REGULATING MULTIPLE BIRTH PREGNANCIES:
COMPARING THE UNITED KINGDOM’S
COMPREHENSIVE REGULATORY SCHEME WITH
THE UNITED STATES’ PROGRESSIVE, INTIMATE
DECISION-MAKING APPROACH

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INTRODUCTION

On January 26, 2009, Nadya Suleman made history by giving birth to the
first set of surviving octuplets. The proud staff at Kaiser Permanente
Bellflower Medical Center in Bellflower, California announced the amazing
news that the eight infants weighed between “1lb 8 ounces (820g) and 3lb

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    of Connecticut 2006, with a major in Political Science, and minors in both English, and
    International Studies. I would like to thank my friends and family for their love, and  support
during these past few years, especially my sister, Carolyn, Allison and George, Judi and
John, Aunt Jan, and my partner, Jeri.  I would also like to thank Professor Melanie B. Jacobs
for inspiring me to write this Note, and for peaking my interest in Family Law and Assisted
Reproductive Technologies. Finally, I would like to thank the MSU College of Law Journal
of International Law for publishing my Note.

1. US Woman Gives Birth to Octuplets, BBC NEWS, Jan. 27, 2009,
4oz (1.47kg),” and were “doing well.” However, public opinion quickly turned from joy to horror when it was revealed that Nadya Suleman was single, unemployed, and living with her parents. Furthermore, she already had six children conceived by in vitro fertilization (“IVF”), and several of them were disabled. The American public was further outraged to learn Nadya supported her six children on food stamps and public assistance. Nadya then dropped another bombshell: Doctor Michael Kamrava, who performed all of Nadya’s IVF treatments, had implanted her with six embryos, well above the American Society for Reproductive Medicine’s (“ASRM”) recommendation of one to two embryos for women under thirty-five. Doctor Kamrava was then subject to an investigation by the Medical Board of California, and he was expelled from ASRM for “repeatedly violat[ing] the group’s standards [of care].” Meanwhile, Nadya Suleman remains the mother and primary caretaker of fourteen IVF children.

The Octomom drama brought Assisted Reproductive Technology (“ART”), IVF, and the problem of multiple birth pregnancies to national attention. In contrast to most European countries, ART in the United States is subjected to limited state and federal regulations. For years, some legal scholars have called for legislators to fill this regulatory void, and prevent desperate baby-obsessed parents and unethical physicians from harming

2. Id.
5. Id.
America’s children and society at large. The Octomom media drama and backlash against Nadya and Doctor Kamrava has fueled renewed calls for regulation.\textsuperscript{12} However, prior to calling for further regulation, submitting ad hoc proposals to regulate ART, or drafting a comprehensive regulatory scheme similar to the one adopted in the United Kingdom, scholars, legislators, and public policy groups need to distance themselves from the Octomom drama. The questions they should be asking themselves are: (1) what specific area of ART are they thinking about regulating; (2) is regulation necessary; and (3) what constitutional rights, if any, are affected by these proposed regulations?

This Note addresses regulations that seek to prevent multiple birth pregnancies by restricting the number of embryos implanted during IVF treatments. In addition, it focuses on the regulation of multiple birth pregnancies rather than the regulation of ART as a whole because each ART treatment presents its own set of risks, and moral and ethical concerns.

Part I gives a brief summary of ART terminology, the increasing use of ART to conceive children in the United States, and the problems associated with multiple birth pregnancies. Part II addresses the history of IVF treatments in the United Kingdom, and its “Single Embryo Transfer” (“SET”) policy. Part III discusses IVF regulations in the United States, self-regulation by medical societies, physicians, and patients, and the problems associated with regulating IVF treatments. Finally, Part IV concludes that even in the face an increasing demand for IVF treatments, the United States cannot and should not adopt the United Kingdom’s SET policy because (1) the regulation of this medical treatment is unnecessary, as there are sufficient ethical, medical, and economic safeguards already in place to protect ART physicians, patients, and children; and (2) the regulation of this medical treatment affects a person’s ability to have a child, and thus, it violates his or her fundamental right to procreate, which is protected by the Due Process Clause of the Fourteenth Amendment. In order to effectively reduce the rate of multiple birth pregnancies, I propose our resources would be better allocated if public funds were spent to raise awareness among patients and physicians about the dangers associated with multiple birth pregnancies, and to further research IVF treatments.

I. ART

A. Terminology

ART is defined by the Center for Disease Control and Prevention (“CDC”) as “[a]ll treatments or procedures that involve surgically removing eggs from a woman’s ovaries and combining the eggs with sperm to help a

These procedures include IVF, “[a]n ART procedure that involves removing eggs from a woman’s ovaries and fertilizing them outside her body. The resulting embryos are then transferred into the woman’s uterus through the cervix.” This Note will focus on IVF treatments using fresh, non-donor eggs. Fresh eggs are “[e]ggs . . . that have not been frozen.” Meanwhile, donor eggs are where “[a]n embryo is formed from the egg of one woman (the donor) and then transferred to another woman who is unable to use her own eggs (the recipient).” Finally, a multiple birth pregnancy, or multiple-infant birth, is “a pregnancy that results in the birth of more than one infant.” Thus, this term encompasses pregnancies that result in twins, triplets, quadruplets, quintuplets, sextuplets, septuplets, and octuplets. Multiple birth pregnancies are more likely to occur where children are conceived using IVF treatments than by natural conception because of (1) the ovarian stimulation injections given to the mother so that the physician can retrieve several eggs, and (2) the implantation of multiple embryos into the mother’s womb.

B. Modern Statistics

The number of infants born who are conceived using ART, including IVF treatments, has steadily increased in the past decade. According to the CDC, “[t]he number of ART cycles performed in the United States has more than doubled, from 64,681 cycles in 1996 to 138,198 in 2006.” Furthermore, “[t]he number of live-birth deliveries in 2006 (41,343) was more than two and a half times higher than in 1996 (14,507).”

In addition to tracking information about ART clinics and their success rates, the CDC also tracks information about the women using ART. The CDC reports “[t]he average age of women using ART services in 2006 was 36.” However, “[t]he largest group of women using ART services were women younger than 35, representing 39% of all ART cycles carried out in 2006.” American women increasingly choose to rely on ART in order to...
conceive children even though there is no corresponding increase in the number of women being diagnosed as infertile. The New York State Task Force on Life and the Law states there has been an increase in ART because

1. medical services for infertile couples are more widely available;
2. there are more women of reproductive age than in the past;
3. there is an ongoing trend toward delayed childbearing, particularly among professional and highly educated women;
4. important risk factors for infertility are increasing among younger women; and
5. adoption is no longer an easy method of family building.

Furthermore, ART, and specifically IVF treatments, are very expensive. It has been estimated that patients pay out of pocket fees totaling $1.7 billion annually to conceive children using IVF treatments, which costs roughly $12,400 per cycle. Thus, IVF treatments are not readily available to the general public, and Nadya Suleman would not have been able to afford her IVF treatments had it not been for a small inheritance from her aunt and a $165,000 Workers Compensation award.

C. Multiple Birth Pregnancies

With the increasing use of IVF treatments come new medical, moral, ethical, and legal concerns. Specifically, the problem of multiple birth pregnancies is one of the most hotly debated issues among legal scholars. Multiple birth pregnancies pose serious medical and psychological risks to both the mother and children conceived using IVF. Mothers are putting their health at risk by carrying multiple fetuses. They are more likely to develop hypertension, pre-eclampsia, hemorrhages, anemia, fluid overload, a myocardial infarction, and heart failure. Multiple birth pregnancies have

23. The CDC reports “about 12% of women of childbearing age in the United States have used an infertility service.” Id. at 1. Meanwhile, the CDC reports, “Of the approximately 62 million women of reproductive age in 2002, about 1.2 million, or 2%, had had an infertility-related medical appointment within the previous year, and an additional 10% had received infertility services at some point in their lives.” Id. at 3.
also been linked to gestational diabetes.\textsuperscript{29} Furthermore, mothers who have multiple birth pregnancies are “more likely to require long periods of bed rest, hospitalization, administration of medication to prevent pre-term labour, surgical procedures, such as emergency Cesarean section and . . . premature labor.”\textsuperscript{30} They are also more likely to require hysterectomies due to pregnancy complications.\textsuperscript{31} Moreover, they suffer “higher rates of miscarriage,” and “there is 2/25,000 risk of maternal mortality during twin pregnancy or birth” as compared with a “1/25,000 risk of maternal mortality during singleton pregnancy or birth.”\textsuperscript{32} Multiple birth pregnancies also increase the infants’ health risks. Children born in multiple birth pregnancies “are more likely to be born prematurely and with a low birth weight than babies from singleton pregnancies.”\textsuperscript{33} They are also “more likely to die within the first year of life than singletons.”\textsuperscript{34} Furthermore, IVF children often suffer from long-term medical problems, such as “cerebral palsy, delayed mental and language development, and motor and coordination difficulties.”\textsuperscript{35} Furthermore, they are more likely to suffer from respiratory distress\textsuperscript{36} and congenital malformations,\textsuperscript{37} and to have mental and physical disabilities.\textsuperscript{38} In the case of Nadya Suleman, three of her previous six IVF children were registered as disabled with the State of California.\textsuperscript{39} Finally, since they were born prematurely, children of multiple birth pregnancies are likely to spend at least their first month of life in neonatal care units.\textsuperscript{40}

As witnessed in the Octomom drama, parents, children, relatives, and the community at large also suffer psychological and financial harm as a result of multiple birth pregnancies. Since it is more difficult to care for multiple infants, IVF patients may not be prepared to deal with the stress of being parents.\textsuperscript{41} It was later reported that several months after delivering the

\begin{itemize}
\item 30. Velikonja, supra note 28, at 472.
\item 31. \textit{Id}.
\item 32. Risks to the Mother, supra note 29.
\item 33. Velikonja, \textit{supra} note 28, at 472.
\item 35. Velikonja, \textit{supra} note 28, at 473.
\item 36. Risks to the Child, \textit{supra} note 34.
\item 37. \textit{Id}.
\item 38. Velikonja, \textit{supra} note 28, at 474.
\item 39. \textit{Octuplets’ Family Facing Foreclosure Threat, supra} note 4.
\item 40. Risks to the Child, \textit{supra} note 34.
\item 41. Velikonja, \textit{supra} note 28, at 475–78. “Multiple births have psychological consequences as well. These include a negative psychological impact on the mother, as
octuplets, Nadya said, “I screwed myself. I screwed up my life, I screwed up my kids’ lives. . . . I have to put on this strong facade and I have to pretend like I don’t regret it.”\textsuperscript{42} Moreover, “parents of multiples are seriously sleep deprived . . . and many become homebound and report feeling isolated.”\textsuperscript{43} Nadya Suleman seems to acknowledge her social isolation in that she has publicly stated, “I cannot maintain a social life and be a mother.”\textsuperscript{44} Having multiple birth infants can also cause problems with the children’s parents, siblings, or other family relatives.\textsuperscript{45} With regards to Nadya, her mother, Angela Suleman, publicly condemned her daughter’s decision to have more children, but they later reconciled after Angela met her grandchildren.\textsuperscript{46}

Finally, both the parents of multiple birth infants and society at large bear the financial costs of paying for the infants’ delivery costs, and long-term medical problems.\textsuperscript{47} The Associated Press reported the Bellflower hospital is seeking reimbursement from California’s Medicaid program for an undisclosed amount to pay the octuplets’ neonatal care.\textsuperscript{48} Moreover, it will cost California taxpayers somewhere between $1.3 million to $2.7 million to support Nadya’s fourteen IVF children from now until age seventeen.\textsuperscript{49}

While Nadya Suleman’s poor decision-making is self-evident, and the financial costs associated with her decision to have more children are astronomical, it is important that legislators, and the American public put the Octomom drama into perspective. In 2006, 11.1\% of ART cycles using fresh nondonor eggs or embryos resulted in multiple-fetus pregnancies.\textsuperscript{50} Furthermore, the CDC reports that of the 28,404 live births resulting from ART cycles using fresh non-donor eggs or embryos, 69.3\% were singletons, indicated by higher rates of depression, drug and alcohol abuse, and divorce among mothers of multiples. Such negative impacts on the mother naturally have an adverse impact on the children as well, and higher rates of child abuse have been found in families of multiples.” Catherine A. Clements, What About the Children? A Call for Regulation of Assisted Reproductive Technology, 84 I.N.D. L.J. 331, 336 (2009).


\textsuperscript{43} Velikonja, supra note 28, at 477.


\textsuperscript{45} Velikonja, supra note 28, at 478.


\textsuperscript{47} Velikonja, supra note 28, at 479–81.


\textsuperscript{49} Id.

\textsuperscript{50} 2006 ART REPORT, supra note 13, at 20.
29% were twins, and about 2% were triplets or more. Thus, the total multiple-infant live birth rate for 2006 was 31%. This 31% figure seems large when compared to the 3% multiple-infant birth rate of naturally conceived children. However, as noted above, only 2% of ART children are triplets or more — or 568 out of 28,404 children. Moreover, as ART live birth rates have increased, the practice of transferring four or more embryos has decreased. Interestingly, the CDC reports success rates have increased for ART cycles when one to three embryos are transferred, but success rates have decreased for transfers that involve four or more embryos. Therefore, the Octomom drama is a psychological, ethical, and medical anomaly.

Despite the general trend in the United States, which indicates “multiple-infant live births decreased between 1996 and 2006 for women of all age groups,” there have been increasing calls for regulating ART, and specifically IVF treatments. In fact, many Western nations have enacted ART regulations in the last few decades, and the United Kingdom, as part

51. Id. at 22.
52. Id.
53. Id.
54. Id. at 68. “From 1996 through 2006, the percentage of transfers that resulted in live births for women younger than 35 increased 33%, from 34% in 1996 to 45% in 2006. Over the same period, the percentage of transfers that resulted in live births increased 28% for women 35–37, 24% for women 38–40, 31% for women 41–42, and 22% for women older than 42.” Id.
55. Id. at 71. “In 1996, almost two-thirds (64%) of ART cycles involved the transfer of four or more embryos; 33%, three embryos; 3%, two embryos; and less than 1%, one embryo. By 2006, four or more embryos were transferred in only 3% of cycles, three in 16% of cycles, two in 75% of cycles, and one in 7% of cycles.” Id. “[I]n 2006, and cycles that involved the transfer of four or more embryos decreased from 62% in 1996 to 16% in 2006.” Id. at 70.
56. Id. at 71. “From 1996 through 2006, the success rates tripled, from 14% to 42%, for ART cycles that involved the transfer of two embryos. The success rates also increased for ART cycles that involved the transfer of either one or three embryos; however, the success rates decreased 13%, from 32% to 28%, for ART cycles that involved the transfer of four or more embryos.” Id.
57. Id. at 75. “In 1996, 43% of live-birth deliveries to women younger than 35 were multiple-infant births, compared with 34% in 2006. Among women older than 42, the percentages of multiple-infant live births decreased from 14% in 1996 to 9% in 2006.” Id.
59. The “One Child At A Time” report summarizes the laws for the following countries: Belgium: “Introduction of a reimbursement system that links funding for 6 IVF cycles per patient to the compulsory use of eSET in the first cycle in women < 36 years, use of eSET in follow-on cycles depends on age and embryo quality”; Finland: “No state regulation, but the sector has moved successfully to wide-spread use of eSET with follow-on
of its comprehensive regulatory scheme, has recently updated its federal regulations to include the “Single Embryo Transfer” policy in an effort to cap the number of embryos implanted into IVF patients.

II. UNITED KINGDOM

A. History

The Human Fertilisation and Embryology Authority (“HFEA”) is the United Kingdom’s regulatory agency that oversees “the use of gametes and embryos in fertility treatment and research.” British Parliament has given the HFEA broad regulatory powers, including the ability to set licensing guidelines for U.K. fertility clinics, to interpret mandatory requirements as established by the “Human Fertilisation and Embryology Act 1990” and the “Human Fertilisation and Embryology Act 2008”, to construct a best-practice guide in order to help British clinics comply with these acts and its subsequent regulations, and to gather data about fertility treatments in the United Kingdom. In short, Parliament has given the HFEA the authority to regulate every aspect of ART, including the authority to reduce the rates of multiple birth pregnancies in IVF treatments.
The United Kingdom’s centralized approach to ART can be traced to the birth of Louise Joy Brown, the world’s first test tube baby.\(^67\) She was born on July 25, 1978, in the Oldham and General District Hospital in Lancashire.\(^68\) Her parents decided to undergo IVF treatment, using their own eggs and sperm, after it was discovered that Louise’s mother had blocked fallopian tubes.\(^69\) Louise’s successful delivery whipped up a frenzy among theologians, physicians, ethicists, social workers, scientists, philosophers, attorneys, church groups, medical societies, and public policy groups, who were concerned with everything from Louise’s health to eugenics to possible governmental intrusion on an individual’s right to procreate.\(^70\) In response to this public outcry, the Committee of Inquiry into Human Fertilisation and Embryology was formed in 1982.\(^71\) In 1984, the Committee published what later became known as the Warnock Report.\(^72\) While the Warnock Report generally supported using ART to treat heterosexual couples with infertility,\(^73\) it recognized a “need” for regulations. Specifically, the Committee states:

> People generally want some principles or other to govern the development and use of the new techniques. There must be some barriers that are not to be crossed, some limits fixed, beyond which people must not be allowed to go. Nor is such a wish for containment a mere whim or fancy. The very existence of morality depends on it. A society which had no inhibiting limits, especially in the areas with which we have been concerned, questions of birth and death, of the setting up of families, and the valuing of human life, would be a society without moral scruples. And this nobody wants.\(^74\)

The Committee then proposes specific recommendations on a variety of issues, including the need to counsel couples using ART,\(^75\) to have informed consent by both parties and for it to be in writing;\(^76\) to establish legal

\(^{67}\) See Stenger, supra note 11, at 139–40.


\(^{70}\) Stenger, supra note 11, at 140–41.


\(^{73}\) Id. at 1–3.

\(^{74}\) Id. at 2 (emphasis in original).

\(^{75}\) Id. at 15–16.

\(^{76}\) Id. at 16, 25–26.
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parentage; to disclose the donor’s ethnic origins and medical information to ART children once they reach eighteen; to limit the number of donations made by a single donor; to outlaw commercial surrogacy; to prevent children conceived posthumously from inheriting via intestate succession, and to regulate the research, storage, and disposal of human embryos. Ultimately, the Committee calls for “the establishment of a new statutory licensing authority to regulate both research and those infertility services which we have recommended should be subject to control.”

The Committee’s call for a new statutory licensing authority was answered in 1990, when the British Parliament passed the Human Fertilisation and Embryology Act 1990. This Act was subsequently amended by the Human Fertilisation and Embryology Act 2008. The 1990 Act sets up the HFEA’s licensing authority, and its ability to regulate fertility clinics’ administrative and medical procedures, as well as the legal and medical rights of ART patients and donors. Neither the Human Fertilisation and Embryology Act 1990 nor the Human Fertilisation and Embryology Act 2008 directly address the issue of multiple birth pregnancies. However, Section 8 of the 1990 Act gives the HFEA the general authority to:

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77. Id. at 25–26.
78. WARNOCK REPORT, supra note 72, at 24–25.
79. Id. at 26–27.
80. Id. at 42–47.
81. Id. at 55.
82. See id. at 58–79.
83. Id. at 56–57.
84. WARNOCK REPORT, supra note 72, at 75.
87. The main provisions of the 2008 act include: (1) “ensuring that the creation and use of all human embryos . . . are subject to regulation”; (2) “a ban on selecting the sex of the offspring for social reasons”; (3) “requiring that clinics take account of “the welfare of the child” when providing fertility treatment, and removing the previous requirement that they also take account of the child’s “need for a father”; (4) “allowing for the recognition of both partners in a same-sex relationship as legal parents of children conceived through the use of donated sperm, eggs or embryos”; (5) “enabling people in same sex relationships and unmarried couples to apply for an order allowing for them to be treated as the parents of a child born using a surrogate”; (6) “changing restrictions on the use of data collected by the HFEA to make it easier to conduct research using this information”; and (7) “provisions clarifying the scope of legitimate embryo research activities, including regulation of ‘human admixed embryos’ (embryos combining both human and animal material).” Human Fertilisation and Embryology Authority, The HFE Act (and Other Legislation), http://www.hfea.gov.uk/134.html (last visited Apr. 20, 2010).
(a) keep under review information about embryos and any subsequent
development of embryos and about the provision of treatment services and
activities governed by this Act, and advise the Secretary of State . . .
(c) provide, to such extent as it considers appropriate, advice and
information for persons to whom licences apply or who are receiving
treatment services or providing gametes or embryos for use for the
purposes of activities governed by this Act, or may wish to do so, and
(d) perform such other functions as may be specified in regulations. 88

Furthermore, Parliament gives the HFEA the authority to maintain a Code
of Practice. The regulations included in this code must take into account the
welfare of ART children, “and of other children who may be affected by
such births.” 89 Moreover, “[t]he code may also give guidance about the use
of any technique involving the placing of sperm and eggs in a woman.” 90
Finally, the HFEA’s licensing committee is given the power to revoke a
practitioner’s license for failure to comply with the Code of Practice. 91 It is
under the HFEA’s authority to research fertility treatments, provide advice,
take into account the welfare of the children, and regulate procedures under
its Code of Practice that it adopted the “Single Embryo Transfer” policy.

B. The Single Embryo Transfer Policy

The HFEA’s “Single Embryo Transfer” (“SET”) policy is a product of
several years of research, debate, and discussion. The first step toward the
adoption of the SET policy occurred in September of 2006, when the HFEA
set up the “Expert Group on Multiple Births after IVF” to research the
problem of multiple birth pregnancies. 92 This expert group was composed
of obstetricians, gynecologists, professors, medical directors, journalists,
pediatricians, fertility specialists, embryologists, international monitors, and
public health specialists. 93 In October 2007, the expert group issued the
pregnancies [in the U.K.] leads to the birth of twins,” which is “more than
ten times higher than would be expected after spontaneous (natural)

88. Human Fertilisation and Embryology Act, 1990, c. 37, § 8 (Eng.), available at
89. Id. § 25(2).
90. Id. § 25(3).
91. Id. § 25(6)(b).
92. Human Fertilisation and Embryology Authority, Timeline of Key Events,
http://www.hfea.gov.uk/3121.html (last visited Apr. 10, 2010) [hereinafter Timeline of Key
Events]; see also BRAUDE ET AL., supra note 59, at 1–105.
93. BRAUDE ET AL., supra note 59, at 4.
94. See id.
conception."\textsuperscript{95} The Report focused on the United Kingdom’s high twin rate because multiple birth pregnancies with three or more children are rare due to the United Kingdom’s strict two-embryo policy.\textsuperscript{96} The Report proceeded to address in great detail the serious health risks to women using and children conceived by IVF treatments when there are multiple birth pregnancies.\textsuperscript{97} Given the numerous medical and psychological risks, as well as the increased financial burden on parents and society, the expert group stated, “A multiple pregnancy should not be regarded as the ideal outcome of IVF treatment.”\textsuperscript{98} Moreover, the Report stated, “The only way to reduce the multiple birth rate after IVF is to transfer only one embryo to those women at most risk of having twins. Overall, eSET [Elective Single Embryo Transfer] needs to be made the norm in IVF treatment.”\textsuperscript{99} In order to transition from a strict two-embryo transfer policy for women under forty and a three embryo transfer policy for women forty and above, the expert group made two recommendations. First, the HFEA should cap the number of multiple births at each clinic.\textsuperscript{100} Second, the HFEA should develop the criteria to determine which group of women is more likely to produce multiples, and then this group would first be offered SET.\textsuperscript{101}

During April of 2007 to May of 2008, the HFEA considered the expert group’s recommendations.\textsuperscript{102} It then enacted the SET policy, which went into effect on January 1, 2009.\textsuperscript{103} The SET policy is being monitored by a “National Strategy Multiple Births Group.”\textsuperscript{104} There are four key elements under the SET policy. First, for the year 2009, “the maximum multiple birth rate for each [U.K.] clinic is [set at] 24%. In other words, all centres should ensure that their annual multiple birth rate does not exceed this figure.”\textsuperscript{105} The HFEA realized clinics may well be under or at this 24% cap. Therefore, these clinics can meet this requirement by working to lower their
current multiple birth pregnancy rates. Second, the HFEA’s long-term goal is to set a maximum multiple birth rate of 10% for each U.K. clinic, and thus, it will gradually lower the maximum multiple birth rates to meet this goal. The HFEA “will carefully monitor the impact of its policy, including any impact on fresh cycle pregnancy rates, to ensure that all rates are appropriate.” Third, all U.K. fertility clinics were instructed to come up with a “multiple births minimisation strategy (the strategy) which will set out how they intend to reduce their annual multiple birth rates and to ensure that they do not exceed [the] HFEA-set maximum figure.” Finally, the SET policy does not replace the strict two or three embryo policy, but “run[s] alongside it.”

In its Code of Practice, the HFEA sets out how a fertility clinic is supposed to come up with a strategy to reduce its multiple birth pregnancy rate. A clinic’s strategy must determine “(a) how the centre aims to reduce the multiple birth rate . . . (b) the circumstances in which the person responsible would consider it appropriate to recommend single embryo transfer (SET) to a patient . . . [and] (c) the criteria for transferring eggs . . .” Furthermore, the clinic is required to audit its progress and, if necessary, revise its strategy. Should a clinic transfer more than one embryo to a patient who meets its SET criteria, the clinic is required to explain why the SET policy was not applied, and it must prove that the patient was informed of the dangers of multiple birth pregnancies. Finally, if a clinic should implant four eggs or three embryos as part of an IVF treatment, it is required to keep medical records that explain why so many eggs or embryos were transferred and “keep a summary log of every treatment cycle.” Surprisingly, these strict reporting requirements, and the overall implementation of the SET policy is supported by the major medical associations in the United Kingdom. In contrast, in the United States, most physicians and medical associations staunchly oppose the

106. Id.
107. Id.
108. Id.
109. Id.
110. Id.
111. MULTIPLE BIRTHS, supra note 66, at 1.
112. Id.
113. Id. at 2.
114. Id. at 2.
government’s regulation of ART. In fact, the Society for Assisted Reproductive Technology adopted the slogan “‘prevention is the best medicine’ with regard to government regulation.”

In conclusion, the United Kingdom has adopted a top down regulatory approach to IVF and the problem of multiple birth pregnancies. The United Kingdom has limited the number of embryos implanted in IVF to one embryo unless a clinic can justify implanting two or three embryos. Should a fertility clinic fail to comply with this numerical limit, it risks having its license revoked by the HFEA.

III. UNITED STATES

The United Kingdom’s comprehensive regulatory approach is the antithesis of the United State’s free market approach. In the United States, fertility clinics are subject to limited federal and state regulations. In lieu of extensive governmental regulation, fertility clinics are self-regulated by professional medical associations, such as SART, the Society for Assisted Reproductive Technology, and ASRM, the American Society for Reproductive Medicine.

A. Federal and State Regulations

The only federal law that directly regulates ART procedures in the United States is the Fertility Clinic Success Rate and Certification Act of 1992. This Act has two primary components. First, it requires all fertility

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116. Most physicians believe the federal government’s regulation of IVF is excessive because “every IVF procedure and its outcome must be reported to the federal government, [and] this is not true for any other medical procedure.” Press Release, American Society for Reproductive Medicine, ASRM Responds to Incidents at IVF Clinic (Sept. 25, 2009), available at http://www.asrm.org/Washington/Bulletins/vol11no50.html. However, physicians may be moving towards the position further regulation may be necessary. In a recent ASRM bulletin, the executive director of ASRM wrote, “The time has come for policy makers to sit down with the leading experts in the field to explore ways we can codify our standards to give them additional regulatory teeth.” Id.

117. Ouellette et al., supra note 11, at 443.


clinics in the United States to submit data to the CDC about their pregnancy success rates. The CDC then publishes this information in its annual report. The CDC and its data collection contractor primarily rely on SART to collect this information. SART is an organization of medical professions, whose mission is “to set and help maintain the standards for ART in an effort to better serve our members and our patients.” It is made up of 392 practitioners, and 95% of all IVF clinics in the United States are SART members. One of the weaknesses of the Fertility Clinic Success Rate and Certification Act is the CDC cannot issue sanctions against clinics that fail to report their pregnancy success rates. Fortunately, all SART members are required to impute their clinics’ data into the SART system, or else risk being sanctioned by SART, and this data is subsequently passed onto the CDC’s data collection contractor. Moreover, while the act makes no mention of multiple birth pregnancies, SART’s Quality Assurance Committee has independently adopted “[a] recent initiative in which programs with triplet rates . . . were formally contacted and asked to comment on their practice patterns and to formalize means by which changes would take place to lower these rates.”

The second part of the Fertility Clinic Success Rate and Certification Act requires the CDC “develop a model program for the certification of embryo laboratories to be carried out by the States.” No state has yet adopted the CDC’s model certification program. In fact, on the state level, the regulation of ART varies dramatically with regards to access, permissible procedural and medical techniques, and licensing, safety, and reporting requirements. New Hampshire has adopted one of the most comprehensive regulatory schemes for IVF treatments. New Hampshire requires IVF patients to be at least twenty-one years old, and medically fit to undergo IVF treatment. Moreover, IVF patients and their spouses must undergo

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122. Id.
123. Ouellette et al., supra note 11, at 424.
125. Id.
127. What is SART?, supra note 124.
counseling, and if the IVF patient is married, her spouse must accept legal
parentage prior to the IVF treatment. New Hampshire’s comprehensive
regulations can be compared with more lax statutes in Louisiana or
Pennsylvania. In Louisiana, fertility clinics are required to follow IVF
guidelines established by the American Fertility Society (later renamed
ASRM), and the American College of Obstetricians and Gynecologists.
Meanwhile, in Pennsylvania, fertility clinics must meet various reporting
requirements.

No state in the United States has adopted laws seeking to curtail multiple
birth pregnancies. However, in the wake of the Octomom drama, two
proposals were made attempting to limit the number of embryos transferred
into IVF patients. In Georgia, the state Senate passed a bill entitled the
“Ethical Treatment of Human Embryos Act,” which makes it “unlawful for
any person or entity to intentionally or knowingly create or attempt to create
an in vitro human embryo by any means other than fertilization or
intracytoplasmic sperm injection of a human egg by a human sperm.”
Intracytoplasmic sperm injection (“ICSI”) is “[a] procedure in which a
single sperm is injected directly into an egg.” This bill was not voted on
in the state’s House, and thus, the proposal is not the law in Georgia.

Furthermore, in Missouri, a somewhat less restrictive bill was proposed,
which states, “When treating infertility, physicians within the state of
Missouri shall not implant more embryos into a human than the current
recommendations set forth by the American Society for Reproductive
Medicine, or its successor.” This bill was passed in the Healthcare
Transformation Committee, but was not voted on by the state House or
Senate, and it is not currently on the calendar. Thus, in the United States
the problem of multiple birth pregnancies is not subject to federal or state
regulation, but rather it is being addressed by self-regulation in the medical
field.

131. Id.
133. 18 PA. CONS. STAT. § 3213(e) (2009). “All persons conducting... in vitro
fertilization shall file quarterly reports with the department... containing the following
information: (1) Names of all persons conducting or assisting in the fertilization or
experimentation process; (2) Locations where the fertilization or experimentation is
conducted; (3) Name and address of any person, facility, agency or organization sponsoring
the fertilization or experimentation except that names of any persons who are donors or
recipients of sperm or eggs shall not be disclosed; (4) Number of eggs fertilized; (5) Number
of fertilized eggs destroyed or discarded; [and] (6) Number of women implanted with a
fertilized egg.” Id. Clinics that fail to keep records, fail to supply their reports, or submit
false reports will be fined $50 per day. Id.
135. 2006 ART REPORT, supra note 13, at 526.
138. Id.
B. Self-Regulation

In the United States, even in the absence of governmental regulation, professional medical associations, individual physicians, IVF patients, and the market are effectively addressing multiple birth pregnancies. Often working in conjunction with SART, ASRM is the leading multidisciplinary medical organization that addresses the medical, procedural, and ethical concerns of using ART in order to protect patients, ART children, physicians, and society as a whole. ASRM is “committed to facilitating and sponsoring educational activities for the lay public and continuing medical education activities for professionals who are engaged in the practice of and research in reproductive medicine.” Its members include medical professionals, such as obstetricians, gynecologists, reproductive endocrinologists, embryologists, mental health professionals, and pediatricians. In addition to providing its members with continuing medical education, ASRM publishes a peer-reviewed medical journal, *Fertility and Sterility*; two newsletters, *ASRM News* and *Menopausal Medicine*; ASRM’s Ethics Committee reports; and ASRM’s Practice Committee reports, which “provide assistance about diagnostic and therapeutic dilemmas.”

139. The judiciary cannot effectively lower the multiple birth pregnancy rate. Malpractice litigation is not applicable to IVF treatments because (1) “most U.S. Courts ‘will not entertain wrongful life suits’”; (2) “even in states that do allow wrongful life or wrongful birth claims, courts limit the damages that the parents or the children recover”; (3) “parental lawsuits ‘may be barred by their prior consent’”; (4) “many states ‘preclude finding negligence if a doctor’s practices are widely shared with others in the field’”; and (5) “most negligently injured patients do not sue.” Velikonja, *supra* note 28, at 492–93.


141. ASRM Mission Statement, *supra* note 140.


143. ASRM Mission Statement, *supra* note 140.

144. History and Purpose, *supra* note 142. “Also published are the ASRM Patient Education Committee’s Patient Information Series booklets and Patient Fact Sheets, which are designed to help the patient understand the complexities of reproductive disorders and their treatment.” *Id.*
ASRM has directly addressed the problem of multiple birth pregnancies, and it is instrumental in continuing to raise awareness about the dangers of multiple birth pregnancies, and in lowering clinics’ multiple pregnancy rates. In 2008, ASRM’s Practice Committee, in conjunction with the Practice Committee for SART, updated its guidelines on the number of embryos to be transferred to patients. ASRM supports the continuing practice of allowing patients and their attending physicians to determine the number of embryos that will be transferred in IVF treatments. Its “guidelines provide the flexibility to give each patient treatment individualized to her needs, and her best chance to become pregnant without risking high-order multiple pregnancy.”

In determining how many embryos to transfer, ASRM recommends physicians consider the patient’s age, the patient’s previous success with IVF, the quality of the embryos to be transferred, and whether the excess embryos are eligible for cryopreservation. ASRM makes the following numerical recommendations:

A. For patients under the age of 35 who have a more favorable prognosis, consideration should be given to transferring only a single embryo. [For all others in this group, no more than two embryos. . . should be transferred.]
B. For patients between 35 and 37 years of age who have a more favorable prognosis, no more than two . . . embryos should be transferred. All others in this age group should have no more than three . . . embryos transferred. . .
C. For patients between 38 and 40 years of age who have a more favorable prognosis, no more than three . . . embryos. . . should be transferred. All others in this age group should have no more than four . . . embryos. . . transferred.

148. GUIDELINES ON NUMBER OF EMBRYOS TRANSFERRED, supra note 8, at 1.
149. Id.
151. GUIDELINES ON NUMBER OF EMBRYOS TRANSFERRED, supra note 8, at 1.
D. For patients [greater than 40] years of age, no more than five . . . embryos . . . should be transferred.152

ASRM also encourages patients and physicians to discuss the patient’s individual circumstances, but it only recommends increasing the number of embryos to be transferred based on the patient’s circumstances if the patient has had two or more failed IVF treatments.153 Cynics have criticized ASRM’s self-regulation, since ASRM lacks enforcement mechanisms to ensure physicians adhere to its guidelines. However, physicians are taking the initiative and following ASRM’s guidelines154 because their primary concern is the health and safety of their patients, and they wish to bolster the reputation of their fertility clinic in this competitive market.

Furthermore, physicians have successfully lowered the rate of multiple birth pregnancies. As R. Dale McClure, President of ASRM, stated in an Octomom press release, ASRM began issuing guidelines about how many embryos to implant in IVF procedures in 1996, and saw almost immediate results.155 “[I]n 1996, 7% of fresh, non-donor ART cycles . . . were triples or more” compared to just 2% in 2005.156 McClure proudly stated, “This [decline in multiple birth pregnancies] was achieved without hurting the pregnancy rates for our patients. In fact, during the same period, the live birth rate from fresh non-donor embryo transfers increased from 28% in 1996 to 34.3% in 2005.”157

In addition to physicians following ASRM’s recommendations on how many embryos to implant in IVF patients, should multiple fetuses develop in a woman’s womb, patients can elect to undergo selective reduction, or multiple pregnancy reduction.158 Selective reduction is “[a] procedure to
reduce the number of fetuses in the uterus." It involves “inject[ing] potassium chloride into the fetus.” This procedure is performed to protect the health of the mother and “to prevent the entire pregnancy from aborting or delivering very prematurely.” Physicians perform selective reduction procedures in one to two percent of pregnancies. Selective reduction procedures are “more likely to be performed when there are four or more fetuses present.” However, selective reduction results in miscarriages in four to five percent of cases. While the CDC does not collect information on selective reduction, “[a]pproximately one-third of infertility patients would not consider selective reduction for religious or ethical reasons.” While some critics argue selective reduction is not an adequate or ethical solution to the problem of multiple birth pregnancies, selective reproduction procedures do address the underlying health risks to both the mother and her children.

Market forces also regulate the availability of IVF treatments, and influence patients’ perceptions of multiple birth pregnancies. Since IVF treatments are expensive and usually not covered by insurance, patients may be delighted to conceive twins or triplets. In order to combat the high costs of IVF treatments, some clinics have offered shared-risk or refund programs. Under shared-risk or refund programs, a patient will pay a high fee, and if the patient conceives, the fertility clinic keeps the money, and if the patient fails to conceive, “90 to 100% of the fee is returned.” Patients will not receive reimbursement for pretreatment screening costs or the cost of fertility drugs. These programs give peace of mind to IVF patients who are concerned about the high costs of IVF, or have a “substantial risk of IVF failure.” These shared-risk plans can also reduce patients’ desires


162. Id.


164. Id.


166. See Velikonja, supra note 28, at 486–90.


168. Id.

169. Id.
for multiple birth pregnancies because patients can go through multiple unsuccessful IVF treatments without accruing too much debt, and thus, IVF patients are not economically pressured into having multiples.

Furthermore, even if a clinic does not offer shared-risk or refund programs, or IVF patients do not undergo multiple IVF treatments, an IVF patient’s knowledge about the high costs of raising a child also acts as an economic deterrent to multiple birth pregnancies. The Department of Agriculture estimates the cost of raising a child from birth to age seventeen is between $221,190 and $366,660 for middle to wealthy income families. This hefty price tag combined with high delivery costs, and companies unwillingness to donate products to multiples — a result of the increase in the number of multiples birth pregnancies — make multiple births less appealing to expectant parents.

To conclude, SART’s and ASRM’s efforts to reduce multiple birth pregnancies combined with selective reduction procedures and market pressures are effectively lowering fertility clinics’ multiple birth pregnancy rates. Given the due diligence of America’s medical societies, the comprehensiveness of their guidelines, and the advancements in the fertility field, the rate of multiple birth pregnancies will continue to decrease. Furthermore, with 95% of all IVF clinics in the United States complying with SART/ASRM’s medical guidelines, federal regulations are simply unnecessary, and redundant.

C. Problems with Regulating IVF treatments

Regulating IVF treatments in order to reduce the rate of multiple birth pregnancies raises a myriad of concerns, such as whether states or the federal government should enact regulations; whether IVF is covered under a person’s fundamental right to procreate, or whether IVF is similar to adoption; whether regulations can be used as a stepping stone for the eugenics movement; whether regulations are necessary based on physicians’


171. “For the year 2000, the projected costs of care for ART multiple births in the United States were $640 million, and $470 million for all IVF and ICSI cycles. The estimated costs for twins, triplets, and quadruplets were $377 million, $220 million, and $43 million, respectively.” ASRM PRACTICE COMMITTEE, MULTIPLE PREGNANCY ASSOCIATED WITH INFERTILITY THERAPY 2 (2006), http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Educational_Bulletins/multiple_pregnancy_associated.pdf.


173. What is SART?, supra note 124.
and patients’ respective interests; whether IVF can withstand strict scrutiny; and whether regulations are obsolete in the face of fertility tourism.

1. Basic Principles in Family and Constitutional Law

First, family law is predominately regulated by state legislatures. Since each of the fifty states adopts different laws, there arises a so-called patchwork or “checkerboard” of ART regulations. This checkerboard effect is not inherently bad. It does not “deny . . . equality before the law,” or “[send] conflicting signal[s] that reduce the law’s capacity to express and support underlying public values.” Instead, diversity among states allows for regulatory innovations. If one state system proves to be particularly effective, other states are free to adopt similar regulations. Furthermore, diversity among the states, and in particular the lack of ART restrictions, allows for medical innovation. Part of the thrust behind SART’s campaign against government regulation is “fear [that] government regulation would limit their flexibility in utilizing innovative ART procedures and techniques, thereby compromising patient care and access.” These current, pressing concerns are assuaged by the states’ general lack of regulation.

Second, if the federal legislature were to regulate ART and IVF treatments, it would have to do so under one of its enumerated Constitutional powers, such as the Commerce Clause, which has been liberally construed by the courts. Congress’s mere desire to create uniformity does not give it the power to trample on state sovereignty, or an area of the law that is and has historically been under the exclusive control of state governments. Third, should a state adopt a measure similar to the U.K. SET policy, and the Supreme Court declare it unconstitutional, the Court’s actions are not likely to prevent states from adopting different regulations, nor would it give the federal government the authority to preemptively regulate ART and IVF treatments. Fourth, should states begin to regulate ART, a regulatory gap will emerge between new ART procedures and current regulation. This gap is evident in other areas of family law, and it is subsequently filled by common law doctrines and public policy arguments.

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175. Id. at 1630.
176. Ouellette et al., supra note 11, at 433.
177. There are gaps in family law with regards to recognizing legal parentage, granting visitation rights, and establishing intestate succession for non-traditional families and family members, i.e. for unmarried heterosexual couples like Brangelina, or for LGBTQAA couples, or for third parties, such as grandparents. See generally Troxel v. Granville, 530 U.S. 57 (2000); Michael H. v. Gerald D., 491 U.S. 110 (1989); Stanley v. Ill., 405 U.S. 645 (1972); O’Neal v. Wilkes, 439 S.E.2d 490 (Ga. 1994); Adoption of Tammy, 619 N.E.2d 315 (Mass. 1993); In re Alison D. v. Virginia M, 572 N.E.2d 27 (N.Y. 1991).
178. See CHARLES P. KINDREGAN, JR. & MAUREEN MCBRIEN, ASSISTED REPRODUCTIVE TECHNOLOGY: A LAWYER’S GUIDE TO EMERGING LAW AND SCIENCE
Finally, ART and IVF treatments are fundamentally different from adoption. Adoption is both a public act, and a statutory right. Each state is free to set different criteria for adoptions, and there is no fundamental right to adoption. In the adoption context, states can intrude into the otherwise protected realm of family privacy because the state is acting in loco parentis, meaning the state is stepping into the shoes of the parent, and assuming the fundamental parental rights of care, custody, and control. The state only assumes this responsibility after proving by clear and convincing evidence that the child’s legal parents are unfit, and a court subsequently terminates parental rights. Courts apply the amorphous “best interests of the child” standard to determine a legal parent’s fitness.

When states regulate ART, states are not acting in loco parentis or assuming parental responsibility because a living child has yet to be born. Instead, the legislature is dealing with eggs, sperm, and embryos. Moreover, when ART disputes arise before a child is conceived, courts are unlikely to apply the “best interests of the child” standard, and even after a child is born, courts often rely on an “intent” standard in lieu of the “best interests of the child” standard. Furthermore, prior to the birth of the child, ART parents are not legal parents, but prospective legal parents. These prospective legal parents are in the same situation as prospective legal parents who conceive naturally. States do not license people to be parents, whether the children are conceived naturally or using IVF. However, should a state apply the adoption approach to IVF treatments and adopt an SET policy, states will effectively be licensing parentage, as limiting the number of embryos to implant will affect some women’s ability to conceive a child.

(2006). “[I]t is unlikely that widespread enactment of uniform laws will be forthcoming in the foreseeable future except possibly in regard to the status of children conceived by ART. The issues involved are politically controversial and often mixed with religious, moral, medical, political, social, and legal disagreement. This makes it too difficult for the political branches of government to develop a consensus as to how to regulate assisted reproduction. . . . Thus it is likely that for many years lawyers and judges will have to struggle with these issues on a common-law or equitable basis and evolve solution on a case-by-case basis.” Id.

180. States’ unlimited ability to regulate adoption permits discriminatory bars on adoption by LGBTQAA couples. See generally Lofton v. Sec’y of the Dep’t of Children and Family Servs., 377 F.3d 1275 (11th Cir. 2004).
181. Id.
182. Id.
184. Id. at 745–63.
2. Eugenics

Regulating IVF and the potential restrictions on IVF procedures creates concerns about eugenics — the idea that governments can use selective breeding to create ideal citizens. The eugenics movement targets homosexuals, the handicapped, the poor, the mentally ill, Jews, Roma, and other minority groups. Supporters of IVF regulation argue eugenics concerns are inapplicable to the regulation of IVF procedures. After all, they argue regulating procedures do not determine who can and cannot conceive children. Yet in May of 2004, the FDA adopted guidelines that ban “[m]en who have had sex with another man in the preceding 5 years” from being anonymous sperm donors. This regulation was adopted under the guise of wanting to prohibit the spread of HIV infections. Yet it ignores the fact that sperm can easily and accurately tested for HIV, that “women with HIV may soon outnumber men with HIV,” and that “[e]ven though blacks (including African Americans) account for about 13% of the U.S. population, they account for about half (49%) of the people who get HIV and AIDS.” Given this blatant refusal to recognize the reliability of HIV testing, or statistical data showing that HIV/AIDS is not a disease that exclusively affects men in the LGBTQAA community, this procedural regulation prohibits gay men from anonymously donating sperm, and passing on their genes to future generations. Thus, concerns about how eugenics will influence the regulation of IVF, if more procedural regulations are adopted, are valid.

3. Social Contract Theory

Supporters of IVF regulation write their proposed regulations knowing their place in society, and whether or not they will likely be subject to their own regulations. If they were a legislator blindly writing IVF regulations, not knowing whether they would be an IVF physician, a patient, or a child conceived using IVF, they may not be so quick to jump to the conclusion that America’s self-regulation is inadequate. A woman seeking IVF treatments at a fertility clinic and her physician do not view her IVF

187. FOOD AND DRUG ADMINISTRATION, supra note 120, at 14.
188. Gardiner Harris, F.D.A. to Limit Sperm Donors, N.Y. TIMES, May 20, 2004, http://www.nytimes.com/2004/05/20/health/20organ.html. “New York State already bars gay men from donating sperm anonymously, and most of the nation’s sperm banks have similar restrictions because of concerns over transmission of H.I.V., the virus that causes AIDS.” Id.
treatment as creating a “baby market” or “treat[ing] something integral to ourselves as a commodity, i.e. as separate and fungible,” but instead view it as a woman conceiving her first child. A couple who seeks IVF after failing to conceive, or suffering a miscarriage does not conceive of themselves being in a “synergistic ‘economic and emotional’ vortex” that “causes them to obsess about conceiving . . . [and to] risk the lives of their future children.” Instead, this couple sees the woman’s IVF treatment as a step toward building a family together. Furthermore, the attending physicians, who practice in fertility clinics and help patients bring children into this world, do not consider themselves to be cowboys operating in the “‘Wild West’ of medicine.” Nor would a conscientious physician, who cares about the health and safety of her patients, “feel the obligation, supported by the ethical patient autonomy, to accede to the strong desires of their patients” when the procedure is not in her patient’s best interests. Finally, where physicians own their own fertility clinics, the desire to maximize their clinics’ baby take-home rate will not compromise patient care if the physicians comply with the ASRM’s guidelines, and their clinics measure success based on singleton births. In conclusion, since the underlying assumptions made by supporters of regulation are far-fetched, and easily rebutted by the concerns of both the physicians and the patients, proposals asking states to apply the adoption model to IVF treatments, to adopt a comprehensive regulatory scheme, or to place strict limitations on the number of embryos implanted in patients are paternalistic, and place unnecessary restrictions on others’ procreative rights.

4. Due Process and IVF Regulations

If states rely upon an adoption approach to IVF treatments, ignore concerns about how cultural biases, stereotypes, and eugenics will influence ART regulations, adopt fanciful presumptions about IVF physicians and patients, and pass a law similar to the U.K. SET policy, limiting the number of embryos to be implanted in an IVF patient, the next question to ask is what level of scrutiny will the Supreme Court apply when determining the constitutionality of these regulations? Proponents of protecting individual, intimate decision-making, and thus, allowing for wide, unencumbered access to IVF treatments, will argue ART is a part of an individual’s fundamental right to procreate. Therefore, they argue IVF treatments are

192. *Id.* at 222.
194. *Id.* at 73.
195. *Id.*
196. *Id.* at 72–73.
protected by the Due Process Clause of the U.S. Constitution, and IVF regulations are subject to strict scrutiny.\textsuperscript{197}

The Due Process Clause in the Fifth Amendment states, “[n]o person shall . . . be deprived of life, liberty, or property, without due process of law.”\textsuperscript{198} The Due Process Clause applies to the states under the Fourteenth Amendment.\textsuperscript{199} The Due Process Clause incorporates restrictions that are not enumerated in the text of the Constitution,\textsuperscript{200} and it generally protects an individual’s right to privacy.\textsuperscript{201} Supreme Court precedent establishes that individuals have a fundamental right to procreation.\textsuperscript{202} The Supreme Court has previously stated, “The decision whether or not to beget or bear a child is at the very heart of . . . constitutionally protected choices.”\textsuperscript{203} It is “one of the basic civil rights of man.”\textsuperscript{204} Furthermore, “the rights of personal intimacy, of marriage, of sex, of family, of procreation . . . are fundamental rights protected by both the federal and the state Constitutions . . . .”\textsuperscript{205}

This fundamental right to procreation gives individuals the broad right to make intimate decisions about procreation.\textsuperscript{206} In \textit{Griswold v. Connecticut}, the Court held a law that made it illegal to give information to married couples about contraception violated Due Process.\textsuperscript{207} Thus, the Court establishes that married couples have the right to use contraception. An individual’s fundamental right to procreation is expanded in \textit{Roe v. Wade}, which establishes that a woman’s right to procreation includes her unfettered right to choose up until the viability of the fetus. The Court analysis is further elaborated upon in \textit{Planned Parenthood of Southeastern Pa. v. Casey}, which establishes that states may regulate abortions before the

\textsuperscript{197} See John A. Robertson, \textit{Genetic Selection of Offspring Characteristics}, 76 B.U.L. REV. 421, 426–28 (1996) (arguing since there is a fundamental right to choose whether or not to be a parent, regulations that restrict access to PGD information, which can influence this decision, are unconstitutional unless the state meets strict scrutiny).
\textsuperscript{198} U.S. CONST. amend. V.
\textsuperscript{199} U.S. CONST. amend. XIV § 1.
\textsuperscript{201} See \textit{Griswold v. Conn.}, 381 U.S. 479, 483–86 (1965).
\textsuperscript{202} See generally \textit{Skinner v. Okla.}, 316 U.S. 535 (1942) (holding that an Oklahoma law requiring the forced sterilization of habitual criminals violates the 14th Amendment on Equal Protection grounds). “Oklahoma deprives certain individuals of a right which is basic to the perpetuation of a race—the right to have offspring.” \textit{Id.} at 536. “And so I think the real question we have to consider is not one of equal protection, but whether the wholesale condemnation of a class to such an invasion of personal liberty, without opportunity to any individual to show that his is not the type of case which would justify resort to it, satisfies the demands of due process.” \textit{Id.} at 544 (Stone, C.J. concurring).
\textsuperscript{204} \textit{Skinner}, 316 U.S. at 541.
\textsuperscript{205} \textit{In re Matter of Baby M.}, 537 A.2d 1227, 1253 (N.J. 1988).
\textsuperscript{206} “Regulations imposing a burden on a decision as fundamental as whether to bear or beget a child may be justified only by compelling state interests, and must be narrowly drawn to express only those interests.” \textit{Carey}, 431 U.S. at 678.
\textsuperscript{207} \textit{Griswold}, 381 U.S. at 485–86. This holding was later extended to unmarried couples in \textit{Eisenstadt v. Baird}. See generally \textit{Eisenstadt v. Baird}, 405 U.S. 438 (1972).
fetus attains viability, so long as they do not place an undue burden on a woman’s right to choose. An undue burden has been defined as having “the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.” If an undue burden is established, the state must then justify this undue burden and the court will apply the strict scrutiny test. Supporters of regulating IVF treatments have argued the United Kingdom’s regulations would pass the Court’s “undue burden” standard, or, alternatively, they would meet strict scrutiny. This conclusions are false.

Limiting the number of embryos that can be implanted in an IVF patient would place an undue burden on a woman seeking to exercise her reproductive choices. After all, under the current ASRM guidelines, it may be appropriate for a doctor to implant up to five embryos in a patient, and in determining how many embryos to implant, doctors can consider the patient’s circumstances if the patient has failed to conceive. Thus, limiting physician-patient discretion may very well prevent a woman from conceiving at all. Since limiting the number of embryos that may be implanted creates an undue burden, the state’s justification must then meet strict scrutiny.

In order to meet strict scrutiny, the government must have a compelling government interest, and the law must be narrowly tailored to achieve that compelling government interest. A state may argue it has a compelling interest in protecting the health and safety of both the mother and the IVF child by limiting the number of multiples. Yet a state lacks a compelling interest in regulating the number of embryos to implant in a patient because it is not protecting a child, but is in fact addressing embryos that have yet to be implanted in a woman. Moreover, there is no guarantee of a health risk for either the mother or the children, as the IVF treatment might fail, the mother may elect to undergo selective reduction, or the children may be twins or triplets and be born healthy. Also, there is no guarantee that families with multiples will place financial burdens on the state. Furthermore, a law limiting the number of embryos implanted would fail the narrow tailoring prong, as a numerical limit will likely prevent

208. Planned Parenthood of Southeastern Pa., 505 U.S. at 877.
209. Garrison, supra note 58, at 1626–28; see also Rosato, supra note 18, at 95–109.
210. GUIDELINES ON NUMBER OF EMBRYOS TRANSFERRED, supra note 8, at 1.
211. Carey, 431 U.S. at 678.
212. After all, Jon and Kate Gosselin, who have twins and a set of sextuplets conceived by artificial insemination, supported their children from the proceeds of the Jon and Kate Plus 8 television show, book deals, and various speaking engagements. See Lahle Wolfe, Biography of Kate Gosselin, ABOUT.COM, http://womeninbusiness.about.com/od/famouswomenentrepreneurs/p/Kate-Gosselin.htm (last visited Mar. 27, 2010); see also Alan Duke, Jon Gosselin’s Epiphany: Reality TV Not Good for My Kids, CNN, Oct. 2, 2009, http://www.cnn.com/2009/SHOWBIZ/TV/10/02/lkl.jon.gosselin/index.html (“Gosselin revealed to King that the family was paid $22,500 per episode, with none of the money specifically designated for the eight children.”).
reproduction in older woman. Again, ASRM guidelines suggest implanting as many as two to five embryos per IVF treatment. Also, numerical limits on IVF transfers will not prevent multiple birth pregnancies that occur due to ovarian stimulation injections. Additionally, there is no history of regulation with regards to the number of embryos implanted in a woman, and “there is no state statutory regulation of in vitro fertilization that restricts or controls choices made by medical personnel, patients, or donors.” Therefore, if state governments adopt a SET policy, these statutes would fail strict scrutiny, and be declared unconstitutional based on the Fourteenth Amendment.

5. Fertility Tourism

Capping the number of embryos implanted during IVF treatments, or imposing a comprehensive regulatory scheme on fertility clinics, will result in “fertility tourism,” meaning couples will travel outside the United States to receive fertility treatments. Fertility tourism is not only a problem because it defeats the goal of the regulations, but it also leads to the “relocation of skilled doctors,” and “significant concentrations of those professionals in minimally regulated areas.” Fertility tourism is popular among British citizens, who frequently come to the United States to take advantage of its progressive laws. They also travel to other less regulated countries, such as Spain and the Czech Republic. Fertility tourism affects women in other heavily regulated nations like Italy, France, the Netherlands, and Germany. “Italian women are crossing the border in droves following tough legal restrictions on IVF imposed in 2004, while large numbers of gay French women bypass a ban by seeking treatment in Belgium.” Yet British women can be distinguished from their European counterparts. According to a study conducted by the European Society for

217. Id.
218. Id.
Human Reproduction and Embryology in Amsterdam, “Although 80 per cent of German women, 70 per cent of Italians and 65 per cent of French women who traveled abroad for IVF cited legal restrictions at home, British women were the most likely to cite access difficulties as their main reason for seeking help in mainland Europe.” Furthermore, “63.5% of the British patients were over 40.” It is worthy to note that patients who are forty and over are more likely to be affected by the SET policy, and its concurrent strict two or three embryo policy. Therefore, not only would a SET policy fail strict scrutiny in the United States, if U.S. states adopt SET policies in the interim, these statutes would simply force older women to seek treatment overseas.

CONCLUSION

In order to avoid imposing unnecessary and unconstitutional regulations upon an individual’s right to procreate, legislators, scholars, and public policy groups concerned with the problem of multiple birth pregnancies should focus their energies on educating health care professionals and IVF patients about the dangers of multiple birth pregnancies, educating infertile couples about alternative options to IVF treatments, such as adoption or surrogacy, and educating physicians on the latest breakthrough ART techniques, which increase their patients’ success rates without leading to multiple birth pregnancies. These goals can be simply and cheaply achieved by increasing funding for ASRM’s and SART’s existing research and educational programs. Funding awareness and research into fertility treatments will lower the rate of multiple birth pregnancies in the United States, and IVF patients and their offspring, such as Nadya Suleman and her children Noah, Maliah, Isiah, Nariyah, Makai, Josiah, Jeremiah, Jonah, Elijah, Amira, Joshua, Aidan, Calissa, and Caleb, will be regarded as merely a blurb in a medical history book.

220. Id.