sup> lies between the fundamentally protected rights of procreation and childrearing. Logic thus suggests that childbirth is a fundamental decision protected by the right to privacy. Recent decisions, however, suggest otherwise.<sup>1364</sup>

A second potential source of competing concerns arises from the mother's right to informed consent and to refuse medical treatment. Prior to medical treatment, a physician must obtain the informed consent of the patient.<sup>1365</sup> The patient has the legal right to determine what is to be done to her body.<sup>1366</sup> A mother's right to refuse medical treatment pursuant to the informed consent doctrine is a logical extension of the right of privacy. At least one federal court<sup>1367</sup> has held explicitly that the constitutional right of privacy protects the procurement or rejection of medical treatment.<sup>1368</sup> State courts also have ruled that the right to die allows refusal of medical treatment.<sup>1369</sup> The right to refuse medical

1362. 410 U.S. at 163. With advancing technology, a state could show a compelling interest in a fetus as viability becomes possible at an earlier stage in pregnancy. See *supra* notes 157-63 and accompanying text. Thus, if science makes possible the maintenance of fetal life in the first or second trimester of pregnancy, a woman's right to terminate her pregnancy might cease.

1363. For purposes of this section, childbirth refers to the actual delivery process of the fetus whether vaginal or by caesarean section.

1364. See *infra* notes 1432-74, 1518-29 and accompanying text.

1365. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979); *Crain v. Allison*, 443 A.2d 558 (D.C. App. 1982); Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977).

1366. See *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914), *rev'd on other grounds*, *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957). In *Schloendorff*, Cardozo stated, "Every human being of adult years has a right to determine what shall be done with his own body." 211 N.Y. at 129, 105 N.E. at 93.

1367. *Andrews v. Ballard*, 498 F. Supp. 1038 (S.D. Tex. 1980).

1368. *Id.* at 1046-47.

1369. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977). See also, *Satz v. Perlmutter*, 379 So.2d 359 (Fla. 1980) (adult patient suffering from terminal illness had constitutional right to refuse or discontinue extraordinary medical treatment). See generally Annot. 93 A.L.R.3d 67, §§ 3 & 4

treatment becomes more complicated, however, when a pregnant woman's decision affects the well-being of her fetus. Before the fetus becomes viable, no state interest can override the potential mother's right to privacy.<sup>1370</sup> As medicine advances, however, the previability time-frame becomes increasingly narrow.<sup>1371</sup> The issue of fetal rights, therefore, will arise more frequently.

The third primary source of conflict is the mother's right to parental autonomy. Traditionally, society respects parental discretion regarding the treatment of children, and courts resolve any conflicts by using a balancing test with a presumption in favor of the parents.<sup>1372</sup> The Supreme Court has interpreted the Constitution to give parents the right to raise their children as they choose.<sup>1373</sup> The right to parental autonomy, however, is not absolute. Although courts give great deference to parents in their choice concerning a seriously ill child,<sup>1374</sup> courts have ordered intervention when a child's life is at stake.<sup>1375</sup> Courts also have ordered intervention when the parent is incompetent.<sup>1376</sup> Parents also may lose the right to parental autonomy when they have neglected, abused, or posed danger to the child.<sup>1377</sup> Thus, although a

(1979) (discussing patient's right to refuse treatment allegedly necessary to sustain life).

1370. *Roe*, 410 U.S. at 163-64. For a discussion of the *Roe* framework, see *supra* notes 542-51 and accompanying text.

1371. See *supra* notes 157-61 and accompanying text.

1372. *Prince v. Massachusetts*, 321 U.S. 158, *reh'g denied*, 321 U.S. 804 (1944). For a discussion of parental rights, see generally, *Santosky v. Kramer*, 455 U.S. 745 (1982); *Quiloin v. Walcott*, 434 U.S. 246 (1978); Keiter, *Privacy, Children, and Their Parents: Reflections on and Beyond the Supreme Court's Approach*, 66 MINN. L. REV. 459, 487-517 (1982).

1373. *Prince v. Massachusetts*, 321 U.S. 158, *reh'g denied*, 321 U.S. 804 (1944); see also *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (discussing parents' traditional right to make decisions for child as constitutional restraint on states). See generally Annot., 52 A.L.R.3d 1118 (1973) (discussing the power of the court or other public agency to order medical treatment, despite parental religious objections, for child whose life is not immediately endangered).

1374. See, e.g., *In re Philip B.*, 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979). See generally Annot., 97 A.L.R.3d 421 (1980) (discussing the power of the court or other public agency to order medical treatment for a child over parental objections not based on religious grounds).

1375. See, e.g., *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978) (without parental consent, court ordered chemotherapy treatment for child with leukemia).

1376. See, e.g., *In re Daniel A.D.*, 106 Misc. 2d 370, 375-76, 431 N.Y.S.2d 936, 940 (Fam. Ct. 1980) (parents' rights terminated because of mental illness).

1377. See *Custody of a Minor*; see also *People in the Interests of D.L.E.*, 645 P.2d 271, 276 (Colo. 1982) (en banc) ("[A] parent's election against medical treatment for a child is not absolute in a life-endangering situation.").

In addition to losing parental autonomy rights, parents face legal sanctions for abusing or abandoning children. See Katz, Howe, & McGrath, *Child Neglect Laws in America*, 9 FAM. L.Q. 1, 63-70 (1975). No statutes, however, define parents' legal obligations toward chil-

competent adult patient has the right to refuse personal medical treatment in the absence of an overriding state interest,<sup>1378</sup> the right to refuse medical treatment for a minor child may be overridden more readily because the decision seriously implicates another life.<sup>1379</sup>

### C. FETAL RIGHTS

The scope of fetal rights is unclear. By definition, the fetus is incapable of speaking for itself, and, in many respects, a fetus is not considered a person for legal purposes.<sup>1380</sup> Courts, however, are beginning to afford the fetus greater protection than it previously enjoyed. Many courts base that protection on the concept of viability—the point at which a fetus can exist independent of its mother. In *Roe v. Wade*, for example, the Supreme Court refused to assign personhood to the fetus, holding only that the government could assert a state interest in human life after the fetus becomes capable of survival independent of the mother.<sup>1381</sup> A state, accordingly, may regulate abortion after viability to promote its interest in the potentiality of human life.<sup>1382</sup>

Viability also has been a relevant distinction for courts considering the issue of tort recovery for prenatal injury. A federal dis-

dren not yet conceived or born.

1378. See *supra* note 1369 and accompanying text.

1379. *Jefferson v. Griffin Spalding County Hosp.*, 247 Ga. 86, 274 S.E.2d 457 (1981).

1380. For example, the United States Census Bureau does not count a fetus as a person. *Abele v. Markle*, 351 F. Supp. 224, 229 n.8 (D. Conn. 1972). The Census Bureau classifications are codified at 42 U.S.C. § 1983 (1983). In computing the total population and its general characteristics, the Census Bureau determines age as that of the individual's last birthday. This figure is based on replies to a question based on month and year of birth. Thus, birth is a necessary prerequisite for being counted in the census. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, COUNTY AND CITY DATA BOOK xxvi (1983).

Similarly, a fetus is not entitled to welfare payments. *Burns v. Alcalá*, 420 U.S. 575 (1975). Congress has not required states receiving financial aid under the Aid to Families with Dependent Children Act (AFDC) to offer welfare benefits to pregnant women for their unborn children. The Supreme Court in *Burns* construed the statutory term "dependent child" to refer only to "an individual already born, with an existence separate from its mother." *Id.* at 581.

1381. *Roe*, 410 U.S. 113. In declining to grant a fetus the legal status of a person, the Court stated:

In areas other than criminal abortion, the law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth . . . . In short, the unborn have never been recognized in the law as persons in the whole sense.

*Id.* at 161-62.

1382. *Id.* at 164-65.

trict court in the District of Columbia, in the landmark case of *Bonbrest v. Kotz*,<sup>1383</sup> established viability as the crucial determinant in allowing a fetus recovery for prenatal torts.<sup>1384</sup> State courts vary in applying the viability standard for recovery in prenatal torts. Although some courts still use viability as the standard,<sup>1385</sup> the general trend seems to be to ignore any distinction between viability and pre-viability.<sup>1386</sup> The New Hampshire Supreme Court, for example, adopted the view that a fetus becomes a separate organism from the time of conception.<sup>1387</sup> Moreover, even if viability remains the key distinction, technological advances will make viability, and thus fetal rights, possible at increasingly earlier points.<sup>1388</sup>

Although no general rule of recovery currently imposes a maternal duty to protect the health of the fetus, courts increasingly are recognizing fetal rights.<sup>1389</sup> The New Jersey Supreme Court, for example, has asserted that a child has a legal right to begin life with a sound mind and body.<sup>1390</sup> Courts have developed several legal fictions that have facilitated this expansion of fetal rights. The

1383. 65 F. Supp. 138 (D.D.C. 1946); see also *supra* notes 1025-27 (discussing *Bonbrest's* impact on the development of wrongful death actions on behalf of the unborn).

*Bonbrest* signalled a departure from the early view established in *Dietrich v. Inhabitants of Northampton*, 138 Mass. 14 (1884), *overruled by*, *Torigian v. Waterton News Co.* 352 Mass. 446, 225 N.E.2d 926 (1967). In *Dietrich*, Justice Holmes denied the wrongful death claim brought on behalf of a child who, although born alive, was fatally injured *in utero* because of the defendant's negligence. Justice Holmes proceeded on the theory that the fetus was not a separate being apart from the mother at the time of injury. Birth, therefore, not viability, was the determinative issue.

1384. 65 F. Supp. at 140.

1385. See Beal, "Can I Sue Mommy?" *An Analysis of a Woman's Tort Liability for Prenatal Injuries to Her Child Born Alive*, 21 SAN DIEGO L. REV. 325, 331 n.42 (1984) for a list of these jurisdictions.

1386. See Annot., 40 A.L.R.3d 1222 (1971). One commentator predicts courts in the future will assess cases and liability based on the rights of the child for all prenatal injuries rather than on the stage of prenatal development. Collins, *supra* note 1005, at 686 (1984).

1387. *Bennett v. Hymers*, 101 N.H. 483, 485, 147 A.2d 108, 110 (1958). See generally Annot., 40 A.L.R.3d 1222 (1971) (discussing liability for prenatal injuries).

1388. See *supra* notes 157-61 and accompanying text.

1389. See cases cited *infra* notes 1439-86, 1500-05; see also *Douglas v. Town of Hartford*, 542 F. Supp. 1267 (D. Conn. 1982) (recognizing a child's causes of action based on injuries sustained *in utero*); *Curlender v. Bio-Science Lab.*, 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980) (infant born with Tay-Sachs disease sued a medical testing laboratory for incorrectly conducting genetic tests on parents when testing error led to conclusion of no danger of transmitting the disease to the infant). See generally Beal, *supra* note 1385; Comment, *Legal Duty to the Unborn Plaintiff: Is There a Limit?*, 6 FORDHAM URB. L.J. 217 (1978). But see *Guyton v. Phillips*, 606 F.2d 248, 250 (9th Cir. 1979) (fetus not a person within fourteenth amendment or Civil Rights Act), *cert. denied*, 445 U.S. 916 (1980).

1390. *Smith v. Brennan*, 31 N.J. 353, 364, 157 A.2d 497, 503 (1960) (infant plaintiff entitled to recover for a prenatal injury received in an automobile accident).

three primary methods are to grant a fetus the status of (1) a victim of a crime, (2) a neglected child, or (3) a patient.

The first means by which courts have expanded fetal rights is to consider the fetus as the victim under a criminal statute. Traditionally, courts refused to construe criminal statutes containing the word "person" to include a fetus.<sup>1391</sup> For example, a California court considered charges brought against a heroin addict for endangering her fetus because her use of heroin during the last two months of pregnancy resulted in the birth of twin boys addicted to heroin.<sup>1392</sup> The court found that the California Penal Code, which prohibited endangering a child,<sup>1393</sup> does not include an unborn child.<sup>1394</sup> Fetal protection, however, has been achieved through statutory amendment<sup>1395</sup> and through courts' expansive reading of criminal statutes. The court in *Commonwealth v. Cass*<sup>1396</sup> extended protection to a viable fetus by defining as homicide the infliction of prenatal injuries that result in the death of a viable fetus before or after it is born.<sup>1397</sup> *Cass* relied on an earlier decision<sup>1398</sup> in which the court ruled unanimously that a viable fetus was a person for the purpose of the Massachusetts wrongful death statute.<sup>1399</sup> The dissent in *Cass* pointed out the dangerous implications of the majority's reliance on a civil wrongful death case to interpret a criminal statute.<sup>1400</sup> Even more disturbing than courts drawing analogies between civil and criminal law is the implication for the liability of women. Courts may be willing to transform parental duties to children into crimes punishable by imprisonment or fine. For example, statutory provisions making the failure to provide

1391. See, e.g., *Keeler v. Superior Court*, 2 Cal. 3d 619, 470 P.2d 617, 87 Cal. Rptr. 481 (1970). *Keeler* was superseded by statute as stated in *Wilson v. Kaiser Foundation Hospitals*, 141 Cal. App. 3d 891, 190 Cal. Rptr. 649 (1983).

1392. *Reyes v. State*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977).

1393. CAL. PENAL CODE § 273a(1) (West Supp. 1986).

1394. *Reyes*, 75 Cal. App. 3d at 219, 141 Cal. Rptr. at 915.

1395. After *Keeler*, the California legislature amended California Penal Code § 187 to define murder as the killing of a human being or of a fetus. CAL. PENAL CODE § 187(a) (West Supp. 1984).

1396. 392 Mass. 799, 467 N.E.2d 1324 (1984).

1397. *Id.* at 804, 467 N.E.2d at 1329. *Cass* considered a vehicular homicide statute.

1398. *Mone v. Greyhound Lines, Inc.*, 368 Mass. 354, 331 N.E.2d 916 (1975). See also Annot., 84 A.L.R.3d 411 (1978) (discussing the right to maintain an action or to recover damages for the death of an unborn child).

1399. 368 Mass. at 355, 331 N.E.2d at 920. The *Cass* court made a semantic leap when it proclaimed, "An offspring of human parents cannot reasonably be considered to be other than a human being, and therefore a person, first within, and then in normal course outside, the womb." 392 Mass. at 800, 467 N.E.2d at 1325.

1400. 392 Mass. at 810, 467 N.E.2d at 1330.



proper medical care for one's child a crime<sup>1401</sup> create the possibility that any violation of a physician's directive, including instructions regarding care for a fetus, would expose a woman to criminal sanctions.

Another trend is to give the fetus rights through the legal fiction of "neglected child." State legislatures often draft child abuse and neglect statutes by setting an upper age limit, usually eighteen.<sup>1402</sup> These statutes generally do not expressly exclude the fetus.<sup>1403</sup> Some state courts have held that a fetus is a "child" for the purposes of child neglect statutes.<sup>1404</sup> In *Hoener v. Bertinato*<sup>1405</sup> a New Jersey court held that the state statute did not preclude application of its provisions to the unborn child.<sup>1406</sup> Under the court's interpretation of the juvenile code, the parents neglected their unborn child by refusing to consent to a blood transfusion.<sup>1407</sup>

Recent court decisions continue to extend abuse and neglect statutes to the unborn.<sup>1408</sup> For example, in *In re Baby X*,<sup>1409</sup> the Michigan Court of Appeals held that a newborn suffering narcotics withdrawal as a consequence of prenatal maternal drug addiction may be considered a neglected child.<sup>1410</sup> The court found that a pregnant woman's prenatal conduct—specifically, extensive narcotics ingestion—can constitute neglect sufficient to give the probate court jurisdiction.<sup>1411</sup>

1401. See, e.g., N.J. STAT. ANN. § 2C:24-4 (West Supp. 1985); R.I. GEN. LAWS § 40-11-2(2)(d) (Supp. 1985).

1402. See, e.g., COLO. REV. STAT. § 19-1-103 (1973 & Supp. 1985) (expressly includes unborn children); ME. REV. STAT. ANN. tit. 15, § 3003 (1964) (includes children under eighteen); N.J. STAT. ANN. § 30-46-11 (West 1981) (expressly includes unborn children).

1403. See, e.g., statutes cited *supra* note 1402.

1404. See *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (1961). See also Annot., 12 A.L.R.2d 1047 (1950) (discussing the failure to provide medical attention for a child as criminal neglect). See generally Myers, *Abuse and Neglect of the Unborn: Can the State Intervene?*, 23 DUQ. L. REV. 1 (1984); Parness, *The Duty to Prevent Handicaps: Laws Promoting the Prevention of Handicaps to Newborns*, 5 W. NEW ENG. L. REV. 431, 460-61 (1983) (advocating state control to protect child's well being). But see *In re Steven S.*, 126 Cal. App. 3d 23, 178 Cal.Rptr. 525 (1981) (finding no juvenile court jurisdiction to declare a fetus the ward of the state because a fetus is not a person under the relevant jurisdictional statute); *Baby X v. Misiano*, 373 Mass. 265, 366 N.E.2d 755 (1977) (holding that the father's duty of support does not extend to the unborn fetus).

1405. 67 N.J. Super. 517, 171 A.2d 140 (1961).

1406. *Id.* at 524, 171 A.2d at 144.

1407. *Id.* at 521, 171 A.2d at 142.

1408. See *infra* notes 1432-74.

1409. 97 Mich. App. 111, 293 N.W.2d 736 (1980).

1410. *Id.*

1411. *Id.* at 115, 293 N.W.2d at 739. See generally Parness, *Crimes Against the Unborn: Protecting and Respecting the Potentiality of Human Life*, 22 HARV. J. ON LEGIS. 97,

The third principal avenue of expanding fetal rights is to consider the fetus as a patient. New medical techniques have increased fetal viability. The fetus can be tested and treated at various stages of pregnancy. The fetus acquires a new status as "patient" once it can be treated in the womb.<sup>1412</sup> The answers to the ethical and legal problems that these new developments raise will define the degree of control pregnant women will retain over their bodies in the future as courts increasingly recognize fetal rights. Whether the fetus' "rights" as a patient can impose restrictions on pregnant women is an issue potentially limited only by medical technology. If a fetus qualifies as a patient, courts confront the need to balance the fetus' "right" to medical treatment and the woman's "right" to bodily integrity. As fetal therapy moves from the experimental to the accepted method of treatment, the balancing of these rights becomes even more difficult. To the extent that courts delineate the duty of the woman to her fetus, their decisions curtail and control her right to bodily integrity. Some courts already have defined a woman's duty to her fetus and, consequently, have exposed her to increased liability and to decreased choice.

#### D. AREAS OF CONFLICT BETWEEN MATERNAL AND FETAL RIGHTS

##### 1. *Conflict in the Courtroom*

##### (a) Erosion of Parental Tort Immunity

The earliest courts considering children's attempts to sue their parents refused to allow children to maintain an action. For example, in *Hewellette v. George*<sup>1413</sup> the Mississippi Supreme Court held that children's suits against parents disrupt family harmony and contravene public policy.<sup>1414</sup> In addition to the desire to preserve family harmony, the concept of parental immunity is designed to avoid fraud and collusion, to allow parents to discipline their children, and to protect familial resources.<sup>1415</sup> The justi-

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155 (1985) (predicting that courts will remain cautious in extending protection to the unborn).

1412. See *supra* notes 97-98 and accompanying text. For historical background of the development of fetal treatment see *THE UNBORN PATIENT* 1, 1-10 (M. Harrison, M. Golbus & R. Filly eds. 1984).

1413. 68 Miss. 703, 9 So. 885 (1891) (refusing to allow unemancipated child to maintain an action against parent for maliciously confining child to an insane asylum).

1414. *Id.* at 711, 9 So. at 887. In addition, the *Hewellette* court held that a child must comfort and aid his parent as long as the parent is obligated to support the child. *Id.*

1415. See Note, *The Child's Right to "Life, Liberty, and the Pursuit of Happiness": Suits by Children Against Parents for Abuse, Neglect, and Abandonment*, 34 *RUTGERS L.*

fications advanced to prevent judicial scrutiny of the family have not prevented an increasing number of jurisdictions from permitting children to maintain tort actions against their parents.<sup>1416</sup> Based in part on the acceptance of children's legal rights and on widespread automobile insurance coverage, the early cases that recognized parental liability were suits alleging negligent parental driving.<sup>1417</sup> Modern courts allow suits against parents for fetal injury by reasoning that the immunity doctrine was created by the courts and, therefore, courts are free to modify any doctrine they create.<sup>1418</sup>

Courts that have modified the parental immunity doctrine differ on its remaining scope. Recent court decisions in California<sup>1419</sup> and New Jersey<sup>1420</sup> highlight contrasting approaches to parental immunity, although both courts allow juries great discretion in deciding community standards for parental care. The California Supreme Court, in *Gibson v. Gibson*, overruled a forty-year-old precedent that shielded parents from liability for injuries they negligently cause their children.<sup>1421</sup> Calling parental immunity a "legal anachronism,"<sup>1422</sup> the California court completely abolished the doctrine. The court allowed a minor child to recover from his father for negligently instructing the son to go out on a highway at night to correct the position of a jeep's wheels. While following his father's instructions, the child was struck by another vehicle.<sup>1423</sup> The California court justified its decision by pointing to the widespread existence of liability insurance and its practical effect on intrafamilial suits.<sup>1424</sup> The California court adopted a liability standard of "an ordinarily reasonable and prudent parent" in similar

REV. 154, 163 (1981).

1416. See Beal, *supra* note 1385, at 335-37.

1417. See, e.g., *Cowgil v. Boock*, 189 Ore. 282, 218 P.2d 445 (1950), *overruled by*, *Winn v. Gilroy*, 296 Ore. 718, 681 P.2d 776 (1984). See *generally* Annot., 6 A.L.R. 4th 1066, 1113 (1981).

1418. See *Stallman v. Youngquist*, 129 Ill. App. 3d 859, 864, 473 N.E.2d 400, 404 (1984) (father brought suit against mother on behalf of three-year-old daughter injured in an auto accident while *in utero*).

1419. *Gibson v. Gibson*, 3 Cal. 3d 914, 479 P.2d 648, 92 Cal. Rptr. 288 (1971). See *generally* Annot., 6 A.L.R. 4th 1066 (1981) (discussing parental liability for negligently caused injury to child).

1420. *Foldi v. Jeffries*, 9 FAM. L. REP. (BNA) 2603, 2605 (N.J. July 13, 1983) (parent-child immunity abrogated except in special cases involving exercise of parental authority and customary child care).

1421. *Gibson*, 3 Cal. 3d at 922, 479 P.2d at 653, 92 Cal. Rptr. at 293.

1422. *Id.* at 916, 479 P.2d at 648, 92 Cal. Rptr. at 288.

1423. *Id.* at 916, 479 P.2d at 649, 92 Cal. Rptr. at 289.

1424. *Id.* at 922, 479 P.2d at 653, 92 Cal. Rptr. at 293.

circumstances.<sup>1425</sup>

In *Foldi v. Jeffries*<sup>1426</sup> the New Jersey court articulated a new standard for parental conduct by holding that, while the doctrine of parental immunity continues to bar suits alleging negligent supervision, the doctrine does not protect a parent who willfully or wantonly fails to supervise her child.<sup>1427</sup> The *Foldi* court considered and rejected the "reasonable parent" guideline adopted by the California Supreme Court in *Gibson*. The New Jersey court objected to the California test because of fear that the jurors would substitute their own standards of childrearing for those of the defendant-parent.<sup>1428</sup> The New Jersey court maintained that parents should have to defend their behavior only when it rises to the level of wanton misconduct.<sup>1429</sup>

The trend of abrogating parental immunity in situations of failure to supervise children sets a precedent for parental liability for prenatal injuries. As one commentator has pointed out, courts may carve out exceptions to parental immunity for prenatal injuries caused by gross negligence due to wanton and willful parental behavior and for injuries caused by ordinary negligence. These exceptions would be similar to the exceptions to immunity for vehicular driving negligence.<sup>1430</sup> Parental malpractice insurance is one suggested solution<sup>1431</sup> that may be a feasible way to insure compensation. This solution, however, does nothing to alleviate the situation that gives rise to the claim—the mother's negligent behavior or refusal of treatment.

### (b) Court-Ordered Intervention

Courts have intervened to ensure medical treatment for children when the treatment is deemed necessary.<sup>1432</sup> Courts thus may usurp parental control by removing the child from his parents' care. When medical treatment of a fetus is at issue, however, pa-

1425. *Id.* at 921, 479 P.2d at 653, 92 Cal. Rptr. at 293.

1426. 9 FAM. L. REP. (BNA) 2605. In *Foldi*, a two-and-a-half-year-old child wandered into a neighbor's yard where a dog bit her on the face. The child's mother was gardening at the time of the incident and defendants claimed the mother's negligent supervision contributed to the accident. *Id.* at 2603.

1427. *Id.* at 2605.

1428. *Id.*

1429. *Id.*

1430. Shaw, *supra* note 1349, at 113.

1431. *Id.*

1432. *In re Adam L.*, 111 D.W.L.R. 25 (Super. Ct. D.C. 1982) (heart operation ordered for child despite parents' objection). See also *supra* notes 1375-77 and accompanying text.

rental autonomy issues take on an added dimension because the mother's bodily integrity is directly affected. Given this dilemma, some commentators posit that the mother's decision regarding the child inside her should be respected at all times. According to this position, the fetus can receive medical care only if the mother gives informed consent.<sup>1433</sup> Others contend that maternal rights are not absolute; rather, the mother's rights to bodily integrity and parental autonomy must be compromised in certain circumstances to accommodate fetal rights.<sup>1434</sup> When ordering women to undergo medical treatment, courts rely on traditional rationales without making the obvious observation that mandating an invasive procedure is fundamentally different from ordering pediatric care. Rationales offered to justify court-ordered intervention include: the state's power to prohibit the abortion of a viable fetus,<sup>1435</sup> the court's power to order medical treatment for children despite parental objections,<sup>1436</sup> the waning doctrine of intrafamily tort immunity,<sup>1437</sup> and the recognition of a cause of action for prenatal torts.<sup>1438</sup>

One form of abrogation of a pregnant woman's rights occurs when courts order blood transfusions for pregnant women. The leading case of *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*<sup>1439</sup> held that "the unborn child is entitled to the law's protection,"<sup>1440</sup> and the court ordered a blood transfusion for an eight months pregnant Jehovah Witness.<sup>1441</sup> The *Raleigh* court recognized two separate issues: (1) the issue of a fetus' right to treat-

1433. Ruddick & Wilcox, *supra* note 1348, at 12; Annas, *supra* note 1348, at 45.

1434. See Note, *The Fetal Patient and the Unwilling Mother: A Standard for Judicial Intervention*, 14 PAC. L.J. 1065, 1089 (1983). These commentators point out that the notion of complete maternal autonomy is inconsistent with state laws that recognize a fetal right to medical care and the state's duty to protect the health of the unborn. *Id.* Therefore, implicit in the recognition of fetal rights is the acceptance of the idea that maternal rights are not absolute. *Id.* One commentator, although recognizing that maternal rights are not absolute, would limit court intervention to situations in which the fetus is a "provisional patient." *Id.* at 1093.

1435. See *supra* notes 1359-61, 1381-82 and accompanying text.

1436. See *supra* notes 1375-77, 1432 and accompanying text.

1437. See *supra* notes 1413-29 and accompanying text.

1438. See *supra* note 1418 and *infra* note 1503 and accompanying text.

1439. 42 N.J. 421, 201 A.2d 537 (per curiam), *cert. denied*, 377 U.S. 985 (1964).

1440. *Id.* at 423, 201 A.2d at 538. *Raleigh* is a pre-*Roe* case. The *Raleigh* court relied on two earlier decisions for its conclusion that an unborn child is entitled to legal protection. In *Smith v. Brennan*, the New Jersey court allowed a child to sue for injuries negligently inflicted prior to birth. 31 N.J. 353, 157 A.2d 497 (1960). In *State v. Perricone*, the New Jersey court held that an infant was entitled to a blood transfusion despite the objection of his Jehovah's Witness parents. 37 N.J. 463, 181 A.2d 751, *cert. denied*, 371 U.S. 890 (1962).

1441. *Raleigh*, 42 N.J. at 423, 201 A.2d at 538.

ment *in utero*<sup>1442</sup> and (2) the issue of compelling an adult to submit to procedures to save her own life.<sup>1443</sup> Regarding the issue of fetal right to treatment, the court simply stated without analysis that the state had an interest in preserving fetal life, which afforded the unborn child the protection of the law.<sup>1444</sup> The court did not decide the second issue because "the welfare of the child and the mother are so intertwined and inseparable that it would be impracticable to attempt to distinguish between them."<sup>1445</sup>

Several limitations on the validity of the *Raleigh* decision exist.<sup>1446</sup> First, *Raleigh* illustrates that medical judgment can be in error. The court relied on medical testimony that transfusions were necessary to save the lives of both the mother and the fetus, but the transfusion was never administered because the woman left the hospital. Subsequently, she delivered a healthy child without the transfusion. Second, implicit in the *Raleigh* court's decision to appoint a special guardian for the fetus is the judgment that a mother is deemed unfit unless she acts in the best interests of her child. The *Raleigh* case illustrates, however, that no one truly knows a child's best interests. The court relied on the medical profession to determine the best interests of the fetus, but the medical determination proved inaccurate. Third, the court refused to acknowledge that fetal and maternal rights conflict in some situations, necessitating difficult policy decisions.

Another form of court-ordered intervention that abrogates a pregnant woman's rights occurs when a court orders the woman to undergo a caesarean section against her wishes. Two relatively recent cases in Georgia<sup>1447</sup> and Colorado<sup>1448</sup> illustrate the outer reaches of the legal system's invasion of personal autonomy. The Georgia Supreme Court, in *Jefferson v. Griffin Spalding County Hospital*,<sup>1449</sup> ordered a caesarean section over the woman's reli-

1442. *Id.* The *Raleigh* court characterized this issue as easier to resolve than the second issue.

1443. *Id.*

1444. *Id.*

1445. *Id.*

1446. For an excellent discussion of the limitations of *Raleigh*, see Annas, *supra* note 1348, at 17.

1447. *Jefferson v. Griffin Spalding County Hosp.*, 247 Ga. 86, 274 S.E.2d 457 (1981) (per curiam).

1448. See Bowes & Selgestad, *Fetal versus Maternal Rights: Medical and Legal Perspectives*, 58 AM. J. OBSTET. & GYNEC. 209, 209-11 (1981) (discussing an unreported Colorado opinion).

1449. 247 Ga. 86, 274 S.E. 2d 457 (1981) (per curiam). For a general discussion of *Jefferson*, see Note, *Court-Ordered Surgery for the Protection of a Viable Fetus*, 5 W.N.

gious objections.<sup>1450</sup> The Georgia court based its decision on medical testimony that surgical intervention was necessary to save both mother and fetus.<sup>1451</sup> As in *Raleigh*, the Georgia court viewed the life of the mother and the fetus as inseparable.<sup>1452</sup> Relying on *Roe* and *Raleigh*, the court extended legal protection to the fetus and authorized the attending physician to administer all medical procedures deemed necessary to preserve the life of the unborn child.<sup>1453</sup> The court engaged in a balancing test and held that the state's interest in the life of the unborn fetus was sufficient to warrant state interference "to protect a living, unborn human being from meeting his or her death before being given the opportunity to live."<sup>1454</sup> Thus, the Georgia court removed the fetus from the woman's custody through the juvenile court system.<sup>1455</sup>

The concurring opinion in *Jefferson* acknowledged the limited power of any court to order a competent adult to submit to surgery.<sup>1456</sup> The concurrence noted that, prior to this "unique" case, such a court power would have seemed nonexistent.<sup>1457</sup> However, the recognition in *Roe* of the state interest in protecting the life of a viable fetus,<sup>1458</sup> coupled with the holding in *Raleigh* that an expectant mother in the later stages of her pregnancy no longer has the right to refuse life-saving medical treatment for her unborn child,<sup>1459</sup> compels the conclusion that the fetus' right to live outweighed the mother's right to practice her religion by refusing surgery.<sup>1460</sup>

A Colorado court exhibited similarly truncated reasoning when the court ordered a pregnant woman to undergo a caesarean section.<sup>1461</sup> After a hearing conducted at the patient's bedside, the

ENG. L. REV. 125 (1982).

1450. *Jefferson*, 247 Ga. at 88, 274 S.E.2d at 459.

1451. *Id.* at 88, 274 S.E.2d at 459. Medical experts testified that if the woman chose to have natural childbirth, she would have a 50% chance of dying and her unborn child would have a 99% chance of dying. *Id.*

1452. *Id.* at 87, 274 S.E.2d at 458.

1453. *Id.*

1454. *Id.* at 89, 274 S.E.2d at 460.

1455. *Id.* at 89, 274 S.E.2d at 460. At least one judge questioned the juvenile court's jurisdiction, commenting that the legislature, in drafting statutes giving the juvenile court jurisdiction over children, meant children who had "seen the light of day." *Id.* at 92, 274 S.E.2d at 461-62.

1456. *Id.* at 89, 274 U.S. 460.

1457. *Id.*

1458. *Roe*, 410 U.S. at 164-65.

1459. 42 N.J. at 423, 201 A.2d at 538.

1460. 247 Ga. at 89, 274 S.E.2d at 460.

1461. Bowes & Selgestad, *supra* note 1448.

juvenile court ordered the doctor to perform a caesarean section to save the fetus' life despite the mother's objections. A psychiatrist interviewed the patient and found her neither delusional nor incompetent.<sup>1462</sup> The court, nonetheless, took jurisdiction by finding that the fetus was a dependent and neglected child within the meaning of Colorado's Children's Code.<sup>1463</sup> The medical staff "viewed the patient's response as one of unreasonable insensitivity to the welfare of her infant,"<sup>1464</sup> but the choice of caesarean section was not without danger to the mother. The patient was obese and the procedure posed a high risk for her.<sup>1465</sup> Nonetheless, the court's directive was clear that doctors could administer medical treatment necessary to save the life of the fetus against the will of the pregnant woman.<sup>1466</sup>

The Colorado decision provides the analytical framework through which fetal rights can override maternal rights. The court relied on the *Raleigh* decision in asserting jurisdiction to protect the interests of the unborn child.<sup>1467</sup> The court also relied on reasoning in *Roe* that the state has a compelling interest to protect the unborn.<sup>1468</sup> The Colorado court found the fetus had protectable rights.<sup>1469</sup> Last, the court invoked the state's *parens patriae* obligation to provide medical treatment to an unborn child to protect its life over the unreasonable objections of its parents.<sup>1470</sup>

In all three of these cases, the medical judgments that formed the basis for court intervention proved to be in error—all three women delivered healthy children without the recommended treatment.<sup>1471</sup> In the Colorado case, the fetal monitor overestimated the amount of damage to the fetus that might result from delayed delivery.<sup>1472</sup> An attending physician commented that the birth of a

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1462. *Id.* at 209.

1463. COL. REV. STAT. § 19-1-103 (1973 & Supp. 1985).

1464. Bowes & Selgestad, *supra* note 1448, at 211.

1465. *Id.*

1466. *Id.*

1467. *Id.* at 212.

1468. *Id.*

1469. *Id.* The court relied on *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (Juv. Ct. 1961). The *Hoener* court declared that the state had a duty to protect children in its jurisdiction. "Children" included an unborn child. *Id.* at 524, 171 A.2d at 144.

1470. Bowes & Selgestad, *supra* note 1448, at 212. In a similar situation in Chicago, a juvenile court judge gave a hospital attorney temporary custody of a fetus after the mother refused to undergo a caesarean section because of religious reasons. The caesarean section was performed and custody reverted to the parents. *Am. Med. News*, Feb. 19, 1982, at 13.

1471. Annas, *supra* note 1348, at 16.

1472. *Id.* at 17.



healthy child illustrated the limitations of continuous fetal heart monitoring as a means for predicting neonatal outcome.<sup>1473</sup> Indeed, all of these cases illustrate that physicians cannot predict fetal danger with a high degree of accuracy. Even if total accuracy were assured, however, the seriousness of depriving women of control over their own bodies makes forced caesarean sections unattractive.<sup>1474</sup> Unfortunately, these courts failed to consider the potential implications for society inherent in their decisions to order intervention.

A third type of court-ordered intervention stems from medical knowledge regarding the effects certain behavior during pregnancy has on the health of the fetus. For example, smoking during pregnancy increases the risks of prematurity and spontaneous abortion,<sup>1475</sup> and drinking has been linked to multiple congenital abnormalities.<sup>1476</sup> A court seeking to protect a fetus, therefore, may decide to order a pregnant woman to adhere to a special diet or to abstain from drinking, smoking, and other toxic substances.<sup>1477</sup> For example, an Illinois circuit court ordered a pregnant woman who had previously given birth to a heroin-addicted child to refrain from using heroin.<sup>1478</sup> Subsequently, the department of children and family services moved to vacate an order appointing a guardian for the fetus because of statutory limits to the juvenile court's authority, practical problems, and difficult policy issues. Before the court could resolve the issue, the mother gave birth to a nonaddicted child. The circuit court nevertheless expressed the view that subject-matter jurisdiction was present.<sup>1479</sup>

In another unreported case, a Baltimore circuit court ordered

1473. Bowes & Selgestad, *supra* note 1448, at 211.

1474. Annas, *supra* note 1348, at 17, 45.

1475. H. TUCHMANN-DUPLESSIS, *DRUG EFFECTS ON THE FETUS* 183 (1975). For a discussion of spontaneous abortion, or miscarriage, see *supra* notes 125-26 and accompanying text.

1476. See Wright, Barrison, Lewis, Macrae, Waterson, Toplis, Gordon, Morris & Murray-Lyon, *Alcohol Consumption, Pregnancy, and Low Birthweight*, 1 *LANCET* 663 (1983); see also, Quелlette, Rosett, Rosman & Weiner, *Adverse Effects on Offspring of Maternal Alcohol Abuse During Pregnancy*, 297 *N. ENG. J. MED.* 528, 528-30 (1977). For a discussion of the effects on the fetus when a mother uses drugs, alcohol or tobacco, see *supra* notes 115-23 and accompanying text.

1477. Shaw, *supra* note 1349, at 74, suggests legal controls on pregnant women's consumption of alcohol similar to DUI statutes.

1478. Unreported 1982 case discussed in Parness, *Protection of Potential Human Life in Illinois: Policy & Law at Odds*, 5 *N. ILL. U.L. REV.* 1, 20-21 (1984). Some medical evidence suggests that a comprehensive methadone maintenance program is preferable to detoxification. Detoxification, as ordered in this case, may be more harmful than passive dependence. Finnegan & Wapner, *Drug Abuse in Pregnancy*, 111 *MED. TIMES* 4 (1983).

1479. Parness, *supra* note 1478, at 20-21.

a pregnant woman to enroll in a drug rehabilitation program and submit to weekly urinalysis until her baby was born.<sup>1480</sup> The court ordered this monitoring intervention after evidence revealed the mother was using large amounts of Quaalude, Valium, morphine and cocaine.<sup>1481</sup> As in the Illinois situation,<sup>1482</sup> the Baltimore woman had previously given birth to an addicted child.<sup>1483</sup>

Some limits on this type of court-ordered monitoring do exist. A California court of appeals refused to prohibit a mother who followed a macrobiotic diet<sup>1484</sup> from conceiving children as a condition of her probation on a child endangerment conviction.<sup>1485</sup> The court did find, however, that if the woman became pregnant, she could "be required to follow an intensive prenatal and neonatal treatment program monitored by both the probation officer and by a supervising physician."<sup>1486</sup> The court thus respected the rights of the potential mother, but revealed a willingness to hold that fetal rights override maternal rights in certain instances. This judicial willingness to override maternal rights again was accompanied by a complete failure to discuss any of the broad implications for society.

### (c) Woman's Right to Refuse Judicial Intervention

The state's power to interfere with a pregnant woman's right to refuse medical treatment is not unlimited. Limitations on state intervention currently exist at viability. Two recent cases clarify this judicial position. In a 1983 decision, *Taft v. Taft*,<sup>1487</sup> a pregnant woman appealed a judgment ordering her to submit to an operation that would preserve her pregnancy. The woman, who had a prior history of requiring a surgical procedure<sup>1488</sup> to carry her

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1480. Shaw, *supra* note 1349, at 104-05.

1481. *Id.*

1482. See *supra* notes 1478-79 and accompanying text.

1483. Shaw, *supra* note 1349, at 104.

1484. A macrobiotic diet is a harmful fad diet which, if followed precisely, results in severe malnutrition. This diet represents extreme adherence to a natural diet containing only organic foods. Depending on the length of adherence to this diet, cases of scurvy, anemia, hypoproteinemia, hypocalcemia, emaciation, loss of kidney function, and death have been reported. Alfin-Slater & Atergood, *Food Fads*, in *NUTRITIONAL SUPPORT OF MEDICAL PRACTICE* 98, 106 (H. Schneider, C. Anderson & D. Coursin eds. 1983).

1485. *State v. Pointer*, 10 FAM. L. REP. (BNA) 1270 (Cal. App. Feb. 17, 1984).

1486. *Id.*

1487. 388 Mass. 331, 446 N.E.2d 395 (1983).

1488. The court described the surgical procedure as a "purse string" operation. *Id.* at 332, 446 N.E.2d at 396.

children to term,<sup>1489</sup> refused to allow a suturing procedure in this instance to prevent the miscarriage of her not yet viable fetus. Although the trial judge found the operation a "very minor one,"<sup>1490</sup> the Massachusetts Supreme Court upheld the woman's refusal to submit to the operation for religious reasons.<sup>1491</sup> The court recognized the state interest in the well-being of "unborn children,"<sup>1492</sup> but found that the state had failed to show an interest sufficiently compelling in this case to overcome the woman's right to practice her religion as she chose.<sup>1493</sup> The court did note, however, that some situations might justify mandatory medical treatment to sustain the completion of a pregnancy.<sup>1494</sup>

In a 1985 decision, *Mercy Hospital v. Jackson*,<sup>1495</sup> a Maryland court denied appointment of a guardian for a patient who refused to consent to blood transfusions during a consensual caesarean section because of her religious convictions.<sup>1496</sup> The court recognized the right to refuse medical treatment as a corollary to the informed consent doctrine.<sup>1497</sup> The court noted, however, that fetal survival or support was not endangered by the woman's refusal to undergo medical treatment.<sup>1498</sup> The opinion thus implied that, if the woman's refusal had threatened the life of the fetus, the court may have decided to order intervention.<sup>1499</sup>

#### (d) The Future of Maternal Liability for Negligence During Pregnancy

Civil liability for actions during pregnancy could impose enormous burdens on women. Courts that have established liability for negligent behavior during pregnancy have set precedent with po-

1489. In the one instance when the woman had not undergone the suturing procedure, her pregnancy terminated in the seventh month and the child did not survive. *Id.*

1490. *Id.*

1491. *Id.*

1492. *Id.*

1493. *Id.* at 334, 446 N.E.2d at 397.

1494. *Id.* "Perhaps the State's interest, in some circumstances, might be sufficiently compelling . . . to justify such a restriction on a person's constitutional right of privacy." *Id.*

1495. 62 Md. App. 409, 489 A.2d 1130 (1985). At the time of the suit the surgery was concluded, the child born, and the patient discharged. The court, nevertheless, decided to hear the case because of the likelihood that the issue would arise again. *See id.* at \_\_\_\_, 489 A.2d at 1132.

1496. The patient was a Jehovah's Witness. *Id.* at \_\_\_\_, 489 A.2d at 1131.

1497. *Id.* at \_\_\_\_, 489 A.2d at 1133 n.7. *See also supra* notes 1365-66 and accompanying text.

1498. 62 Md. App. at \_\_\_\_, 489 A.2d at 1134.

1499. *Id.*

tentially far reaching ramifications. A Michigan court, for example, recognized a fetal right to be born healthy rather than merely to be born alive by allowing a trial court to hold a mother responsible for negligently impairing fetal health.<sup>1500</sup> The suit, brought on behalf of an infant whose teeth were discolored because of the mother's ingestion of tetracycline, alleged that the woman was negligent in failing to seek medical care and in failing to inform the physician that she was taking tetracycline.<sup>1501</sup> In remanding the case for determination of the reasonableness of the mother's action, the *Grodin* court relied on prior decisions abrogating parent-child tort immunity<sup>1502</sup> and decisions holding that a child could bring an action for negligently inflicted prenatal injuries.<sup>1503</sup>

The *Grodin* court concluded that the mother would bear the same liability for negligently injuring her child as would a third person.<sup>1504</sup> The *Grodin* decision is an attempt to regulate the actions of a pregnant or fertile woman prior to the time of viability or even conception of the fetus. The implications are far reaching. Under the *Grodin* rationale, only the doctrine of intrafamilial tort immunity, which is increasingly waning,<sup>1505</sup> and the impracticalities of initiating the action prevent a child injured by the mother's prenatal conduct from suing her.

If, as the court suggested in *Grodin*, a mother can be sued for conduct during her pregnancy that results in harm to the child she is carrying, the failure to avail oneself of prenatal diagnosis of defects<sup>1506</sup> or the refusal to undergo recommended fetal surgery could subject the mother to liability. Some see the advent of new techniques in prenatal care as justifiable limitations on a woman's right of bodily integrity once she has given up her right not to procreate.<sup>1507</sup> These commentators argue that as soon as a woman becomes pregnant, she must give up some of her rights because she

1500. *Grodin v. Grodin*, 102 Mich. App. 396, 301 N.W.2d 869 (1980).

1501. *Id.* at 398, 301 N.W.2d at 870.

1502. *Plumley v. Klein*, 388 Mich. 1, 199 N.W.2d 169 (1972).

1503. *Womack v. Buchhorn*, 384 Mich. 718, 187 N.W.2d 218 (1971) (recovery allowed for brain damage suffered during the fourth month *in utero* based on reasoning that a child has a legal right to begin life with a sound mind and body).

1504. 102 Mich. App. at 400, 301 N.W.2d at 870.

1505. See *supra* notes 1413-29 and accompanying text.

1506. See Kolata, *First Trimester Prenatal Diagnosis*, 221 SCIENCE 1030 (1983) (discussing advancing medical capabilities to diagnose chromosomal and biochemical defects earlier in pregnancy); Shaw, *supra* note 1349, at 76 n.85 (explaining prenatal diagnosis procedures).

1507. For a discussion of the constitutional right not to procreate, see generally *supra* section V of this Special Project.

has created a new being with a new set of rights.<sup>1508</sup> Another commentator views the parental right to reproduce as a privilege to produce healthy infants.<sup>1509</sup> Therefore, to the extent that the health of the fetal patient is jeopardized by the mother's intentional or negligent acts, courts should hold the woman liable.<sup>1510</sup> This line of thinking and recent developments in the courts have led one scholar to conclude that thirty jurisdictions would be receptive to the recognition of a mother's duty to her unborn child at any stage of development.<sup>1511</sup> The illogical result of such a rule would be that a woman would have the right to abort her fetus early in pregnancy, but could be liable in tort for injuring that fetus during the same period.<sup>1512</sup>

One method of limiting a woman's increased liability is by statute. For example, a California statute provides that no cause of action arises against a parent on the claim that the parent's child should not have been conceived, or, if conceived, should not have been born.<sup>1513</sup> California courts interpret this statute as prohibiting suits brought on behalf of a fetus or infant.<sup>1514</sup> The court in *Turpin v. Sortini* found that this statute relieved parents of liability for deciding to conceive or failing to abort a potentially defective child.<sup>1515</sup>

Absent statutory protection, a woman's liability for prenatal negligence is a definite possibility. The degree to which a parent can jeopardize the health—and possibly the life—of her fetus is a

1508. See Robertson, *Legal Considerations: The Duties of Mothers and Physicians in Fetal Treatment*, in *THE UNBORN PATIENT* 171, 179 (M. Harrison, M. Golbus & R. Filly eds. 1984).

1509. Shaw, *The Potential Plaintiff*, in 2 *GENETICS AND THE LAW* 225, 227 (A. Milunsky & G. Annas eds. 1980).

1510. *Id.* at 228. See also Shaw, *supra* note 1349, at 116. Shaw describes the "moral duty" to promote the health and well-being of children. She sees healthy children as an ultimate societal goal to which parental wishes should be subordinated. *Id.*

1511. Beal, *supra* note 1385, at 357.

1512. See Note, *A Maternal Duty to Protect Fetal Health?* 58 *IND. L.J.* 531, 541-45 (1983) (discussing the complex remedy issues involved in a cause of action based on maternal duty to the fetus). This problem could be avoided if legislation created a duty of care only after the fetus was viable.

1513. See, *CAL. CIV. CODE* § 43.6 (West 1982).

1514. See *Turpin v. Sortini*, 31 *Cal. 3d* 220, 229, 643 P.2d 954, 959, 182 *Cal. Rptr.* 337, 345 (1982).

1515. *Id.* The *Turpin* court analyzed the legislative history of § 43.6 and concluded that the legislature had intended to eliminate "any liability or other similar economic pressure which might induce potential parents to abort or decline to conceive a potentially defective child." *Id.*

decision that some feel the mother should make,<sup>1516</sup> while others argue society should monitor that decision.<sup>1517</sup> If opinion becomes resolved, the legal system is poised to attach liability to certain acts of a woman during her pregnancy.

## 2. *Conflict in the Hospital*

### (a) Conflicts Resolved without Resort to the Court System

Not all conflicts between maternal and fetal rights are resolved in the court system. Often those situations that are not litigated present the conflicts in a most cogent way. Many of these situations occur in the hospital.

Some persons in the medical profession champion the well-being of the fetus<sup>1518</sup> and would resolve conflicts between the rights of a fetus and of a mother in favor of the fetus.<sup>1519</sup> In one instance,<sup>1520</sup> after determining the life of the fetus was at risk,<sup>1521</sup> physicians performed a caesarean section despite the objections of an unmarried pregnant woman. In discussing the case, the physician-authors point out that no force was necessary to subdue the patient, although she continued to protest verbally.<sup>1522</sup> This fact seemed to assuage any misgivings that the medical staff had in choosing to bypass the "orderly decision-making process"<sup>1523</sup> of requesting juvenile court intervention.

In other situations medical personnel resolve the conflict in favor of maternal rights. In two instances doctors decided to honor the mother's refusal to deliver by caesarean section and both fetuses died.<sup>1524</sup> In one of the cases, the woman who refused consent explained that the fetus' death would resolve personal problems.<sup>1525</sup> In the second instance the patient refused because

1516. See Annas, *supra* note 1348; Ruddick & Wilcox, *supra* note 1348.

1517. See Shaw, *supra* note 1349; Robertson, *supra* note 1354; Mathieu, *supra* note 1352.

1518. See Jurow & Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 AM. J. OBSTET. & GYNEC. 596, 598 (1984); Bowes & Selgestad, *supra* note 1448, at 213.

1519. Jurow & Paul, *supra* note 1518, at 597.

1520. *Id.*

1521. *Id.*

1522. *Id.*

1523. *Id.*

1524. Lieberman, Mazor, Chaim & Cohen, *The Fetal Right to Live*, 53 AM. J. OBSTET. & GYNEC. 515, 515-16 (1979).

1525. *Id.* at 516.

she was afraid of dying.<sup>1526</sup> The authors reporting these cases characterize the conflict as one that requires the physician either to be a passive accomplice to homicide or to act against the patient's will and the law.<sup>1527</sup> They conclude that the physician must warn the patient she is committing a felony<sup>1528</sup> but that the physician cannot proceed without her consent.<sup>1529</sup>

### (b) Suggested Theories to Resolve Conflicts

Some medical journalists resolve maternal-fetal conflicts by analyzing the status of the persons involved<sup>1530</sup>—the mother with fully recognized rights at law and the fetus with potential rights. After analyzing the status of the mother and fetus, one approach to resolving conflicts is to employ a balancing test.

One attorney writing in the medical literature balances these respective rights by biological reference to the dependent condition of the fetus.<sup>1531</sup> The mother can exercise her rights by not acting, but a fetus can realize its rights only through a third person's affirmative act.

The third party capable of acting, the obstetrician, may refuse to order surgery without the mother's consent because of potential civil and criminal liability. Thus, the fetus is effectively prevented from realizing any rights.<sup>1532</sup> Absent any acceptable alternative to requiring a patient's consent to surgery, the obstetrician's role in situations of conflict between maternal and fetal rights remains that of counselor.<sup>1533</sup> Although legislatures could provide the obstetrician with a cloak of immunity by drafting statutes making criminal a woman's wrongful refusal to consent to surgery, a woman's good faith refusal based on fear for her own life or health would seriously weaken the effectiveness of such a statute.<sup>1534</sup> A second method of resolving the conflict focuses on the relative risks to the

1526. *Id.*

1527. *Id.*

1528. *Id.* at 517.

1529. *Id.* The authors recognized that the existence of risks to the patient might negate the felony charge. *Id.* See Feldman & Freiman, *Prophylactic Caesarean Section at Term?*, 312 N. ENG. J. OF MED. 1264, 1267 (1985). The authors point out that caesarean sections pose increased risk. *Id.* at 1265.

1530. Shriner, *Maternal Versus Fetal Rights: A Clinical Dilemma*, 53 AM. J. OBSTET. & GYNEC. 518 (1979).

1531. *Id.* at 518.

1532. *Id.* at 519.

1533. *Id.*

1534. *Id.*

mother and fetus rather than the parties' abilities to act.<sup>1535</sup> Balancing the risks, however, might prove impractical because the balance might always favor the mother. The respected right not to undergo surgery implicates principles of individual liberty widely accepted by society.<sup>1536</sup>

Some areas of conflict between maternal and fetal rights are not susceptible to a balancing test. For example, medical commentators have posited other methods of resolving conflicts when pregnant women use substances harmful to the fetus, including tobacco, alcohol, and certain drugs. Physicians discourage the use of tobacco, hallucinogens, and alcohol during pregnancy.<sup>1537</sup> The potential for women of childbearing age to use or abuse these substances is great. Accordingly, the potential for exposing fetuses to adverse effects is great. Some in the medical community feel that the solution rests with educating the pregnant woman about the dangers posed by these substances.<sup>1538</sup> Others suggest that medical personnel monitor the woman's actions and resort to legal sanction when necessary to protect the health of her fetus.<sup>1539</sup>

### (c) The Possibility of Compulsory Fetal Surgery

Medical advances have made possible the surgical correction of certain fetal problems.<sup>1540</sup> The pregnant woman's cooperation is assumed. In rare cases, however, a woman may refuse to consent to fetal surgery. These situations raise the possibility of compulsory fetal surgery. Physicians already have forced women to undergo caesarean sections for the sake of the fetus.<sup>1541</sup> As fetal surgery moves from experimental to accepted medical practice, the possibility that a woman could be forced to undergo fetal surgery without consent could become a reality.<sup>1542</sup> Terming the woman's refusal "fetal abuse," or "child abuse" at a later stage in pregnancy,

1535. *Id.*

1536. *Id.*

1537. See Finnegan & Wapner, *Drug Abuse in Pregnancy*, 111 *MED. TIMES* 4 (1983) (general discussion of harmful effects of drugs during pregnancy). See also *supra* notes 115-23 and accompanying text.

1538. See Lieberman, *supra* note 1524, at 517.

1539. See Shaw, *supra* note 1349, at 84, 89 102-04.

1540. Elias & Annas, *Perspectives on Fetal Surgery*, 145 *AM. J. OBSTET. & GYNEC.* 807 (1983). The authors predict routine application of fetal surgery. *Id.* at 809. See *supra* notes 97-98 and accompanying text.

1541. For a discussion of one situation in which a woman was forced to undergo a caesarean section, see *supra* notes 1520-23 and accompanying text.

1542. See Elias & Annas, *supra* note 1540, at 811.



might enable a court to order treatment against the mother's wishes.

The possibility of compulsory fetal therapy raises several problems.<sup>1543</sup> First, a woman will be forced to undergo a procedure for the benefit of another. Presently, parents are not required to undergo surgery for the benefit of their children who have been born alive.<sup>1544</sup> Second, compulsory fetal surgery deprives a woman of autonomy because her body is invaded against her consent for the potential benefit to the fetus. Last, compulsory fetal surgery may abrogate the woman's constitutional rights.

Commentators have approached this dilemma from different angles. One approach stems from the Supreme Court's indication that a mother has a greater stake in an abortion decision than the potential father.<sup>1545</sup> Some physicians argue that the logical extension of this premise leads to the conclusion that the mother should prevail in any conflict between the father and the mother about medical treatment of their fetus.<sup>1546</sup> These commentators view the mother's consent as a necessary precondition for surgery even if the father consents to the surgery.<sup>1547</sup> Other physicians argue that the establishment of safe and effective prenatal surgical techniques alters the rights and duties of mothers and physicians. These new duties would lead to criminal or civil penalties for not acting in a reasonable fashion to avoid the birth of a defective child.<sup>1548</sup> The potential conflict between mother and child is further complicated by the lack of consensus among physicians about what duty they owe to the unborn child. A third approach, therefore, focuses on the physician's duties. A physician is subject to two antithetical principles: the need to protect and promote the best interests of his fetal patient versus the need to respect the personal autonomy of his maternal patient whose values and beliefs give her a perspective on her own best interests. Recognizing these polar influences,

1543. Ruddick & Wilcox, *supra* note 1348, at 10 (raising problematic situations in which decisions will have to be made regarding fetal surgery); Robertson, *supra* note 1508, at 174-77.

1544. See Annas, *supra* note 1348, at 17.

1545. See *Danforth v. Planned Parenthood*, 428 U.S. 52, 71 (1976). ("The obvious fact is that when the wife and the husband disagree on this decision [abortion] the view of only one of the two marriage partners can prevail. Inasmuch as it is the woman who physically bears the child and who is the more directly and immediately affected by the pregnancy, as between the two, the balance weighs in her favor.")

1546. Elias & Annas, *supra* note 1540, at 810-11.

1547. *Id.* at 811. The authors state that the mother must be informed of all the risks to herself and to her fetus.

1548. See Robertson, *supra* note 1508, at 174-77.

some have suggested a framework for identifying the physician's moral obligations to the fetus and its mother and reaching decisions by assessing the relative weights of those obligations.<sup>1549</sup>

As a result of current uncertainty about fetal surgery, doctors generally resolve conflicts between fetal and maternal interests in favor of the woman.<sup>1550</sup> Control of a woman is restricted to educating her about the harmful effects of cigarette, alcohol, and drug abuse<sup>1551</sup> to attempt vigorously to persuade her to consent to fetal treatment.<sup>1552</sup> The rights and duties of mothers and physicians will change drastically, however, when fetal surgery becomes routine. As in the case of forced caesarean section intervention, if the medical profession and members of society reach a consensus that fetal surgery should be compulsory, the legal machinery exists to negate a woman's choice.

### 3. *Conflict in the Workplace*

Women account for increasingly large numbers of workers in the marketplace, yet women's choices in the workplace increasingly have been restricted. One focus of attention is the link between toxins in the workplace and fetal harm.<sup>1553</sup> Although workplace toxins affect the reproductive capabilities of both men and women,<sup>1554</sup> policies normally restrict the employment of fertile women but not of fertile men.<sup>1555</sup> These policies threaten equal opportunity for women by seriously reducing the job choices available to females of childbearing age. Existing legislation protects

1549. See Chervenak & McCullough, *Perinatal Ethics: A Practical Method of Analysis of Obligations to Mother and Fetus*, 66 AM. J. OBSTET. & GYNEC. 442 (1985) (This process requires thorough documentation and objective assessment of fetal and maternal best interests, which sometimes may be an impossible task. *Id.* at 446. See also Robertson, *supra* note 1508, at 174-75 (suggesting a balancing approach to determine when the need for fetal intervention outweighs maternal rights to bodily integrity).

1550. Chervenak & McCullough, *supra* note 1549, at 446.

1551. *Id.* at 444-45.

1552. *Id.* at 445.

1553. See, e.g., Furnish, *Prenatal Exposure to Fetally Toxic Work Environments: The Dilemma of the 1978 Pregnancy Amendment to Title VII of the Civil Rights Act of 1964*, 66 IOWA L. REV. 63, 119-29 (1980) (summary of fetal vulnerability as affected by hazardous environmental factors); Nothstein & Ayres, *Sex-Based Considerations of Differentiation in the Workplace: Exploring the Biomedical Interface between OSHA and Title VII*, 26 VILL. L. REV. 239 (1981) (exclusion of women only from agents that affect reproductive capacity will not solve the problem of toxic effects); Williams, *Firing the Woman to Protect the Fetus: The Reconciliation of Fetal Protection with Employment Opportunity Goals under Title VII*, 69 GEO. L.J. 641 (1981) (employers adopt exclusionary policies for women).

1554. See Nothstein & Ayres, *supra* note 1553, at 243-56.

1555. See Williams, *supra* note 1553, at 647-51.

women in the employment arena,<sup>1556</sup> but judicial interpretations can limit the choices of women of childbearing age. In upholding employers' policies that are designed to protect the unborn, courts implicitly recognize that fetal rights not only exist but also override a woman's right to a higher paying, albeit more dangerous, job. Two recent cases, *Wright v. Olin Corp.*<sup>1557</sup> and *Oil, Chemical & Atomic Workers International Union v. American Cyanamid Co.*,<sup>1558</sup> illustrate judicial approval of the growing restrictions on a woman's personal autonomy.

In *Wright v. Olin Corp.*<sup>1559</sup> female employees challenged the defendant-company's "female employment and fetal vulnerability" program, which excluded or restricted pregnant and fertile women from jobs exposing them to workplace toxins.<sup>1560</sup> The defendant stated that its program was designed to protect the unborn fetuses of female workers from workplace dangers.<sup>1561</sup> The United States Court of Appeals for the Fourth Circuit differentiated between a woman's right to make her own choices regarding workplace hazards and her right to make the same choices on behalf of her unborn children.<sup>1562</sup> In addressing the justifications for the company's policy, the court analogized the fetus to invitees and licensees who may be exposed to hazards when legitimately on business

1556. Title VII of the Civil Rights Act of 1964 forbids discrimination on the basis of sex in the hiring, discharge, compensation, or other terms, conditions or privileges of employment. Title VII was amended in 1978 by the Pregnancy Discrimination Act which expanded further the definition of sex discrimination to include discrimination on the basis of "pregnancy, childbirth, or related medical conditions." 42 U.S.C. § 2000e(k) (1983). The legislative history indicates that the amendment extended protection to both fertile and pregnant women. The House report indicated that the purpose of the amendment was to expand protection to the "whole range of matters concerning the childbearing process." H.R. REP. No. 948, 95th Cong., 2d Sess. 5, reprinted in 1978 U.S. CODE CONG. & AD. NEWS 4749, 4753. Neither the language of the amendment nor its legislative history uses a fetal protection rationale to resolve the issue of excluding women from workplace toxins.

1557. 697 F.2d 1172 (4th Cir. 1982). See generally Note, *The Fetus as Business Customer in the Toxic Workplace: Wright v. Olin Corp. Sets Standards for Fetal Protection Programs*, 1984 DET. C.L. REV. 973.

1558. 741 F.2d 444 (D.C. Cir. 1984).

1559. 697 F.2d 1172.

1560. *Id.* at 1182. Defendant's program defined workplace toxins to include "known or suspected abortifacient or teratogenic agents." Abortifacients are harmful agents that induce abortion. See generally *supra* section II of this Special Project, for a discussion of a challenge before the Supreme Court of a state law regulating abortifacients' use as contraceptives. A teratogenic agent is a chemical that manifests an effect upon the fetus from fertilization until birth.

1561. 697 F.2d at 1189.

1562. *Id.* at 1189 n.25. But see *In Re National Airlines*, 434 F. Supp. 249, 259 (S.D. Fla. 1977) (commenting that the question of harm to the fetus is the mother's decision and not that of the court).

premises.<sup>1563</sup> Based on this analogy, the court reasoned that the safety of workers' unborn children should be no less a legitimate business concern than the safety of the traditional business licensee or invitee.<sup>1564</sup> The court, therefore, concluded that employers may impose otherwise impermissible restrictions on women's employment opportunities if those restrictions are reasonably necessary to protect the health of the unborn children of female employees against the hazards of the workplace.<sup>1565</sup> The court then issued guidelines for determining when a business necessity defense would justify excluding pregnant women from hazardous areas of the workplace.<sup>1566</sup> The employer will prevail if objective evidence<sup>1567</sup> shows that (1) significant risks of harm to unborn children exist, (2) the risks are confined to exposure of women, (3) the restrictive policy effectively protects the unborn, and (4) no acceptable alternative policy exists.<sup>1568</sup>

In *Oil, Chemical & Atomic Workers International Union v. American Cyanamid Co.*<sup>1569</sup> the defendant announced it would exclude women of childbearing capacity from certain high risk jobs to protect unborn children. This category included women between the ages of sixteen and fifty unless the women elected voluntary sterilization. The Occupational Safety and Health Administration (OSHA) challenged this fetal protection policy.<sup>1570</sup> The United States Court of Appeals for the District of Columbia affirmed an administrative law judge's decision that held the sterilization op-

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1563. 697 F.2d at 1189.

1564. *Id.*

1565. *Id.* at 1189-90.

1566. *Id.* at 1190-92. *But see* *Zuniga v. Kleberg County Hosp.*, 692 F.2d 986, 992-94 (5th Cir. 1982) (firing of a pregnant X-ray technician illegal for failing to utilize a less discriminatory alternative).

1567. The court emphasized that the employer's subjective, good faith belief will not suffice; independent, objective evidence must support these contentions. 697 F.2d at 1190.

1568. *Id.* at 1190-91. The Fourth Circuit upheld the district court's judgment for defendant, *EEOC v. Olin Corp.*, 24 Fair Empl. Prac. Cas. (BNA) 1646 (W.D.N.C. 1980), in all respects except the lower court's holding that medical evidence justified the fetal vulnerability policy and that the company instituted the policy with no intent to discriminate. 697 F.2d at 1176, 1192. The Fourth Circuit then remanded the case for further adjudication according to the newly established guidelines. *Id.* at 1192. On remand, *Wright v. Olin*, 585 F. Supp. 1447 (W.D.N.C. 1984), the lower court held that defendant had met the Fourth Circuit's standards and had successfully rebutted the prima facie case of discrimination by showing that the risk was substantially confined to women and that no acceptable alternative policies existed. *Id.* at 1452. In issuing its opinion, the lower court praised defendant for choosing a policy of fetal protection and called the choice "a social good that should be encouraged and not penalized." *Id.* at 1453.

1569. 741 F.2d 444 (D.C. Cir. 1984).

1570. *American Cyanamid Co.*, 9 O.S.H. Cas. (BNA) 1596 (1981).

tion of the fetus protection policy was not a "hazard" of "employment" under the language of OSHA<sup>1571</sup> and, therefore, did not violate OSHA standards. The court asserted that the policy's application to women was "imposed by unavoidable physiological facts."<sup>1572</sup> The court conceded that women "were put to a most unhappy choice."<sup>1573</sup> Arguably, however, women had no choice at all. The company policy did not allow a female employee to choose whether to risk the danger to a potentially developing fetus. Instead, the company made the choice for her under the euphemism of a "fetus protection policy." Under this policy all women employees of childbearing age, not just pregnant women, are prohibited from working at jobs that expose them to toxic substances at levels scientists believe to be unsafe for a developing fetus.

Neither the *Olin* nor the *American Cyanamid* decision was articulated in terms of fetal rights, yet the recognition that the fetus is owed protection underlies not only the company's articulation of the policy but also the judicial reasoning upholding the policy. Historically, employers have limited equal employment opportunities for women by restricting their employment on the basis of a professed concern for the health of women and their offspring.<sup>1574</sup> Perhaps the underlying reason for these emerging workplace toxin policies is a renewed effort to exclude women from high paying jobs traditionally filled by males. Employers of typically female-dominated jobs have not demonstrated as much concern with shielding their workers from contact with hazardous substances.<sup>1575</sup> The *Olin* and *American Cyanamid* courts only superficially considered the question of the effects of exposure on male workers. Because scientific studies of hazards posed to the fetus by workplace toxins fo-

1571. 741 F.2d at 445. Occupational Safety and Health Act of 1970 Pub. L. No. 91-596, § 5(a)(1), 84 Stat. 1590 (codified as amended at 29 U.S.C. § 654(a)(1) (1982)).

1572. 741 F.2d at 450.

1573. *Id.*

1574. See *Muller v. Oregon*, 208 U.S. 412 (1908).

1575. Address by Lucinda Finley, New York University National Conference on Labor (June 7, 1985) reprinted in *DAILY LAB. REP.* (BNA) No. 116, at A-13 (June 17, 1985).

Lucinda Finley, Yale University law professor, warned New York University's annual National Conference on Labor that overbroad fetal plans that remove women workers of child-bearing age from jobs involving exposure to workplace toxins may restrict women's employment opportunities. Professor Finley suggested that employers who adopted fetal protection policies focusing on female workers avoided measures that would make the workplace safer for workers of both sexes. In addition, she stated that fetal protection plans directed solely at women have a "potentially discriminatory motivation." She urged employers to stop thinking of the issue "as solely a women's [sic] problem." *Id.*

cus on the exposure of women rather than of men,<sup>1576</sup> more scientific data is available to support employer policies that exclude women on a business necessity rationale.

The more appropriate solution to the issue of workplace toxins is for the woman, rather than the employer, to weigh the risks. Employers can avoid liability<sup>1577</sup> by informing female workers of any risks and acting reasonably to clean up the workplace. The potential for control and the obvious exercise of control over women is readily apparent from these two recent decisions. *Olin* and *American Cyanamid* illustrate, however, that the workplace has joined the courtroom and the hospital as an arena in which control may be exercised over women's choices with regard to the fetus she carries or may carry in the future.

### E. CONCLUSION

As moral codes, social customs, and ethical considerations change, the law evolves. Scientific advances, which pose new questions for judicial scrutiny, create the momentum for legal innovations. The definition of both maternal and fetal rights will evolve depending on how the law responds to changes in medical technology.

Although the law acknowledges fetal rights to certain material things,<sup>1578</sup> a fetal right to life itself remains unsettled. Increasingly, courts recognize fetal interests and often prefer them to the interests of the mother.<sup>1579</sup> Medical advances elevate the fetus to the status of patient.<sup>1580</sup> Employers seek to protect the fetus from the hazards of the workplace.<sup>1581</sup> Advocates for maternal rights have not been silent. These proponents have pressed their arguments in the courtroom, hospital, and workplace. In spite of these efforts, recent court decisions, medical advances, and workplace fetal protection policies evidence the erosion of maternal rights in major arenas.

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1576. Williams, *supra* note 1553, at 656-58. "Exposure of either parent prior to conception to substances that damage the germ cells is an additional way in which fetuses may be harmed." *Id.* at 656.

1577. See Rothstein, *Employee Selection Based on Susceptibility to Occupational Illness*, 81 MICH. L. REV. 1379, 1489-91 (1983) (discussing legal and factual issues surrounding application of prenatal recovery theories to a toxic workplace setting).

1578. For example, a fetus possesses certain inheritance rights. See generally *supra* section IV of this Special Project.

1579. See *supra* notes 1432-86 and accompanying text.

1580. See *supra* accompanying and following note 1412.

1581. See *supra* notes 1553-76 and accompanying text.

Balancing the competing considerations of maternal and fetal interests to determine reasonable solutions is a difficult process. A woman's interest in deciding what is to be done to her own body and society's interest in producing healthy offspring each deserve serious attention. Neither interest automatically tips the balance in either direction. Moreover, the resolution of this conflict has serious implications for the kind of society in which we shall live.

A mother rarely will refuse medical treatment that is necessary to protect the health of her fetus, and the instances of conflict between fetal rights and maternal interests in bodily integrity will be few. Deciding that fetal rights will prevail in those few instances, however, inevitably will lead to a society that will require monitoring of all pregnant and potentially fertile women to assure effective enforcement of those fetal rights. As medical advances turn the experimental into the routine, the pregnant woman conceivably could be forced to undergo surgery for the sake of the fetus she carries even though she would not be forced to undergo surgery for a child who was already born. Monitoring and enforcement problems could threaten to turn our society into a prototype of an Orwellian novel if fetal interests override maternal choice.

Maternal choice can only extend so far. The law does not allow a woman to abort a fetus after it is viable. A competent woman, however, should have the right to make decisions about her own body up until the time of birth. The difference between fetus and child is a great one; the separateness of the latter from the mother is contrasted with the oneness of the former. Until the moment of birth, everything done to the fetus also affects the woman. In a difficult decision, the woman's present right to bodily integrity should prevail over the rights of a "potential" person. Furthermore, physicians' attempts to predict potential harm to a fetus are not always accurate. Indeed, in the two reported instances of court-ordered caesarean section, the orders were never carried out, and both women delivered healthy children despite medical and judicial judgment to the contrary.

Rather than subjecting women to control by courts and physicians, the answer lies in educating women about the potential dangers their behavior poses for the fetus. A woman who is aware of the harm to the fetus she carries rarely rejects medical help. Although some tragedies may occur as a result of respecting a woman's right to refuse an operation that physicians believe to be warranted, the instances will be few. Because of the fallibility of medical science, preserving the rights of all competent adults to

control their own bodies is preferable to living in a society that would attempt to monitor every action of a pregnant woman. No one can see into the future to ascertain the correctness of one's decisions. To create a society in which the "right" decision will always be made is to undermine choice in its most basic sense. By asking what kind of society we want, we may opt for an imperfect world, but one that leaves room for personal autonomy.

## XII. Conclusion

As medical technology continues to advance rapidly, new legal issues arise and increase in complexity. This is particularly true of the law surrounding conception, pregnancy, and birth. This Special Project has examined the medical techniques themselves and their implications on various legal issues. While recognizing that the law inevitably lags behind technology, the Special Project has pointed out the need for prompt judicial and legislative response to medical advances. These advances necessitate a thorough examination and understanding of the legal issues surrounding conception, pregnancy, and birth. It is hoped that this Special Project will point out the need for, and contribute to, such an understanding.

HUTTON BROWN

MIRIAM DENT

L. MARK DYER

CHERIE FUZZELL

ANITA GIFFORD

SAM GRIFFIN

A.G. KASSELBERG, M.D.

JAYNE WORKMAN

MELINDA L. COOPER

*Special Project Editors*