

PLAYING THE ODDS OR PLAYING GOD? LIMITING  
PARENTAL ABILITY TO CREATE DISABLED CHILDREN  
THROUGH PREIMPLANTATION GENETIC DIAGNOSIS

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Suppose [persons with disabilities] believe that their child will be happier if she shares her parents' condition, and take action to prevent her from developing normally, for example, not giving the growth hormone that will make her taller, or not providing a cochlear implant that might overcome a mild form of congenital deafness. Such actions would arguably harm the child and constitute child abuse, for the child would be denied a treatment essential for future functioning in society.

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Unless it could be shown that children born to such parents are in fact better off if they share the parents' disability, stopping parents from prenatal lessening of offspring abilities would not . . . interfere with their procreative liberty.<sup>1</sup>

These words, written by Professor John A. Robertson, resonate more in today's society than when first written fifteen years ago, when screening of preimplantation embryos for genetic disease was only experimental.<sup>2</sup> No longer are Professor Robertson's words a supposition of what our future holds—our future is here. And while originally preimplantation screening was thought to be a mechanism to discard embryos carrying disease, clearly Professor Robertson foresaw the downside to this technology long before it became a reality. Today, some couples are no longer satisfied with

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<sup>1</sup> JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 171 (1994).

<sup>2</sup> *Id.* at 155.

having perfectly healthy babies; they would rather have a child that is disabled, like them.

This Comment argues that parents do not have a moral or legal right to harm their children by ensuring that they are born with a disability or disease through the use of preimplantation genetic diagnosis (“PGD”) or other assisted reproductive technologies (“ARTs”). There is no constitutional right to use PGD, and so the individual states should be free to regulate this arena. At this time, however, no states have implemented any legislation that would prevent parents from using PGD in any capacity, whether to help or harm their future children. As such, those children already born through PGD, who cannot benefit from present or future regulation of reproductive technologies, should benefit from indirect methods of regulation through the tort law system.

Part I of this Comment will explain the science behind current ARTs, specifically PGD, and address instances in which parents have used PGD to create disabled or diseased children. Part II will discuss the current state of reproductive law in the United States, as well as legislation currently in effect in Canada and Western Europe. Part III will examine the ethical implications presented by the use of PGD to limit a child’s opportunities, mainly the conflict between the ethical principles of beneficence and autonomy, and how both of these cannot be achieved when parents use PGD for this purpose. Part IV will analyze why parents do not have a constitutional right to use PGD to create disabled or diseased children, and why the states may intervene with regulation. Finally, Part V will present an alternative solution to direct regulation through federal or state legislation by using the tort law system as an indirect method to regulate these issues.

## I. BACKGROUND ON PGD AND ITS USES TODAY

ARTs refer to those fertility treatments that include the handling of both sperm and eggs.<sup>3</sup> ART encompasses in vitro fertilization

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<sup>3</sup> U.S. DEPT OF HEALTH AND HUMAN SERVS., CTRS. FOR DISEASE CONTROL AND PREVENTION, 2006 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 3 (2008), <http://www.cdc.gov/art/ART2006/508PDF/2006ART.pdf> [hereinafter CENTERS FOR DISEASE CONTROL]. According to the Centers for Disease Control and Prevention (“CDC”), ART does not include “treatments in which only sperm are handled (i.e., intrauterine—or artificial—insemination) or procedures in which a woman takes drugs only to stimulate egg production without the intention of having eggs retrieved.” *Id.* Some, however, do continue to include artificial insemination or intrauterine insemination as a type of ART. WebMD, Assisted Reproduction, <http://www.webmd.com/baby/healthtool-assisted-reproduction> (last visited Nov.

("IVF")<sup>4</sup> and its variations, which include: intracytoplasmic sperm injection ("ICSI"),<sup>5</sup> gamete intrafallopian transfer ("GIFT"),<sup>6</sup> zygote intrafallopian transfer ("ZIFT"),<sup>7</sup> and PGD.<sup>8</sup> Accomplished prior to IVF transfer, PGD is the process by which one or two cells are removed from a human zygote, or biopsied, after which the genetic makeup of the cells is analyzed.<sup>9</sup> Only those embryos that were not carriers of whatever gene was being screened for are then implanted in the uterus.

PGD was designed to screen for disabilities or diseases in order to avoid passing on serious genetic defects to offspring.<sup>10</sup> Clinics can use PGD to test for colon cancer, cystic fibrosis, early-onset familial Alzheimer disease, Fanconi anemia, hemophilia, Huntington chorea, Marfan syndrome, muscular dystrophy, polycystic kidney disease, sickle cell anemia, and Tay-Sachs disease, as well as for milder conditions, including hereditary deafness.<sup>11</sup> Once the popularity of PGD began to grow, an unanticipated side effect occurred: rather than using PGD to avoid disability or disease, some parents began *choosing* to have offspring that carried the inheritable disability or disease. Anecdotal evidence shows that parents have requested clinics to select for deafness, achondroplasia (dwarfism), Down's syndrome, and phenylketonuria.<sup>12</sup>

A reported three percent of IVF clinics in the United States have allowed parents to use PGD or other ARTs to select for embryos with disabilities or diseases.<sup>13</sup> When it became possible in 1995 to

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13, 2009).

<sup>4</sup> CENTERS FOR DISEASE CONTROL, *supra* note 3, at 3. IVF is the process by which an egg is extracted from a female and is then fertilized in a laboratory. The resulting embryos are implanted into the uterus through the cervix.

<sup>5</sup> *Id.* ICSI involves the injection of a single sperm directly into the egg.

<sup>6</sup> *Id.* With GIFT, a fiber-optic laparoscope is used to guide unfertilized eggs and sperm into the fallopian tubes through incisions in the abdomen.

<sup>7</sup> *Id.* ZIFT involves a laparoscope to guide the transfer of zygotes (eggs which have been fertilized in a laboratory) into the fallopian tubes.

<sup>8</sup> Andrea L. Bonnicksen, *Oversight of Assisted Reproductive Technologies: The Last Twenty Years*, in REPROGENETICS: LAW, POLICY, AND ETHICAL ISSUES 64, 64 (Lori P. Knowles & Gregory E. Kaebnick eds., 2007). For purposes of this paper, I shall focus only on PGD.

<sup>9</sup> Soren Holm, *Ethical Issues in Pre-Implantation Diagnosis*, in THE FUTURE OF HUMAN REPRODUCTION: ETHICS, CHOICE, AND REGULATION 176, 176 (John Harris & Soren Holm eds., 2000).

<sup>10</sup> Bratislav Stankovi, "It's a Designer Baby!": *Opinions on Regulation of Preimplantation Genetic Diagnosis*, 2005 UCLA J.L. & TECH. 3, 3 (2005).

<sup>11</sup> Kirsten Rabe Smolensky, *Creating Children with Disabilities: Parental Tort Liability for Preimplantation Genetic Interventions*, 60 HASTINGS L.J. 299, 303-04 (2008) [hereinafter Smolensky, *Creating Children*].

<sup>12</sup> Jaime King, *Duty to the Unborn: A Response to Smolensky*, 60 HASTINGS L.J. 377, 378 (2008) [hereinafter King, *Duty to the Unborn*].

<sup>13</sup> Susannah Baruch et al., *Genetic Testing of Embryos: Practices and Perspectives of US In Vitro Fertilization Clinics*, 89 FERTILITY & STERILITY 1053, 1055-56 (2008).

screen for the gene that causes achondroplasia, a dwarf couple decided to use IVF and PGD in order to have a dwarf child.<sup>14</sup> In 2002, deaf parents Sharon Duchesneau and Candy McCullough received much hostile backlash when they sought to have a second deaf child.<sup>15</sup> By using the sperm of a deaf donor, Duchesneau and McCullough eliminated the possibility of having a hearing child.<sup>16</sup> As predicted, their son was born with severely impaired hearing.<sup>17</sup> These representative cases are by no means the sole occurrences, and children born with a disability or disease by means of preimplantation screening deserve some protection under the law.

## II. CURRENT STATE OF THE LAW

Currently, the United States has yet to enact any federal law to regulate the use of PGD, and similarly, no individual state has set forth legislation to regulate PGD. Nevertheless, the ART industry is not completely without guidance. The United States Supreme Court has handed down decisions on parental rights and reproductive liberties, and some states, as well as Congress, have enacted legislation on some aspects of human reproduction. Furthermore, much of Western Europe has passed legislation on the regulation of PGD.

### A. Precedent Concerning Parental Rights and Procreation

#### 1. The Parental Right to Direct the Care, Custody, and Control of Children

The Supreme Court has long recognized that parents have a fundamental right to make decisions regarding the care, custody, and control of their children.<sup>18</sup> First, in a long line of cases beginning in 1923, the Court held in *Meyer v. Nebraska* that parents have a right to “establish a home and bring up children” and “to control the education of their own.”<sup>19</sup> Shortly thereafter, the Court in *Pierce v. Society of Sisters* held that the liberty interest of parents

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<sup>14</sup> See Dov Fox, *Silver Spoons and Golden Genes: Genetic Engineering and the Egalitarian Ethos*, 33 AM. J.L. & MED. 567, 581 n.96 (2007); Faye Flam, *Designing the Family Tree: A Road to Eugenics?*, BUFFALO NEWS, June 25, 1995, Viewpoints, at F7.

<sup>15</sup> RUTH DEECH & ANNA SMAJDOR, FROM IVF TO IMMORTALITY: CONTROVERSY IN THE ERA OF REPRODUCTIVE TECHNOLOGY 59–60 (2007).

<sup>16</sup> *Id.*; see also Liza Mundy, *A World of Their Own*, WASH. POST, Mar. 31, 2002, Magazine, at W22.

<sup>17</sup> DEECH & SMAJDOR, *supra* note 15, at 59–60.

<sup>18</sup> *Troxel v. Granville*, 530 U.S. 57, 65 (2000).

<sup>19</sup> 262 U.S. 390, 399, 401 (1923).

includes directing the upbringing and education of their children.<sup>20</sup> Several years later, in *Prince v. Massachusetts*, the Supreme Court declared “that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.”<sup>21</sup> Following these cases, the Court has continuously held that there is a strong presumption that fit parents act in the best interests of their children.<sup>22</sup> As such, as long as a parent continues to “adequately care[] for his or her children . . . there will normally be no reason for the state to inject itself into the private realm of the family to further question the ability of that parent to make the best decisions concerning the rearing of that parent’s children.”<sup>23</sup>

Under the doctrine of *parens patriae*, however, the government has a responsibility to care for and protect children from neglect, abuse, and fraud.<sup>24</sup> Under the Child Abuse and Prevention and Treatment Act, child abuse can occur through act or omission and is defined as any “physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child . . . by a person . . . responsible for the child’s welfare under circumstances indicating harm or threatened harm to the child’s health or welfare.”<sup>25</sup> The courts have further defined neglect as a willful or unintentional “failure to exercise the care that the circumstances justly demand.”<sup>26</sup> It has also been recognized that the meaning of neglect changes as the context of the surrounding circumstances change.<sup>27</sup> While one most often thinks of child abuse or neglect as physically manifested, abuse and neglect frequently occurs by omission of care; and in these circumstances as well, the state has a compelling interest to interfere with the parental right to make decisions regarding the care, custody, and control of their children.

## 2. The Fundamental Right to Procreate

The Supreme Court has also found that there exists a

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<sup>20</sup> 268 U.S. 510, 534–35 (1925).

<sup>21</sup> 321 U.S. 158, 166 (1944).

<sup>22</sup> *Parham v. J.R.*, 442 U.S. 584, 602–03 (1979); *see also Troxel*, 530 U.S. at 68.

<sup>23</sup> *Troxel*, 530 U.S. at 68–69.

<sup>24</sup> *See, e.g., People ex rel. Wallace v. Labrenz*, 104 N.E.2d 769, 773 (Ill. 1952).

<sup>25</sup> 45 C.F.R. § 1340.2 (2008). Negligent treatment or maltreatment is defined as “failure to provide adequate food, clothing, shelter, or medical care,” and threatened harm to a child’s health or welfare is defined as “a substantial risk of harm to the child’s health or welfare.” *Id.*

<sup>26</sup> *Wallace*, 104 N.E.2d at 773.

<sup>27</sup> *Id.*

fundamental right to procreation, as “[m]arriage and procreation are fundamental to the very existence and survival of the race.”<sup>28</sup> The Court framed this issue as one of privacy, stating that “[i]f the right of privacy means anything, it is the right of the individual . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”<sup>29</sup> The right to procreate, however, is not absolute. The Court has consistently held that states may intrude upon one’s fundamental rights, including the right to procreate, where the state has a compelling interest.<sup>30</sup>

Historically, people viewed as being mentally incompetent have been denied the right to procreation.<sup>31</sup> Some state statutes still provide for sterilization of the incompetent.<sup>32</sup> Sterilization for the mentally incapacitated is usually done when it is in the best interest of the person or out of medical necessity, even though it eliminates the right to procreate.<sup>33</sup> For instance, in *In re Angela D.*, the California Court of Appeal, Fourth District, authorized the sterilization of an incompetent where alternate forms of contraception and full-time supervision were not available, and where she was likely to engage in future sexual activity.<sup>34</sup> Because the twenty-year-old severely developmentally impaired woman was forced to leave her fully-supervised school and enter a public day program, the court decided it would be in her best interest to be sterilized because she would not be likely to resist sexual advances.<sup>35</sup> Furthermore, she was unable to take any form of birth control medication because it would conflict with her epilepsy and diabetes medications, and physicians had advised that if she were pregnant, she would have such severe seizures that they would

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<sup>28</sup> *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942).

<sup>29</sup> *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) (emphasis omitted).

<sup>30</sup> *E.g.*, *Carey v. Population Servs. Int’l*, 431 U.S. 678, 686 (1977). And, of course, the means of the state to regulate must be narrowly tailored to fit only that compelling interest. *Id.*

<sup>31</sup> See *Buck v. Bell*, 274 U.S. 200, 207 (1927).

<sup>32</sup> *E.g.*, COLO. REV. STAT. § 27-10.5-130 (2008); ME. REV. STAT. ANN. tit. 34-B, § 7011 (1988); N.C. GEN. STAT. § 35A-1245 (2007).

<sup>33</sup> *E.g.*, Kris W. Druhm, Comment, *A Welcome Return to Draconia: California Penal Law § 645, the Castration of Sex Offenders and the Constitution*, 61 ALB. L. REV. 285, 323 (1997); see also *In re C.D.M.*, 627 P.2d 607, 613 (Alaska 1981) (recognizing the lower court’s power to authorize sterilization of a nineteen-year-old woman with Down’s Syndrome where it was proven by clear and convincing evidence that it was in the best interest of the incompetent); *In re Grady*, 426 A.2d 467, 481 (N.J. 1981) (finding that under the doctrine of *parens patriae*, the court has the power to authorize sterilization for incompetent persons so long as there is clear and convincing proof that sterilization is in the person’s best interests).

<sup>34</sup> 83 Cal. Rptr. 2d 411 (Ct. App. 1999).

<sup>35</sup> *Id.* at 418–19.

result in her death and the death of her fetus.<sup>36</sup>

Prisoners have also been denied the right to procreate. In *Turner v. Safley*, the Supreme Court held that when a prison marriage regulation interferes with an inmate's constitutional right to marry, the regulation is valid so long as it is reasonably related to "legitimate penological objectives."<sup>37</sup> Two United States circuit courts thereafter found that regulations limiting procreation while incarcerated were constitutional.<sup>38</sup> In each case, the inmate sought to have his wife artificially inseminated. In *Goodwin*, the Eighth Circuit found that the "restriction on inmate procreation [was] reasonably related to furthering the legitimate penological interest of treating all inmates equally, to the extent possible."<sup>39</sup> The Ninth Circuit in *Gerber*, however, did not even purport to apply the rational basis standard set out in *Turner*, as it held that "the right to procreate while in prison is fundamentally inconsistent with incarceration."<sup>40</sup> The court relied heavily on the Supreme Court's implication in *Turner* "that while the intangible and emotional aspects of marriage survive incarceration, the physical aspects do not."<sup>41</sup> Hence, even though artificial insemination does not involve physical consummation of a marriage, it would still give way to procreation, to which prisoners do not have a fundamental right.

Procreation rights have been denied to probationers as well, and as with prisoners, courts apply rational basis review in these situations. For instance, in *State v. Oakley*, the Wisconsin Supreme Court held that the fundamental right to procreate was not infringed upon where a condition of the defendant's probation was that he must avoid having additional children unless he showed that he was able to support those children and his current children.<sup>42</sup> The *Oakley* court found that the probation condition was valid because it did not eliminate the defendant's ability to

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<sup>36</sup> *Id.* at 413.

<sup>37</sup> 482 U.S. 78, 99 (1987). In this case, a regulation permitted marriage only with the prison superintendent's permission and only when there was a compelling reason to do so—generally only in instances of pregnancy or the birth of an illegitimate child. The Court applied a rational basis test for the incarcerated rather than a strict scrutiny review that would apply to non-prisoners, and found that an almost complete ban on marriages was not reasonably related to legitimate penological objectives.

<sup>38</sup> *Gerber v. Hickman*, 291 F.3d 617 (9th Cir. 2002); *Goodwin v. Turner*, 908 F.2d 1395 (8th Cir. 1990). These cases were decided after *Turner*, in which the Supreme Court said that when inmates marry while incarcerated they can expect that their marriages will not be fully consummated until they are released, implying that the right to procreation is abridged while incarcerated. *Turner*, 482 U.S. at 96.

<sup>39</sup> *Goodwin*, 908 F.2d at 1400.

<sup>40</sup> *Gerber*, 291 F.3d at 623.

<sup>41</sup> *Id.*

<sup>42</sup> 629 N.W.2d 200, 208 (Wis. 2001).

procreate, and the condition was reasonably related to the goal of rehabilitation.<sup>43</sup> In another case, where a father physically abused his two-and-one-half-month-old daughter, and having previously broken his son's arm, the Oregon Court of Appeals upheld a probation condition requiring that he seek prior written approval by the court before fathering another child.<sup>44</sup> The court held that the defendant's prior abusive behavior "warranted a provision keeping [him] from young children, especially his own," and that the condition of probation did not impose a total ban on his right to procreate, because the condition could be modified once he completed drug treatment and anger management programs.<sup>45</sup> The condition "provide[d] potential victims with protection from future injury and interfere[d] with defendant's fundamental rights to a permissible degree."<sup>46</sup>

These examples demonstrate that even though Americans are afforded the fundamental rights to procreate and thereafter to direct the care, custody, and control of their children, these rights are not absolute and may be abridged when circumstances so require.<sup>47</sup>

### *B. Federal and State Legislation on Human Reproduction*

The United States Congress has passed little legislation on the regulation of human reproduction. In addition to the fear of interfering with procreation rights, Congress has largely avoided policy initiatives on ART because of conflicts over abortion and the legal and moral status of fetuses and embryos.<sup>48</sup> In 2009, President Barack Obama, by Executive Order, overturned the Order of the Bush administration that had declared research be done "without creating a human embryo for research purposes or destroying, discarding, or subjecting to harm a human embryo or fetus."<sup>49</sup> But this has not resulted in any further oversight from the federal

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<sup>43</sup> *Id.* at 213.

<sup>44</sup> *State v. Kline*, 963 P.2d 697, 699 (Or. Ct. App. 1998).

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> It is true that probationers and prisoners hold a different status than free citizens, which justifies restricting their rights; therefore, it is difficult to apply these cases in different contexts. These decisions, however, serve as examples that there are situations that do require these fundamental rights to be limited.

<sup>48</sup> Bonnicksen, *supra* note 8, at 65–66.

<sup>49</sup> Removing Barriers to Responsible Scientific Research Involving Human Stem Cells, Exec. Order No. 13,505, 74 Fed. Reg. 10,667 (Mar. 9, 2009), *revoking* Exec. Order No. 13,435, 72 Fed. Reg. 34,591 (June 20, 2007).

government on ART,<sup>50</sup> meaning that regulation of ART research, including PGD, is essentially left to states, agencies, or professional societies.

In order to prevent the spread of disease, the Food and Drug Administration's Center for Biologics Evaluation and Research ("CBER") began a regulatory program in 1998 consisting of three stages.<sup>51</sup> The program is now termed Human Cells, Tissues, and Cellular and Tissue-Based Products, and has been codified in the Code of Federal Regulations.<sup>52</sup> The first stage, passed in 2001, requires that manufacturers of human cellular products register with the CBER.<sup>53</sup> The second stage, passed in 2005, requires that cell and tissue donors be tested.<sup>54</sup> The third and final stage was finalized in 2004, and requires that manufacturers follow good tissue practices.<sup>55</sup> Almost all ART facilities already conformed to these regulations, having followed industry standards, accreditation programs, state licensing requirements, and professional society guidelines.<sup>56</sup>

State legislation has gone a bit further than federal legislation and administrative regulations. Twenty-four states have passed laws concerning research on the fetus or embryo.<sup>57</sup> In addition, many states have banned human reproductive cloning<sup>58</sup> and have

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<sup>50</sup> Bonnicksen, *supra* note 8, at 66.

<sup>51</sup> *Id.* at 75–76.

<sup>52</sup> Human Cells, Tissues, and Cellular and Tissue-Based Products, 21 C.F.R. § 1271.1–.440 (2009).

<sup>53</sup> § 1271.21–.37.

<sup>54</sup> § 1271.45–.90.

<sup>55</sup> § 1271.145–.320.

<sup>56</sup> Bonnicksen, *supra* note 8, at 76.

<sup>57</sup> See ARIZ. REV. STAT. ANN. § 35-196.04 (Supp. 2005); ARK. CODE ANN. § 20-17-802 (2005); CAL. HEALTH & SAFETY CODE § 125305 (West 2006); CONN. GEN. STAT. § 19a-32d (Supp. 2009); FLA. STAT. § 381.855 (Supp. 2009); 720 ILL. COMP. STAT. 510/6 (1985); 720 ILL. COMP. STAT. ANN. 510/12.1 (West 1980); IND. CODE § 16-34.5-1-2 (2008); IOWA CODE § 707C.2 (2009); KY. REV. STAT. ANN. § 311.715 (LexisNexis 2007); LA. REV. STAT. ANN. § 9:122 (2008); MD. CODE ANN., ECON. DEV. § 10-438 (LexisNexis 2008); MASS. GEN. LAWS ch. 111L, § 8 (2004); MICH. COMP. LAWS § 333.2689 (2005); MO. REV. STAT. § 188.037 (1979); NEB. REV. STAT. § 71-8806 (Supp. 2008); N.J. STAT. ANN. § 2C:11A-1 (West 2004); N.M. STAT. § 24-9A-3 (2006); N.Y. PUB. HEALTH LAW § 265-a (McKinney 2007); N.D. CENT. CODE § 14-02.2-01 (2004); OKLA. STAT. tit. 63, § 1-270.2 (2009); R.I. GEN. LAWS § 11-54-1 (2002); S.D. CODIFIED LAWS § 34-14-16 (2004); TENN. CODE ANN. § 39-15-208 (2006); VA. CODE ANN. § 23-286.1 (2006).

<sup>58</sup> See ARIZ. REV. STAT. ANN. § 35-196.04 (2008); ARK. CODE ANN. § 20-16-1002 (2005); CAL. HEALTH & SAFETY CODE § 24185 (West 2006); CONN. GEN. STAT. § 19a-32d (2009); 410 ILL. COMP. STAT. 110/40 (2008); IND. CODE § 16-34.5-1-2 (2008); IND. CODE § 35-46-5-2 (2008); IOWA CODE § 707C.2 (2009); LA. REV. STAT. ANN. § 40:1299.36 (2009); MD. CODE ANN., ECON. DEV. § 10-440 (LexisNexis 2008); MASS. GEN. LAWS ch. 111L, § 8 (2009); MICH. COMP. LAWS ANN. § 333.16274 (2008); MO. ANN. STAT. § 1.217 (2000); NEB. REV. STAT. §§ 71-8801–8806 (2008); N.J. STAT. ANN. § 2C:11A-1 (West 2004); N.Y. PUB. HEALTH LAW § 265-a (McKinney Supp. 2009); N.D. CENT. CODE § 12.1-39-02 (Supp. 2009); OKLA. STAT. tit. 63, § 1-270.2 (2009); R.I. GEN. LAWS § 23-16.4-2 (2008); S.D. CODIFIED LAWS § 34-14-27 (2009); VA. CODE ANN. §

passed regulations on embryonic stem cell research.<sup>59</sup> But again, these regulations do not extend to the actual practice of PGD. Medicine, however, is regulated within the states through licensing of clinics and laboratories and tort law enforcement.<sup>60</sup>

Currently, professional societies regulate the ART and PGD industries more than any other governing body in the United States. The American Society for Reproductive Medicine (“ASRM”) oversees three major areas of ART clinical practice: practice standards, laboratory certification and quality control, and ethics guidelines.<sup>61</sup> ASRM initially released a PGD practice standard in 2001, and an update was issued in December of 2007.<sup>62</sup> These standards are recommendations as to a particular approach to a treatment or an evaluation, but are only guidelines and are not legally enforceable.<sup>63</sup> In addition, ASRM supports the use of PGD only so far as “to prevent the transmission of serious genetic disease,” and has, in related instances, condemned PGD use for nonmedical trait selection.<sup>64</sup>

The lack of federal and state legislation on ART and PGD practices leaves much to be desired. Much of the industry is adhering to the guidelines issued by professional societies, but a clear position from the government is needed to ensure that all ART and PGD clinics are following the same policies and procedures when it comes to these types of sophisticated reproductive technologies.

### C. *International Regulation*

While the United States seemingly allows unlimited use of ART

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32.1-162.22 (2009).

<sup>59</sup> See ARIZ. REV. STAT. ANN. § 41-1518 (2008); ARK. CODE ANN. § 20-8-502 (Supp. 2009); CAL. HEALTH & SAFETY CODE § 125119 (West 2006); CONN. GEN. STAT. § 19a-32d (2009); FLA. STAT. § 381.855 (2007); 410 ILL. COMP. STAT. 110/5 (2009); IOWA CODE § 707C.2 (2009); MD. CODE ANN., ECON. DEV. § 10-437 (LexisNexis 2008); MASS. GEN. LAWS ch. 23I, § 1 (2009); MO. CONST. ART. 3, § 38(d) (2009); NEB. REV. STAT. § 71-8801 (2008); N.Y. PUB. HEALTH LAW § 265-a (McKinney Supp. 2009); OKLA. STAT. tit. 63, § 1-270.2 (2009); VA. CODE ANN. § 23-286.1 (2006).

<sup>60</sup> Bonnicksen, *supra* note 8, at 73.

<sup>61</sup> *Id.* at 77.

<sup>62</sup> *Id.* at 78; American Society for Reproductive Medicine, Genetics and Preimplantation Genetic Diagnosis, <http://www.asrm.org/Patients/topics/genetics.html> (last visited Nov. 13, 2009). The PGD practice standard is currently under another revision. *Id.*

<sup>63</sup> American Society for Reproductive Medicine, Practice Committee Reports, <http://www.asrm.org/Media/Practice/practice.html> (last visited Nov. 13, 2009).

<sup>64</sup> See Ethics Committee of the American Society of Reproductive Medicine, *Sex Selection and Preimplantation Genetic Diagnosis*, 72 FERTILITY & STERILITY 595, 598 n.1 (1999) (discouraging PGD for sex selection for purely nonmedical purposes).

and PGD, these practices are far more stringently regulated internationally, namely within Canada and much of Western Europe. Many of these countries have based their own human reproduction policies on the United Kingdom's Human Fertilisation and Embryology Act ("HFEA") of 1990.<sup>65</sup> Under the HFEA, the use of PGD is allowed only where there is risk of a serious inherited condition,<sup>66</sup> and even then, clinics must be licensed to perform PGD procedures for each individual genetic disorder.<sup>67</sup> The intention of this legislation was to use PGD to avoid implantation of affected embryos.<sup>68</sup> A recent enactment, however, has changed the HFEA to include a ban on screening out *unaffected* embryos. The new act states that:

Persons or embryos that are known to have a gene, chromosome or mitochondrion abnormality involving a significant risk that a person with the abnormality will have or develop—(a) a serious physical or mental disability, (b) a serious illness, or (c) any other serious medical condition, must not be preferred to those that are not known to have such an abnormality.<sup>69</sup>

This legislation furthers the goal of the original HFEA; its guidance on PGD makes it clear that selection for something other than a serious genetic condition will not be permitted.<sup>70</sup>

Therefore, under current law in the United States, as well as in most countries worldwide with the exception of the United Kingdom, using PGD to select for disabled embryos is perfectly legal. Due to the newly revised HFEA and the public outrage resulting from the past instances in which PGD has been used for this purpose, it is clear that there are severe moral implications to this use. This technology is developing rapidly, and the law needs to respond accordingly.

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<sup>65</sup> Lori P. Knowles, *The Governance of Reproductive Technology: International Models*, in REPROGENETICS, *supra* note 8, at 127, 129.

<sup>66</sup> Andrew Grubb, *Regulating Reproductive Genetics in the United Kingdom*, in REPROGENETICS, *supra* note 8, at 144, 154.

<sup>67</sup> *Id.* at 156. The HFEA "recognizes that there should be a high level of regulation [for] these procedures," so "only . . . those conditions that are included by [the licensing] committee" can be genetically screened. *Id.* To use PGD, "there must be a 'significant risk' of a 'serious genetic condition,'" and the decision to use PGD should be made based on "the patients' perception of the condition and its impact on them and their family." *Id.* at 156–57.

<sup>68</sup> *Id.* at 155.

<sup>69</sup> Human Fertilisation and Embryology Act, 2008, c. 22, § 14(9) (U.K.). This bill was proposed as a measure to avoid future situations like the Duchesneau/McCullough case discussed above. See Dominic Lawson, *Of Course a Deaf Couple Want a Deaf Child*, INDEPENDENT (London), Mar. 11, 2008, at 40; *supra* notes 15–17 and accompanying text.

<sup>70</sup> Grubb, *supra* note 66, at 160.

### III. DO PARENTS HAVE A *MORAL* RIGHT TO USE PGD TO CREATE A DISABLED OR DISEASED CHILD?

The primary ethical conflict that emerges from using PGD to ensure that a child is born with some sort of disability, disease, or otherwise harmful disorder, is between two ethical principles known as beneficence and autonomy. Beneficence requires that we do what is in the best interest of others, or that we “act for the benefit of others.”<sup>71</sup> Autonomy is founded on a basis of free will and individual choice,<sup>72</sup> and it promotes the idea that “independent actions and choices of the individual should not be constrained by others.”<sup>73</sup> Both concepts will be explored below.

#### A. *Beneficence (and Nonmaleficence)*

To be beneficent is to do what is in the best interest of a patient, or, in this case, to do what is best for a child. According to renowned bioethicists Tom Beauchamp and James Childress, there are three forms beneficence takes, including the prevention of harm, the removal of harm, and the promotion of good.<sup>74</sup> A closely related principle is that of nonmaleficence, which “asserts an obligation not to inflict harm on others.”<sup>75</sup> Each form of beneficence requires that an action be taken to help a patient, whereas nonmaleficence requires restraint from harmful action.<sup>76</sup>

To determine whether using PGD to choose an affected embryo for implantation represents harm to the child, we must first define *harm*. This is exceedingly difficult to do, especially when considering the groups of people that have thus far sought out PGD for this use. Let us consider, for example, whether being deaf is a harm. Destroying someone’s hearing is clearly a harm.<sup>77</sup> But many deaf people do not view deafness as a harm. Rather, they pride themselves on being deaf and do not see themselves as disabled.<sup>78</sup> Deaf activists describe Deafness—with a capital “D”—as a culture, not a disability.<sup>79</sup> Some even consider the use of a cochlear implant

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<sup>71</sup> TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 166 (5th ed. 2001).

<sup>72</sup> *Id.* at 58.

<sup>73</sup> BARRY R. FURROW ET AL., *BIOETHICS: HEALTH CARE LAW AND ETHICS* 4 (6th ed. 2008).

<sup>74</sup> BEAUCHAMP & CHILDRESS, *supra* note 71, at 115.

<sup>75</sup> *Id.* at 113.

<sup>76</sup> *Id.* at 115.

<sup>77</sup> Dena S. Davis, *Genetic Dilemmas and the Child’s Right to an Open Future*, 28 *RUTGERS L.J.* 549, 570 (1997).

<sup>78</sup> *Id.* at 570–71.

<sup>79</sup> *Id.*

to enable a deaf child to hear a form of genocide, because they feel so strongly about maintaining their Deaf culture.<sup>80</sup>

Deafness, however, is still a serious disability. The Americans with Disabilities Act defines deafness or hearing impairment as a disability because it substantially limits a major life activity: hearing.<sup>81</sup> In addition to loss of hearing, deaf people suffer other losses as well, such as substantially lower levels of income—by as much as forty percent—than hearing people.<sup>82</sup> Furthermore, educational standards for the deaf are shocking; many deaf students cannot even read a newspaper upon high school graduation.<sup>83</sup> Stated aptly, “[i]f Deafness is a culture rather than a disability, it is an exceedingly narrow one.”<sup>84</sup> It is true that some deaf children raised learning sign language are good readers, but once they are beyond secondary education, occupational barriers exist.<sup>85</sup> Even with reasonable accommodations made by employers, there are many occupations that inherently cannot be fulfilled by a deaf person.<sup>86</sup>

Dena Davis has stated it best:

If deafness is a disability which substantially narrows a child’s career, marriage, and cultural options in the future, then deliberately creating a deaf child counts as a moral harm. If Deafness is a culture . . . then deliberately creating a Deaf child who will have only limited options to move outside of that culture also counts as a moral harm.<sup>87</sup>

Therefore, once we define disabilities as harms, we can see that in

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<sup>80</sup> *Id.* at 571.

<sup>81</sup> Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213 (2006); *see also* Americans with Disabilities Act Questions and Answers, <http://www.ada.gov/q%26aeng02.htm> (last visited Nov. 13, 2009). The ADA webpage currently lists “hearing” as one of the major life activities. *Id.* Congress approved the same classification as part of the ADA Amendments Act of 2008, which took effect on January 1, 2009. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified as amended at 42 U.S.C.A. § 12102 (West Supp. 2009)).

<sup>82</sup> Davis, *supra* note 77, at 571–72.

<sup>83</sup> *Id.* at 572; *see also* MARC MARSCHARK, RAISING AND EDUCATING A DEAF CHILD 164–65 (2007) (noting that “without special attention, deaf children frequently end up not being fully literate in either English or in sign language” and that “[e]vidence from standardized testing in the United States indicates that 50 percent of 18-year-old deaf and hard-of-hearing students read below the fourth-grade level (equivalent to a hearing 9-year-old), compared to about 1 percent of their hearing peers”).

<sup>84</sup> DENA S. DAVIS, GENETIC DILEMMAS: REPRODUCTIVE TECHNOLOGY, PARENTAL CHOICES, AND CHILDREN’S FUTURES 81 (2d ed. 2010).

<sup>85</sup> Davis, *supra* note 77, at 574.

<sup>86</sup> *Id.* For instance, a hearing-impaired person may have a difficult time pursuing a career as a musician, a pilot, a firefighter, etc.

<sup>87</sup> *Id.* at 575. “A decision made before a child is born that confines him forever to a narrow group of people and a limited choice of careers so violates the child’s right to an open future that no genetic counselor should acquiesce to it.” DAVIS, *supra* note 84, at 82.

order to act in accordance with the principles of beneficence and nonmaleficence, we must do everything in our power to protect future children from the harms that their parents may inflict upon them. This should include passing on a disability or disease to one's offspring; physicians and parents should act with beneficence in preventing harm to befall upon the future patient—the child—and they should also act with nonmaleficence by intentionally disengaging from PGD use when it will result in the disability of the future child.<sup>88</sup>

With PGD, however, the child will either exist with a disability or disease, or not at all, because the particular embryo would never be implanted or allowed to grow. The question then becomes whether it is more harmful to live a disabled or diseased life, or is it more harmful not to exist at all? Most courts refrain from entering into this “nonexistence comparison,”<sup>89</sup> because it assumes that all lives are *not* equally valuable and constitutes “a repudiation of the value of human life.”<sup>90</sup> But people are fully capable of assessing the value of their own lives.<sup>91</sup> For instance, if a competent patient refuses life-saving treatment, we allow him to do so, even if that means he will die.<sup>92</sup> That patient would rather face death than face a life of potential suffering. This notion is also evidenced by the growing popularity of physician-assisted death, now legal in Oregon and Washington.<sup>93</sup> In those states, people facing an imminent death within six months have the option to end their lives in a more desirable manner rather than prolong their pain and suffering until the bitter end. Likewise, a person is capable of assessing the value of life and opportunity lost to him because of a disability or disease from which he suffers. Thus, if the child believes that his disability

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<sup>88</sup> It has been suggested that some couples have used prenatal diagnosis to detect and abort non-deaf fetuses so that they could be certain to have a deaf child who could be fully integrated into Deaf culture. See Dorothy C. Wertz, *Society and the Not-So-New Genetics: What Are We Afraid Of? Some Future Predictions from a Social Scientist*, 13 J. CONTEMP. HEALTH L. & POL'Y 299, 340 (1997); Davis, *supra* note 77, at 558–59. From this standpoint, one can argue that it is less harmful to the child that is the product of PGD if the alternative is aborting the non-deaf fetus, as it is the difference between life and death. But “parents should have no greater right to produce [a] handicapping condition . . . just because they would not otherwise bring the child into the world.” ROBERTSON, *supra* note 1, at 171.

<sup>89</sup> PHILIP G. PETERS, JR., HOW SAFE IS SAFE ENOUGH?: OBLIGATIONS TO THE CHILDREN OF REPRODUCTIVE TECHNOLOGY 49 (2004).

<sup>90</sup> *Blake v. Cruz*, 698 P.2d 315, 321 (Idaho 1984).

<sup>91</sup> PETERS, JR., *supra* note 89, at 52.

<sup>92</sup> See *Washington v. Glucksberg*, 521 U.S. 702, 720, 725 (1997); *Cruzan ex rel. Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

<sup>93</sup> The Oregon Death with Dignity Act is codified at OR. REV. STAT. §§ 127.800–897 (2007); The Washington Death with Dignity Act is codified at WASH. REV. CODE ANN. §§ 70.245.010–.904 (West Supp. 2009).

or disease is more harmful to him because of certain life choices he would have made otherwise, then he has been harmed.

Finally, recent scientific discoveries have revealed that the PGD process itself can be harmful to the future child. The embryo biopsy may lead to a considerably reduced rate of successful pregnancies in PGD patients as opposed to IVF patients.<sup>94</sup> Also, embryo biopsies performed imprecisely or with a lack of proper technique and experience result in irreversible damage to the embryo.<sup>95</sup> Additionally, many long-term risks extending past childhood are still unknown because the resulting PGD children have not yet reached puberty.<sup>96</sup> Thus, “[t]he known and unknown risks of embryo biopsy should be weighed against the benefit of being able to select between embryos. In cases of selecting for an embryo with a disabling trait, establishing a benefit significant enough to outweigh the risk of the procedure will be difficult.”<sup>97</sup>

### *B. Parental Autonomy vs. Child’s Future Autonomy*

To confer upon a person respect for autonomy means affording him or her “self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice.”<sup>98</sup> Two conditions are universally held to be fundamental for autonomy: liberty, meaning “independence from controlling influences,” and agency, meaning “capacity for intentional action.”<sup>99</sup> Beauchamp and Childress advocate a balanced approach to autonomy that is not excessively individualistic (disregarding the impact of individual actions upon others), not excessively focused on reason (neglecting emotion), and not unduly legalistic (downplaying social practices while highlighting legal rights).<sup>100</sup> When considering autonomy with regard to using PGD to choose a potentially disabled embryo, we must take into account both parental autonomy and the child’s future autonomy.

When any individual chooses to become a parent and to bring a

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<sup>94</sup> Sebastiaan Mastenbroek et al., *In Vitro Fertilization with Preimplantation Genetic Screening*, 357 *NEW ENG. J. MED.* 9, 9 (2007).

<sup>95</sup> Press Release, Reprogenetics, Preimplantation Genetic Diagnosis Pioneers from the USA and Europe Refute New England Journal of Medicine Article (July 10, 2007), available at <http://www.medicalnewstoday.com/articles/76269.php>.

<sup>96</sup> King, *Duty to the Unborn*, *supra* note 12, at 385–86.

<sup>97</sup> *Id.* at 386.

<sup>98</sup> BEAUCHAMP & CHILDRESS, *supra* note 71, at 58.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.* at 57.

child into this world, he or she is acting out of his or her own personal autonomy. No child exists yet, so the future parent cannot be acting with regard to the future child's autonomy; "[t]he child is a means to [his or her] ends."<sup>101</sup> Therefore, parents who desire to have children with disabilities, and do so intentionally, are doing so to satisfy their own autonomy and their own needs, without respect to the future autonomy of the child in question. Take, for instance, the case of a mother of two who sought to have a third child. Her first two children both suffered from celiac disease, which meant that to prevent the children from enduring painful abdominal discomfort, retarded physical growth, and muscular debility, she had to keep them from eating grain-based foods.<sup>102</sup> The mother sought out a genetics counselor because she wanted help in assuring that her third child would be born with the disease as well.<sup>103</sup> She felt that the diet her two children followed was so complicated, incorporating an alternate "normal" diet would be too difficult.<sup>104</sup> Due to medical limitations at the time, screening for this particular gene was not possible, and so her request was denied.<sup>105</sup> Her demand was not morally acceptable; "[t]o gratify her wishes for a child and to spare herself the inconvenience of adding an additional dietary regimen to her duties, she was willing to impose a life-long sentence of pain and disability on the child."<sup>106</sup> Ultimately, this mother's objectives were selfish, and so her right to parental autonomy should be limited in favor of the child's autonomy.

Furthermore, the President's Council on Bioethics has expressed concern that even "[t]he present, more modest, applications of PGD—screening for severe medical conditions, screening for genetic predispositions or risk factors for a given disease, elective sex selection, and selection with an eye to creating a matching tissue donor"—treat the child as merely a "means to the parents' ends."<sup>107</sup> Duchesneau and McCullough, for example, wanted to bring a deaf baby into their family because they felt that it would be easier for

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<sup>101</sup> Davis, *supra* note 77, at 570.

<sup>102</sup> Ronald M. Green, *Parental Autonomy and the Obligation Not to Harm One's Child Genetically*, 25 J.L. MED. & ETHICS 5, 13 (1997).

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> THE PRESIDENT'S COUNCIL ON BIOETHICS, REPRODUCTION AND RESPONSIBILITY: THE REGULATION OF NEW BIOTECHNOLOGIES 95 (2004), available at [http://www.bioethics.gov/reports/reproductionandresponsibility/\\_pcbe\\_final\\_reproduction\\_and\\_responsibility.pdf](http://www.bioethics.gov/reports/reproductionandresponsibility/_pcbe_final_reproduction_and_responsibility.pdf).

them to care for a deaf child than a hearing child.<sup>108</sup> While this is arguably self-serving, it can also be recognized that a hearing child would have a harder time learning to speak and communicate within an all-deaf family.

That being said, the problem in violating the child's own autonomy by deliberately ensuring that he is born with a disability is that it limits a child's future choices, thereby violating that child's right to what Joel Feinberg terms an "open future."<sup>109</sup> Feinberg would grant to a child certain "rights-in-trust," which are to be "saved for the child until he is an adult."<sup>110</sup> These rights could be violated by the parent *now*, before a child reaches adulthood, in ways that eliminate the option of the child ever exercising them.<sup>111</sup> These rights include almost all of the significant rights adults have "but which must be protected now to be exercised later."<sup>112</sup> By violating the right of the child to an open future, a parent is defining the child as a thing solely existing "to fulfill parental hopes and dreams," rather than a human with hopes and dreams of his own.<sup>113</sup> And as the Supreme Court has aptly stated: "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."<sup>114</sup> As such, parents should never make a decision for a child or fetus *now* that will severely limit the future opportunities of that child once he or she reaches adulthood.

Davis further argues "that the autonomy of the individual is ethically superior to the autonomy of the group."<sup>115</sup> She explains that when the rights of a particular group impinge upon the rights of individuals within the group to make their own autonomous choices, "the liberal state must support the individual against the group."<sup>116</sup> With this in mind, we can consider both parental autonomy and the child's future autonomy together with an understanding that the child's future autonomy should be satisfied

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<sup>108</sup> Mundy, *supra* note 16, at W22.

<sup>109</sup> Joel Feinberg, *The Child's Right to an Open Future*, in WHOSE CHILD? CHILDREN'S RIGHTS, PARENTAL AUTHORITY, AND STATE POWER 124, 126 (William Aiken & Hugh LaFollette eds., 1980) (emphasis omitted).

<sup>110</sup> *Id.* at 125.

<sup>111</sup> Davis, *supra* note 77, at 563.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.* at 570.

<sup>114</sup> *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

<sup>115</sup> Davis, *supra* note 77, at 566.

<sup>116</sup> *Id.*

over parental autonomy.<sup>117</sup> This is because children are vulnerable—they are easily coerced by adults—and must be protected at all costs. When parents move to eliminate the ability of the child to make his or her own life choices, then the state must support the child against the parents.<sup>118</sup>

Finally, the nature of autonomy is that it involves both liberty and agency.<sup>119</sup> It is true that technically speaking, children have no legal capacity to make their own decisions regarding their healthcare—thereby nullifying the “agency” condition of autonomy. But, at the same time, we talk about how patients must be afforded the greatest amount of autonomy possible. Considering this, the child’s future autonomy—when he or she will have capacity for intentional action—cannot be disregarded in favor of present parental autonomy just because right now they want a child that is just like them. To afford the child the greatest amount of autonomy possible requires that we consider his or her future opportunities when making decisions in the present. Also supporting this argument is the reality of the conflict between beneficence and autonomy.

### *C. Beneficence vs. Parental Autonomy*

The principle conflict in this situation is between beneficence—doing what is best for the child—and parental autonomy. If parents choose to act selfishly out of their own interests to meet their own end desires, they are necessarily disregarding beneficence to the child, and are rather thinking of their own autonomy and beneficence—that is, what is best for them. This inherent conflict is common; consider a patient who refuses treatment. A physician must act with beneficence, but must also afford the patient respect for autonomy. The patient desires to make her own decisions regarding her treatment, and she has decided she does not want it. The physician believes that it would be in the best interest of the patient to have the treatment and encourages her to go through with it. So how is this conflict resolved?<sup>120</sup>

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<sup>117</sup> This is especially true with parents that are members of the Deaf culture, as so much focus is on retaining the validity of the group rather than the individual.

<sup>118</sup> See Davis, *supra* note 77, at 566–67.

<sup>119</sup> BEAUCHAMP & CHILDRESS, *supra* note 71, at 58.

<sup>120</sup> As long as the patient has capacity, she is able to refuse treatment, and thus her autonomy wins out. See *Washington v. Glucksberg*, 521 U.S. 702, 720, 725 (1997). Many bioethicists hold that patient autonomy should be considered above any other ethical principles, but as discussed at *supra* Part III.B., Beauchamp and Childress argue for a more balanced approach.

Luckily, in situations like these, which could go on forever unresolved, the law has stepped in, and it is there that we can look for guidance. I argue that there is no *moral* right for parents to use PGD to ensure their child is born with a genetic disability or undesirable genetic trait for the aforementioned reasons. We must, however, determine whether there exists a *legal* right.

#### IV. DO PARENTS HAVE A *LEGAL* RIGHT TO USE PGD TO CREATE A DISABLED OR DISEASED CHILD?

The Due Process Clause of the Fourteenth Amendment of the United States Constitution provides that “[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law.”<sup>121</sup> The Supreme Court has long recognized that the Due Process Clause embraces and protects those rights that are “implicit in the concept of ordered liberty”<sup>122</sup> and those that are “so rooted in the traditions and conscience of our people as to be ranked as fundamental.”<sup>123</sup> As such, any legislation or restriction that is found to infringe upon a fundamental right must serve a compelling state interest, must be narrowly tailored to achieve that purpose, and must use the least restrictive means to achieve that interest.<sup>124</sup> Should the right in question not be fundamental, however, only a rational basis review is necessary.<sup>125</sup>

In order to determine whether or not parents have a *legal* right to intentionally pass on a genetic disability or disease to their child through the use of PGD screening for the affected embryos, we first must decide how to characterize the right in question. With this particular issue, one can characterize the question narrowly, broadly, or even in some middle road between the two.<sup>126</sup> Once the

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<sup>121</sup> U.S. CONST. amend. XIV, § 1.

<sup>122</sup> *Palko v. Connecticut*, 302 U.S. 319, 325 (1937).

<sup>123</sup> *Id.* (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

<sup>124</sup> ERWIN CHERMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 792 (3d ed. 2006).

<sup>125</sup> *Id.* at 794.

<sup>126</sup> See *Michael H. v. Gerald D.*, 491 U.S. 110, 127 n.6 (1989) (plurality opinion). In his plurality opinion, Justice Scalia argues that when the court decides the meaning of a right under due process, it must “refer to the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified.” *Id.* at 127–28 n.6. Justice Brennan vehemently disagreed in his dissent, arguing that these questions should be stated more generally. *Id.* at 137–41 (Brennan, J., dissenting). Justice O’Connor, while concurring with the plurality, argued that “[o]n occasion the Court has characterized relevant traditions protecting asserted rights at levels of generality that might not be ‘the most specific level’ available,” and therefore would not impose a singular method of analysis. *Id.* at 132 (O’Connor, J., concurring) (citation omitted). See also CHERMERINSKY, *supra* note 124, at 20, 795.

right is characterized, we can determine whether the right is fundamental, and whether rational basis review or strict scrutiny review would be required, should it be determined that the state should intervene in these parental decisions. Within the following section, this Comment will show that regardless of how this right is characterized, whether it be specific or general, and regardless of whether that right is fundamental or not fundamental, parents do not have a legal right to use PGD to create a disabled or diseased child.

A. *A Narrow Characterization: Is Using PGD to Disable a Child a Fundamental Right?*

The narrowest way to frame the right in question is whether there is a fundamental right to use PGD in order to harm a child. To determine whether a particular right can be deemed fundamental, the courts have traditionally looked to precedent, history and tradition, public policy, and contemporary attitudes when the right is not explicitly represented in the text of the U.S. Constitution.<sup>127</sup> Under this narrow characterization, an analysis of history and tradition does not help much due to the relatively recent expansion of this technology. Only a handful of couples have used PGD for this purpose, so the other means of interpretation should be explored in more depth.

First, there is little to no precedent at which to look. *Palko* does give some guidance, however, as to what makes a right fundamental. Justice Cardozo states in his majority opinion that fundamental rights are those for which “neither liberty nor justice would exist if they were sacrificed.”<sup>128</sup> While this is arguably vague, it is even harder to argue that using PGD to create a disabled or diseased child eliminates notions of liberty and justice. Justice is more properly served by restricting this use of PGD to ensure that a future child will not be born with an impairment.

Second, if a particular right goes against public policy, it will be less likely to be found fundamental. Much effort has been made to eliminate genetic diseases and disabilities in future generations. For instance, many parents, in an attempt to avoid passing on a particular trait, have resorted to various methods like aborting a fetus after prenatal testing or using PGD to screen out affected

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<sup>127</sup> CHEMERINSKY, *supra* note 124, at 18, 27, 795–96. Policy is the least persuasive argument, however, and it is rarely relied upon alone.

<sup>128</sup> *Palko*, 302 U.S. at 326.

embryos.<sup>129</sup> Furthermore, we strive to make life easier for those who are disabled through mechanisms like the ADA.<sup>130</sup> Therefore, it would be counterproductive and against public policy to encourage parents to use PGD to ensure that their child is disabled.

Third, if we consider contemporary attitudes as a means to determine whether the right in question is fundamental, we need only look to the backlash that Duchesneau and McCullough received around the world after they created their deaf son. Very few praised their actions, and most just condemned them.<sup>131</sup> Moreover, look to what the House of Lords in the United Kingdom has done: the bill to ban this particular use of PGD was introduced—and since passed—to eliminate the chance of this happening in the future.<sup>132</sup> Contemporary values and norms thus seem to signal that PGD should not be used to produce a disabled or diseased child.

Hence, after careful consideration of precedent, history and tradition, public policy, and contemporary attitudes, we are left to conclude that using PGD to create a disabled or otherwise harmed child is not a fundamental right of the parents. Therefore, any attempt to impinge upon this right should be scrutinized under a rational basis review.

### *B. The Middle Road: Is Using PGD as a Means to Procreate a Fundamental Right?*

Perhaps a more reasonable way to characterize this right is whether using PGD as a method of procreation is a fundamental right. Again, we must look to precedent, history and tradition, public policy, and contemporary attitudes, as the courts would, to make this determination.

While there is, as of yet, no precedent to guide us on the use of PGD to procreate, there is case law that guides other methods of procreation when the traditional methods fail. For instance, in *J.R.*

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<sup>129</sup> Lori B. Andrews, *Prenatal Screening and the Culture of Motherhood*, 47 HASTINGS L.J. 967, 968 (1996).

<sup>130</sup> Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213 (2006).

<sup>131</sup> See Virginia Blackburn, *Selfish Parents Who Stifle Kids' Identity*, EXPRESS (U.K.), Apr. 9, 2002, at 12; James Langton, *Lesbians: We Made Our Baby Deaf on Purpose*, EVENING STANDARD (London), Apr. 8, 2002, at 9; Alanna Mitchell, *Genetic Engineering is Getting Out of Hand*, GLOBE & MAIL (Toronto), Apr. 13, 2002, at F3; Rosemary Neill, *Don't Breed Disabilities*, AUSTRALIAN, Apr. 19, 2002, at 11; Noula Tsavdaridis & Barry Hailstone, *Ethical Storm Rages Over Defiant Lesbian Couple's Decision*, ADVERTISER (Australia), Apr. 13, 2002, at 34.

<sup>132</sup> See Lawson, *supra* note 69, at 40; Isabel Oakeshott & Sarah-Kate Templeton, *An Embryonic Disaster?*, SUNDAY TIMES (London), Mar. 16, 2008, at 12.

*v. Utah*, the Utah District Court held that the genetic and biological parents of children carried by a gestational carrier surrogate birth mother had fundamental liberty interests applicable to the parent-child relationship with those children.<sup>133</sup> In that case, a married couple was medically unable to have children on their own, so they contracted with a surrogate mother for a child to be conceived in vitro by the biological parents.<sup>134</sup> For these parents, gestational surrogacy was their only chance to have a child “that would truly be theirs, a true genetic and biological child of the marriage.”<sup>135</sup> In our case, however, where the parents are selecting traits for nonmedical purposes, many other options exist as viable alternatives for PGD. Considering that PGD is only done prior to a standard IVF procedure, PGD is not necessary at all, unlike the case with the parents in *J.R.*, whose only option was surrogacy.<sup>136</sup> Because PGD is not the only means to procreate when traditional methods fail, and in fact increases the number of steps involved prior to implantation, precedent tells us that it should not be a fundamental right.<sup>137</sup>

With the right in question characterized this way, the remaining three criteria—history and tradition, contemporary attitudes, and public policy—should be discussed together, as all three are intertwined. There is little guidance to derive from history and tradition of using PGD to procreate. Although it is still new technology, more and more couples are using PGD every year.<sup>138</sup> This does, however, shed light upon the contemporary attitudes of Americans surrounding this technology. PGD is slowly becoming more widely accepted in the United States, and while it is most commonly used to avoid disease, it could soon be possible to use PGD for cosmetic, rather than medical purposes. If people do have a fundamental right to procreate using PGD, then couples can start selecting embryos for hair color, eye color, gender, sexual preference, intelligence, athleticism, musical ability—the options

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<sup>133</sup> 261 F. Supp. 2d 1268, 1296 (D. Utah 2002).

<sup>134</sup> *Id.* at 1270.

<sup>135</sup> *Id.* at 1274 (emphasis omitted).

<sup>136</sup> “Their singular opportunity to procreate through gestational surrogacy necessarily implicates their fundamental right to bear children, thereby invoking the protections of the United States Constitution . . .” *Id.*

<sup>137</sup> There may, however, be a fundamental right to use PGD as a method of procreation where there is risk of passing on disease or disability and the couple is seeking to avoid doing so. If PGD is the only way for this couple to procreate safely, a fundamental right may be found. This finding has yet to occur.

<sup>138</sup> Jaime King, *Predicting Probability: Regulating the Future of Preimplantation Genetic Screening*, 8 YALE J. HEALTH POL’Y L. & ETHICS 283, 291 (2008).

are seemingly endless. We must ask ourselves where the line should be drawn. As a matter of public policy, a court should find that there is not a fundamental right to use PGD for cosmetic purposes, in order to avoid this kind of slippery slope. Should PGD be used for the medical purpose of eliminating a genetic disease, however, a fundamental right may exist if it is the only available method of procreation.

Characterizing the right as whether one can use PGD to procreate leaves us with two possibilities after analysis of the court's methods of interpretation: (1) the right is fundamental if PGD is used for medical purposes and it is the only option for procreating safely, and therefore, strict scrutiny shall apply; and (2) the right is not fundamental if PGD is used for cosmetic purposes, and therefore, rational basis review shall apply.<sup>139</sup>

### C. A Broad Characterization: Is Procreation a Fundamental Right?

The most general characterization is deeply rooted in traditional notions of due process—whether procreation is a fundamental right. We need not look far to answer this question; courts have long held that “procreation [is] fundamental to the very existence and survival of the race.”<sup>140</sup> The Supreme Court, in *Griswold v. Connecticut* and its progeny, identified procreation as a fundamental privacy right.<sup>141</sup> The right to procreate has further been described as including not only the right to give birth, but as including “[t]he rights to conceive and raise” a child as well.<sup>142</sup> So not only are procreation and reproductive liberties implicated, but also the parents' fundamental right to care and nurture their children. Since the question of whether procreation—and along with that, parental control of the children—is a fundamental right has already been answered by precedent, we do not need to spend much time looking to the other modes of determination. Clearly, however, the rights of parents and the rights to procreate are well-founded in the history and tradition of our nation, and they can be

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<sup>139</sup> Both of these options, however, reframe the original right in question. Neither possibility would open the door to using PGD to create a disabled child. See discussion *infra* Part IV.D.

<sup>140</sup> *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942).

<sup>141</sup> 381 U.S. 479, 485–86 (1965). The line of cases following *Griswold* dealt with laws attempting to interfere with the right to avoid procreation, including *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Both of these cases held that procreation is a privacy right. *Roe*, 410 U.S. at 152; *Casey*, 505 U.S. at 859.

<sup>142</sup> *Stanley v. Illinois*, 405 U.S. 645, 651 (1972).

deemed “principle[s] of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental.”<sup>143</sup> As such, any regulation impinging upon these rights must be evaluated by a strict scrutiny review, but these rights are not absolute. As we have seen, the courts have found “compelling interests” on behalf of the state to uphold such legislation in the past,<sup>144</sup> and I propose that any future legislation enacted to ban the use of PGD to create a disabled or diseased child will be upheld under the same analysis.

*D. To Intervene or Not To Intervene: That Is the Question*

We now have two different ways by which to review the issue of whether a parent has a legal right to use PGD to create an impaired child: (1) rational basis review when characterizing the right as to use PGD to create a disabled child or as to use PGD to procreate for cosmetic purposes; and (2) strict scrutiny review when characterizing the right as to use PGD to procreate for medical purposes or as to simply procreate. No matter how the right in question is characterized, a restriction on a parent’s right to use PGD to create a disabled or diseased child is able to survive either level of scrutiny.

1. Rational Basis Test

Under a rational basis review, the court will uphold a state or local law as long as the restriction or regulation in question is rationally related to a legitimate government purpose.<sup>145</sup> This standard favors the legislature in that the law is afforded a presumption of validity and the challenger has the burden to show that the regulation is not sufficiently related to a government purpose.<sup>146</sup> Here, where we are dealing with using PGD to create a disabled or diseased child, or using PGD to procreate for cosmetic reasons, it is fairly easy to come up with a “legitimate government purpose.” A legitimate purpose would be to avoid undue hardship upon children by preventing disability from being passed on when it is a possibility to do so, or to avoid unnecessary, complicated, and costly IVF procedures when it is only done for a cosmetic enhancement. Currently, of course, there are no regulations of this

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<sup>143</sup> *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

<sup>144</sup> See discussion *supra* Part II.A.

<sup>145</sup> CHEMERINSKY, *supra* note 124, at 540.

<sup>146</sup> *Id.*

nature within the United States.

At this level of review, a blanket ban on PGD may survive, because it is still rationally related to a legitimate goal. The challenger of the regulation must then show that the regulation is not a reasonable way to attain the goal.<sup>147</sup> In the present case, a blanket ban is probably not reasonable because it would eliminate the more-favored purposes to using PGD—as a means to avoid passing on genetic diseases or disorders. But it is an extremely rare occurrence for a regulation to fail rational basis review in the Supreme Court.<sup>148</sup> Considering the high moral implications of such controversial reproductive technologies, it is likely that a court would find that so long as any future law is rationally related to a legitimate purpose, like those mentioned above, it would pass rational basis review and be upheld.<sup>149</sup>

## 2. Strict Scrutiny Review

Under strict scrutiny review, a law will be upheld if it is necessary to achieve a compelling government purpose, and the government must show that the least restrictive alternative is used to accomplish that purpose.<sup>150</sup> We are now dealing with implication of the fundamental right of procreation and the fundamental right of a parent to direct the care, custody, and control of his or her children. In order to determine whether regulations impinging upon these rights can survive strict scrutiny, we must first analyze the “compelling purpose” requirement to see when the state can intervene with a parent’s right to use PGD to create a disabled or diseased child.

In order for the state to intervene on these rights, there must be a compelling governmental interest. The government already intervenes with parental rights in instances of child abuse and neglect.<sup>151</sup> To overcome the presumption that parents act in the best interests of their children, the state must show that the parents are, in fact, unfit to act as guardians for their children—that the parents have committed acts of child abuse or neglect—

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<sup>147</sup> *Id.*

<sup>148</sup> *See, e.g.,* Craig v. Boren, 429 U.S. 190, 210 n.\* (1976) (Powell, J., concurring) (recognizing the “relatively deferential ‘rational basis’ standard of review”); *see* CHEMERINSKY, *supra* note 124, at 540.

<sup>149</sup> The new HFEA in the United Kingdom would clearly stand up to this test; it is directly related to preventing the intentional passing on of disability and disease.

<sup>150</sup> CHEMERINSKY, *supra* note 124, at 541.

<sup>151</sup> *See* discussion *supra* Part II.A.1.

before the state may intervene.<sup>152</sup> Some actions by parents are blatant child abuse. Say for example, a child is born hearing, but her parents wish her to be deaf like them, and so they decide to shove knitting needles in her ears to break her eardrums. Clearly, the parents are not acting in the best interests of their child. But other forms of child abuse are harder to recognize. Neglect is defined as the “failure to provide adequate food, clothing, shelter, or *medical care*” creating “a substantial risk of harm to the child’s health or welfare.”<sup>153</sup> It is my position that creating a child with a disability or disease by using PGD is a form of medical neglect, because fit parents acting in the best interests of their child would not seek for that child to be impaired.

In medical neglect, the general rule is that the state can order necessary medical treatment to protect a child’s life.<sup>154</sup> Questions arise, however, where the child’s life is not in immediate risk, and on this issue, the courts are split. Some courts have decided that when medical treatment that is reasonably necessary for the wellbeing of the child—though not necessary to survive—is withheld, it constitutes medical neglect on the parents’ behalf.<sup>155</sup> These courts tend to compel treatment that is reasonably necessary when it is in the best interest of the child.<sup>156</sup> For example, where a father refused to authorize removal of his children’s tonsils and adenoids for religious reasons, the court compelled surgery, finding that the removal of the tonsils and adenoids was “necessary with reasonable medical certainty to restore and preserve the health of [the children].”<sup>157</sup> This is somewhat analogous to our case. In order to restore and preserve the health of a future child, he should be given the “treatment essential for future functioning in society.”<sup>158</sup> A child should not have a disability or disease forced upon him that will limit his ability to function in the future. The ability to hear, while not essential, is reasonably necessary and is in the best interest of the child because it affords him the most opportunities upon reaching an age where he is able to make his own decisions. Therefore, a parent who uses PGD to create a disabled or diseased child is engaging in medical neglect.

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<sup>152</sup> *Troxel v. Granville*, 530 U.S. 57, 68 (2000).

<sup>153</sup> Child Abuse and Prevention and Treatment Act, 45 C.F.R. § 1340.2 (2008) (emphasis added).

<sup>154</sup> See, e.g., *Commonwealth v. Barnhart*, 497 A.2d 616, 623–25 (Pa. Super. Ct. 1985).

<sup>155</sup> See, e.g., *In re Karwath*, 199 N.W.2d 147, 150 (Iowa 1972).

<sup>156</sup> *Id.*

<sup>157</sup> *Id.* at 150.

<sup>158</sup> ROBERTSON, *supra* note 1, at 171.

Another factor considered by the courts in deciding whether to order medical treatment is the emotional or psychological effect of a disfiguring condition on a child.<sup>159</sup> This type of treatment would remove the disfigurement, even though it is not necessary to the child's life. For instance, a court compelled surgery for a ten-year-old girl with a leg deformity, taking into account that a child with a physical deformity "suffers from a sense of rejection" and has difficulty fitting in socially.<sup>160</sup> The court found that "[t]o the extent that medical science can correct the deformity . . . that service should be accorded."<sup>161</sup> This criterion of "emotional or psychological effect" is particularly poignant with parents who have achondroplasia, or dwarfism, and use PGD to create a child also suffering from dwarfism. If fit parents act in the best interests of their children, then why would a parent not consider the social rejection—and resulting psychological effect—a dwarf child might endure on a daily basis at school?<sup>162</sup> If PGD can be used to avoid these effects on children, rather than increasing the likelihood, the state should intervene to prevent parents from making these decisions for their children.

Furthermore, in evaluating medical neglect, one must consider the actual harm to the child caused simply by the IVF transfer. Children born from ART have a greater likelihood of being born premature and at low or very low birth weight.<sup>163</sup> Because of a low birth weight, they are more likely to be born with serious birth defects.<sup>164</sup> Some children born from IVF procedures having a normal birth weight are also more likely to have birth defects.<sup>165</sup> In addition, the risk of harm is increased by the high rate of multiple births. The general practice in IVF of implanting many pre-embryos at one time increases the probability of multiple births, and these children have an increased "risk of serious health

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<sup>159</sup> *In re Seiferth*, 127 N.E.2d 820, 823 (N.Y. 1955).

<sup>160</sup> *In re Rotkowitz*, 25 N.Y.S.2d 624, 626 (Dom. Rel. Ct. 1941).

<sup>161</sup> *Id.*

<sup>162</sup> *See, e.g.,* FELISSA R. LASHLEY, *CLINICAL GENETICS IN NURSING PRACTICE* 190 (3d ed. 2005) (describing the psychological effects on children affected by achondroplasia, such as slow emotional maturation, diminished popularity and isolation, and low self-esteem). Children with achondroplasia also tend to obtain lower test scores, and often endure taunting and teasing from their classmates. *Id.* "School can be very traumatic for little people." *Id.* Even adults with achondroplasia suffer from self-doubt, embarrassment, and prejudice, not to mention the limitations they face with regard to occupations and other life activities. *Id.* at 191.

<sup>163</sup> Jennifer L. Rosato, *The Children of ART (Assisted Reproductive Technology): Should the Law Protect Them From Harm?*, 2004 UTAH L. REV. 57, 60 (2004).

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

problems that can cause life-long impairment.”<sup>166</sup> For couples who are infertile and cannot conceive a child any other way, this may seem like an acceptable risk to take. But it is not acceptable for parents who decide they want to further exacerbate the harm to their child by using PGD to ensure that he will have a disability or disease from day one.

As such, in order to protect a child from medical neglect caused by his parents, the state has a compelling interest to infringe upon the parents’ rights to procreate and direct the control, care, and custody of their children. This compelling interest, however, can only be achieved by means that are as least restrictive as possible—means that are necessary. Suppose a governing body in the United States, either federal government or state government, were to enact legislation to ban the selection of disabled embryos through the use of PGD. This law is directly related to the compelling interest of creating healthy babies that are disabled, medically neglected, or otherwise harmed. This law would be the least restrictive, because anything less restrictive would no longer achieve the governmental goal of preventing children from harm. A couple would still be able to use traditional IVF and play the odds; after all, if both parents share a particular genetic condition, there is a tremendous chance that their children will end up with it as well. Moreover, if our “supposed” legislation were to look like the recently passed HFEA in the United Kingdom,<sup>167</sup> it would survive a strict scrutiny review, because it is very narrowly tailored (listing all conditions which are approved for PGD use and specifying that those embryos with disorders or disabilities are not to be preferred over healthy embryos) and it furthers a compelling interest of the state (protecting children from being born with a disability or disease).<sup>168</sup>

Therefore, no matter how the characterization of the right in question is framed, the ability of parents to use PGD to create a child with a disability or disease can be limited. Where there is no fundamental right (using PGD for cosmetic purposes or for ensuring an impairment), under a rational basis test, any legislation rationally related to the welfare of children will survive. Where there is a fundamental right (using PGD for medical purposes or just procreation, in general), under strict scrutiny, a regulation that

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<sup>166</sup> *Id.* at 61.

<sup>167</sup> Human Fertilisation and Embryology Act, 2008, c. 22, § 14(9) (U.K.).

<sup>168</sup> Some, however, argue that the HFEA of 2008 was designed to discriminate specifically against deafness. See Lawson, *supra* note 69, at 40. If this is the case, then the Act may not survive a Fourteenth Amendment Equal Protection analysis, but that issue is outside the scope of this paper.

is the least restrictive to protect children from entering the world already harmed or disabled will survive. Therefore, there is no legal right to use PGD to create a disabled or diseased child.

## V. ALTERNATIVE REGULATION THROUGH TORT LAW

In the United States, we have direct methods of regulation, through the judicial and legislative system, and we have indirect methods of regulation. Since parental rights can be regulated, but use of PGD is currently unrestricted in the United States, I propose that we turn to the tort law system as an indirect way to regulate. Even if legislation is passed in the future, children who have already been created through PGD cannot benefit from this direct regulation.<sup>169</sup> Children should not be made to suffer from their parents' decisions, and should have some alternative method of recourse against the parents or the physicians responsible for opportunities they have lost as a result of living with a disability.

### A. Tort Claims Brought Against Parents

There are several tort claims that children may bring against their parents; however, the parental immunity doctrine may block these actions in many states. Historically, a child was not allowed to bring a civil action against his or her parent for any injury caused by the parent.<sup>170</sup> The principal reason for barring these actions is that, as a matter of public policy, the state has an interest in preserving family unity.<sup>171</sup> In situations where insurance is involved, the danger of fraud and collusion between parent and child has been cited as a justification for the immunity;<sup>172</sup> another is the protection of parental discretion and authority.<sup>173</sup> In a few states, the rule of parental immunity stands in order to preserve these policy justifications.<sup>174</sup> The *Restatement (Second) of Torts*

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<sup>169</sup> I agree with Professors King, Ouellette, and Smolensky that the tort system is probably not the best method of deterring parental abuse of PGD; however, until the United States becomes less laissez-faire in regulating reproductive technologies, this is the only method we have. See King, *Duty to the Unborn*, *supra* note 12, at 392–93; Alicia R. Ouellette, *Insult to Injury: A Disability-Sensitive Response to Smolensky's Call for Parental Tort Liability for Preimplantation Genetic Interventions*, 60 HASTINGS L.J. 397, 409–10 (2008); Kirsten Rabe Smolensky, *Parental Tort Liability for Preimplantation Genetic Interventions: Technological Harms, the Social Model of Disability, and Questions of Identity*, 60 HASTINGS L.J. 411, 412–13 (2008).

<sup>170</sup> RESTATEMENT (SECOND) OF TORTS § 147 scope note (1965).

<sup>171</sup> *Hewellette v. George*, 9 So. 885, 887 (Miss. 1891).

<sup>172</sup> *Holodook v. Spencer*, 324 N.E.2d 338, 343 (N.Y. 1974).

<sup>173</sup> *McKelvey v. McKelvey*, 77 S.W. 664, 664 (Tenn. 1903).

<sup>174</sup> Only a few states have maintained the traditional parental immunity doctrine. See,

later added that “[a] parent or child is not immune from tort liability to the other solely by reason of that relationship.”<sup>175</sup> As such, the increasing trend in many states is to create exceptions to the absolute parental immunity rule,<sup>176</sup> and some states have even

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*e.g.*, *Sears, Roebuck & Co. v. Huang*, 652 A.2d 568 (Del. 1995) (preserving the parental immunity doctrine); *Mohorn v. Ross*, 422 S.E.2d 290 (Ga. Ct. App. 1992) (maintaining full parental immunity; the state’s highest court has not revisited the issue in some time); *Pedigo v. Rowley*, 610 P.2d 560 (Idaho 1980) (retaining the parental immunity doctrine); *Bondurant v. Bondurant*, 386 So. 2d 705 (La. Ct. App. 1980) (retaining immunity as prescribed by LA. REV. STAT. ANN. § 9:571 (2008)).

<sup>175</sup> RESTATEMENT (SECOND) OF TORTS § 895G(1) (1979).

<sup>176</sup> A majority of states have created one or more exceptions to the traditional parental immunity doctrine. *See, e.g.*, *Newman v. Cole*, 872 So. 2d 138 (Ala. 2003) (holding that the exception exists where a parent willfully and intentionally caused injury); *Hebel v. Hebel*, 435 P.2d 8 (Alaska 1967) (finding an exception for a mother’s negligent driving); *Robinson v. Robinson*, 914 S.W.2d 292 (Ark. 1996) (finding an exception for willful and wanton conduct by a parent); *Terror Mining Co. v. Roter*, 866 P.2d 929 (Colo. 1994) (finding an exception for actions within a parent’s business or employment); *Squeglia v. Squeglia*, 661 A.2d 1007 (Conn. 1995) (finding that exceptions exist to parental immunity for conduct done at a business enterprise, for the negligent operation of a motor vehicle, and for sexual abuse); *Herzfeld v. Herzfeld*, 781 So.2d 1070 (Fla. 2001) (holding that there is an exception for intentional sexual abuse); *Fager v. Hundt*, 610 N.E.2d 246 (Ind. 1993) (finding an exception for a parent’s intentional felonious conduct); *Clark v. Rice ex rel. Rice*, 653 N.W.2d 166 (Iowa 2002) (finding an exception for negligent driving); *Nocktonick v. Nocktonick*, 611 P.2d 135 (Kan. 1980) (finding an exception for negligent driving); *Bentley v. Bentley*, 172 S.W.3d 375 (Ky. 2005) (finding an exception for commonplace incidents of family life); *Flagg v. Flagg*, 458 A.2d 748 (Me. 1983) (finding an exception for negligent driving); *Allstate Ins. Co. v. Kim*, 829 A.2d 611 (Md. 2003) (finding an exception for negligent driving); *Stamboulis v. Stamboulis*, 519 N.E.2d 1299 (Mass. 1988) (stating that there is no absolute shield protecting parents from negligence actions by their children); *Sweeney v. Sweeney*, 262 N.W.2d 625 (Mich. 1978) (abrogating parental immunity as to negligent driving); *Smith v. Holmes*, 921 So. 2d 283 (Miss. 2005) (finding an exception for negligent driving); *Transamerica Ins. Co. v. Royle*, 656 P.2d 820 (Mont. 1983) (finding an exception for negligent driving); *Frey v. Blanket Corp.*, 582 N.W.2d 336 (Neb. 1998) (finding an exception for brutal, cruel, or inhuman treatment inflicted by a parent); *Briere v. Briere*, 224 A.2d 588 (N.H. 1966) (finding an exception for negligent driving); *Foldi v. Jeffries*, 461 A.2d 1145 (N.J. 1983) (noting that immunity is abrogated except in situations involving the exercise of parental authority and customary child care); *Holodook*, 324 N.E.2d 338 (abrogating immunity but not in cases of negligent supervision); *Doe ex rel. Connolly v. Holt*, 418 S.E.2d 511 (N.C. 1992) (finding an exception for willful and malicious acts of a parent); *Hooper ex rel. Hooper v. Clements Food Co.*, 694 P.2d 943 (Okla. 1985) (finding an exception for injuries caused in course and scope of a parent’s employment); *Silva v. Silva*, 446 A.2d 1013 (R.I. 1982) (noting that there is no immunity for the negligent operation of a motor vehicle); *Brunner v. Hutchinson Div., Lear-Siegler, Inc.*, 770 F. Supp. 517 (W.D.S.D. 1991) (refusing to officially adopt parental immunity but noting that South Dakota has a general policy of not interfering with the parent-child relationship); *Butterworth v. Butterworth*, 154 S.W.3d 79 (Tenn. 2005) (noting that the determination of whether to apply parental immunity relies upon the facts and circumstances of each particular case); *Shoemake v. Fogel, Ltd.*, 826 S.W.2d 933 (Tex. 1992) (finding an exception to claims arising in the course of a parent’s business activities or to automobile tort actions); *Pavlick v. Pavlick*, 491 S.E.2d 602 (Va. 1997) (finding an exception for negligence in automobile or business-related situations); *Zellmer v. Zellmer*, 188 P.3d 497 (Wash. 2008) (holding that there is no immunity when injury results from parental conduct outside parental capacity); *Courtney v. Courtney*, 413 S.E.2d 418 (W. Va. 1991) (finding an exception for negligent operation of a motor vehicle); *Goller v. White*, 122 N.W.2d 193 (Wis. 1963) (holding that the immunity rule is abrogated except when the negligent act involves exercise

abrogated the doctrine completely.<sup>177</sup> Whatever form the immunity takes, it is uniformly limited to personal torts.<sup>178</sup> Other commonly cited exceptions to immunity are the “intentional or reckless infliction of bodily harm,”<sup>179</sup> bodily harm inflicted by negligent conduct in the course of a parent’s business activity,<sup>180</sup> and bodily harm resulting from the parent’s negligent operation of a motor vehicle.<sup>181</sup>

The present case—a child suing his or her parents for damages resulting from the PGD process—likely falls into the category of intentional or reckless infliction of bodily harm. This exception has not only been applied to intentional parental conduct, but also to conduct that causes bodily harm in “conscious and deliberate disregard of a high degree of risk of [harm]” and is referred to as “‘wilful,’ ‘wanton’ or ‘reckless’ misconduct.”<sup>182</sup> Regardless of the state in which an action of this nature is brought, parental immunity will almost always be abrogated, either by means of this exception or by the doctrine having already been abolished in that state. Assuming that a child is able to overcome parental immunity, the most likely tort claims for which he or she may be granted damages are battery and intentional infliction of emotional distress.

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of parental authority or ordinary parental discretion); *Dellapenta v. Dellapenta*, 838 P.2d 1153 (Wyo. 1992) (finding an exception for negligent operation of motor vehicle).

<sup>177</sup> See, e.g., *Broadbent v. Broadbent*, 907 P.2d 43 (Ariz. 1995) (abolishing the parental immunity doctrine); *Gibson v. Gibson*, 479 P.2d 648 (Cal. 1971) (abrogating parental immunity); *Rousey v. Rousey*, 528 A.2d 416 (D.C. 1987) (abrogating parental immunity); *Petersen v. City & County of Honolulu*, 462 P.2d 1007 (Haw. 1969) (refusing to adopt the parental immunity doctrine); *Anderson v. Stream*, 295 N.W.2d 595 (Minn. 1980) (abrogating the parental immunity doctrine, opting for a reasonable parent standard); *Hartman v. Hartman*, 821 S.W.2d 852 (Mo. 1991) (abrogating parental immunity in favor of reasonable parent standard); *Rupert v. Stienne*, 528 P.2d 1013 (Nev. 1974) (recognizing that parental immunity does not exist in common law, state constitutional law, or statutory law); *Guess v. Gulf Ins. Co.*, 627 P.2d 869 (N.M. 1981) (abolishing parental immunity); *Nuelle v. Wells*, 154 N.W.2d 364 (N.D. 1967) (noting that there is no parental immunity due to a state statute that makes any person liable for negligent injury to another); *Kirchner v. Crystal*, 474 N.E.2d 275 (Ohio 1984) (abolishing without reservation); *Winn v. Gilroy*, 681 P.2d 776 (Or. 1984) (abrogating the broad doctrine of parental immunity); *Falco v. Pados*, 282 A.2d 351 (Pa. 1971) (refusing to continue to recognize parental immunity); *Elam v. Elam*, 268 S.E.2d 109 (S.C. 1980) (abrogating parental immunity); *Elkington v. Foust*, 618 P.2d 37 (Utah 1980) (noting that while parental immunity formerly existed at common law, there is no basis in state statutory or decisional law for immunity today); *Wood v. Wood*, 370 A.2d 191 (Vt. 1977) (declining to adopt immunity rule and deeming policy reasons insufficient).

<sup>178</sup> RESTATEMENT (SECOND) OF TORTS § 895G cmt. d (1979).

<sup>179</sup> § 895G cmt. e.

<sup>180</sup> § 895G cmt. f.

<sup>181</sup> § 895G cmt. k.

<sup>182</sup> § 895G cmt. e.

## 1. Battery

Battery is defined as intentional contact that is harmful or offensive.<sup>183</sup> Specifically, an actor is liable for battery if he or she “acts intending to cause a harmful or offensive contact with the person of the other” and such a contact “directly or indirectly results.”<sup>184</sup> There are essentially three elements that a plaintiff must prove in order to succeed in a battery cause of action: the actor’s intent to cause contact, a contact that is harmful or offensive, and a lack of consent to the contact. First, the intent of the actor must be established by showing the actor had the purpose or the desire to cause the contact<sup>185</sup> or had knowledge with substantial certainty that the contact would occur.<sup>186</sup> The actor need not intend to cause injury; he need only intend the contact itself.<sup>187</sup> Second, the plaintiff must establish that the contact was harmful or offensive. A harmful contact is one that causes “any physical impairment of the condition of another’s body, or physical pain or illness.”<sup>188</sup> Offensive contact is must be “offensive to a reasonable sense of personal dignity,”—meaning that it would offend an ordinary person—and “unwarranted by the social usages prevalent at the time and place at which it is inflicted.”<sup>189</sup> Third, and lastly, the plaintiff must show that he or she did not consent to the contact. While a lack of consent is not explicitly expressed in the definition of battery, consent to the contact precludes the actor’s liability.<sup>190</sup> As such, it is unanimously held that establishing a lack of consent is essential in proving battery.<sup>191</sup>

To establish the relative intent of his or her parents, the child must show that the parents had either the purpose to cause contact or that they knew that contact was substantially certain to occur. The PGD process is comprised of a great many purposeful actions, all of which cause eventual contact with the embryo. The parents must first seek out health care professionals to assist them with their reproductive measures.<sup>192</sup> Eggs must be extracted from either an egg donor or the intended mother, and sperm must be collected

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<sup>183</sup> RESTATEMENT (SECOND) OF TORTS §§ 13, 18 (1965).

<sup>184</sup> § 13.

<sup>185</sup> *See, e.g.*, *Am. Nat’l Fire Ins. Co. v. Schuss*, 607 A.2d 418, 423 (Conn. 1992).

<sup>186</sup> *See, e.g.*, *Frey v. Kouf*, 484 N.W.2d 864, 867–68 (S.D. 1992).

<sup>187</sup> RESTATEMENT (SECOND) OF TORTS § 16(1) cmt. a (1965).

<sup>188</sup> § 15.

<sup>189</sup> § 19 cmt. a.

<sup>190</sup> § 13 cmt. d.

<sup>191</sup> *Id.*

<sup>192</sup> Smolensky, *Creating Children*, *supra* note 11, at 318.

from a sperm donor or the intended father.<sup>193</sup> The eggs are fertilized in a lab, and then the pre-embryos gestate to the blastomere stage—eight cells.<sup>194</sup> After the cell biopsies are performed, the parents must choose which embryos to transfer to the mother's uterus.<sup>195</sup> The transfer procedure is physically invasive for the mother, involves an informed consent procedure, and thus demands parental intent.<sup>196</sup> Hence, all of the actions undertaken by the parents to create a child from PGD are carried out purposefully or with knowledge to a substantial certainty that contact will occur.

The child can easily prove the element of intent, because it is inconsequential whether the parents intended to benefit the child through their actions.<sup>197</sup> “[One] need show only an intent to bring about the contact; an intent to do harm is not essential to the action.”<sup>198</sup> Even if the parents believe that having a disability or disease will in some way bestow an advantage on their child—for example, the case of deaf parents believing that a deaf child will benefit from being raised in a deaf home more than a hearing child—what matters is that the contact was intended, and so we must look at the actual result of the intent to contact.

The child next must prove that there was a contact that was harmful or offensive. Again, many steps taken by the parents throughout the PGD process involve contact with the future child. Most of the parental actions are indirect, accomplished through the actions of health care professionals or instruments; however, this does not bar a battery claim. “[I]t is enough that the defendant sets a force in motion which ultimately produces the result . . . . Proof of the technical invasion of the integrity of the plaintiff's person by even an entirely harmless, but offensive, contact entitles him to vindication of his legal right by an award of . . . damages . . . .”<sup>199</sup>

This theory is demonstrated in *Mink v. University of Chicago*. In *Mink*, around 1,000 pregnant women were administered diethylstilbestrol (“DES”) as part of a double-blind research study to determine whether this drug would help prevent miscarriages.<sup>200</sup> These women were not informed that they were part of an

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<sup>193</sup> CENTERS FOR DISEASE CONTROL, *supra* note 3, at 3–4.

<sup>194</sup> Smolensky, *Creating Children*, *supra* note 11, at 318.

<sup>195</sup> *Id.*

<sup>196</sup> *Id.* at 318–19.

<sup>197</sup> RESTATEMENT (SECOND) OF TORTS § 16(1) cmt. a (1965).

<sup>198</sup> *Mink v. Univ. of Chicago*, 460 F. Supp. 713, 718 (N.D. Ill. 1978).

<sup>199</sup> WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS § 9, at 35 (4th ed. 1971).

<sup>200</sup> *Mink*, 460 F. Supp. at 715.

experiment or that the pills ingested were DES.<sup>201</sup> After the born children developed conditions that increased their risk of cancer, a battery claim was brought, alleging that the medical experimentation performed on the women without their knowledge or consent was an “offensive invasion of their persons.”<sup>202</sup> The court held that the administration of the drug was an offensive contact.<sup>203</sup> The court compared the physical ingestion of the pill to administering a drug through a hypodermic needle—where physical contact would clearly be established—and found that the two were indistinguishable.<sup>204</sup>

Likewise, parental conduct that “sets a force in motion which ultimately produces the result”<sup>205</sup> will be sufficient to establish the requisite contact to the child, even though it was the health care professional ultimately *touching* the embryo and not either of the parents.

It is not necessary that the contact with the [child] be directly caused by some act of the [parent]. All that is necessary is that the [parent] intend to cause the [child], *directly or indirectly*, to come in contact with a foreign substance in a manner which the [child] will reasonably regard as offensive.<sup>206</sup>

The physician’s actions, in physically touching the eggs, sperm, and pre-embryo during the PGD and IVF procedures, cause the parents indirectly to contact their future child.

Whether the harm created by the contact is measured subjectively or objectively, the result is that the contact is harmful and offensive. A disabled or diseased child may believe his disability or disease to be harmful, regardless of what his parents think. And considering that people with disabilities and diseases are provided with special accommodations and benefits under federal legislation like the ADA,<sup>207</sup> under an objective analysis, the contact would almost certainly be considered harmful.

To address the “nonexistence comparison”<sup>208</sup> argument: just because a particular child is benefitted by being born does not mean

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<sup>201</sup> *Id.*

<sup>202</sup> *Id.* at 716.

<sup>203</sup> *Id.* at 718.

<sup>204</sup> *Id.*

<sup>205</sup> PROSSER, *supra* note 199, § 9 at 35.

<sup>206</sup> RESTATEMENT (SECOND) OF TORTS § 18 cmt. c (1965) (emphasis added).

<sup>207</sup> Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213 (2006); *see also* discussion *supra* Part III.A.

<sup>208</sup> PETERS, JR., *supra* note 89, at 49; *see* discussion *supra* Part III.A.

that his parents have not wronged him.<sup>209</sup> Consider an airline that bars African-Americans from boarding, but then claims credit for saving African American lives when the “whites only” plane crashes.<sup>210</sup> Likewise, when a child is born with a disability or disease, the sole fact that he has been born does not negate his parents’ wrongful conduct in using PGD for this purpose. When a child is born, should it not be to the fullest extent of his potential health and development, rather than to the extent that his parents purposefully truncate that development?

Additionally, the harms resulting from the IVF and PGD procedures cannot be ignored. Already discussed in detail above, the IVF process is precarious because of the high risks of multiple births, low-birth weight, and the attendant dangers.<sup>211</sup> Recent studies show that PGD comes with the known risks of unsuccessful pregnancies and permanent damage to the embryo, and the unknown long-term risks to the child.<sup>212</sup>

Finally, the child must establish that he did not consent to the contact. Clearly, the child could not have consented to the contact because the contact was made while he was a pre-embryo. Parents, however, can usually consent to medical treatment for their children.<sup>213</sup> But non-therapeutic treatment that is “risky, invasive, and permanent” requires more than parental consent.<sup>214</sup> With the child’s inability to consent to the risks of PGD, this type of genetic intervention necessitates third-party oversight.

Having established the requisite elements of a battery claim—intent, contact, and lack of consent—a child can successfully recover against his parents for the injuries he has suffered due to his disability or disease.

## 2. Intentional Infliction of Emotional Distress

Intentional infliction of emotional distress (“IIED”) is a tort claim brought against an actor who, by extreme and outrageous conduct, intentionally, or with reckless disregard, causes severe emotional

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<sup>209</sup> I. Glenn Cohen, *Intentional Diminishment, The Non-Identity Problem, and Legal Liability*, 60 HASTINGS L.J. 347, 370 (2008).

<sup>210</sup> F.M. Kamm, *Cloning and Harm to Offspring*, 4 N.Y.U. J. LEGIS. & PUB. POL’Y 65, 72 (2000).

<sup>211</sup> See *supra* text accompanying notes 163–66.

<sup>212</sup> See *supra* text accompanying notes 94–97.

<sup>213</sup> See Ouellette, *supra* note 169, at 408–09 (discussing non-therapeutic treatments to which parents may not freely consent).

<sup>214</sup> *Id.* at 408.

distress to another.<sup>215</sup> Similar to a battery claim, the actor's intent can be established by showing the actor's purpose or desire to cause severe distress or by showing the actor had knowledge with substantial certainty that severe distress would result from his or her conduct.<sup>216</sup> Unlike battery, however, IIED incorporates a *reckless* characterization of intent.<sup>217</sup> If the actor acts in reckless disregard of a high risk that emotional distress will result from his conduct, his intent is also established.<sup>218</sup> Second, the plaintiff must show that the actor's conduct was extreme or outrageous.<sup>219</sup> Courts have only found liability in instances where the actor's conduct was so outrageous and extreme, "as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community."<sup>220</sup> The conduct must be of the type that shocks the conscience and causes a reasonable person to shout, "Outrageous!"<sup>221</sup> Third, the emotional distress suffered by the plaintiff must be severe.<sup>222</sup> Transient distress is not enough; a severe reaction is necessary to establish IIED, and bodily harm will go a long way in proving this element.<sup>223</sup>

First, the child must establish that his parents intended to cause him emotional distress or that they acted with reckless disregard of the risk of emotional distress. We can assume that most parents deciding to undergo PGD do not intend to cause emotional distress for their child; however, their conduct does show reckless disregard for the risk of emotional distress. Resources exist that detail the emotional and psychological effects that disabilities and diseases have on children when they are young, and yet, these parents have decided to go forward with PGD regardless.<sup>224</sup> Worse yet are the parents who suffered emotionally when they were children as a result of their own disabilities, but nevertheless decide to create children just like them. Take Sharon Duchesneau, for example. As a child, she suffered embarrassment because she was deaf and could not communicate with hearing children, but did not want to associate herself with other deaf kids.<sup>225</sup> As a result, she was

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<sup>215</sup> RESTATEMENT (SECOND) OF TORTS § 46 (1965).

<sup>216</sup> § 46 cmt. i.

<sup>217</sup> *Id.*

<sup>218</sup> *See, e.g.*, Pollard v. E.I. Du Pont de Nemours, Inc., 412 F.3d 657, 664–65 (6th Cir. 2005).

<sup>219</sup> RESTATEMENT (SECOND) OF TORTS § 46 cmt. d.

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> § 46 cmt j.

<sup>223</sup> *See, e.g.*, Flores v. Baca, 871 P.2d 962, 969–70 (N.M. 1994).

<sup>224</sup> *See, e.g.*, LASHLEY, *supra* note 162, at 190–91.

<sup>225</sup> Mundy, *supra* note 16, at W27.

somewhat of an outcast. From the outside, Duchesneau looked fine, but inside, she always felt like there was something wrong with her; she had a “chronic sense of falling short.”<sup>226</sup> And yet, when it came time to have a child, Duchesneau did not hesitate to bring a deaf child into the world, completely disregarding the risk of emotional distress to the child. Thus, these parents have knowledge with substantial certainty that distress will result from their conduct, and so parental intent is proven.

Second, the child must show that his parents’ conduct was extreme or outrageous. This is probably the most difficult element to establish to state an IIED claim. Taking into account the “communities” in which these children will most likely be raised, this type of parental conduct would not be considered “atrocious and utterly intolerable.”<sup>227</sup> In fact, if we once again consider the deaf community these parents would be praised for seeking to expand rather than diminish the Deaf culture; this is probably true for many of those who are disabled. But we cannot only allow for the views of these communities. The Restatement of Torts calls for the behavior to be such that a *reasonable person* would find it outrageous.<sup>228</sup> Intentionally creating a disabled or diseased child is quite arguably outrageous, and most reasonable persons would want to provide their child with every opportunity possible. A jury should find that this parental conduct shocks the conscience and is extreme and outrageous.

Third, to make out a *prima facie* case for IIED, the child must show that his emotional distress was severe. The element of severity will depend entirely upon a particular child’s level of emotional distress; however, statistics show that children having a disability or disease are much more likely to suffer emotionally. For instance, children with achondroplasia are likely to be affected by slow emotional maturation, diminished popularity and isolation, and low self-esteem.<sup>229</sup> They are often teased and taunted by their classmates.<sup>230</sup> Even into adulthood, people with achondroplasia are likely to suffer from self-doubt, embarrassment, and prejudice.<sup>231</sup> If effects like these build up enough to create a severe emotional reaction, then a child will easily be able to show that his emotional distress is severe.

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<sup>226</sup> *Id.*

<sup>227</sup> RESTATEMENT (SECOND) OF TORTS § 46 cmt. d (1965).

<sup>228</sup> *Id.*

<sup>229</sup> LASHLEY, *supra* note 162, at 190.

<sup>230</sup> *Id.*

<sup>231</sup> *Id.* at 191.

With a showing that a child's parents engaged in extreme and outrageous conduct with either intent or reckless disregard of the risk of emotional distress, and that his distress was severe, a child will be able to successfully state a claim for intentional infliction of emotional distress against his parents.

### *B. Tort Claims Brought Against Physicians*

In addition to the claims a disabled or diseased child may bring against his or her parents, there are means to recovery against the health care professionals that may succeed. The most obvious claim with regard to this particular set of facts is battery. Another likely cause of action here is negligence, in the form of medical malpractice.

#### 1. Battery

It has already been recognized that in order to prove battery, the plaintiff must show the actor's intent to cause a contact that is harmful or offensive without consent. The third element, lack of consent, does not need to be discussed further, because it is satisfied in the same way as against the child's parents—the child could not have consented in pre-embryo status.<sup>232</sup>

Like parental intent, the intent of the physician to cause contact is fairly easy to establish. Intent here is best characterized as *purpose* to cause contact with the future child. During the PGD process, a physician must purposefully retrieve eggs and fertilize them with the collected sperm.<sup>233</sup> After allowing the fertilized eggs to develop to about eight cells, the physician extracts a cell in order to perform the biopsy.<sup>234</sup> The physician then must decide, with the parents' guidance, which embryos to implant; then, he implants them.<sup>235</sup> All of his actions are with purpose, and thus the relevant intent is shown.

Contact is also established very similarly to parental contact; but while the parents' contact is indirect, the physician's contact is direct. Unlike the parents, the physician has directly made a contact with the future child. It was his intentional conduct to perform the cell biopsy and to implant the embryo into the mother's uterus. This makes the harmful and offensive contact element

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<sup>232</sup> See *supra* text accompanying notes 213–14.

<sup>233</sup> Smolensky, *Creating Children*, *supra* note 11, at 318.

<sup>234</sup> *Id.*

<sup>235</sup> *Id.* at 318–19.

much easier to establish in this case, and so a battery claim is properly made out.

## 2. Medical Malpractice

Malpractice is “[a]n instance of negligence or incompetence on the part of a professional.”<sup>236</sup> For negligence claims against physicians, four elements must be established: (1) the physician owed a duty of care to the patient; (2) the standard of care was breached; (3) the physician caused the injury; and (4) an injury resulted. Unlike the intentional torts already discussed, negligent torts do require a showing of actual damages to establish liability.

Generally, there must be a direct doctor-patient treatment relationship between the plaintiff and the physician in order to establish that the physician owed a duty of care to the plaintiff.<sup>237</sup> On occasion, however, the physician’s duty of care is extended to third parties—for instance, when the health or well being of immediate family members or other persons are directly affected by the patient.<sup>238</sup> While it may first appear in the present case that the child is a third party rather than the primary patient—the mother—it is commonly recognized in the obstetrics field that the physician has more than one patient: the mother and the fetus.<sup>239</sup> Moreover, most courts have agreed that a duty of care is owed to *future persons* whenever the risk to them is foreseeable.<sup>240</sup>

For example, in *Johnson v. Thompson*, the Georgia Court of Appeals allowed a child to sue an obstetrician for an act of medical malpractice committed while the child was only a fetus.<sup>241</sup> Several months before the child’s birth, his mother’s obstetrician failed to diagnose him as unusually large for his gestational age.<sup>242</sup> As a

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<sup>236</sup> BLACK’S LAW DICTIONARY 978 (8th ed. 2004).

<sup>237</sup> *Tenuto v. Lederle Labs.*, 687 N.E.2d 1300, 1302–03 (N.Y. 1997).

<sup>238</sup> *Id.* at 1303.

<sup>239</sup> Anne Drapkin Lyerly & Peter Schwartz, *Is the Patient Always Right?*, 34 HASTINGS CTR. REP. 13, 14 (2004).

<sup>240</sup> PETERS, JR., *supra* note 89, at 212; *see, e.g.*, *Burgess v. Superior Court*, 831 P.2d 1197, 1202 n.7 (Cal. 1992) (“[B]y virtue of [the physician’s] physician-patient relationship with [the mother], [he] assumed a duty of care to [the mother], the scope of which extended to providing competent medical treatment for both [the mother] and her fetus.”); *Johnson v. Thompson*, 650 S.E.2d 322, 324 (Ga. 2007) (holding that an obstetrician providing prenatal care owes a duty of care to both the mother and the fetus); *Broadnax v. Gonzalez*, 809 N.E.2d 645, 648 (N.Y. 2004) (“In treating a pregnancy, medical professionals owe a duty of care to the developing fetus.”); *HCA, Inc. v. Miller ex rel. Miller*, 36 S.W.3d 187, 195 n.21 (Tex. App. Div. 2000) (“Provided it is subsequently born alive, even an unborn fetus is a ‘patient’ to whom a doctor treating the mother owes a duty of care.”).

<sup>241</sup> 650 S.E.2d at 323.

<sup>242</sup> *Id.*

result, the obstetrician failed to recommend a cesarean section, and the child suffered physical injuries during a vaginal birth.<sup>243</sup> The court held that it was “beyond dispute that both the fetus and the mother are patients of the obstetrician and that the obstetrician owes a duty of care to both of them.”<sup>244</sup> So this duty “exists even though the identity of the individuals who will be harmed is not yet known and even though some of them may not yet exist.”<sup>245</sup> If this duty of care extends to a non-viable fetus, should it not also extend to a non-viable embryo that the physician has created, biopsied, and implanted into the womb?

While some do argue that no duty is owed to a non-viable fetus or embryo because the alleged injury occurred before the individual was even in utero,<sup>246</sup> there are instances in which the law says otherwise. Consider anti-incest legislation: a primary driving force in enacting criminal and civil prohibitions on incest was “to protect children born to close blood relatives from the negative hereditary effects of recessive genetic abnormalities.”<sup>247</sup> Recently, this position has been widely condemned in part due to a lack of definitive proof,<sup>248</sup> but the fact remains that many state statutes incorporate measures to limit the risk of procreation between blood relatives.<sup>249</sup> In seeking to protect future persons from genetic disorders and diseases prior to conception, these states evidence the same goals that would be achieved by preventing the practice of implanting only those embryos which are carriers of genetic disabilities or diseases that will harm a future child. Therefore, if a recognized duty exists with regard to a child born from an incestuous couple, the duty of care should exist between a physician and a child born with a disability or disease through the PGD process.

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<sup>243</sup> *Id.*

<sup>244</sup> *Id.* at 324.

<sup>245</sup> PETERS, JR., *supra* note 89, at 13.

<sup>246</sup> See *Andrews v. Keltz*, 838 N.Y.S.2d 363, 370 (Sup. Ct. 2007).

<sup>247</sup> Christine M. Metteer, *Some “Incest” Is Harmless Incest: Determining the Fundamental Right to Marry of Adults Related by Affinity Without Resorting to State Incest Statutes*, 10 KAN. J.L. & PUB. POL’Y 262, 273 (2000).

<sup>248</sup> *Id.* at 274.

<sup>249</sup> See, e.g., ALA. CODE § 13A-13-3 (2005) (finding justification for criminal sanctions for incest based on the higher probability of recessive gene disorders in the children of blood-related parents); ARIZ. REV. STAT. ANN. § 25-101(B) (2007) (allowing first cousins to marry when it is proven one or both are unable to reproduce); 750 ILL. COMP. STAT. 5/212(a)(4) (1999) (first cousins may marry if both are over fifty years of age or either has presented a certificate signed by a licensed physician to the county clerk stating that he or she is “permanently and irreversibly sterile”); ME. REV. STAT. ANN. tit. 19-A, § 701(2)(B) (1997) (first cousins may marry provided they provide physicians’ certificates of genetic counseling); UTAH CODE ANN. § 30-1-1(2) (2007) (first cousins may marry if both are sixty-five years of age or older, or if both are fifty-five years of age or older and either is unable to reproduce).

Thus, the physicians or other health care professionals involved in the PGD process necessarily owe the child a duty of care, not only because of the foreseeable risk to the child due to his relationship with his mother, but also because the child as embryo and future person is owed a duty of care, notwithstanding the fact that the injury arose prior to implantation in the womb.

Having established that the physician owed the child a duty of care, the child next must show that the physician breached the standard of care. Every physician has a duty to:

use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable diligence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment, and options.<sup>250</sup>

More simply put, what did the physician know or what should he have known, and what did the physician do or fail to do in light of that knowledge? Normally, if there is more than one method of treatment for a particular medical condition, and all the methods are accepted by the medical profession, the physician's choice of treatment is not negligence.<sup>251</sup> This principle is also referred to as the "respectable minority opinion doctrine."<sup>252</sup> As long as the treatment chosen by the physician was approved by at least a respectable minority of the medical profession, the physician was acting within the standard of care. In American IVF-PGD clinics, 4 out of 137 clinics select for disabilities or diseases.<sup>253</sup> These clinics make up only three percent of all clinics performing PGD procedures, an insignificant minority.<sup>254</sup> This treatment therefore does not have approval from at least a respectable minority, and so a breach of the standard of care has been established.

Next, the child must establish that his injury both was caused-in-fact by the physician and was proximately caused by the physician's failure to adhere to the standard of care. The following three part analysis will establish "but for" cause or cause-in-fact.<sup>255</sup> First, one

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<sup>250</sup> Hall v. Hilbun, 466 So. 2d 856, 873 (Miss. 1985).

<sup>251</sup> Ouellette v. Subak, 391 N.W.2d 810, 815 (Minn. 1986).

<sup>252</sup> See, e.g., Mitchem v. Morgan, No. 20994-2-II, 1999 WL 39498, at \*5 (Wash. Ct. App. Jan. 29, 1999) (quoting Swanson v. Hood, 170 P. 135, 137 (Wash. 1918)).

<sup>253</sup> Baruch et al., *supra* note 13, at 1056.

<sup>254</sup> It is my opinion that three percent is not enough to represent a respectable minority, as no definitive standard has been established as to what represents a "respectable minority."

<sup>255</sup> Herskovits v. Group Health Coop., 664 P.2d 474, 477 (Wash. 1983).

must identify clearly and as precisely as possible the injury or loss to be compensated.<sup>256</sup> Second, one must identify the particular act of the physician's malpractice.<sup>257</sup> Third, if the act of malpractice did not occur—meaning that the physician adhered to the standard of care—one must determine whether the injury or loss would still have occurred.<sup>258</sup> Without going into exhaustive detail, the child's primary injury to be compensated is the disability or disease from which he suffers. The physician breached the standard of care by selecting and implanting only those embryos that carried the gene for the disability or disease. If we assume that the physician adhered to the standard of care, two outcomes may have occurred. First, if the physician had implanted the embryos that did not carry the gene for the particular disability or disease, the child's resulting disability or disease would not have occurred. Second, if the physician had not selected for disability, but rather just implanted a few embryos as in a traditional IVF procedure, the child's disability or disease may have occurred or it may not have occurred—it would be left up to pure chance, as are many genetic traits. The fact remains, however, that because the physician did select and implant only those embryos carrying the gene for the particular disability or disease, the child's injury was guaranteed to occur. Therefore, the physician's breach of the standard of care is a "but-for" cause of the child's disability or disease.

Proximate cause is a tool used to limit the scope of liability. To show that a physician proximately caused an injury, the plaintiff has the burden to establish that the physician's deviation from the standard of care caused the plaintiff's resulting injury.<sup>259</sup> Mere possibility that the physician's negligence caused the injury is not enough; rather, "there must be evidence that the negligence complained of *probably* caused the injury."<sup>260</sup> This evidence is usually established by expert medical testimony; however, there is an exception to this requirement when a layperson can easily understand the link between the breach of the standard of care and the resulting injury and "can reliably determine the issue of causation without expert testimony to assist in that determination."<sup>261</sup> Therefore, the child in this case must establish

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<sup>256</sup> *Id.*

<sup>257</sup> *Id.*

<sup>258</sup> *Id.*

<sup>259</sup> *Thone v. Reg'l W. Med. Ctr.*, 745 N.W.2d 898, 908 (Neb. 2008).

<sup>260</sup> *Mobile Infirmary Ass'n v. Tyler*, 981 So. 2d 1077, 1093 (Ala. 2007) (quoting *Parker v. Collins*, 605 So. 2d 824, 826 (Ala. 1992)).

<sup>261</sup> *Cain v. Howorth*, 877 So. 2d 566, 576 (Ala. 2003).

that when the doctor failed to adhere to the standard of care by implanting disabled or diseased embryos, he *probably* caused the child's resulting disability or disease. This connection, while better determined by an expert, is still readily understandable by a layperson. Not only did the physician *probably* cause the child's injury, he most definitely caused it. Thus, the requisite proximate cause is established.

Finally, the child must establish a tangible, physical harm, because one cannot assert liability unless one can prove damages to be compensated for. In the present case, this is quite simple: the child has a disability or disease, and consequently, he is seeking recovery for a disability or disease that otherwise would not have occurred.

### *C. Damages to Be Awarded*

In the present case, a child who is able to establish an injury, whether resulting from negligence, battery, or another intentional tort, will likely be able to recover special damages for medical and schooling expenses and loss of earning capacity.

#### 1. Wrongful Life Special Damages: Extraordinary Expenses Necessary to Treat a Hereditary Ailment<sup>262</sup>

A wrongful life action is an ancillary claim to a medical malpractice action brought by the child against the physician—usually in cases where the child is born with a hereditary disability or other genetic disorder—alleging that if the physician had performed her job correctly, the plaintiff would not have been born with his impairment because he would not have been born at all.<sup>263</sup> In this kind of case, courts are unwilling to award general damages, because they will not assign value to living versus not living at all.<sup>264</sup> Hence, a plaintiff may not predicate an award of damages on the basis that the plaintiff's life itself is worse than not being alive at all. Some jurisdictions, however, are open to awarding special damages for the extraordinary expenses necessary to treat the hereditary ailment from which he or she suffers, including specialized teaching, training, and medical costs.<sup>265</sup> The state of

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<sup>262</sup> *Turpin v. Sortini*, 643 P.2d 954, 966 (Cal. 1982).

<sup>263</sup> *E.g.*, *Willis v. Wu*, 607 S.E.2d 63 (S.C. 2004).

<sup>264</sup> *See* Deana A. Pollard, *Wrongful Analysis in Wrongful Life Jurisprudence*, 55 ALA. L. REV. 327, 327 (2004).

<sup>265</sup> *Turpin*, 643 P.2d at 965; *see Galvez v. Fields*, 107 Cal. Rptr. 2d 50, 59 (Ct. App. 2001).

California started a movement in this direction, beginning with *Turpin v. Sortini*, in 1982.<sup>266</sup>

The plaintiff in *Turpin* was an infant, Joy, born with hereditary deafness.<sup>267</sup> Prior to Joy's conception, the defendant had assured her parents that their first child, Hope, tested at hearing levels within normal range, when in fact she was deaf.<sup>268</sup> On behalf of Joy, her parents filed a complaint alleging that had they known of Hope's deafness, they would not have conceived a second child.<sup>269</sup> The wrongful life claim sought recovery for general damages for being "deprived of the fundamental right of a child to be born as a whole, functional human being without total deafness" and special damages for the "extraordinary expenses for specialized teaching, training and hearing equipment."<sup>270</sup> The Supreme Court of California held that general damages for pain and suffering could not be rewarded because the measure between being born impaired and not being born at all was incalculable.<sup>271</sup> Special damages, however, were awarded to Joy.<sup>272</sup> The court found that because the failure to diagnose a hereditary ailment placed both a medical and financial burden on the plaintiff, this damage was measurable.<sup>273</sup> As such, special damages were recoverable for the "extraordinary expenses necessary to treat the hereditary ailment."<sup>274</sup>

The case considered here is remarkably similar. Having established battery and negligence causes of action against the physician, a child will be able to recover medical, schooling, and training expenses, because these claims can be brought outside of a wrongful life claim. These expenses will vary depending on the type and severity of disability or disease from which the child suffers.

## 2. Special Economic Damages for Loss of Earning Capacity

A damages award for loss of earning capacity provides compensation for the "permanent diminution of the ability to earn money."<sup>275</sup> Damages for the impairment of earning capacity can be

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<sup>266</sup> *Turpin*, 643 P.2d 954.

<sup>267</sup> *Id.* at 956.

<sup>268</sup> *Id.*

<sup>269</sup> *Id.*

<sup>270</sup> *Id.*

<sup>271</sup> *Id.* at 964–66.

<sup>272</sup> *Id.* at 966.

<sup>273</sup> *Id.* at 965.

<sup>274</sup> *Id.* at 966.

<sup>275</sup> *Dep't of Transp. & Pub. Facilities v. Miller*, 145 P.3d 521, 531 (Alaska 2006) (quoting *Grimes v. Haslett*, 641 P.2d 813, 818 (Alaska 1982)).

awarded when two elements are established: a permanent injury and a reasonable degree of certainty of the damages.<sup>276</sup> To show that the future consequences are reasonably certain, the plaintiff must prove “that it is more likely than not . . . that the projected consequence will occur.”<sup>277</sup> In order to recover special damages for loss of earning capacity, the plaintiff must also attach a physical harm to those losses, because damages based solely on economic loss will generally not be awarded.<sup>278</sup>

First, the child must establish that he or she has a permanent injury. The types of disabilities and diseases that PGD is most often used to screen for are permanent, so this element is easy to establish. Second, the child must establish that it is more probable than not that the expected outcome will occur. The projected outcome will vary depending on the particular disability or disease the child has and the anticipated earning capacity. Any career opportunity that is foreclosed to the child because of the disability or disease will have to be considered in calculating these damages. For instance, if a deaf child desires to be a professional athlete and is otherwise capable and talented, the loss in earning capacity should be awarded. Furthermore, in tort law, it is universally held that one must take the plaintiff as they are.<sup>279</sup> If one child’s loss of earning capacity is greater than another child’s due to the particular disability or disease he suffers from—or because his desired occupation demands higher earning capacity—then the child should recover damages proportionately.

## VI. CONCLUSION

Children should not be made to suffer as a result of their parents’ choices. Parents do not have a legal or moral right to use PGD to create a disabled or diseased child. The Constitution does not provide the right, nor is it included within the right to procreate. As individual states have not yet implemented legislation to directly

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<sup>276</sup> *Craighead v. Norfolk & W. Ry. Co.*, 475 S.E.2d 363, 373 (W. Va. 1996).

<sup>277</sup> *Moattar v. Foxhall Surgical Assocs.*, 694 A.2d 435, 439 (D.C. 1997) (quoting *Wilson v. Johns-Manville Sales Corp.*, 684 F.2d 111, 119 (D.C. Cir. 1982)).

<sup>278</sup> *See, e.g., Robins Dry Dock & Repair Co. v. Flint*, 275 U.S. 303, 309 (1927) (“[A] tort to the person or property of one man does not make the tortfeasor liable to another merely because the injured person was under a contract with that other, unknown to the doer of the wrong.”); *Stevenson v. E. Ohio Gas Co.*, 73 N.E.2d 200, 203 (Ohio Ct. App. 1946) (“If one who by his negligence is legally responsible for an explosion . . . should be required to respond in damages not only to those who have sustained personal injuries or physical property damage but also to every one who has suffered an economic loss, by reason of the explosion . . . we might well be appalled by the results that would follow.”).

<sup>279</sup> *See, e.g., Thompson v. Lupone*, 62 A.2d 861, 863 (Conn. 1948).

regulate the use of PGD, children must be able to rely on indirect methods of regulation, largely through the tort system. Even if legislation at a federal or state level were to be passed, disabled or diseased children already born from PGD would have no protection. Until that time, these children can recover against their parents and physicians under claims of both intentional and negligent torts.