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Choice, Conscience, and Context

by
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To begin, Professor Shapiro should be commended for challenging each of the participants in this Symposium to assess our arguments with some analytical rigor, checking them to make sure they do not suffer from the systematic errors that he has articulated.[1] He admonishes us that the value laden nature of discussions about how the new reproductive technologies affect our understanding of personhood is not an excuse for sloppy analysis and we should heed this counsel. When it comes to substance, I basically agree with Professor Shapiro's conclusion that the broad lines of criticisms he addresses—criticisms based on charges of selfishness, objectification, and violation of the second formulation of Kant's categorical imperative—are not by themselves up to the task of convincingly condemning and justifying the prohibition of new reproductive techniques and collaborations (NRTCs) across the board.[2] Instead, as Professor Shapiro argues, we need to conduct more particularized assessments of specific practices.[3]

Rather than respond directly to each of Professor Shapiro's points, however, I would like to build on his discussion to consider two specific practices that increasingly are becoming part of the new reproductive landscape: selective reduction of multiple pregnancy and prenatal genetic testing to enable selective abortion. Professor Shapiro does not directly address either practice, but each may raise troubling questions that sound suspiciously like the arguments that Professor Shapiro has sought to discredit. The concerns that selective reduction and prenatal genetic screening raise, however, relate not to why and in what circumstances persons employ NRTCs in order to become genetic parents, but to the nature and consequences of the

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[1] *See* Michael H. Shapiro, *Illicit Reasons and Means For Reproduction: On Excessive Choice and Categorical and Technological Imperatives*, 47 HASTINGS L.J. 1081,1087-91 (1996).

[2] *Id.* at 1087.

[3] *Id.* at 1090-91.

actions that persons undertake in order to achieve that goal. Still, these practices may be troubling precisely because of the effects they may have on our understanding of personhood.[4] After discussing these two practices, I will consider a practical response suggested by my concerns.

I. Selective Reduction of Multiple Pregnancy

Selective reduction of multiple pregnancy[5] is a procedure now available to many women who find themselves encountering a multiple pregnancy[6] as a result of infertility treatment. Most multiple pregnancies, particularly high order multiple pregnancies in which a woman carries three or more fetuses, do not occur naturally, but are instead iatrogenic in nature.[7] Multiple pregnancies usually result from the use of infertility drugs that hyperstimulate the ovaries to produce multiple eggs. This hyperstimulation may be followed either by insemination or by in vitro fertilization and the transfer of multiple em-

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[4] As several participants at this Symposium have argued, we may have good cause to be concerned about the new reproductive technologies for reasons other than the impact of those technologies on personhood. *See generally* Radhika Rao, *Assisted Reproductive Technology and the Threat to the Traditional Family*, 47 HASTINGS L.J. 951 (1996) (expressing concern regarding impact on family); Lori B. Andrews, *Prenatal Screening and the Culture of Motherhood*, 47 HASTINGS L.J. 967 (1996) (expressing concern regarding impact on women); Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935 (1996) (expressing concern regarding role that race plays). In my comments, I limit myself to concerns relating to personhood.

[5] The procedure is also referred to as "multifetal pregnancy reduction" and "selective termination." *See* Mark I. Evans et al., *Multifetal Pregnancy Reduction and Selective Termination*, 7 CURRENT OPINIONS OBSTETRICS & GYNECOLOGY 126, 126-28 (1995) [hereinafter *MFPR and Selective Reduction*]; Judith F. Daar, *Selective Reduction of Multiple Pregnancy: Lifeboat Ethics in the Womb*, 25 U.C. DAVIS L. REV. 773, 779 n.26 (1992).

[6] In my comments, I focus on the use of selective termination of fetal life as a response to the medical exigencies created by high order multiple pregnancies. The procedure described, however, may also be used when one fetus in a twin pregnancy is diagnosed with a physical or genetic abnormality. *See* Evans, *MFPR and Selective Reduction*, *supra* note 5, at 128 (describing "selective termination for fetuses with congenital abnormalities"). Although the response (i.e., selective termination) may be the same in each scenario, the rationale is different: "[T]he intention in selective termination is to avoid having a child with a known medical problem, whereas the intention in multifetal reduction is to prevent problems that are secondary to multifetal gestation and premature birth." Richard V. Grazi & Joel B. Wolowelsky, *Multifetal Pregnancy Reduction and Disposal and Untransplanted Embryos in Contemporary Jewish Law and Ethics*, 165 AM. J. OBSTETRICS & GYNECOLOGY 1268, 1270 (1991) (quoting AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, MULTIFETAL PREGNANCY REDUCTION AND SELECTIVE FETAL TERMINATION, COMMITTEE OPINION NO. 94 (Apr. 1991)).

[7] *See* JOHN A. ROBERTSON, CHILDREN OF CHOICE 203 (1994). *Cf.* Evans, *MFPR and Selective Reduction*, *supra* note 5, at 126 (relating increasing rate of multiple births to development of assisted reproductive technology).

bryos to the woman.[8] Estimates are that about twenty-five percent of pregnancies resulting from fertility treatment are multiple pregnancies;[9] the percentage runs as high as fifty percent in some programs.[10]

High order multiple pregnancy creates serious health risks for both the pregnant woman and the fetuses she is carrying. Among the increased risks that a woman with a multifetal pregnancy faces are preeclampsia, postpartum hemorrhage, preterm labor, and premature delivery. She is also likely to require long-term bedrest or hospitalization during the pregnancy.[11] The risks to the fetuses are more dramatic. Each additional fetus in a pregnancy increases both the risks of premature delivery, with its resultant problems of low birth weight and respiratory distress syndrome for the infant, and the rate of perinatal and infant death. The risks associated with premature delivery often cause long-term impairments for the infants who survive.[12] In addition to these health risks, women and couples encountering high order multiple pregnancies face daunting social, financial, and personal burdens in caring for their offspring, even if, against the odds, their offspring suffer no long-term impairments.[13] Faced with these

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[8] *See* Mark I. Evans et al., *Evolving Patterns of Iatrogenic Multifetal Pregnancy Generation: Implications for Aggressiveness of Infertility Treatments*, 172 AM. J. OBSTETRICS & GYNECOLOGY 1750, 1752 (1995) (describing procedures) [hereinafter *Evolving Patterns*].

[9] *See* Antoinette Martin, *Is Society Really Ready for More Multiples?*, N.Y. TIMES, Feb. 8, 1996, at B1, B6.

[10] Evans, *MFPR and Selective Termination*, *supra* note 5, at 126. The majority of these multiple pregnancies are twin pregnancies and not high order multiple pregnancies for which selective reduction might be recommended. Data from 1993 indicate that of pregnancies resulting from in vitro fertilization (IVF) or related technologies, approximately 6% to 7% were high order multiple pregnancies. *See* Society for Assisted Reproductive Technology, *Assisted Reproductive Technology in the United States and Canada: 1993 Results Generated from the American Society for Reproductive Medicine/Society for Assisted Reproductive Technology Registry*, 64 FERTILITY & STERILITY 13, 14-17 (1995). *See also* Martin, *supra* note 9, at B1 (stating that the number of supertwin births has increased at a rate faster than twin births).

[11] *See* Mark I. Evans et al., *Multiple Gestation: The Role of Multifetal Pregnancy Reduction and Selective Termination*, 19 CLINICS PERINATOLOGY 345, 352 (1992) [hereinafter *Multiple Gestation*]; Mark I. Evans et al., *Attitudes on the Ethics of Abortion, Sex Selection, and Selective Pregnancy Termination among Health Care Professionals, Ethicists, and Clergy Likely to Encounter Such Situations*, 164 AM. J. OBSTETRICS & GYNECOLOGY 1092, 1097 (1990) [hereinafter *Attitudes*].

[12] *See* Daar, *supra* note 5, at 778-79; Evans, *MFPR and Selective Termination*, *supra* note 5, at 126; Martin, *supra* note 9, at B6 (stating that the rate of cerebral palsy in multiple births is six times that for singletons).

[13] *See generally* Martin, *supra* note 9 (describing the burdens that multiple births place on families and society).

risks and potential burdens, the woman (or couple)[14] has three options: (1) terminate the entire pregnancy through abortion and attempt to conceive again; (2) seek to continue the pregnancy with all the fetuses, despite the risks; or (3) reduce the fetuses to a number that poses a lower level of risk.[15]

For those women who choose selective reduction, the procedure is performed during the first trimester of pregnancy and most commonly involves the insertion of a needle through the abdominal wall and the injection of potassium chloride into the thorax of one or more of the fetuses.[16] Ordinarily, the physician chooses the fetus(es) to be terminated based on proximity to the abdominal wall[17] and terminates as many as are necessary to leave only two, or perhaps three, fetuses surviving.[18]

The existing medical, ethical, and legal literature contains only limited discussion of the ethical issues that selective reduction raises.[19]

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[14] In the discussion that follows, I will use both the terms "woman" and "couple" in describing the actors employing reproductive technology. I use the term "couple" deliberately, particularly with respect to selective reduction, for the vast majority of high order multiple pregnancies are the result of infertility treatment and the vast majority of recipients of infertility treatment are married couples. By using the term "couple," however, I do not intend to denigrate the woman's (at least theoretical) role as the ultimate voice in decisions regarding her own reproductive capacity.

[15] *See* Evans, *Multiple Gestation*, *supra* note 11, at 347.

[16] *See id.* at 348-49. Recent data indicate that alternative methods involving transcervical aspiration or transvaginal needle injection of potassium chloride into the fetal thorax are as safe and effective as the transabdominal procedure in reducing the number of fetuses. *See* Ilan E. Timor-Tritsch et al., *Multifetal Pregnancy Reduction by Transvaginal Puncture: Evaluation of the Technique Used in 134 Cases*, 168 AM. J. OBSTETRICS & GYNECOLOGY 799, 803 (1993); Mark I. Evans et al., *Transabdominal Versus Transcervical and Transvaginal Multifetal Pregnancy Reduction: International Collaborative Experience of More Than One Thousand Cases*, 170 AM. J. OBSTETRICS & GYNECOLOGY 902, 905 (1994).

[17] Evans, *Multiple Gestation*, *supra* note 11, at 349 ("The decision of which embryo to choose has been strictly a technical issue of which embryos are easiest to reach."). In these cases, the "selection" involved in selective reduction does not raise eugenic concerns. The medical literature, however, also suggests that "physicians performing the procedure will select an embryo that appears to be significantly smaller or one which appears to be anomalous." Evans, *MFPR and Selective Termination*, *supra* note 5, at 128.

[18] Most reductions are to two fetuses. ROBERTSON, *supra* note 7, at 204; Evans, *Multiple Gestation*, *supra* note 11, at 350. It appears that most obstetricians are not willing to reduce to a singleton pregnancy because the pregnancy outcomes for twin births are nearly as good as for singletons. *See* Richard M. Zaner et al., *Selective Termination in Multiple Pregnancies: Ethical Considerations*, 54 FERTILITY & STERILITY 203, 204 (1990). By the same token, as the outcomes for triplets improve, some physicians may express ethical qualms about reducing the number of fetuses in a pregnancy below three. *See* ROBERTSON, *supra* note 7, at 204.

[19] For discussions that pay more than passing notice to ethical issues, see, for example, ROBERTSON, *supra* note 7; Daar, *supra* note 5; Evans, *Attitudes*, *supra* note 11; Grazi & Wolowelsky, *supra* note 6; Christine Overall, *Selective Termination of Pregnancy and Wo-*

To the extent that ethical concerns are addressed, many commentators begin their analysis at the point when multiple pregnancy is already established and either analogize to the morality and legality of abortion generally[20] or focus on the ethical permissibility of destroying some life in order to protect other life.[21] From the latter perspective, high order multiple pregnancies may be seen as creating a lifeboat situation, in which one fetal life may be sacrificed to save others.[22]

To my mind, however, a more fundamental ethical issue arises not once a high order multiple pregnancy is established, but when persons choose a course of conduct creating a substantial risk of high order multiple pregnancy.[23] To draw on the lifeboat metaphor, it seems we would view as morally troubling the decision of a ship's captain to set sail in stormy seas in a rickety boat without a radio. This decision is disturbing not only because it poses a risk of physical harm to the ship's passengers and crew, but also because it risks placing those persons in a lifeboat situation where they face grave mortal decisions. By the same token, the use of aggressive infertility treatments entailing hyperovulation followed by insemination or multiple embryo transfer raises ethical questions because that treatment choice willingly entertains the risk that high order multiple pregnancy will result.

Two lines of reasoning, which are unlikely to coincide in a single case, explain why this willing entertainment of risk may be troubling. The first line of reasoning applies when a couple understands the risk of multiple pregnancy and the availability of selective reduction and they choose to pursue aggressive infertility treatment that maximizes their chance of a live birth.[24] Thus, in order to achieve their goal of

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men's Reproductive Autonomy, HASTINGS CENTER REP., May-June 1990, at 10-11; Zaner, *supra* note 18.

[20] *See* Evans, *Multiple Gestation*, *supra* note 11, at 352-53; Elizabeth Villiers Gemmette, *Selective Pregnancy Reduction: Medical Attitudes, Legal Implications, and a Viable Alternative*, 16 J. HEALTH POL. POL'Y & L. 383, 387-90 (1991).

[21] *See, e.g.*, Daar, *supra* note 5; Grazi & Wolowelsky, *supra* note 6.

[22] Daar, *supra* note 5.

[23] *Cf.* ROBERTSON, *supra* note 7, at 205 ("The avoidability of the need . . . poses more difficult issues.").

[24] In using the phrase "aggressive infertility treatment," I refer to treatment designed to maximize the chances of pregnancy. By calculating the dosage of ovulation induction drugs or transferring large numbers of embryos to a woman, a physician maximizes the chance of pregnancy, but also increases the risk of multiple pregnancy. The medical literature suggests that the development of selective reduction procedures has encouraged some fertility specialists to become more aggressive. *See* Evans, *Evolving Patterns*, *supra* note 8, at 1753 ("[I]t is . . . abundantly clear that for a small group of physicians and centers the use of ovulation-stimulating medications is very cavalier, with reduction seen as a relatively unimportant side effect of aggressive infertility therapy.").

producing a child genetically related to one or both of them, the couple deliberately seeks to create, and is potentially willing to deliberately destroy, fetal life.

In this scenario, a possible ethical affront lies in what Professor Shapiro calls "selfishness." He describes selfish conduct as creating a disproportionate risk of harms to others in order to advance the actor's personal needs or goals.[25] Here, one could argue that advancement of the goal sought—the creation of a child genetically related to its parents—creates a disproportionate risk of harm. One obvious potential harm is the termination of fetal life. The question of the magnitude of this harm lies at the center of the abortion debate, and attempts to achieve complete agreement on this question are almost certainly in vain. Nonetheless, even persons who disagree on the absolute level of harm associated with terminating fetal life may agree that the proportionality of the harm varies depending on the context in which the choice to terminate is made.[26] Were the loss of fetal life itself the only potential harm threatened by aggressive infertility treatment, it would be difficult to distinguish that treatment from an individual's decision to engage in unprotected sexual intercourse without a willingness to procreate. In both scenarios, the actors apparently assume a risk that the termination of fetal life may become necessary to achieve the actors' life goals. One might conclude that the assumption of that risk in the infertility treatment scenario is less troubling because it reflects an ardent (possibly selfless?) desire to create new life, as opposed to mere irresponsibility.

From another perspective, however, it is this very intent of the couple to create the fetal life that they are then willing to destroy that can be seen as risking an additional, symbolic harm. The image of persons desirous of being parents who deliberately create life, only to turn around and destroy the life just created, may have a powerful symbolic impact.[27] Furthermore, the use of aggressive infertility treatment smacks of a willingness on the couple's part to use human life, albeit unborn human life, instrumentally for no purpose other than to advance their own ends.[28] This threatened symbolic harm too must be

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[25] *See* Shapiro, *supra* note 1, at text accompanying note 65.

[26] For example, many persons with varying beliefs regarding the moral status of the fetus would likely agree that abortion is less troubling morally when a pregnancy threatens a woman's life than when a pregnancy threatens a woman's vacation plans.

[27] *See* Shapiro, *supra* note 1, at Part IX (discussing relevance of arguments based on symbolism).

[28] *See* Shapiro, *supra* note 1, at Part IV (discussing instrumental use of persons). It is not entirely clear exactly how Professor Shapiro would apply the second formulation of

considered in balancing the goal sought against the potential harms wrought. From this perspective, prospective parents' decision to use aggressive infertility treatment to maximize their chance for "success," while contemplating the availability of selective reduction should their efforts produce an overabundance of fetal life, may better fit Professor Shapiro's description of selfishness than, for example, a postmenopausal woman's decision to bear a child or a man's hiring a woman to act as a "surrogate" mother.[29]

By contrast, when a couple pursues aggressive infertility treatment *without* first having been fully informed of the risk of multiple pregnancy and the availability and nature of selective reduction, the treatment decision should give us ethical pause for a different reason. Although the medical literature's discussions of selective reduction do at times note the need to provide infertility patients with this information, anecdotal accounts from infertility patients indicate that the first time some couples learn about selective reduction is when a high order multiple pregnancy has already been diagnosed.[30] In these cases, the physician's failure to communicate places the couple in the position of having to make a grave moral decision—a position they might have chosen to avoid had they been informed prior to the commencement of treatment. Even worse is the scenario in which fertility specialists obtain consent to perform selective reduction of a multiple pregnancy without accurately advising a couple whose religion condemns abortion of the procedure's nature.[31]

Kant's categorical imperative (the "Formula") in this context. On the one hand, he suggests that the Formula's mandate to treat humanity as ends, and not means, "probably includes fetuses *scheduled* to be born." *Id.* at text accompanying note 153. On the other hand, his discussion of the Ayala case describes an aborted fetus as "not otherwise scheduled to be born." *Id.* at text accompanying note 208. Thus, he seems to suggest, without making explicit his rationale, that only fetal life that is not deliberately terminated should be part of the Formula's calculus.

[29] *See* Shapiro, *supra* note 1, at Parts IIID2 and IIID4 (discounting selfishness argument in these scenarios).

[30] *See, e.g.*, Kevin Simpson, *Modern Technology of Fertility Drove the Hardest Bargain*, DENVER POST, July 18, 1995, at B1. *Cf.* Daar, *supra* note 5, at 739 (quoting physician who said he does not inform infertility patients of the possible need for and availability of selective reduction before commencing treatment).

[31] In her comments at the Symposium, Janet Benshoof, President of the Center for Reproductive Law & Policy, alluded to one program in Utah where physicians transferred eight embryos to a woman and then, when she was diagnosed with a high-order multiple pregnancy, advised her that they could "take care of it" without explicitly informing her that the proposed solution involved terminating fetal life. Janet Benshoof, Address at the *Hastings Law Journal* Symposium (Feb. 10, 1996).

Cases in which aggressive infertility treatment is pursued without true informed consent are emblematic of the harms that can flow from a "system" of infertility treatment too often powered by the twin engines of desire: the providers' desire for profit and prestige and infertile couples' desire for genetically related children.[32] More seems to be at stake here than in a garden variety informed consent case. The failure to inform infertility patients of the risks, including medical, psychological,[33] social, and ethical risks, of multiple pregnancy and selective reduction represents a more serious affront to the patients' dignity as autonomous individuals—to their *personhood*—than does a failure to inform in a case involving risks more purely medical in nature. This is true because, as developed below, respect for autonomy is most vital to personhood when the decision at issue involves not simply any choice among alternatives, but a choice that implicates an individual's deeply held values and beliefs.

II. Prenatal Genetic Testing

Unlike selective reduction, which remains an extreme response employed in a relatively small number of cases, prenatal genetic testing to enable selective abortion for genetic anomalies has become part of standard obstetrical practice, both as an adjunct to assisted reproduction and in prenatal medical care more generally.[34] As part of this Symposium, Professor Andrews has provided impressive empirical support for a variety of impacts that prenatal genetic testing can have on women.[35] Further consideration of the practice, however, is appropriate in response to Professor Shapiro, for prenatal genetic testing

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[32] *See* Trip Gabriel, *High-Tech Pregnancies Test Hope's Limit*, N.Y. TIMES, Jan. 7, 1996, at 1.

[33] *See* Patricia Schreiner-Engel et al., *First Trimester Multifetal Pregnancy Reduction: Acute and Persistent Psychologic Reactions*, 172 AM. J. OBSTETRICS & GYNECOLOGY 541, 545-46 (1995) (assessing the emotional reactions and attitudes of women who underwent selective reduction).

[34] *See* Lois Shephard, *Protecting Parents' Freedom to Have Children with Genetic Differences*, U. ILL. L. REV. 761, 776 (1995) (stating that prenatal testing has been elevated to the standard of care found in reproductive health care); Abby Lippman, *Prenatal Genetic Testing and Screening: Constructing Needs and Reinforcing Inequities*, 17 AM. J.L. & MED. 15, 19 (1991) ("Prenatal diagnosis, already designated a 'ritual' of pregnancy, at least for white, middle-class women in North America, is the most widespread application of genetic technology to humans today."). *See generally* Michael J. Malinowski, *Coming into Being: Law, Ethics, and the Practice of Prenatal Genetic Screening*, 45 HASTINGS L.J. 1435 (1994). Some of the concerns discussed herein with respect to prenatal genetic testing may also be raised by preimplantation genetic testing and pre- or postnatal gene therapy for enhancement purposes if those practices come to be widely available.

[35] *See generally* Andrews, *supra* note 4.

often engenders critiques raising selfishness and objectification concerns of the type he describes. These critiques argue that prospective parents are acting to further their own selfish desires and to satisfy their consumeristic preferences by seeking to influence the traits that their offspring will have. Critics further fear that those actions will erode the ideally noncontingent bonds between parent and child.[36]

In addition, persons concerned with societal attitudes toward persons with disabilities have voiced the argument that prenatal genetic testing and selective abortion reinforce oppressive attitudes toward persons with disabilities and implicitly devalue persons with those traits tested for.[37] The message sent, from this perspective, is that a child with the condition would be unacceptable to the prospective parents. This devaluation appears more subtly in the promotion of prenatal genetic testing as allowing prospective parents to ensure that they will have "healthy" children.[38] This rhetoric of good health fails to acknowledge that some traits screened for do not necessarily affect a child's health, although they may impair the child's abilities.[39] A perfectly healthy child with Down syndrome or with deafness comes to mind. Viewed in this light, the appeal to good health, while unobjectionable on its face, may promote eugenic attitudes that individuals

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[36] *See* Nancy (Ann) Davis, *Reproductive Technologies and Our Attitudes Towards Children*, 9 LOGOS 51, 59-60 (1988); *cf.* Rochelle Cooper Dreyfuss & Dorothy Nelkin, *The Jurisprudence of Genetics*, 45 VAND. L. REV. 313, 320 (1992) ("With the availability of new reproductive technologies, choosing a baby can become like catalog shopping."); Lippman, *supra* note 34, at 23 ("Prenatal diagnosis does approach children as consumer objects subject to quality control.").

[37] *See* Adrienne Asch, *Reproductive Technology and Disability*, *in* REPRODUCTIVE LAWS FOR THE 1990s 69, 83-85 (Sherrill Cohen & Nadine Taub eds., 1989); Marsha Saxton, *Prenatal Screening and Discriminatory Attitudes about Disability*, 13 WOMEN & HEALTH 217 (1988); Angus Clarke, *Is Non-Directive Genetic Counselling Possible?*, 338 LANCET 998, 1000-01 (1991).

[38] *See generally* Laura Purdy, *Loving Future People*, *in* REPRODUCTION, ETHICS AND THE LAW 300, 313 (Joan Callahan ed., 1995); *cf.* Malinowski, *supra* note 34, at 1453 (noting medicalization of choices created by prenatal genetic testing and the premium our society places on normalcy). Moreover, as Ruth Hubbard has pointed out, focusing on prenatal testing and selective abortion to promote healthy children ignores that maternal age and poverty, and not genetics, are the main predictors of disability or disease for newborns and young children. "It makes no sense to be putting resources into learning how to diagnose relatively rare diseases so as to prevent the babies who have them from being born, while we permit potentially healthy babies to be disabled for reasons that are well understood and preventable." Ruth Hubbard, *Eugenics: New Tools, Old Ideas*, 13 WOMEN & HEALTH 225, 233 (1988).

[39] *Cf.* Saxton, *supra* note 37, at 221-22 (making similar point regarding the stereotype associating "suffering" and disability).

with some disabilities are properly excludable, not only from society, but also from existence.[40]

A third, less often voiced concern regarding prenatal genetic testing and selective abortion is that the practice encourages reductivism. This point draws on the theory of cognition that practices may have learning effects on social attitudes, a theory of described elsewhere by Professor Shapiro.[41] Here, the concern is that using prenatal testing for trait selection (or deselection) purposes will encourage the identification of a specific child with his selected trait(s) or, more generally, the identification of all persons with their selectable traits.[42] The identification of individuals primarily with a single, physical trait rather than with their personhood is precisely opposed to disability rights advocates' efforts to promote "people first" language in describing persons with disabilities.[43]

Even if the practice of prenatal genetic testing and selective abortion does not lead society to reduce individuals to a single selectable trait, the proliferation of the practice may more subtly encourage society to disassemble persons (or, more properly, the concept of per-

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[40] *Cf.* Hubbard, *supra* note 38, at 231-32 (characterizing as eugenic the idea that humans have "any right to determine who should and should not inhabit the world"); Lippman, *supra* note 34, at 24-25 (characterizing disclaimer of eugenic motive as disingenuous).

[41] *See* Michael H. Shapiro, *Fragmenting and Reassembling the World: Of Flying Squirrels, Augmented Persons, and Other Monsters*, 51 OHIO ST. L.J. 331, 352 (1990) [hereinafter *Flying Squirrels*]; *see generally* Michael H. Shapiro, *How (Not) to Think About Surrogacy and Other Reproductive Innovations*, 28 U.S.F. L. REV. 647 (1994).

[42] Susan Wolf recently made this point in the context of discussing health insurers' use of genetic information about individuals:

> [T]he social practice [of drawing genetic conclusions about individuals] involves creating genetic categories, actively looking for any kind of information about people in order to sort them into those categories, and harboring attitudes and prejudices that motivate such behavior. Thus, it is systematic, not just individual; a matter of cognitive mindset, not just isolated behaviors; and a domain of stereotypes and unfounded beliefs, not just accuracy and rationality.

Susan M. Wolf, *Beyond "Genetic Discrimination": Toward the Broader Harm of Geneticism*, 23 J.L. MED. & ETHICS 345, 347 (1995).

Richard McCormick makes the point with respect to preferential breeding for superior genotypes. "[T]he most glaring defect in preferential breeding is the perversion of our own attitudes: we begin to value the person in terms of the trait that he or she was programmed to have. We reduce the whole to a part." Richard A. McCormick, *Blastomere Separation: Some Concerns*, HASTINGS CENTER REP., Mar.-Apr. 1994, at 15; *see also* Lippman, *supra* note 34, at 18.

[43] The "people first" approach prefers describing a person who has a disabling condition as a "person with a disability," rather than a "disabled person." For example, the preference is for a "child with mental retardation" over a "mentally retarded child" and for a "person with a spinal cord injury" over a "quadriplegic." *See* Allan H. Macurdy, *Disability Ideology and the Law School Curriculum*, 4 B.U. PUB. INT. L.J. 443, 443 n.1 (1995).

sons)[44] into their traits and, consequently, to see persons as nothing more than the sum of their parts (i.e., traits), rather than as something greater than the sum of their parts.[45] The possibility of reductivism appears particularly troublesome for two reasons. First, it threatens the loss of an intangible aspect of how we view our fellow humans. Our very respect for the dignity of the individual, a respect on which liberal society is based, seems premised on our understanding that each individual represents a unique bundle of humanity or, stated differently, that each individual is greater than the sum of his or her parts. If, by contrast, we were to view our children or the persons with whom we interact in society as simply a combination of traits, then persons with similar traits would begin to appear largely fungible, and we would lose an important sense of the humanity and individuality of persons.[46]

Second, reducing our understanding of individuals to the sum of their traits also threatens to create new, and exacerbate existing, bases for social division.[47] Many of the seemingly intractable social divisions of our day are traceable, at least in part, to social groups focusing on one "part" of individuals (for example, their race, ethnicity, religion, or sexual orientation), rather than on their humanity. It is easy to hate and castigate a label; it is more difficult to hate an individual when one views that individual as being a bundle of humanity—with joys, fears, dreams, concerns, vulnerabilities, and strengths.

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[44] Michael Shapiro previously has described how technology may lead to the breakdown or disassembly of existing conceptual systems or moral frameworks. *See* Shapiro, *Flying Squirrels*, *supra* note 41, at 352; *see generally* Michael H. Shapiro, *The Technology of Perfection: Performance Enhancement and the Control of Attributes*, 65 S. CAL. L. REV. 11 (1991).

[45] Professors Dreyfuss and Nelkin cite a striking example of this reductivist attitude: During a presentation on the Human Genome Project, a researcher pulled out a compact disk and announced to his audience, "This is you." *See* Dreyfuss & Nelkin, *supra* note 36, at 319.

[46] Professors Dreyfuss and Nelkin have discussed a related concern, which they label "genetic essentialism." Dreyfuss & Nelkin, *supra* note 36, at 320-21. They describe "genetic essentialism" as positing "that personal traits are predictable and permanent, determined at conception, 'hard-wired' into the human constitution." *Id.* While Professors Dreyfuss and Nelkin broadly acknowledge that "[g]enetics has profoundly altered the perception of personhood within our culture," their article focuses principally on how genetic essentialism affects normative constructs of community, responsibility, and opportunity embodied in our legal system. *Id.* at 315.

Similarly, Professor Lippman has described "geneticization" as "an ongoing process by which differences between individuals are reduced to their DNA codes, with most disorders, behaviors and physiological variations defined, at least in part, as genetic in origin." Lippman, *supra* note 34, at 19.

[47] *Cf.* Wolf, *supra* note 42, at 347-49 (comparing "geneticism" to racism and sexism).

By encouraging us to conceptually break down persons into traits, prenatal genetic testing threatens to reinforce our existing and destructive reductivist tendencies.

Now, at this point in my commentary, I can almost hear Professor Shapiro interrupting to raise a concern: "Isn't this whole line of reasoning rather speculative?" Of course it is. While Lori Andrews has commandeered an impressive amount of empirical data on how prenatal genetic testing affects the culture of motherhood, I have no hard evidence that prenatal genetic testing and selective abortion lead to reductivist attitudes. I am not convinced, however, that the label "speculative" must be seen as damning all arguments in this context. To consider the potential impact of procedures not yet in common practice, such as gene therapy for enhancement purposes, it seems we must speculate. And even when we consider practices already increasingly widespread, like prenatal genetic diagnosis and selective reduction, prudence would counsel us to try to anticipate untoward consequences, so that we can try to avert those consequences to the extent possible. After all, an ounce of prevention is worth a pound of cure.

III. A Focus on Context

So where do these speculations leave me? They leave me concerned that some practices employed in conjunction with the new reproductive technologies risk the erosion of our sense of the humanity and individuality of persons and our sense of connection between parent and child. That said, I hasten to add that I recognize that, of course, the values, the intuition, the sense of proportion, and (with all due apologies to Professor Shapiro) the cognitive errors displayed in this commentary are only my own. Consequently, I do not presume to assert that the specific practices addressed in this commentary should be prohibited based on the concerns articulated; nor do I suggest that the use of selective reduction or prenatal testing is necessarily a basis for ethical criticism of the actors involved. The motivations and circumstances involved in reproductive decision making are far too varied for across-the-board judgments.

What I will assert, however, is that we who are concerned about the impact of assisted reproduction on our sense of personhood could find value in paying closer attention to the context in which persons considering whether and how to employ new reproductive technologies make their decisions.[48] Specifically, I propose that we should be spending more time thinking and talking about how those contexts might be shaped to encourage meaningful information transmission, values clarification, and reflection. We should be concerned about what goes on in the fertility clinics and the genetic counselor's office and other venues in order to ensure that persons seeking assistance get the information they need to make decisions—information not only about medical risks and benefits, but also about the psychological, social, and ethical implications of their decisions.

Beyond attending to the immediate context of decisions, we need—and this is a much larger task—to occupy ourselves with the larger social, cultural, and economic context in which women make reproductive choices.[49] The purpose of improving the immediate decision-making context is to allow women and couples to reach thoughtful decisions consistent with their values, beliefs, and desires. To the extent that economic or social constraints impede women's ability to implement these decisions, however, the increased attention to immediate context will not truly enhance "free choice,"[50] and indeed, in some cases, may only create heartache.[51]

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[48] I am not the first to suggest the importance of the context in which decisions regarding the use of reproductive technologies are made. *See, e.g.*, ROBERTSON, *supra* note 7, at 233 (suggesting ways to attempt to assure the responsible use of reproductive technologies); Rayna Rapp, *Chromosomes and Communication: The Discourse of Genetic Counseling*, *in* NEW APPROACHES TO HUMAN REPRODUCTION: SOCIAL AND ETHICAL DIMENSIONS 25, 25 (Linda M. Whiteford & Marilyn L. Poland eds., 1989) (exploring the social impact and cultural interpretations of prenatal diagnosis in the context of genetic counseling).

[49] *See* Lippman, *supra* note 34, at 49 (stressing importance of considering prenatal testing decisions in relation to "time and place and . . . the broader health and social policy agenda of which they are a part"); *cf.* Joan Williams, *Gender Wars: Selfless Women in the Republic of Choice*, 66 N.Y.U. L. REV. 1559, 1561 (1991). As Professor Williams argues:

> [F]eminists need to become more self-conscious about the gender eddies that swirl around the rhetoric of choice. . . . [O]f course, choice always occurs with constraints. Where one's goal is not to defend a realm of freedom currently enjoyed, but to challenge the constraints limiting that "freedom," the rhetoric of choice helps reinforce the gender structures feminists need to challenge.

Id.

[50] *See* Lippman, *supra* note 34, at 32, 35 (giving example of a woman who may feel compelled to terminate a pregnancy not because she sees the diagnosed genetic anomaly itself as a reason for abortion, but because of her financial inability to provide for the child's special needs).

[51] Barbara Katz Rothman, in writing about women's experience with amniocentesis, describes the illusory nature of "choice" exercised within constraints.

> The whole thing about the new technology that they [women] are offered is that it gives choice. That is what it is all about, after all, the opening up of new reproductive choices. But for most women the choices are all so dreadful that trying to find one she can live with is terribly hard. Taking the least-awful choice

If we were to pay more heed to the context—both immediate and broader—in which decisions regarding the new reproductive technologies are made, what might happen? In some cases, we might see couples deciding to limit the number of embryos transferred to the woman following IVF to two or three, even though that limitation would lower the odds of a successful pregnancy.[52] Nonetheless, some couples might decide that they are willing to accept the lower odds in return for assuredly avoiding a high order multiple pregnancy and the dilemma posed by the availability of selective reduction.[53]

Or, if we paid more regard to context, we might see more pregnant women consciously focusing on whether the traits for which they are considering prenatal testing would significantly detract from their reasons for choosing to bring new life into the world, rather than simply acceding to social, medical, or financial pressures to engage in testing.[54] As Adrienne Asch thoughtfully reflects:

> is not experienced as "choosing," not really. It is experienced as being trapped, caught.
>
> . . . .
>
> These women are not the villains some would have us believe, aborting fetuses it would be inconvenient to raise, searching for the "perfect" child. They are the victims. They are the victims of a social system that fails to take collective responsibility for the needs of its members, and leaves individual women to make impossible choices. We are spared collective responsibility, because we individualize the problem. We make it the woman's own. She "chooses," and so we owe her nothing.

BARBARA KATZ ROTHMAN, THE TENTATIVE PREGNANCY: HOW AMNIOCENTESIS CHANGES THE EXPERIENCE OF MOTHERHOOD 180-81, 189 (1993).

[52] In England a regulatory body (the Human Fertilisation and Embryology Authority) restricts most transfers to no more than three embryos. Robert M.L. Winston & Alan H. Handyside, *New Challenges in Human In Vitro Fertilization*, 260 SCIENCE 932, 932 (1993). Of course, this approach of limiting the number of embryos transferred provides little ethical comfort for persons who view in vitro embryos as morally equivalent to ten week old fetuses, for if a successful pregnancy does result from the initial transfer, the untransferred, "surplus" human embryos may be destroyed. In order to avoid the ethical dilemma, persons believing in the sanctity of in vitro human embryos could choose either to donate untransferred embryos to another infertile person, rather than destroying them, or simply attempt to fertilize no more than three oocytes as part of a single cycle of IVF.

[53] When hyperstimulation of the ovaries is followed by insemination, and not in vitro fertilization, the risk is less controllable. The medical literature suggests that monitoring of hormone levels, in combination with ultrasonography, may be able to reduce, but not totally eliminate, the risk of high order multiple pregnancy by monitoring follicular development. Evans, *Evolving Patterns*, *supra* note 8, at 1753.

[54] *See* Andrews, *supra* note 4, at Part I (citing to empirical evidence of pressures). Simply by creating a choice and thus establishing responsibility for the consequences of the choice made, prenatal testing may place pressures on women to undergo testing and to abort when testing shows a disability. "If a test is available and a woman doesn't use it, or completes the pregnancy although she has been told that her child will have a disability, the child's disability is no longer an act of fate. She is now responsible; it has become her

> We all . . . must honestly acknowledge what we value and individually seek in being parents. . . . Seeking to avoid the experience of raising disabled children is no crime or callous, selfish statement, as some may claim. It is an honest, understandable, if perhaps misinformed, response to the fears that a disabled child will not fulfill what most women seek in mothering . . . . Let us frame our thinking about prenatal diagnosis and selective abortion in a sincere discussion of what we long for in the experience of having children. Let us then ask how a child's disability will compromise that dream.[55]

Ultimately, though, the reason I advocate attending to questions of context is not because that attention will necessarily produce outcomes that are "better" or less threatening to personhood. Rather, by shaping contexts that encourage moral reasoning and reflection, we will buttress our humanity and our understanding of personhood against any assaults that the new reproductive technologies might mount.

To illustrate my point, let me offer a parable. Let us imagine that we all dwell together in Fort Personhood, a special spot in the universe that we love dearly and wish to protect. One day, we spy on the horizon masses of persons mounted on horses riding toward us with great haste. As we in Fort Personhood do not know with certainty whether these intruders are friend or foe, we are somewhat uneasy: What if they are coming to do harm to Fort Personhood? We could respond by immediately taking steps to repel the trespassers, to make sure we beat them away before they can do any harm. Of course, this approach bears a risk, for they may be bringing us goodwill and gifts that would enhance our common life in Fort Personhood. It seems unwise to act decisively—either to greet or to repel—until we have a better sense of whether the invaders bring us good or ill. So what can we do in the meantime? My suggestion is to strengthen and build up our walls. Fortifying the walls of Fort Personhood can only help us.

Returning to the possible threats to personhood posed by reproductive technologies: We can build up our walls by paying attention to the context that surrounds decisions about the uses of those technologies. After all, the ability to engage in moral reasoning is an attribute that most would agree is central to our personhood, and the self-definition that occurs through the process of values-based reasoning makes us more human irrespective of the outcomes that are reached.

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fault." Hubbard, *supra* note 38, at 232. Of course, this line of reasoning raises the question whether a woman who knowingly brings into the world a child with a severe genetic anomaly should bear some legal liability to the child.

[55] Asch, *supra* note 37, at 86.

Accordingly, our focus on shaping contexts should have the purpose of encouraging moral reasoning and conscience searching by the individuals involved in the process, not of attempting to promote certain outcomes. In this respect, I echo those who stress the importance of respecting individuals' liberty to make reproductive decisions for themselves. At the same time, however, simply exercising the right to choose among alternatives does not by itself further the ideal of autonomy that most strengthens our personhood.[56] Instead, the autonomy that we should value most highly in this context depends upon educated, reflective, and values-based decision making.[57]

Although I leave to another day the task of describing how we can shape contexts to achieve the desired goal of strengthening our personhood, let me offer a few preliminary ideas. Although I stress the importance of individual decision making, some role for regulatory action or professional standards may be appropriate *if* those actions and standards are designed to enhance individual decision making, and not to promote a certain outcome. Examples may include the development of professional standards by obstetricians and fertility specialists, perhaps in conjunction with psychologists and social workers, regarding a baseline of information that should be provided to prospective patients who seek infertility treatment, and the formation of support groups for infertility patients that encourage discussion of ethical and societal issues. Or perhaps fertility clinics could be required to pay the salary of counselors, who would operate under the aegis of an independent agency, to provide counseling for clinic patients.

A rich dialogue has already emerged regarding the role of genetic counselors in counseling women and couples with respect to prenatal diagnosis. While general agreement exists that counseling should be nondirective in scrupulously respecting patient autonomy, some commentators argue that nondirectiveness should not be conflated with

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[56] To illustrate with an extreme example: A person who bases all binary decisions in his life on the outcome of coin tosses is exercising his right to decide among alternatives. His choices, however, presumably will reflect little of his personal values and goals (except, perhaps, some commitment to arbitrary decision making), and this process of choosing is unlikely to contribute to his development of a sense of personal identity. Moreover, I would guess that most people would find such a practice unfathomable, and probably inconsistent with how we expect persons to act. *Cf.* Shapiro, *supra* note 1, at text accompanying note 19 (discussing aspects of autonomy).

[57] I recognize that I am describing an ideal of autonomy, and I do not suggest that the autonomy of persons acting in a less reflective manner is undeserving of respect. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 121-24 (4th ed. 1994) (discussing theories of autonomy).

moral neutrality.[58] In other words, the genetic counselor may play an important role in identifying, and helping the patient autonomously address, the ethical and social issues raised.[59] This growing scholarly attention to the role of values in genetic counseling, however, is taking place against the backdrop of a practical recognition of the enormous difficulties in assuring that the growing number of pregnant women for whom prenatal diagnostic services are offered receive even minimally acceptable counseling.[60]

Many challenges await us if we seek to shape the contexts in which reproductive decisions are made in an effort to boost both the role of conscience and freedom of choice for individual patients. Doubtless, some models for what we might aspire to already exist.[61] Nonetheless, the current boom in the highly profitable market for infertility treatment has created contexts that are too often inimical to values-based reasoning. Thus, as we continue to explore the implications of new reproductive technologies, a worthy goal would be to ensure that *all* choices regarding the use of reproductive technologies are made in settings that enhance, rather than detract from, our personhood.

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[58] *See, e.g.*, Robert Wachbroit & David Wasserman, *Patient Autonomy and Value-Neutrality in Nondirective Genetic Counseling*, 6 STAN. L. & POL'Y REV. 103 (1995) (arguing that nondirective patient counseling does not require value-neutrality); Arthur R. Caplan, *Neutrality is Not Morality: The Ethics of Genetic Counseling*, *in* PRESCRIBING OUR FUTURE: ETHICAL CHALLENGES IN GENETIC COUNSELING 149 (Dianne M. Bartels et al. eds., 1993) (arguing that the time has come to abandon the ethic of moral neutrality in genetic counseling).

[59] In addition to the issues suggested in this commentary, the coincidence of increasing prenatal diagnostic capabilities with mounting pressures to contain medical costs is likely to present an issue that will challenge the moral neutrality of genetics counselors. "Political pressure for genetic counselors to take a normative stance, which accommodates society's need to decrease the cost of diseases and disorders with strong hereditary origins, will escalate as more becomes known about the role played by heredity in human health." Caplan, *supra* note 58, at 155-56.

[60] Professor Andrews has noted:

> Increasingly, prenatal diagnostic services are being provided not in genetic centers, but in private hospitals and clinics, and or in the offices of obstetricians and family physicians. There is little standardization in how services are provided, and the majority of women undergoing prenatal testing may receive only a subset of the counseling previously described [as desirable]. Some receive group counseling with or without individual assessment and counseling, some receive written information, and some receive information over the telephone prior to testing. Procedures for informed consent also vary widely.

ASSESSING GENETIC RISKS: IMPLICATIONS FOR HEALTH AND SOCIAL POLICY 168 (Lori B. Andrews et al. eds., 1994) (citation omitted).

[61] Dr. Mary Martin's description of the education and values clarification process that she goes through with patients at UCSF's IVF program comes to mind. *See* Mary Martin, M.D., Address at the *Hastings Law Journal* Symposium (Feb. 10, 1996).