

## **Multiple Choice Test: Physician Responsibilities and Patient Rights in the Implantation of Multiple Embryos Without the Use of Selective Reduction**

The "Octomom"<sup>1</sup> drew the public's eye to assisted reproductive technology (ART),<sup>2</sup> a rapidly-developing medical science.<sup>3</sup> ART's law and ethics are likewise in flux, providing a rich area of study for the attorney who advises ART providers. The stakes are high in any potential medical malpractice case, but all the more so in this arena because of the high cost of ART procedures,<sup>4</sup> the patient's intense desire for healthy children, and the provider's professional reputation.

Part 1 of this paper examines whether it is medical malpractice for Dr. Welby to implant six embryos by in vitro fertilization (IVF) in his patient, 41-year-old Julie, at her request. Part 2 explores whether Welby may lawfully deny Julie services because selective reduction, a practice contrary to his religious beliefs, may become medically necessary. Each Part examines the relevant law, including statutes and case law, both state and federal; theories in contract law, constitutional law, and tort law, with special emphasis on medical malpractice negligence, the role of custom, and informed consent; and the opinion of professional societies.<sup>5</sup> In each Part, the examination of the law is followed by an analysis of its applicability, followed then by the attorney's recommendations to Welby.

### **1. Is it Medical Malpractice for a Provider to Implant Six Embryos in an Older Woman?**

Welby, in considering whether to implant six embryos, must make a medical decision: will a high-order multiple implantation pose a danger to either Julie or the eventual fetuses? Should the answer be yes, Welby must decide whether it is an acceptable risk in light of Julie's goal of bearing several children in this one pregnancy. Welby's attorney must identify the law that predicts his client's liability in the case of a bad outcome.

#### **1.1 Governing Law**

Federal statutes regulating ART are few; most work by legal scholars examining ART regulation begins by noting its dearth.<sup>6</sup> What little national regulatory law there is "oversees clinical laboratory services, drugs, and medical devices used in IVF treatments; has standards that establish safe use of human tissue . . . ; and provides monitoring of fertility clinic success rates to protect ART consumers from fraudulent advertisements."<sup>7</sup>

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<sup>1</sup> Randal C. Archibold, *Octuplets, 6 Siblings, And Many Questions*, N.Y. TIMES, Feb. 4, 2009, at A14.

<sup>2</sup> ART is defined as "all fertility treatments in which both eggs and sperm are handled." Center for Disease Control and Prevention, *Assisted Reproductive Technology: Home* (June 30, 2009), <http://www.cdc.gov/art/>.

<sup>3</sup> The first baby conceived by in vitro fertilization was born in 1978. *Conceiving the Inconceivable*, N.Y. TIMES, July 28, 1978, at A22.

<sup>4</sup> The average cost of one IVF attempt is \$12,400. Associated Press, *Most Fertility Clinics Break the Rules*, Feb. 20, 2009, available at <http://www.msnbc.msn.com/id/29305552/>.

<sup>5</sup> Because custom is dependent on medical practice and ethics, this paper includes medical and public health literature in addition to the usual legal sources.

<sup>6</sup> "[T]he federal government has made little attempt to provide true regulation of [ART] in the United States." Charles P. Kindregan & Maureen McBrien, *ASSISTED REPRODUCTIVE TECHNOLOGY: A LAWYER'S GUIDE TO EMERGING LAW AND SCIENCE* 197 (2006). See also Susan B. Apel, *Access to Assisted Reproductive Technologies*, 2007, [http://works.bepress.com/susan\\_apel](http://works.bepress.com/susan_apel), at 27. "The medical establishment . . . would probably prefer the status quo, which is non-existent legislation and incremental self-regulation."

<sup>7</sup> Naomi R. Cahn & Jennifer M. Collins, *Eight is Enough*, 103 NW. U. L. REV. COLLOQUY 501, 507-8 (2009).

State statutes are more in evidence, as follows from the "deep tradition of state, rather than federal responsibility for the key issues of malpractice: development of common law principles of negligence; licensing and regulation of hospitals, physicians, and other health care workers ..."<sup>8</sup> Shortly after the Octomom birth, the Georgia Assembly introduced legislation restricting to three the number of embryos permitted to be transferred.<sup>9</sup> Following objections by the American Society of Reproductive Medicine (ASRM),<sup>10</sup> among others, this provision was quickly excised from the bill.<sup>11</sup> An unsuccessful Missouri bill contained restrictions on embryo transfer which specifically referenced ASRM/SART (Society for Assisted Reproductive Technology) guidelines.<sup>12</sup>

Case law involving ART is similarly sparse. Much of what has appeared concerns issues of "misplaced embryos, diseased gametes or unauthorized use of sperm,"<sup>13</sup> what John A. Robertson terms "dispositional control" of reproductive materials.<sup>14</sup> One of few cases to deal specifically with high-order multiple pregnancies is *Frustaci v. Marik*,<sup>15</sup> in which plaintiffs sued in a California state court for the wrongful death of four septuplets.<sup>16</sup> The Frustacis alleged that their physician, in using a fertility drug to stimulate egg production, had failed to perform tests to reveal the large number of eggs so that fertilization of some eggs could have been prevented. The case was settled while still in trial court.<sup>17</sup> It is hardly surprising that the Frustaci case is one of few; regulation of this sort is served more efficiently by statute than by litigation.<sup>18</sup>

The heart of medical malpractice lies in the negligence theory of tort law, under which professional custom<sup>19</sup> determines the standard of care. Medical societies often provide guidelines within their specialties, as alluded to in Missouri's use of ASRM guidelines.<sup>20</sup> ASRM stresses the need to reduce high-order multiple pregnancies generated by ART: "High-order multiple pregnancy (three or more implanted embryos) is an undesirable consequence... Multiple gestations lead to an increased risk of complications in both the fetuses and the

<sup>8</sup> Sylvia A. Law, *A Consumer Perspective on Medical Malpractice*, 49 LAW & CONTEMP. PROBS. 305, 319 (1986).

<sup>9</sup> *Equal Treatment of Embryos Act*, H.B. 169, 2009-10 Gen. Assem., Reg. Sess. (Ga. 2009).

<sup>10</sup> *Georgia's Equal Treatment of Embryos Act: Committee Hearing Tomorrow*, 11 ASRM BULLETIN available at March 4, 2009, <http://www.asrm.org/Washington/Bulletins/vol11no13.html>. See also

<sup>11</sup> Kimberly D. Krawiec, *Why We Should Ignore the 'Octomom'*, UNC LEGAL STUDIES RES. PAPER NO. 1409037 (2009) at 9, available at <http://ssrn.com/abstract=1409037>.

<sup>12</sup> H.B. 810, 95<sup>th</sup> Gen. Assem., 1<sup>st</sup> Reg. Sess. (Mo. 2009). See also *infra*, note 21.

<sup>13</sup> Charles P. Kindregan, *Thinking About the Law of Assisted Reproductive Technology*, LEGAL STUD. RES. PAPER SERIES, RES. PAPER 08-01, SUFFOLK U LAW SCH., December 7, 2007, at 3.

<sup>14</sup> John A. Robertson, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 104 (1994).

<sup>15</sup> *Frustaci v. Jaroslav Marik, MD., Tyler Medical Clinic*. Not available at Westlaw; see instead Dummit, Buchholz & Trapp, Attorneys at Law, [http://dummitlaw.net/previous\\_cases.html](http://dummitlaw.net/previous_cases.html) (last visited July 25, 2009).

<sup>16</sup> Gary Jarlson, *Frustacis Sue, Charge Malpractice*, L.A. TIMES, at B1, Oct. 9, 1985.

<sup>17</sup> Ronald Chester, *Double Trouble: Legal Solutions to the Medical Problems of Unconsented Sperm Harvesting and Drug-Induced Multiple Pregnancies*, 44 St. Louis U. L.J. 451, 464 n.73 (2000).

<sup>18</sup> "...courts have an extremely difficult time making meaningful public policy in the realm of assisted reproduction because they are limited to deciding individual disputes after the fact. The legislature, which ideally can foresee and prevent disputes, is the preferred law-making body in this arena." George J. Annas, AMERICAN BIOETHICS: CROSSING HUMAN RIGHTS AND HEALTH LAW BOUNDARIES 142 (2005).

<sup>19</sup> Restatement (Second) of Torts § 299A. (1965).

<sup>20</sup> Mo. H.B. 810.

mothers."<sup>21</sup> Selective reduction, an early-term abortion used to decrease the number of fetuses, itself carries risk and is not always acceptable to patients<sup>22</sup> - or, as in Welby's case, to doctors.

Therefore, ASRM limits by patient age the number of embryos to be implanted. Julie falls under the following category: "For patients greater than 40 years of age, no more than 5 cleavage-stage embryos or 3 blastocysts should be transferred."<sup>23</sup> However, this guideline is tempered by an emphasis that strict limits would "not allow treatment plans to be individualized after careful consideration of each patient's own unique circumstances."<sup>24</sup> For that reason, ASRM recommends the guidelines be interpreted and applied freely, although clinics are required to record data and monitor trends. "Programs that have a high-order multiple pregnancy rate that is greater than two standard deviations above the mean rate for all SART reporting clinics for two consecutive years will be audited by SART."<sup>25</sup> The guidelines do not address consequences of a SART audit, but an Associate Press article reports that the only penalty is "expulsion from some of the industry's professional organizations, though that can affect whether insurance companies will cover a clinic's treatments."<sup>26</sup> This deterrent effect is weakened by IVF's largely privately funded status.<sup>27</sup> The finding that 80% of practitioners do not follow the guidelines confirms the guidelines' flexibility and the lack of an external control mechanism.<sup>28</sup>

More generally, the ASRM Ethics Committee states that when physicians believe a particular treatment being considered has a low chance of success and may harm the patient, "clinicians may refuse to begin treatment or decline to continue with the current protocol. Indeed, some ethicists argue that clinicians have a duty to withhold [such] treatments..."<sup>29</sup>

## 1.2 Analysis

In the case of a bad outcome of Julie's proposed high-multiple pregnancy, would Welby survive a malpractice action? Nirvana may eventually enact restrictions similar to those attempted by Georgia and Missouri,<sup>30</sup> but in their absence and that of federal statutes or case law on point, custom is key. ASRM's recommendations generally advise against such a high-order multiple implantation. Should Welby claim that he was following the customary practice of the 80% of his colleagues who also do not comply with guidelines,<sup>31</sup> opposing counsel would almost

<sup>21</sup> The Practice Committee of the Society for Assisted Reproductive Technology and the Practice Committee of the American Society for Reproductive Medicine, *Guidelines on Number of Embryos Transferred*, 90 FERTIL. STERIL. S163 (2008), available at [http://www.asrm.org/Media/Practice/Guidelines\\_on\\_number\\_of\\_embryos.pdf](http://www.asrm.org/Media/Practice/Guidelines_on_number_of_embryos.pdf) [hereinafter, *ASRM Guidelines*].

<sup>22</sup> *Id.*

<sup>23</sup> *Id.* The distinction between cleavage-stage embryos (implanted 2 or 3 days after fertilization) and blastocysts (implanted 5 or 6 days after fertilization) renders the guidelines less certain, as it is not known to which Welby was referring. Because the Missouri bill in echoing the ASRM guidelines specified 3 embryos (*see supra* note 12), this paper will proceed on the assumption that the embryos Welby would implant are blastocysts.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> Associated Press, *supra* note 4.

<sup>27</sup> "Most health plans exclude [IVF] from coverage on the grounds that it is not medically necessary." Tarun Jain & Mark D. Hornstein, *To Pay or Not to Pay*, 80 FERTIL. STERIL. 27, 27 (2003).

<sup>28</sup> Associated Press, *supra* note 4.

<sup>29</sup> The Ethics Committee of the American Society for Reproductive Medicine, *Fertility Treatment when the Prognosis is Very Poor or Futile*, 82 FERTIL. STERIL. 806, 807 (2004) [hereinafter *Prognosis is Poor*].

<sup>30</sup> Ga. H.B. 169; Mo. H.B. 810.

<sup>31</sup> Associated Press, *supra* note 4.

certainly assert that the recommendations of professional societies take precedence in establishing custom.<sup>32</sup> Because of the guidelines' laxity,<sup>33</sup> Welby could claim that although he exceeded the specific guidelines, he was individualizing Julie's treatment plan after careful consideration of her unique circumstances. However, opposing counsel would most likely point out that Julie had already carried to term multiple IVF fetuses, and therefore could be predicted to succeed again; thus, she had no need for a high number implantation as insurance. More to the point, though, the earlier pregnancy resulted in damage of the exact nature predicted by those warning against high-order multiples: "prematurity (associated with the respiratory distress syndrome...) ... and physical, mental, and developmental disabilities."<sup>34</sup> The respiratory disorders and autism from which Julie's children suffer can be seen as a clear warning against a future high-order multiple pregnancy, supporting possible liability for negligence or – in the worst case – wrongful death. Finally, Welby's refusal to offer selective reduction makes it more likely that Julie will carry a high-order multiple pregnancy to term. Opposing counsel might argue that a practitioner who knows he would be unable to prevent a patient from carrying such a pregnancy to term should not himself set the stage for that eventuality.

Anticipating these problems, Welby might attempt to contract around the issue by having Julie sign a waiver stating that in requesting the implantation of six embryos, she is willfully disregarding her doctor's best judgment, and that she will assume all risk and bear all consequences of that action. Welby would at that time inform her of the dangers of her proposed course of action as well as his unwillingness to perform selective reduction, thereby fulfilling the informed consent requirement.<sup>35</sup> However, *Tunkl v. Regents of the University of California*<sup>36</sup> set a persuasive precedent of invalidating assumption of risk where a public policy interest is at stake.<sup>37</sup> The public policy in Welby's case is preventing harm to a patient and her eventual children, where there is not an "arm's length bargain between roughly equal parties."<sup>38</sup>

Although not part of a malpractice action, a state medical board may move against a physician if it finds he acted incompetently or unprofessionally. A complaint leading to an investigation may be filed by persons or organizations other than the injured patient.<sup>39</sup>

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<sup>32</sup> "A clinical standard may be presumptive evidence of due care if expert testimony introduces the standard and establishes its sources and its relevancy. The guidelines can also be used to impeach the opinion of a medical expert." Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29 J.L. MED. & ETHICS 28, 32 (2001).

<sup>33</sup> Practice Committee of the SART & ASRM, *supra* note 22, at S163.

<sup>34</sup> Tarun Jain, Bernard L. Harlow, & Mark D. Hornstein, *Insurance Coverage and Outcomes of in Vitro Fertilization*, 347 NEW ENG. J. MED 661, 665 (2002).

<sup>35</sup> Informed consent was initially defined in *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). *See also Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181. "A physician violates his duty to his patient and subjects himself to liability [in tort] if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."

<sup>36</sup> *Tunkl v. Regents of the Univ. of California*, 383 P.2d 441, 447 (Cal. 1963) *Tunkl* has been followed by *Am. Structural Composites, Inc. v. ICBO Evaluation Servs.*, 220 Fed. Appx. 660 (9th Cir. 2007).

<sup>37</sup> Glen O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks between Patients and Providers*, 49 LAW & CONTEMP. PROBS. 173, 192 (1986).

<sup>38</sup> Chester, *supra* note 18, at 470. Chester notes that ART patients are often "psychologically desperate, viewing the fertility center as their last hope to help them conceive a child." He contrasts this with the provider's "expert" status.

<sup>39</sup> Federation of State Medical Boards, *Protecting the Public: How State Medical Boards Regulate and Discipline Physicians*, [http://www.fsmb.org/smb\\_protecting\\_public.html](http://www.fsmb.org/smb_protecting_public.html) (last visited July 19, 2009).

### 1.3 Recommendations

Even though a malpractice action might be defensible, conservative counsel would advise Welby to refrain from exceeding the ASRM guidelines. Reasons for caution abound: possible harm to the patient and fetuses, reprisals from professional organizations, investigations by state medical boards. The ASRM Ethics Committee's direction on the duty to withhold treatment is particularly compelling.<sup>40</sup> At the same time, there is very little to gain from fulfilling Julie's request. Certainly, Welby might collect a large fee; however, he might collect that fee from a another, less dangerously demanding patient. As the number of patients seeking IVF continues to rise,<sup>41</sup> Welby occupies an enviable position in a seller's market. If Julie will compromise, Welby can safely implant the maximum number of embryos recommended for her age group; indeed, SART recommends implanting more than one embryo for most IVF clients.<sup>42</sup> Attempts to contract around the limits, as discussed above,<sup>43</sup> would be inadvisable in an ART context. In summation, Welby ethically owes his patient his best medical judgment; happily, in this case, this is the same duty he owes in law.

## 2. Can a Physician Lawfully Deny Services Because a Practice Contrary to his Religious Beliefs May Become Medically Necessary?

Dr. Welby and Dr. Kildare's faith tradition objects to the practice of selective reduction. Julie, on the other hand, must walk a delicate balance between implanting sufficient embryos to generate the multiple fetuses she wishes, yet not so many as to pose a risk. Part 2 of this paper examines what right, if any, a patient has to demand service in order to procreate; the nature of the provider's right to deny service for a specific procedure; and whether that right extends to denying all service because the provider believes the procedure may eventually be necessary.

### 2.1 Governing Law

The Universal Declaration of Human Rights, although a declaration rather than binding law,<sup>44</sup> lists the right "to found a family."<sup>45</sup> However, the right to procreate is not enumerated in the United States Constitution. The case law most often cited in supporting this basic right is *Skinner v. Oklahoma*,<sup>46</sup> in which Justice William O. Douglas held that procreation is "one of the basic civil rights of man."<sup>47</sup> Robertson extends Justice Douglas's assertion to ART, writing that "if bearing, begetting, or parenting children is protected as part of personal privacy or liberty, those experiences should be protected whether they are achieved coitally or noncoitally."<sup>48</sup>

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<sup>40</sup> Practice Committee of the SART & ASRM, *supra* note 22, at S163.

<sup>41</sup> "The number of ART cycles performed in the United States has more than doubled, from 64,681 cycles in 1996 to 138,198 in 2006." *2006 Assisted Reproductive Technology (ART) Report: Section 5—ART Trends, 1996–2006*, Centers for Disease Controls and Prevention, Dec. 12, 2008, <http://www.cdc.gov/art/ART2006/section5.htm>.

<sup>42</sup> Society for Assisted Reproductive Technology, *Questions and Answers* (2009), [http://www.sart.org/Guide\\_QuestionsAndAnswers.html](http://www.sart.org/Guide_QuestionsAndAnswers.html) (last visited July 20, 2009).

<sup>43</sup> *Tunkl*, 383 P.2d at 447.

<sup>44</sup> Peter Bailey, *The Creation of the Universal Declaration of Human Rights*, <http://www.universalrights.net/main/creation.htm> (last visited July 28, 2009).

<sup>45</sup> U.N., Universal Declaration of Human Rights, Dec. 10, 1948, Art. 16, *available at* <http://www.un.org/en/documents/udhr/index.shtml#a16>.

<sup>46</sup> *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942). An Oklahoma statute authorizing the sterilization of repeat felons was found to be unconstitutional as violating the Fourteenth Amendment's equal protection clause.

<sup>47</sup> *Skinner*, 316 U.S. at 541.

<sup>48</sup> Robertson, *supra* note 15, at 49.

However, Robertson also characterizes procreative liberty as a *negative* right which "does not imply the duty of others to provide the resources or services necessary to exercise one's procreative liberty ..." and applies chiefly "against state interference with choices to procreate or to avoid procreation. It is not a right against private interference ..."<sup>49</sup>

The question of the physician or other provider's right to deny services in the realm of ART is customarily divided into two types: cases in which the provider expresses judgment about a particular procedure or medication, such as abortion or contraception, and cases in which the provider expresses judgment about the patient,<sup>50</sup> asserting that some patient characteristic, such as lesbianism, unmarried status, or even race, makes her unfit to birth or parent a child. The latter type of case has received considerable attention in the medical and legal literature, but is beyond the scope of this paper. However, it is worth mentioning that at times providers have refused service because the basis of their religious objections were characteristics of the patient. In such situations, the resultant law is applicable to Welby's circumstances.

One such case is *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court*.<sup>51</sup> The plaintiff sued the North Coast ART practice for refusal to perform intrauterine insemination, claiming sexual orientation discrimination in violation of California's Unruh Civil Rights Act.<sup>52</sup> The defendant asserted an affirmative defense that any alleged misconduct "was protected by the rights of free speech and freedom of religion set forth in the federal and state Constitutions."<sup>53</sup> On appeal, the Supreme Court of California found that "under the United States Supreme Court's most recent holdings, a religious objector has *no federal constitutional right* to an exemption from a neutral and valid law of general applicability on the ground that compliance with that law is contrary to the objector's religious beliefs."<sup>54</sup>

This ruling provides only persuasive authority to the State of Nirvana, and would in any case be dependent on the presence of a state law of general applicability. A more relevant body of law is the alternately designated Refusal Clause or Conscience Clause legislation, from its beginnings as an institutional reaction to the ruling in *Roe v. Wade*<sup>55</sup> to its present-day incarnation of pharmacist refusals to dispense contraception. In 1973 Congress enacted the Church Amendment, which gives private hospitals receiving federal funds an exemption from offering abortion or sterilization services on the basis of religious beliefs or moral convictions.<sup>56</sup> A series of similar federal acts followed,<sup>57</sup> culminating in President George W. Bush's now-

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<sup>49</sup> *Id.* at 23.

<sup>50</sup> Judith F. Daar, *Accessing Reproductive Technologies: Invisible Barriers, Indelible Harms*, 23 BERKELEY J. GENDER LAW & JUST. 18, 67 n.181 (2008).

<sup>51</sup> *North Coast Women's Care Med. Group, Inc. v. San Diego County Superior Court*, 189 P.3d 959.

<sup>52</sup> *Id.* at 964.

<sup>53</sup> *Id.* "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof..." U.S. CONST. amend. I. The California equivalent: CA. CONST. art I, § 4.

<sup>54</sup> 189 P.3d at 966.

<sup>55</sup> 410 U.S. 113 (1973)

<sup>56</sup> Health Programs Extension Act of 1973, Pub. L. No. 93-45, § 401, 87 Stat. 95 (codified at 42 U.S.C. § 300a-7 (2000)).

<sup>57</sup> The 1977 Hyde Amendment limits abortion services provided by Medicaid, the 1996 Public Health Service Act Section 245 protects individuals who refuse training in abortion or who refuse to make abortion referrals, and the 2004 Hyde/Weldon Conscience Protection Amendment extends refusal protections to federally-funded health

rescinded Provider Conscience Regulations, which situated pharmacist refusal in a much broader interpretation of Church Amendment-era law, including expanded categories of employees, lines of funding and procedures, which some commentators believed might extend to infertility treatment.<sup>58</sup>

During this pursuit of a federal standard, "the majority of states [had] adopted refusal clauses [which were] extended to include *assisted reproductive technologies*, contraception and emergency contraception, ... [and] *in vitro fertilization* ..." <sup>59</sup> A majority of states enacted conscience clause legislation, while a minority expressly precluded such refusals.<sup>60</sup> A state standard reached a national forum on July 8, 2009, in *Stormans v. Selecky*: the Ninth Circuit Court of Appeals reversed a lower court's preliminary injunction which had halted enforcement of the State of Washington Pharmacy Board's requirement that pharmacies dispense all FDA-approved medication.<sup>61</sup>

The relevant professional associations take the middle ground, presumably with the hope of satisfying the greatest possible number of their membership. The American Pharmacists' Association supports the pharmacist's right to refuse (to "step away"), but with the expectation that the customer nevertheless receives "seamless" delivery of the prescription and, in fact, remains unaware that the pharmacist has dissented.<sup>62</sup> The American College of Gynecologists and Obstetricians mirrors that balance of protecting both provider conscience and patient access in its recommendations for reproductive healthcare generally.<sup>63</sup> The ASRM Ethics Committee has not taken a public position on the issue of provider refusal.<sup>64</sup> However, a personal communication from ASRM stated that the standard for providers who do not perform selective reduction is to refer patients to partners within the practice.<sup>65</sup> On the whole, ASRM holds that physicians may "decline to accept individuals as patients as long as they do not violate laws

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insurance. Amy Henry, *Accessories by Force: Moves Against Conscience Protections Threaten More than Pro-Life Doctors and Pharmacists*, WORLD, July 18, 2009, <http://www.worldmag.com/articles/15596>.

<sup>58</sup> Posting of Christine Cupaiuolo to Our Bodies Ourselves, <http://www.ourbodiesourblog.org/blog/2009/07/13> (July 13, 2009, 7:42 EST).

<sup>59</sup> Posting of Pamela Merritt to RH Reality Check, <http://www.rhrealitycheck.org/blog/2008/12/04/conscience-clauses-refusing-serve-womens-health-care-needs> (Dec. 11, 2008, 8:00 EST), *emphasis added*. See also Pharmacist Conscience Clauses: Laws and Legislation, NATIONAL CONFERENCE OF STATE LEGISLATURES (2009), <http://www.ncsl.org/default.aspx?tabid=14380>. See also The Kaiser Family Foundation's summary of state conscience clause legislation, <http://www.statehealthfacts.org/comparecat.jsp?cat=10>, Women's Health, select Refusal Policies For Health Services (2009).

<sup>60</sup> Representative of the majority is Louisiana House Bill 517 (Regular Session, 2009, Section B2). Occupying the middle ground is Miss. Code Ann. § 41-107-5 (1998), which protects against racial and other discrimination. The minority view, requiring pharmacies to fill all lawful prescriptions, is represented by New Jersey's P.L. 2007, Chapter 199, 1a., Nov. 2, 2007.

<sup>61</sup> *Stormans, Inc. v. Selecky*, 2009 WL 1941550, 27 (9<sup>th</sup> Cir. 2009).

<sup>62</sup> Letter from John A. Gans, President, American Pharmacists' Association, to Department of Health and Human Services (Sept. 25, 2008), <http://www.pharmacist.com/AM>, search for 17810.

<sup>63</sup> *The Limits of Conscientious Refusal in Reproductive Medicine*, ACOG Committee Opinion No. 305 (Nov. 2007), [http://www.acog.org/from\\_home/publications/ethics/co385.pdf](http://www.acog.org/from_home/publications/ethics/co385.pdf).

<sup>64</sup> *Ethical Considerations of Assisted Reproductive Technologies*, ASRM Ethics Committee Reports & Statements, <http://www.asrm.org/Media/Ethics/ethicsmain.html> (last visited July 28, 2009).

<sup>65</sup> E-mail from Eleanor Nicoll, ASRM, to author (July 23, 2009) (on file with author).

against impermissible discrimination. In addition, they are free to terminate a physician–patient relationship as long as they provide timely notice to patients."<sup>66</sup>

A failure to provide service based on a perception that a religiously-objectionable procedure may be necessary might fall within the scope of contract law. A patient who had signed a contract for IVF could sue for breach, unless the contract included an express condition to discharge the provider's duty of performance if selective reduction became necessary. Of course, it would not be in the patient's financial interest to sign such a contract unless another provision compensated the patient for past expenditures and future delays. Even with such compensation, the contract might be greatly to the patient's disadvantage, in which case a court might not enforce such an uneven agreement in a physician-patient context.<sup>67</sup>

Finally, state medical boards provide another avenue for redress of unethical or otherwise improper provider behavior.<sup>68</sup> The refusal to complete treatment because of the emergence of a need for a service which the provider objects to on a religious basis is not a cause of action described in the Federation of State Medical Boards literature.<sup>69</sup> However, it speaks of a need to investigate patterns of negative behavior as independently reported by multiple patients. Thus, if an ART provider routinely severed relationships with patients under treatment just as they expressed an interest in selective reduction, those patients would be justified in seeking a remedy through their state medical boards.

## 2.2 Analysis

Julie could not claim that Welby's refusal to perform any given ART procedure violated her right to procreate, as that is considered a negative right.

Welby's objections center on the practice of selective reduction itself, not Julie's lesbianism, unmarried status, or other personal characteristic. However, these issues are easily conflated, as in *North Coast*, where the religious objections to performing a certain procedure for a lesbian were defended, albeit unsuccessfully, as actually being due to a reluctance to do so for an unmarried woman.<sup>70</sup> To apply North Coast's persuasive authority to Nirvana would require that the state have both an equivalent civil rights act and statutory authority designating Welby's private medical practice a place of public accommodation. Should Nirvana's code include only the latter, Julie might consider invoking the 1964 Civil Rights Act's barriers to access provision.<sup>71</sup> However, Dayna Matthew observes that the Act has been "singularly ineffective in

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<sup>66</sup> *Prognosis is Poor*, *supra* note 30, at 807.

<sup>67</sup> Chester, *supra* note 18, at 470.

<sup>68</sup> This paper cannot detail the many and complex relationships that connect each state's medical boards and that state's law; in general, however, most state medical boards can censure a physician, put him on probation, cause him to pay restitution to the patient, or revoke his medical license. *Protecting the Public*, *supra* note 39.

<sup>69</sup> *State of the States: Physician Regulation 2009*, FEDERATION OF STATE MEDICAL BOARDS, [http://www.fsmb.org/pdf/2009\\_state\\_of\\_states.pdf](http://www.fsmb.org/pdf/2009_state_of_states.pdf) (last visited July 26, 2009).

<sup>70</sup> At the time, The Unruh Civil Rights act did not prohibit discrimination against unmarried people. *North Coast*, 189 P.3d at 963, n1.

<sup>71</sup> 42 U.S.C. § 2000e, et seq.

addressing certain well-known forms of persistent health care inequalities."<sup>72</sup> These potential avenues, in any case, lean closer to remedies for refusal on the basis of patient characteristics.

Welby's refusal to perform selective reduction can be both analogized to and distinguished from the history of conscience clause legislation. Unless Welby receives a very specific kind of federal funding – unlikely, as ART practices tend to be privately funded and excluded from most insurance coverage<sup>73</sup> – federal law has minimal applicability. The physician's usual tie to public funding, Medicaid, is doubly discounted, as Medicaid need not cover ART treatment<sup>74</sup> and the Hyde Amendment forbids Medicaid coverage of abortion.<sup>75</sup> This dual disqualification extends to the remaining federal legislation discussed on pages 5-6.

State statutes should be considered in light of the persuasive effect they might exert on Julie to seek relief in litigation. If Nirvana is in the Ninth Circuit, it will be bound by *Stormans v. Selecky*,<sup>76</sup> that is, if Nirvana contains a neutral law of general applicability requiring pharmacists to dispense all lawful prescriptions, they must do so. That this would extend by analogy to compelling Welby, a physician, to perform selective reduction (or, more likely, to make accommodations in his practice to have it performed) is improbable.

The laws regulating women's reproductive health options show a tendency to converge: the post-*Roe v. Wade* federal regulations on abortion and sterilization built a support for later conscience clause measures, while those conscience clause laws extended their reach from abortion and sterilization to contraception<sup>77</sup> and eventually to new reproductive technologies, including IVF. However, that convergence is still too tenuous to represent binding law.

Finally, whether a provider may deny services based on the eventuality that selective reduction may be required must be viewed from the point in time the refusal is made. If it occurs before the provider has officially accepted the patient (i.e. before contract formation and certainly before billing), he may deny service so long as it is not based on discrimination. If the provider wishes to deny service after accepting the patient, and the denial is not made on a medical basis,<sup>78</sup> he is susceptible to a breach of contract suit, possibly a malpractice action, and perhaps within the reach of the state medical board's disciplinary process, whatever it may be in his particular state, but not guilty of disobeying any law.

### 2.3 Recommendations

Welby's is not compelled by law to offer the procedure, provided that he can be very clear that his objection is to the procedure of selective reduction, rather than to any of the characteristics of his patient. His attorney should advise him that he can freely refuse Julie this aspect of ART service. It follows, then, that he can also refuse to accept Julie as a patient at all

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<sup>72</sup> Daar, *Accessing Reproductive Technologies*, *supra* note 51 (quoting Dayna B. Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DEPAUL J. HEALTH CARE L. 793, 796 (2006)).

<sup>73</sup> *To Pay or Not to Pay*, *supra* note 28 at 27.

<sup>74</sup> "... no one now seriously argues that the financially strapped Medicaid system should cover ARTs." John A. Robertson, *Normalizing Assisted Reproduction*, 25 HEALTH AFFAIRS 291, 291 (2006).

<sup>75</sup> See *supra*, note 58.

<sup>76</sup> 2009 WL 1941550.

<sup>77</sup> See *supra*, note 58-62,

<sup>78</sup> *Prognosis is Poor*, *supra* note 30, at 807.

based on the possibility that she might desire or require a selective reduction procedure, which he will not be able to provide. In fact, unless Julie accepts that she must carry all implanted embryos to term or leave Welby's practice mid-pregnancy for selective reduction, Welby is ethically bound to refuse her service, as enforced in varying degrees by professional associations and, presumably, the Nirvana state medical board, although not by state or federal statute.

### 3. Conclusion

An attorney's advice should not end with the black-letter law.

Welby finds himself between Scylla and Charybdis. Knowing that a high-order multiple pregnancy poses risks to Julie and her offspring, he still considers implanting six embryos as per her wishes; yet he finds himself unable to reduce the risk by selectively reducing embryos to a safer number of embryos. His best choices are either to implant fewer embryos or to refuse Julie care altogether. Since it is unrealistic to base a practice on Single Embryo Transfer,<sup>79</sup> Welby's remaining option is to refer candidates for selective reduction to his partner, Dr. Kildare.<sup>80</sup> Unfortunately, that choice is precluded by Kildare's identical objections to selective reduction. Kildare might be replaced in the practice with a physician who has no such objections, but as the practice was founded on Welby and Kildare's shared beliefs, that course of action is unlikely. Referring patients outside his practice would vastly narrow his client base and financially undercut his ability to do business – and even so, might constitute grounds for a suit: the victorious plaintiff in *North Coast* filed suit after being referred to an external practice.<sup>81</sup> The best Welby can do, therefore, is to accept only those patients who are willing to carry all implanted embryos to term, and to prominently feature in his publicity materials and all patient documents the fact that selective reduction is not available in his practice. This use of informed consent as a preventive measure is strongly urged from both ethical and legal standpoints.<sup>82</sup>

Should Welby ignore this advice and proceed to implant more embryos than patients are prepared to carry to term, he might eventually find himself facing a jury that wonders what kind of moral actor will not perform selective reduction due to the rigors of his conscience, yet is willing to imperil the health of women and children with high-order multiple implantations. Although the law does not demand moral consistency of a defendant, a jury, as led by opposing counsel, might be more exacting.

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<sup>79</sup> The author's ASRM contact knew of no physicians performing SET exclusively. Nicoll, *supra* note 65.

<sup>80</sup> *Id.*

<sup>81</sup> The plaintiff was seen by various doctors in the practice for almost a year before they referred her request for IUI. That she brought suit after sinking so many resources into a practice which ultimately refused to serve her is hardly surprising. *North Coast*, 189 P.3d at 963-5.

<sup>82</sup> A recent Michigan bill mandates that patients be informed of the possibility of "embryos in excess of the potential number of children the individual might consider bringing to birth." H.B. 5133, 95th Leg., Reg. Sess. (Mi. 2009). Compare with Bryan R. Hecht et al., *C\_a\_n\_t\_h\_e\_Epidemic\_o\_f\_Iatrogenic Multiples be Conquered?*, 41 CLIN. OBSTETRICS & GYN. 127, 132 (1998): "Influencing the decisions of patients rather than imposing legislative mandates would be the ideal intervention strategy to decrease the incidence of multiples. Such an effort would start by providing proper and complete informed consent about the probability of iatrogenic multiples...."