A DIFFICULT CHOICE IN A DIFFERENT VOICE:† MULTIPLE BIRTHS, SELECTIVE REDUCTION AND ABORTION

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I. INTRODUCTION

Multiple births have been in the news lately, with sextuplets,[1] septuplets,[2] octuplets[3] and more[4] grabbing newspaper and magazine headlines across the nation and the world,[5] and provoking discussion and controversy.[6] But equally

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† Reference here and throughout this Article to "a different voice" draws on the psychological theories of Carol Gilligan articulated in her still timely and influential book. *See* CAROL GILLIGAN, IN A DIFFERENT VOICE (1982).

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1. *See, e.g.*, Byrna L. Bates, *Miracle Births: The Tide Finally Turns for the Surviving Sextuplets*, EBONY, Feb. 1, 1998, at 38. *But see* discussion of deaths of three sextuplets and disability of two survivors, *infra* note 127.

2. *See, e.g.*, Kathryn Casey, *Oh Baby: Meet the McCaughey Septuplets*, LADIES HOME J., June 1, 1998, at 138; Marc Peyser & Jay Wagner, *Happy Birthday Babies (update on McCaughey septuplets as they celebrate first birthday)*, NEWSWEEK, Nov. 16, 1998, at 76; Chana Stiefel, *Seven Up! (Bobbi McCaughey Successfully Gave Birth to Seven Babies, November 1997)*, SCI. WORLD, Feb. 23, 1998, at 4; Nicole Walker, *Miracle Parents and Doctors: Two High-Risk Specialists Deliver Iowa Septuplets*, EBONY, Feb. 1, 1998, at 39.

3. *See, e.g.*, Claudia Kalb, *Families: The Octuplet Question*, NEWSWEEK, Jan. 11, 1999; Mark Babineck, *Mom Heading Home—Surviving Octuplets to Stay in Hospital* (Dec. 30, 1998) <http://www.abcnews.go.com/sections/us/DailyNews/octuplets981230.html>.

4. *See, e.g.*, *Malaysian Mother Gives Birth to Nine Babies but None Survive*, Associated Press Newswires, March 27, 1999; *Tragic Mum Has Nine Babies*, SUNDAY MAIL (Scotland), Mar. 28, 1999, at 18 ("A woman equaled a world record by giving birth to nine babies in Malaysia—but none survived . . . The multiple birth record was set in Sydney, Australia. None of the babies lived more than six days."); *Zurina Sad None of Her Nine Babies Survived*, BERNAMA (Malaysia Nat'l News Agency), Mar. 27, 1999.

5. *See Malaysian Mother Gives Birth to Nine Babies but None Survive*, *supra* note 4, *Tragic Mum Has Nine Babies*, *supra* note 4; *Zurina Sad None of Her Nine Babies Survived*, *supra* note 4; *see also* Mark Nichols, *Clinging to Life: The Surviving Octuplets' Chances are Improving*, MACLEAN'S, Jan. 11, 1999, at 66.

6. *See* Dorothy J. Barnhouse, *Birth of Octuplets Reignites Fertility Debate*, N.Y. TIMES, Jan. 5, 1999, at F7; Ezekiel J. Emanuel, *Eight is Too Many*, NEW REPUBLIC, Jan. 25, 1999, at 8; Maura Lerner, *Multiple Births Provoke Debate—Health and Ethics Experts Question Fertility Treatments That Preceded Iowa Septuplets and Houston Octuplets*, STAR TRIB. (Minneapolis-St. Paul), Dec. 23, 1998, at 1A; Mary McNamara, *America Has a Family Argument*, L.A. TIMES, Dec. 30, 1998, at E1 ("To some, the octuplets

deserving of the media spotlight and equally provocative are the less sensational stories of women who have *not* delivered large batches of babies, women who were pregnant with multiple fetuses and who "chose"[7] to selectively reduce the number they were carrying to a safer[8] and more manageable[9] size.

Selective reduction or selective termination are the terms used[10] to describe the procedure of "aborting one or more of the fetuses in a multiple gestation, while allowing the remaining one or more to develop."[11] While the effect is tantamount to aborting the targeted fetus(es),[12] both parallels to and distinctions from abortion have been drawn.[13] "[S]elective reduction involves inserting a

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are a miracle; to others, eight is more than enough. But we all feel compelled to take a stand."); Editorial, *Reproductive Science and Ethics*, CHI. TRIB., Dec. 24, 1998, at 1 ("[T]he current story out of Houston, about the birth last weekend of octuplets—eight babies!—to a 27-year-old woman is disturbing, because it raises serious questions about medical ethics, or the lack of them, in an era when technology has given doctors the ability to work 'miracles' for desperate would-be parents."); E. Scott Sills & Mark Perloe, *Eight is Enough* (visited Jan. 21, 2000) <http://www.obgyn.net/english/pubs/features/ eight-is-enough.htm>; *see also* Robert Scheer, *Iowa Seven, Houston Eight: A Difference—Only Racism Explains Some Reactions to the Year-Apart Multiple Births*, L.A. TIMES, Dec. 29, 1998, at B7. Sheer posits that the different societal reactions to the births of the McCaughey septuplets and the Chukwu octuplets can be explained by the race of the octuplets:

> Whatever the reason, the decline in wonderment and concern this time around is startling. Whereas the media trumpeted every burp in the septuplets' lives as proof of a miracle to an eagerly expectant world, one is hard pressed to find any news of the black babies. . . . Now, the emphasis of reporting is on the cost—an estimated $250,000 per child—to get through the first year of life and the dim prospects for children of large multiple births.

Id.

7. *See* discussion about why the word "select," and consequently the word "choose," are inaccurate, *infra* notes 16-18.

8. *See infra* note 20 discussing maternal and fetal risks attaching to multiple gestation.

9. *See* Sills & Perloe, *Eight is Enough* (visited Jan. 21, 2000) <http://www.obgyn.net/english/pubs/features/eight-is-enough.htm> ("Selective fetal reduction . . . destroys some of the fetuses in the womb during early gestation in the hopes of . . . making for a more manageable pregnancy and birth.").

10. Most articles use the term selective reduction of multi-fetal pregnancies. Some authors have given different names to different procedures, and distinguish between selective reduction and selective termination. *See* Mary V. Rorty & JoAnn V. Pinkerton, *Elective Fetal Reduction: The Ultimate Elective Surgery*, 13 J. CONTEMP. HEALTH L. & POL'Y 53, 55 (1996) (defining multi-fetal pregnancy reduction ("MFPR") as "first trimester procedures performed as a result of sheer fetal number," a procedure that has also been called "embryonic reduction," "selective embryo reduction," "selective reduction of multifetal pregnancies," and "selective abortion in multiple pregnancy"; MFPR is distinguished from selective termination ("ST"), a second-trimester procedure dealing with fetal abnormalities, usually for genetic reasons rather than as a result of sheer fetal number). Selective termination, as it is defined by Rorty and Pinkerton, is beyond the scope of this article. *See infra* note 34.

11. Diane M. Gianelli, *New York Panel Urges Stricter Controls Over Fertility Clinics*, AM. MED. NEWS, May 18, 1998, at 3. Selective pregnancy reduction has also been defined as "a medical procedure used to reduce a multiple pregnancy, often a multiple pregnancy induced by in vitro fertilization or drug therapy. In such instances, healthy embryos are sacrificed in order to maximize the chances of survival of the remaining embryos or to allow the mother to choose the number of babies she wishes to deliver." Elizabeth Villiers Gemmette, *Selective Pregnancy Reduction: Medical Attitudes, Legal Implications, and a Viable Alternative*, 16 J. HEALTH POL., POL'Y & L. 383, 383 (1991).

12. *See* Arthur Allen, *Too Many Babies*, GLAMOUR, Nov. 1998, at 286, 317 (describing selective reduction as "half an abortion").

13. *See* Judith F. Daar, *Selective Reduction of Multiple Pregnancy: Lifeboat Ethics in the Womb*, 25 U.C. DAVIS L. REV. 773, 796 (1992).

needle through the woman's abdomen into one of the gestational sacs. The needle is then maneuvered into the fetal chest, and if possible, into the fetal heart, where potassium chloride is injected."[14] In most cases, fetal cardiac arrest occurs immediately, but if it does not, the procedure is repeated, lest the fetus survive in a state of "permanent damage."[15]

The term "selective reduction" is itself a misnomer[16] for two reasons: first, it implies that a woman selects which particular fetuses to carry to term and which to terminate, when in fact this decision is generally dictated by proximity of the fetus to the uterine wall;[17] second, it overstates the ultimate choice available to a woman pregnant with multiple fetuses,[18] when most often the decision to selectively reduce is seemingly forced upon her by medical practitioners[19] and by the precariousness of her situation.[20] Despite the problems inherent in the term

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14. *Id.* at 780.

15. William Walters, *Selective Termination in Multiple Pregnancy*, 152 MED. J. AUSTL. 451, 452 (1990).

16. *See generally* Richard L. Berkovitz & Lauren Lynch, *Selective Reduction: An Unfortunate Misnomer*, 75 OBSTETRICS & GYNECOLOGY 873 (1990). *But see* Daar, *supra* note 13, at 779, n.26 (arguing that "selective reduction" is an appropriate and accurate term for two reasons: first, a woman can "select" or "choose" the option of reducing her multifetal pregnancy, and second, "a woman, in consultation with her physician, should select the number of fetuses to be reduced").

17. *See* Berkovitz & Lynch, *supra* note 16, at 873 (stating that the decision about which fetus(es) to terminate is based on accessibility, so no intentional selection of one fetus over another occurs, with the exception of deliberate selection where a prenatal diagnostic technique like amniocentesis detects an anomalous fetus). *But see* Lynne Marie Kohn, *Sex Selection Abortion and the Boomerang Effect of a Woman's Right to Choose: A Paradox of the Skeptics*, 4 WM. & MARY J. WOMEN & L. 91, 92-93 & 114 (1997) (discussing "gendercide" and the fact that "[s]ex selection abortion, or sex preselection as it may also be labeled, is rapidly becoming an acceptable family planning alternative for Americans").

18. In the selective reduction context, the choice seems largely out of the woman's hands; while no other party may have a recognized right to make a decision on behalf of the woman, third-party medical intervention and pressure in the decision is common. *See infra* note 19. In the abortion decision, however, the decision is plainly that of the woman alone. *See, e.g.*, People of Interest of S.P.B., 651 P.2d 1213 (Colo. 1982) (holding that father may not require mother to abort; his request for abortion does not relieve him of responsibility for child support after its birth); Molly Diggins, Comment, *Paternal Interests in the Abortion Decision: Does the Father Have a Say?*, 1989 U. CHI. LEGAL F. 377 (1989); Maria F. Walters, Note, *Who Decides?, The Next Abortion Issue: A Discussion of Father's Rights*, 91 W. VA. L. REV. 165 (1988).

19. *See* Allen, *supra* note 12, at 315 ("'We didn't have to make a choice,' says Scott as they wait. 'Our doctor said, 'You won't be able to carry them.' Our priority is Christine's survival. And better two babies than nothing.'"); *see also* David Finkel, *Dispatches From the Front in the War on Infertility—Behind Media Hype Over Multiple Births Lies a Painful Terrain*, PITT. POST GAZETTE, Apr. 4, 1999, at A4. Finkel describes the case of Dawn Solesi-Gross and her husband Michael, who lost five babies after repeated attempts at fertility treatments and a premature delivery:

> [I]nstead of celebrating, she and Michael were given more numbers to consider, more odds. The odds for twins to be born successfully . . . Reduce the number of fetuses to two, they were told, and the odds for success would increase substantially . . . 'You want to stick a needle through my stomach into my baby? And kill my baby?' Dawn said. 'What kind of choice is that? . . . It just wasn't a choice.'

Id.

20. Multiple pregnancies are associated with greater risks to both mother and children. *See, e.g.*, ROBERT BLANK & JANNA C. MERRICK, HUMAN REPRODUCTION, EMERGING TECHNOLOGIES, AND CONFLICTING RIGHTS 91-92 (1995) (pointing to particular risks posed by multiple pregnancies to older women undergoing IVF: "[M]ultiple pregnancies might produce an unbearable overload for

"selective reduction," however, it will be used throughout this Article, for it is a term that frequently recurs in the relevant literature.

Selective reduction of multi-fetal pregnancies is not a new topic, and it has been previously discussed in law journals.[21] It remains deserving of attention here, however, for two reasons. First, the problems posed are *not* disappearing and are even on the rise[22] as multiple births continue to make news,[23] and

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the cardiovascular and renal functions, among other body systems."); Louis C. Blumenfeld et al., *Retinopathy of Prematurity in Multiple-Gestation Pregnancies*, AM. J. OPTHAMOLOGY, Feb. 1, 1998, at 197; Mary A. Crossley, *Choice, Conscience and Context*, 47 HASTINGS L.J. 1223, 1224 (1996); Immaculada de Melo-Martin, *Ethics and Uncertainty: In Vitro Fertilization and Risks to Women's Health*, 9 RISK: HEALTH SAFETY & ENV'T 201, 211 (1998) (noting that "specific obstetric or pediatric risks, such as the use of caesarian sections, early labor, and low-birthweight children that are associated with multiple births" frequently are not mentioned to women); Eberhad Mueller-Heubach, *Complications of Multiple Gestation*, 27 CLINICAL OBSTETRICS & GYNECOLOGY 1003, at 1003 (1984) (noting that pregnancy with multiple gestation is a high-risk situation associated with increases in maternal complications, prenatal mortality and morbidity); Geoffrey Cowley & Karen Springen, *Multiplying the Risks*, NEWSWEEK, Dec. 1, 1997, at 48 (noting that when fetuses are crowded inside the womb, the gestation period is shortened: usually, the gestation period for a single fetus is approximately 37 to 40 weeks with about three and one-half weeks taken off for each additional fetus); Kenneth Walker, *High Multiple-Birth Trend Could Lead to Disasters*, CHI. SUN-TIMES, Aug. 2, 1998, at 40 ("Multiple pregnancies have always been associated with the whole range of textbook complications. The major problems are high blood pressure, hemorrhage and diabetes."). These risks are often not focused on in the media, which has tended to celebrate the miracle of multiple births. *See* Jane Simeone, *Letter to the Editor*, WASH. POST, Apr. 2, 1999, at A28. Simeone discusses the deaths of two of her three triplets who were born premature:

> After six years of infertility, I gave birth to triplets born at 25 weeks gestation. My eldest died at two and one-half days, my other daughter died at 15 days. I have a surviving son who is 21 months old. I pray that newspapers take the lead in showing reality that the television media will follow. I don't know all the answers, but I do believe that multiple births are being glorified when their 'success' is the minority and our sorrow is really the majority.

Id. See also Ulysses Torassa, *Saving Preemies Takes Toll on Nurses—Keeping Extremely Early Newborns Alive Tests Emotions, Ethics*, S.F. EXAMINER, Mar. 22, 1999, at A1. Torassa reports that some nurses have difficulty coping with the emotional strain caused by caring for premature infants who have serious health problems or who die:

> Several nurses said they were happy to be interviewed on the subject because they want people to be aware of the difficulties faced by tiny infants. They were concerned that too often the media focuses only on the miracle children and not on the many others who don't, or who end up poorly.

Id.

21. *See* Daar, *supra* note 13; *see also* Villiers Gemmette, *supra* note 11; Rorty & Pinkerton, *supra* note 10.

22. *See* Gianelli, *supra* note 11, at 25 ("Though the medical literature for years has advised the importance of minimizing the possibility of multiples, reported data indicate that the number of such pregnancies is rising."); Jeremy Manier, *Risky, Costly Multiple Births Not Inevitable*, CHI. TRIB., Dec. 23, 1998, at 1 ("[W]idely used fertility drugs [have been] linked to the dramatic increase in multiple births during the past two decades."); Laura Meckler, *Report Finds Large Increase in Multiple Births of Three, More*, SAN DIEGO UNION-TRIB., July 1, 1998, at A11 ("A record 6,000 babies were born in sets of three, four or more in 1996, a one-year leap of 19 percent and a huge jump from the days before fertility drugs."); Walker, *supra* note 20, at 40. Walker urges,

> Consider what's happened at Women's College Hospital. The number of triplets has increased 300-fold over the last five years because of this new technology . . . . [O]bstetricians used to be lucky if they saw two sets of triplets in their lifetimes. Now 180 have been seen in the last five years.

women continue to resort to selective reduction, albeit in a somewhat clandestine fashion.[24] Second, and more importantly, while selective reduction has been examined from a legal and an ethical standpoint,[25] it has not yet fully been explored from a psychological vantage point. The complexity of the decision and the emotional and psychological toll of selective reduction on a woman receiving treatments for infertility[26] warrant attention and should be considered in shaping future policy and law.

This Article will begin by addressing the analogy that has been drawn between abortion and selective reduction[27] by examining whether this analogy is appropriate, and why it falls short of aptly encapsulating the unique position of a woman pregnant with multiple fetuses. It will then briefly discuss how selective reduction is treated under the law. Next, it will analyze whether choice exists in selective reduction[28] by juxtaposing couples' narratives and personal experiences against Carol Gilligan's abortion study, a psychological study of women's construction of moral dilemmas.[29] It will also examine the psychological impact on women after they finalize and carry out their decisions. Finally, it will explore the problems that are unique to the context of selective reduction and that do not surface in the abortion debate.

Id. See also John Elliott, *High Order Multiple Gestations* (last modified Mar. 1., 1997) <http://www.perinatal.com/multiple/mult.html> ("There has been a dramatic increase in the occurrence of so called high order multiple gestations, those with triplets, quadruplets, quintuplets and beyond. Most of these pregnancies are created in the process of overcoming infertility. Assisted reproductive techniques account for greater than 95% of all high order multiples.").

23. *See supra* notes 1-5.

24. Fertility doctors and clinics do not widely publicize the frequency of selective reduction. *See* Allen, *supra* note 12, at 318. Allen claims that clinics are not properly warning women about the risk of multi-fetal pregnancy:

> Clinics may be alerting women to the chance of multiple births, but it's a decidedly mixed message. 'When you go to the fertility clinic and ask for rates of multiple births . . . they give you the number who gave birth to quads—not the number they impregnated with quads who then had reductions.'

Id. See also Editorial, *supra* note 6 ("[T]he best of [doctors] report no reduction in pregnancy rates, only in their rates of large multiple births. This ought to become standard practice."). *But see* Villiers Gemmette, *supra* note 11, at 384 (quoting Dr. Joseph Schulman, director of the Genetics and IVF Institute of Fairfax Virginia, who noted that "no one's attempting to hide it. No one's proud of doing it, but doctors see it as a medical necessity.").

25. *See supra* note 21; *see also* Shirley J. Paine et al., *Ethical Dilemmas in Reproductive Medicine*, 18 WHITTIER L. REV. 51 (1996); Daar, *supra* note 13, at 782, 820-21 (contemplating "a basic question pondered over time by moral philosophers and others: Is it ever right to do harm to one just to benefit another?").

26. Infertility has been defined as the failure to become pregnant after twelve consecutive months of unprotected intercourse. *See* U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, INFERTILITY: MEDICAL & SOCIAL CHOICES 25 (1988); *see also* SUSAN FALUDI, BACKLASH: THE UNDECLARED WAR AGAINST AMERICAN WOMEN 28 (1991) (suggesting that financially motivated, self-interested fertility specialists coined a self-serving definition of infertility, and positing that the cure for infertility is often time); Virginia Rutter, *Who Stole Fertility?*, PSYCHOL. TODAY, Mar. 13, 1996, at 46 (noting that many men deemed infertile "wound up needing only low-tech assistance, such as boxer shorts instead of briefs").

27. *See supra* notes 12-14.

28. *See* discussion of why the term selective reduction is a misnomer, *supra* notes 16-20.

29. *See* Gilligan, *supra* note †, at 64-105.

II. THE ABORTION ANALYSIS

A. Parallels and Pitfalls of the Analogy

Selective reduction simultaneously is and is not akin to abortion, but this is not the paradox it seems to be. "[F]ew would argue with the proposition that selective reduction bears some relation to abortion; both are surgical procedures performed on a pregnant woman for the purpose of terminating one or more fetuses."[30] Selective reduction has even been defined using the word "abortion."[31] The similarities, however, stop there.

Selective reduction, unlike abortion, does not involve the expulsion or extraction of the terminated fetus(es) from the womb; instead the terminated fetus(es) remain(s) in the uterus until resorption and ultimate delivery with the placenta.[32] Thus, selective reduction is also different from miscarriage. "When a couple suffers a fatal demise in a singleton pregnancy, they either miscarry or undergo a procedure to end the pregnancy quickly. In the case of the multiple gestation with one demise, the mother is often called upon to continue carrying the dead fetus for weeks to months."[33]

In addition to the medical difference, a second fundamental difference between abortion and selective reduction is one of intent: the former is performed to end the entire pregnancy, while the latter is performed to salvage the pregnancy.[34] This difference in intent has been called a dividing line that "so separates these two procedures as to render them wholly distinguishable."[35] Selective reduction is generally undertaken after couples have already resorted to fertility treatments,[36] when the pregnancy is long-awaited and highly sought-

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30. Daar, *supra* note 13 at 796.

31. *See* Gianelli, *supra* note 11, at 25.

32. *See* Yael Gonen et al., *Transvaginal Ultrasound in Selective Embryo Reduction For Multiple Pregnancy*, 75 OBSTETRICS & GYNECOLOGY 720, 721 (1990).

33. Michael Berman, *Loss and Multi-Fetal Pregnancies* (visited Jan. 22, 2000) <http://www.hygeia.org/poems20.htm>.

34. *See* Daar, *supra* note 13, at 783 ("A woman undergoing a 'traditional' abortion intends that her entire pregnancy will be terminated: that following successful completion of the procedure she will no longer be pregnant. In contrast, a woman undergoing selective reduction intends that her pregnancy will not be terminated, but rather will be enhanced by creating a better environment for her fetus(es) to develop."); *see also* Walters, *supra* note 15, at 452 (emphasizing that the intention with multifetal pregnancy reduction is to continue rather than terminate the pregnancy). Selective reduction of multiples or of twin-to-singleton may also occur because of genetic, chromosomal, or other defects, *see* Villiers Gemmette, *supra* note 11, at 386; David Stoller, *Prenatal Genetic Screening: The Enigma of Selective Abortion*, 12 J.L. & HEALTH 121 (1998), but the existence of birth defects raises issues beyond the scope of this Article. This Article focuses its analysis on selective reduction opted for based on numbers alone.

35. Daar, *supra* note 13, at 783.

36. *See* Meckler, *supra* note 22; *see also* Mark I. Evans et al., *Selective First-Trimester Termination in Octuplet and Quadruplet Pregnancies: Clinical and Ethical Issues*, 71 OBSTETRICS & GYNECOLOGY 289, at 289 (1988) ("The induction of grand multiple gestations is a known complication of infertility treatments."); Mark I. Evans, et al., *Selective Termination: Clinical Experience and Residual Risks*, 162 AM. J. OBSTETRICS & GYNECOLOGY 1568, at 1568 (1990) (noting that the incidence of multiple gestation after ovulation induced by hyperstimulation of the ovaries may range from 6-8% with clomiphene citrate and from 15-53% with gonadotropin); Lauren Lynch et al., *First-Trimester Transabdominal Multifetal Pregnancy Reduction: A Report of 85 Cases*, 75 OBSTETRICS & GYNECOLOGY 735, 736 (1990) (noting that

after.[37] While selective reduction may be a life-saving technology,[38] both to the mother,[39] and to the surviving fetuses,[40] it still raises the ire of many who embrace a pro-life philosophy,[41] since the "right to life" position treats conception as genetically establishing a new "human being."[42] Arguably, the differences in the intent and in the end result of abortion and selective reduction should be adequate to satisfy the pro-life movement.[43] In reality, however, these differ-

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some form of infertility treatment precedes virtually all reported cases of selective reduction). *But see* Rorty & Pinkerton, *supra* note 10, at 63 (noting that not all multi-fetal pregnancy reduction ("MFPR") occurs in the context of assisted reproduction. "Unassisted multiple pregnancies, though rare, do occur . . . Multifetal pregnancies do not constitute a 'failure' in the context of normal reproduction and most physicians do not offer MFPR in these cases.").

37. *See generally* Allen, *supra* note 12; *see also* Judy Peres, *Giving Birth to Controversy*, CHI. TRIB., July 21, 1998, at 1 (describing a 29-year-old woman who "was able to persuade her doctor to transfer six embryos . . . although she concedes he was reluctant. 'I'm impatient,' she said. 'I've been taking hormones for close to a year and have failed to get pregnant in seven previous attempts.'"). *But see* Margarete Sandelowski, *Failures of Volition: Female Agency and Infertility in Historical Perspective*, *in* TIES THAT BIND: ESSAYS ON MOTHERING AND PATRIARCHY 35, 56-57 (Jean F. O'Barr et al. eds., 1990) (tracing the tendency within the infertility discourse "to suggest that infertile women who seek to achieve motherhood may not really want it").

38. *See* Daar, *supra* note 13, at 783.

39. *See* discussion of risks *supra* note 20.

40. *See id.*; *see also* Daar, *supra* note 13, at 819 ("Selective reduction maximizes the chance that any of the fetuses will survive."); Villiers Gemmette, *supra* note 11, at 387 (referring to "the reduction of a multiple pregnancy consisting of all healthy fetuses in order to ensure the live births of a selected number").

41. *See* Jay Johansen, *The McCaughey Case: Selective Reduction* (visited Feb. 20, 2000) <http://www.ohiolife.org/aborters/mccaugh.htm> (lauding the decision of Bobbi McCaughey to carry her septuplets to term and cursorily dismissing the risks posed by multiple births: "In most large multiple births, many of the babies do not survive. But it is not at all clear how a child is better off to be deliberately killed by abortion rather than to die of natural causes.").

42. *See, e.g.*, Thornburgh v. American College of Obstetrics and Gynecologists, 476 U.S. 747, 792 (1986) (White, J., dissenting). Justice White articulated what can be characterized as a "right-to-life" position and view of the fetus:

> However one answers the metaphysical or theological question of whether the fetus is a 'human being' or the legal question of whether it is a 'person' as that term is used in the Constitution, one must at least recognize, first, that the fetus is an entity that bears in its cells the genetic information that characterizes a member of the species homo sapiens and distinguishes an individual member of that species from all others, and second, that there is no nonarbitrary line separating a fetus from a child or, indeed, an adult human being.

Id.

43. *See* Daar, *supra* note 13, at 819. Daar comments on how selective reduction actually demonstrates respect for the moral status of fetal life:

> For those who embrace an extreme pro-life philosophy, selective reduction may initially be rebuffed because it appears to arbitrarily confer unequal status to the fetuses in a multiple pregnancy. Because doctors randomly select for termination those fetuses closest to the maternal abdominal wall, selective reduction may seem to be trading one life for another—an act that the pro-life movement fundamentally rejects. But selective reduction is not trading one life that could be saved for another. In the case of a grand multiple pregnancy, the chance that even one fetus will survive is slight . . . . To reject the procedure is to doom the fetuses to an almost certain death. To reduce the pregnancy is the only way to show respect for the substantial moral status of fetal life.

Id.

ences have not fully been appreciated,[44] in spite of the fact that without selective reduction, all of the fetuses in a multi-fetal pregnancy could be lost.[45]

In brief, selective reduction is different from abortion because of the multiplicity of factors involved: not only are the mother and a single fetus considered, but the well-being of the other fetuses must be factored into the equation. This multiplicity of factors has even been recognized by some rabbis. "Most rabbinic decisors agree that multi-fetal pregnancy reduction is permitted in certain circumstances,"[46] though there is disagreement over what these circumstances are. Some rabbis would permit multi-fetal pregnancy reduction "only in situations where the continuation of the pregnancy threatens the mother's life, others also allowing it if the pregnancy itself is threatened."[47] This rabbinical recognition of a threat to the pregnancy as a whole captures the essence of selective reduction.

In spite of these distinctions, abortion remains a useful analogy for several reasons. First, although it is the termination of a pregnancy in whole instead of in part, it is a clear framework for the understanding of selective reduction. Second, many opponents of abortion also oppose selective reduction,[48] so abortion and selective termination are often lumped together in public discourse. Finally, Carol Gilligan's abortion study,[49] to be discussed later in this Article, is premised on the complexity of women's abortion decisions. In order to extend the insights gleaned from this study to the selective reduction context, it is important to see how the two contexts are similar.

B. Law, Abortion and Selective Reduction

The existence of a constitutional right to selective reduction has been the subject of some debate. On one hand is the argument that women could actually be afforded greater constitutional rights to abort than to reduce because of the difference between the two procedures and the parties involved: "[W]hile a total abortion deals with the rights of the mother versus the rights of the fetus or fetuses, selective abortion involves the additional rights of fetus versus fetus."[50] Others have framed the right to abort as one that is constantly eroded,[51] with this

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44. *See* Jay Johansen, *The McCaughey Case: Selective Reduction* (visited Feb. 20, 2000) <http://www.ohiolife.org/aborters/mccaugh.htm>.

45. *See* Geoffrey Cowley & Karen Springen, *More Is Not Merrier*, NEWSWEEK, Aug. 26, 1996, at 49 (describing the case of one woman, Mandy Allwood, who had conceived eight babies with the help of fertility drugs. She chose not to reduce because she viewed the pregnancy as "the more, the merrier." Her decision to take the risk of continuing with the pregnancy ultimately resulted in the loss of all eight fetuses.).

46. Daniel Eisenberg, *Multifetal Pregnancy Reduction in Halacha* (last modified June 10, 1999) <http://www.ijme.org/Content/Transcripts/Eisenberg/reduction.html>.

47. *Id.*

48. *See* Jay Johansen, *The McCaughey Case: Selective Reduction* (visited Feb. 20, 2000) <http://www.ohiolife.org/aborters/mccaugh.htm>.

49. *See* Gilligan, *supra* note †; *see also* discussion *infra* Part II.3.

50. Villiers Gemmette, *supra* note 11, at 390.

51. *See, e.g.*, Lisa Hemphill, *American Abortion Law Applied To New Reproductive Technology*, 32 JURIMETRICS J. 361, 361 (1992). Hemphill argues that a woman's right to choose to have an abortion has been constantly eroding:

> Women were guaranteed the right to choose abortion with little restriction until the point of fetal viability by *Roe v. Wade*. Yet, we are seeing the inception of a movement by the

erosion being a reason to distance selective reduction from abortion, so that greater rights could be ultimately afforded to women seeking to reduce a pregnancy.[52] An in-depth analysis of the Supreme Court's decision in *Roe v. Wade* and its progeny need not be undertaken here, for this has already been done at length.[53] For the purposes of analysis, it is sufficient to emphasize that the existence of a constitutional right to selective reduction is not wholly guaranteed and is still tenuous.[54]

Later discussion in this Article of the relational dimension of the abortion decision[55] will illustrate how selective reduction could be commensurate not with "the individual right of privacy—the right to be left alone, [but] the relational right of privacy—the right to connect with others."[56] This relational conception of privacy has been alluded to by the Supreme Court as one that grants "certain kinds of highly personal relationships a substantial measure of sanctuary from unjustified interference from the state."[57] However, it is not the prevailing view of constitutional privacy, which instead "currently reflects the liberal paradigm, sheltering isolated individuals from an overwhelming power of government."[58] Some have argued for reconceptualizing privacy as a right that is inherently relational,[59] thus allowing the relational elements of the abortion and selective reduction decisions to be protected.

One key way to distinguish selective reduction from abortion, and to argue for the existence of a right to selectively reduce, is to focus on the aforemen-

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> courts and governments, as they proclaim the superiority of fetal rights over parental rights. Soon, we will be confronted with the possibility of 'viability'—that is, the ability to survive outside the womb—at the moment of conception. Does this mean women will lose their right to choose abortion?

52. *See* Daar, *supra* note 13, at 783-84. Daar advocates distancing selective reductive from abortion in public discourse:

> Given the predicated demise of *Roe v. Wade* and the constitutional right to choose abortion, it is important to keep selective reduction out of the abortion debate. Physicians practicing in the area of reproductive technologies must be permitted to offer this life-saving technology to their patients free from whatever restrictions their state governments may place on abortion. Moreover, to allow selective reduction to be swallowed up in the abortion debate would be to bury it in the political process much the way other seemingly abortion-related technologies have been buried.

Id. See also id. at 796 (arguing that "selective reduction is fundamentally different from abortion, warranting its exclusion from the increasingly strict regulations surrounding abortion.").

53. *See, e.g.*, Susan Frelich Appleton, *More Thoughts on the Physician's Constitutional Role in Abortion and Related Choices*, 66 WASH. U. L.Q. 499 (1998); April L. Cherry, *Choosing Substantive Justice: A Discussion of "Choice," "Rights," and the New Reproductive Technologies*, 11 WIS. WOMEN'S L.J. 431 (1997); Daar, *supra* note 13, at 806-11; Kohn, *supra* note 17; Seth Kreimer, *The Law of Choice and Choice of Law: Abortion, the Right to Travel, and Extraterritorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451 (1992); Linda C. McClain, *The Poverty of Privacy?*, 3 COLUM. J. GENDER & L. 119 (1992); Maggie O'Shaughnessey, Note, *The Worst of Both Worlds?: Parental Involvement Requirements and the Privacy Rights of Mature Minors*, 57 OHIO ST. L.J. 1731 (1996); Villiers Gemmette, *supra* note 11, at 388.

54. *See* Villiers Gemmette, *supra* note 11, at 383 ("Physicians appear to rely on *Roe v. Wade* in assuming the legality of the procedure, although such an assumption may be erroneous.").

55. *See* discussion *infra* Part II.3.

56. *See* Radhika Rao, *Reconceiving Privacy: Relationships and Reproductive Technology*, 45 UCLA L. REV. 1077, 1104 (1998).

57. Roberts v. United States Jaycees, 468 U.S. 609, 618 (1984).

58. Rao, *supra* note 56, at 1122.

59. *See id.*

tioned difference in intent: "The law's failure to recognize a miscarriage as an abortion most likely stems from its focus on state of mind."[60] In other words, abortion is viewed under the law as a knowing or intentional act, while "a miscarriage is not an abortion because it occurs naturally, devoid of any associated state of mind."[61] Most multiple pregnancies occur as the result of fertility drugs or treatments,[62] which can hardly be characterized as occurring "naturally." However, selective reduction to save the pregnancy is most akin to miscarriage, since the resulting loss of the fetus(es) is a necessary but not a desired result of the fertility enhancement treatments. As with miscarriage, there should be no room for selective reduction under the law's conception of abortion. "[T]he law seems to define abortion by one's motivation to avoid producing a live birth,"[63] which consequently excludes the motivation of terminating fetal life in order to produce a live birth.[64] This focus on state of mind, intent and motivation is additionally related to an examination of the complexity of women's decision-making in abortion and in selective reduction, which will be explored next.

While the existence of a legally-enshrined right to abort or to selectively reduce obviously provides greater safeguards for women, it should be recognized that women may make certain personal reproductive decisions regardless of the legal landscape: "Important as the law is, it has never been determinative or definitive of women's response to pregnancy or their desire for fertility and birth control."[65]

C. Psychology, Abortion and Selective Reduction

1. Overview

Carol Gilligan's abortion study chronicled in her book, *In a Different Voice*,[66] is an appropriate lens through which to begin to better understand selective reduction,[67] even if the abortion analogy is flawed and even if the underlying in-

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60. Daar, *supra* note 13, at 800.

61. *Id.*

62. *See supra* note 36 and accompanying text.

63. Daar, *supra* note 13, at 800.

64. *See id.*

65. Shelley Gavigan, *On "Bringing on the Menses": The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law*, 1 CAN. J. WOMEN & LAW 279, 280 (1986) ("Although the abortion law has been the site of struggle in recent years, what has occasionally been lost sight of is the historical, prefeminist struggle of women to control their fertility.").

66. *See* Gilligan, *supra* note †, at 71-105.

67. Carol Gilligan's theories are consistent with relational feminism or the difference approach, which is also ascribed to and articulated by Robin West. *See* Robin L. West, *The Difference in Women's Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory*, 3 WIS. WOMEN'S L.J. 81, 140 (1987). West comments on the relational character of women's lives:

> Women's lives are not autonomous, they are profoundly relational. This is at least the biological reflection, if not the biological cause, of virtually all aspects . . . of our 'difference.' Women, and only women, and most women, transcend physically the differentiation or individuation of biological self from the rest of human life trumpeted as the norm by the entire Kantian tradition. When a woman is pregnant her biological life embraces the embryonic life of another. When she later nurtures children, her needs will embrace their needs.

tent is different from that underlying selective reduction. The abortion study, conducted from 1973 to 1975 in the immediate aftermath of *Roe v. Wade*, involved interviews with twenty-nine women, ranging in age from fifteen to thirty-three, who came from diverse ethnic backgrounds and social classes.[68] It was "designed to clarify the ways in which women construct and resolve abortion decisions."[69] The analysis of selective reduction herein will, in turn, focus on women's decision-making in selective reduction as gleaned from articles, and not from a series of personal interviews. Moreover, ethnic and social diversity is probably much more lacking in the context of infertility treatments and selective reduction, since the technologies are so costly,[70] and tend to be used by white

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Id. It is important to note that while they are most worthy of examination here, Gilligan's theories are not uncontroverted and have been challenged. *See, e.g.*, Catharine MacKinnon, *Difference and Dominance: On Sex Discrimination*, *in* FEMINISM UNMODIFIED 32 (Harvard University Press, 1987) ("Women value care because men have valued us according to the care we give them, and we could probably use some. Women think in relational terms because our existence is defined in relation to men."); *id.* at 43 ("The difference approach tries to map reality; the dominance approach tries to challenge and change it. In the dominance approach, sex discrimination stops being a question of morality and starts being a question of politics."); Carol Stack, *The Culture of Gender: Women and Men of Color*, 11 SIGNS 321, 324 (1986) (noting that Gilligan's theories must be placed in the context of culture and class, and analyzing Black return migrants to the rural South to uncover an African-American model of moral development: "Future research must contribute another dimension to the construction of feminist theory: it should provide a critical framework for analyzing gender consciousness and a cautionary reminder to those theorists who think that gender construction is the same in all societies."); Joan Tronto, *Beyond Gender Difference to a Theory of Care*, 12 SIGNS 644, 650 (1987) ("To my knowledge, no one has examined minority group members using Gilligan's methodology to see if they fit the morality of care better than they fit Kohlberg's categories. Gilligan's abortion study, like Kohlberg's work, is limited in that it focuses solely on the privileged."); Pamela S. Karlan & Daniel R. Ortiz, *In a Diffident Voice: Relational Feminism, Abortion Rights, and the Feminist Legal Agenda*, 87 NW. U. L. REV. 858, 860 (1993) ("Although we understand the appeal of relational feminism, we think it is somewhat dangerous and misguided, particularly in its most prominent form . . . The problem with this view is not only that, as some others have noted, it may celebrate the terms of women's oppression and represent nothing more than a 'slave morality,' but, more importantly, that it stands in some tension with women's felt needs, particularly as expressed in the feminist legal agenda."); John M. Broughton, *Women's Rationality and Men's Virtues: A Critique of Gender Dualism in Gilligan's Theory of Moral Development*, 50 SOC. RES. 597, 632-34 (1983).

68. *But see* Tronto, *supra* note 67, at 650, for a critique that Gilligan's abortion study was not diverse. Gilligan has responded to this critique that her work focuses on the privileged by noting that her abortion study interviewed poor women and women of color. *See* Carol Gilligan, Address at N.Y.U. School of Law, Gender in Law and Culture Seminar (March 30, 1999).

69. Gilligan, *supra* note †, at 71.

70. *See, e.g.*, BLANK & MERRICK, *supra* note 20, at 89 (noting that expenses incurred in a series of attempts at pregnancy include travel, lodging, and the loss of employment during the duration of the treatment); D'Andra Millsap, *Sex, Lies, and Health Insurance: Employer-Provided Health Insurance Coverage of Abortion and Infertility Services and the ADA*, 22 AM. J.L. & MED. 51, 56 (1996) ("Infertility treatments can range in cost from relatively inexpensive counseling to very expensive high-tech methods."); Sharon Begley, *The Baby Myth: High Tech Fertility Clinics Offer More Hype Than Hope*, NEWSWEEK, Sept. 4, 1995, at 38 (estimating that couples spend at least $10,000 and as much as $100,000 on diagnostic tests, fertility drugs and assisted reproductive techniques); Manier, *supra* note 22, at 1 ("A typical in-vitro regimen costs $10,000, with some institutions reporting a successful delivery rate of about 55 percent. Fertility drugs cost between $1,000 and $2,000 a month, with a pregnancy rate of about 14 percent for any given month of treatment."); Jane Wulf, *What if My Test-Tube Babies Were Swapped in the Lab?*, TIME, Apr. 12, 1999, at 69 ("[B]aby-making technology is both heart-wrenching and expensive (as much as $18,000 for a procedure).").

women with the means to afford them.[71] Gilligan describes the main findings of her abortion study in a later reflection upon it:[72]

> [W]omen were constructing the dilemma in a way that was completely at odds with the public conversation. Then, as now, the public discussion of abortion was framed as a conflict between the right to life and the right to choice, raising the question of whose rights took precedence in a formulation that pitted the fetus against the mother (according to the right-to-lifers) or women against men (according to pro-choicers). Yet women were saying, 'I'm in this dilemma of relationship and I can't see any way of acting that will not cause hurt. So I don't know what to do. There is no good thing to do here.' So I would ask them, 'What are you thinking about? Who is involved?' And they would say, 'Well, everybody affected by the decision is involved. It was like someone on a trampoline. You make a move and the whole thing is shaking. Women said, it will affect my parents, it will affect this person, it will affect that person, all these people, and I don't know how to move without having an effect on all these people, and if I don't move, I will have a baby.[73]

This analogy to being on a trampoline is equally applicable to selective reduction—but if the woman doesn't move, she could have multiple babies, or possibly no babies at all. Moreover, the pitting of the fetus's interests against those of the mother is apparent in selective reduction; in addition, each fetus's interests are in competition with the other's.[74] The abortion study demonstrates, above all else, that women's abortion discussions are much more multi-layered, complex, and relational than the public debate of rights versus murder. In other words, the private discourse and public discourse about abortion are starkly different. The abortion study portrays women connected to key people in their lives, be it their boyfriend, their husband, or their parents, and additionally as connected to their fetus that they may feel conflicted about carrying. This connection with the fetus has not always been viewed as one with an adversary. Patricia Williams describes it by saying, "I do not believe that a fetus is a separate person from the moment of conception. How could it be? It is so intercon-

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71. *See* Dorothy E. Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935, 937 (1995-1996) ("One of the most striking features of the new reproduction is that it is used almost exclusively by white people. Of course, the busiest fertility clinics can point to some black patients; but they stand out as rare exceptions."); *id.* at 939 ("[T]he racial disparity in new reproduction has nothing to do with rates of infertility. Married black women have an infertility rate one and one-half times higher than that of married white women. In fact, the profile of people most likely to use IVF is precisely the opposite of those most likely to be infertile. The people in the United states most likely to be infertile are older, poorer, black and poorly educated. Most couples who use IVF services are white, highly educated and affluent."). In this regard, the experience of assisted reproduction is different from the experience of reproduction, which, at some basic level, transcends race and social class. *See* Sheilah L. Martin, *The Control of Women Through Gender-Biased Laws on Human Reproduction*, *in* CANADIAN PERSPECTIVES ON LEGAL THEORY 291, 309 n.2 (Richard F. Devlin ed., 1991) ("In some respects, I believe the reproduction-related experiences of women tend to be among the more basic of shared experience. Because sex is used to define all women, regardless of colour or social situation, it is an important common denominator that we share.").

72. *See* Carol Gilligan, *Remembering Larry*, 27 J. MORAL EDUC., 125, 130-31 (1998) [hereinafter Gilligan, *Remembering Larry*].

73. *Id.* at 130.

74. *See* Villiers Gemmette, *supra* note 11, at 390.

nected, so flesh-and-blood-bonded, so completely a part of a woman's body. Why try to carve out one from the other?"[75]

The public perception of, and discourse about, abortion seems to have been based on an assumption that the woman's right necessarily conflicts with, instead of connects to, other rights. Anthropological evidence shows, "in primitive and ancient societies that have regarded abortion as wrong, it is not usually the fetus that is considered the wronged party . . . [but] the family, the tribe, the state, or the husband or maternal uncle, depending on the prevailing basis of patriarchal authority."[76] The abortion study allows us to move away from a finding of a wronged party, and from a dichotomous analysis of whose rights trump and whose rights are trumped. This study can help broaden the present debate about both abortion and selective reduction, which remains polarized to this day,[77] by injecting real women with real decisions into the analysis. The focus on real women is a reminder that actual people with complex lives and multi-factorial decisions are involved, something that has arguably not been the primary concern of the Supreme Court. One author has remarked that women have been viewed by the Supreme Court as comprised uniquely of their reproductive capacity: "Women have been subsumed into their reproductive organs. The woman as an independent person with interests and needs is invisible in the Court's decisions: instead law has treated women first and foremost as potential or actual mothers."[78]

It is true that the rights discourse does have some utility, even though it is not commensurate with how women have framed the issues. This utility lies in the fact that rights discourse "speaks in the language of those who hold power. In order for any dissenting view to be seriously considered in legal discourse, those in control must understand the claims of the dispossessed and take those claims seriously."[79] In spite of this utility, the analysis here will focus on views not as frequently considered in legal discourse, on loss of voice, competing values, and the psychological impact of a decision.

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75. Patricia Williams, *Fetal Fictions: An Exploration of Property Archetypes in Racial and Gendered Contexts*, 42 FLA. L. REV. 81, 92 (1990).

76. ROSALIND POLLACK PETCHESKY, ABORTION AND WOMEN'S CHOICE: THE STATE, SEXUALITY AND REPRODUCTIVE FREEDOM 332 (2d ed. 1990) (citing GEORGE DEVEREUX, A STUDY OF ABORTION IN PRIMITIVE SOCIETIES (1976)).

77. Constructing the abortion debate as an either/or proposition, an issue of rights versus murder, as black or white with little tolerance for shades of gray persists. *See, e.g.*, UPI, *Bush Allies Defend Abortion Position*, March 21, 1999, at <wysiwyg://10/http://nt.excite.com/news/u/990321/14/news-bush>. Anti-abortion advocates have criticized Bush's position on abortion:

> Leading conservative supporters of Texas Gov. George W. Bush for president are lining up to defend his position on abortion from attacks by strict anti-abortion rights groups who decry it as weak. Bush said he supports restrictions on abortion in all three trimesters, except when a mother's life is at risk or in cases of rape or incest. The *Dallas Morning News* quotes Colleen Parro, director of the Dallas-based Republican National Coalition for Life, saying, 'There is no way his stance can be described as pro-life.'

Id.

78. Elizabeth A. Reilly, *The Rhetoric of Disrespect: Uncovering the Faulty Premises Infecting Reproductive Rights*, 5 AM. U. J. GENDER & L. 147, 157-58 (1996).

79. Cherry, *supra* note 53, at 438.

2. Loss of Voice

The public framing of the abortion debate has, according to Gilligan, excluded women's voices by its very nature and construction.

> Moral problems arise when we close ourselves off from relationship—when we lose connection with ourselves, with others, and with the realities of life. There was no way to bring this psychological understanding into a conversation about whose rights take precedence, the fetus' or the mother's, and does the fetus have rights, is it a life, and do women have choices, and are liberty rights selfish for women? It was like trains passing. If the woman said that the fetus is a life, the she would be a murderer, so she couldn't say that, but if she said it was not a life, then she didn't know what she knew, so she couldn't say that. So as women said, 'What could you say?' or 'You can't say anything.'[80]

This apparent inability to say anything, this blatant loss of voice, surfaces not only in the way the debate is framed, but also in the way women are seemingly excluded from their own decisions.[81] "When women feel excluded from direct participation in society, they see themselves as subject to a consensus or judgment made and enforced by the men on whose protection and support they depend and by whose names they are known."[82] This exclusion from participation in society and in one's own life decisions is evidenced in the experience of a divorced, middle-aged woman whose words are captured by Gilligan: "There were the three men in my life: father, husband, and clergyman, and they had much more to say about what I should or shouldn't do. They were really authority figures which I accepted."[83] To this list of authority figures, one could add "physicians," as fertility doctors may deny women any real say in the decision about selective reduction. This exclusion of voice is apparent in an article describing selective reduction that follows several couples and a doctor in Detroit.[84]

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80. Gilligan, *Remembering Larry*, *supra* note 72, at 131; *see also* Carol Gilligan, *Getting Civilized*, 63 FORDHAM L. REV. 17, 17 (1994) ("At the time I began writing *In a Different Voice* almost twenty years ago, women's voices were conspicuously missing from the psychology that I was teaching. Or rather, women's voices were inconspicuously missing.").

81. Loss and suppression of voice and women's silences have been discussed by a number of feminist legal scholars. *See, e.g.*, MacKinnon, *supra* note 67, at 45 ("Take your foot off our necks, then we will hear in what tongue women speak."); HIMANI BANNERJI, THINKING THROUGH: ESSAYS ON FEMINISM, MARXISM AND ANTI-RACISM 41 (1995). Bannerji discusses the prominence of the word "silence" in feminist's scholarly writing:

> From its very early phase the word 'silence' has been important in the vocabulary of feminist writing. It spoke of being *silent* or having been *silenced*—of two distinct but related themes. In a cluster with 'silence' there are other words speaking of gaps, absences, being 'hidden in history,' of being organized *out* of social space or discourse, or *into apathy*, and of 'a problem without a name.' Not exceptionally, therefore, there also appeared other expressions—signifying women's struggles—about gaining or giving a voice, a direct assumption of our subjectivity, creating a version of the world from 'our' own standpoint, and thus speaking from our own 'self' or 'center' or experience.

Id.; *see also* Kathleen A. Lahey, *On Silences, Screams and Scholarship: An Introduction to Feminist Legal Theory*, *in* CANADIAN PERSPECTIVES, *supra* note 71, at 319.

82. Gilligan, *supra* note †, at 67.

83. *Id.*

84. *See* Allen, *supra* note 12.

> The presurgery counseling session is mostly one-sided. Dr. Evans lists the risks of a quintuplet pregnancy—50 percent chance of miscarriage, 90 percent chance of low birth weight—versus the risks that will remain after he finishes. He assures Christine that the procedure will be quick and fairly painless. 'Compared to what you've been through, this is a piece of cake,' he says, handing her a consent form. 'OK?'[85]

The one-sidedness of the discussion denies any real ability to say, "No, this is not OK." This loss of voice is exacerbated by the fact that many women feel they lose control over the process after the very first fertility treatment.[86] In addition, voice is also excluded by the way selective reduction is constructed as the only "right" thing to do; the fact that the births of the McCaughey septuplets and the Chukwu octuplets are seen as anomalous[87] indicates that only one choice is seen as socially and medically acceptable.[88]

In sum, it is difficult for a woman to have a choice when she does not have a voice.[89] Thus, the suppression of voice by the medical profession makes any conception of real choice illusory. Similarly, no real choice can exist when a woman does not have control over her own body and bodily integrity.[90] "Under choice rhetoric, a woman chooses to use contraception, abort a pre-viable fetus, or use alternative means of insemination based on private circumstances."[91] This rhetoric may ring hollow, however, since "[b]ecause of the operation of patriarchy, women historically have had, and currently have, little control over their physical selves."[92] This loss of control over one's physical self can certainly be seen where, for example, a woman suddenly finds herself pregnant with eight fetuses, a situation that could likely have been avoided if her egg-producing follicles had been monitored following drug treatments, or if fewer embryos had been implanted from the outset.[93]

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85. *Id.* at 287.

86. *See id.* at 318.

87. *See* Emanuel *supra* note 6; Sills & Perloe, *Eight is Enough* (visited Jan. 21, 2000) <http://www.obgyn.net/english/pubs/features/eight-is-enough.htm>; McNamara, *supra* note 6; Barnhouse, *supra* note 6; Lerner, *supra* note 6.

88. *See* Finkel, *supra* note 19, at A4 (describing the feelings of Doctor Claire Weitz, who delivered premature quintuplets who died shortly after delivery: "'I hated being in that room, with that poor woman suffering,' Claire Weitz says. 'There was nothing I could do. I was helpless. You know how much these people invest—not just financially, but emotionally. And then you wonder: Why can't they have come to the decision that made sense medically? Not morally. Medically.'").

89. Carol Gilligan, Address at N.Y.U. School of Law, Gender in Law and Culture Seminar (March 17, 1999).

90. *See* Cherry, *supra* note 53, at 432-33.

91. *Id.* at 493.

92. *Id.*

93. *See* Allen, *supra* note 12, at 318; Joe Haertel, *Letters to the Editor*, WASH. POST, Apr. 2, 1999, at A28 ("Let me get this straight: First, the doctor removes eggs from the woman's body and fertilizes them so than an embryo or embryos will be created. Then the embryo or embryos are returned to the woman's body. Finally, an embryo or embryos that have successfully implanted themselves in the uterus are killed by the doctor with a shot of potassium chloride. Is this medicine or a perversion of medicine?"); Rorty & Pinkerton, *supra* note 10, at 59-60 (noting that multifetal pregnancy "marks a failure of the fertility procedure; in curing the deficiency of being unable to conceive, the procedure goes too far"); Villiers Gemmette, *supra* note 11, at 391 ("It is callous and arbitrary to

3. Competing Values

A woman pregnant with multiple fetuses encounters not only the suppression of her own voice, but, in facing her moral dilemma, she is also confronted with a host of competing values. Here too, the issue of choice is raised, since "[t]he essence of moral decision is the exercise of choice and the willingness to accept responsibility for that choice."[94] In contrast with the polarized rhetoric of the public abortion debate, "women impose a distinctive construction on moral problems, seeing moral dilemmas in terms of conflicting responsibilities."[95] The principal findings of Gilligan's abortion study demonstrate "the centrality of concepts of responsibility and care in women's constructions of the moral domain, the close tie in women's thinking between conceptions of self and morality."[96] The interviews about women's construction of the abortion dilemma repeatedly revealed "the language of selfishness and responsibility, which defines the moral problem as one of obligation to exercise care and avoid hurt."[97] In other words, these interviews uncovered the "reiterative use by women of the words *selfish* and *responsible* in talking about moral conflict and choice."[98]

What is perhaps most interesting about the abortion study is that the classification of one option (be it carrying the fetus to term or aborting it) as selfish and the alternate option as responsible oscillated with each woman and depended upon a number of factors, including but not limited to her stage of life, her age, her own wishes, the wishes of her parents, the wishes of her lover, and her ability to support a child. The study reflects the tendencies of the women interviewed to label whatever they wanted as selfish and whatever others wanted as responsible, and then to ultimately question these labels.[99] In contrast, in the context of multi-fetal pregnancies, there is much complexity to each woman's decision, but slightly less ambiguity: selective reduction is generally seen as the socially[100] and medically[101] more responsible choice, except perhaps by those who rule it out for religious reasons.[102] While religion may play a part in women's moral decisions, and while it did surface as a key motivating factor in the decisions of both Bobbi McCaughey[103] and Nkem Chukwu,[104] it is not de-

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overpopulate a womb knowing that a subsequent procedure will enable the reduction of 'wombmates' to make a house that fits.").

94. Gilligan, *supra* note †, at 67.

95. *Id.* at 105.

96. *Id.*

97. *Id.* at 73.

98. *Id.* (emphasis in original).

99. *See* Gilligan, *Remembering Larry*, *supra* note 72, at 130-31 ("[W]hatever a woman wanted to do, she tended to label 'selfish' and wrong, whether it was having the baby or having the abortion. It didn't matter what she wanted, because the very fact of her wanting it meant that it was selfish, bad and wrong, and what she didn't want was selfless and good.").

100. *See* discussion *supra* note 6.

101. *See* discussion *supra* notes 20, 85 and accompanying text.

102. *See, e.g.*, Gilbert Meilander, *Biotech Babies: How Far Should Christian Couples Go in the Quest for a Child of Their Own?*, CHRISTIANITY TODAY, Dec. 7, 1998.

103. *See, e.g.*,, Marantha Christian Science Journal, *Iowa Woman Gives Birth to Septuplets*, December 1, 1997 at <wysiwyg://34/http://www.pe.net/mcj/news2327.htm> ("The McCaugheys were advised early in the pregnancy to abort some of the fetuses—a process called 'selective reduction'—to increase survival chances for the others. But the couple refused to consider that option because of

terminative. Religion does not necessarily dictate that a woman will rebuff either abortion, as evidenced in the abortion study,[105] or selective reduction.[106] In both the abortion and the selective reduction decisions, a recurring refrain is the belief that the ultimate abortion or reduction is never good, but that it is occasionally necessary.[107]

Gilligan discusses encountering a view of care that involved "an effort to sort out the confusion between self-sacrifice and care inherent in the conventions of feminine goodness."[108] She later draws a crucial distinction between a feminine ethic of care, premised on selflessness and self-sacrifice, and a feminist ethic of care, which "begins with connection, theorized as primary and seen as fundamental in human life."[109] She notes that when "speaking of connection, of responsiveness and responsibility in relationships, women heard themselves sounding either selfish or selfless, because the opposition of self and other was

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their religious beliefs. The pair are committed Baptists who met in Bible college. 'God gave us those kids,' said the father. 'He wants us to raise them.'")

104. *See, e.g.*, Associated Press, *Octuplets' Mother: 'It Wasn't Easy,'* December 30, 1998 at <wysiwyg://31/http://www.wfaa.com/news/9812/30/octuplets_update.html> ("Mrs. Chukwu declined to address the debate about whether infertility doctors should try to prevent multiple births. But she did say she would not consider undergoing selective reduction . . . . 'I've never seen such a word in my bible,' she said she told her doctor, Brian Kirshorn. 'I wasn't even going to give it a thought, a second thought.'").

105. The abortion study describes, in particular, two religious women who are able to morally justify their abortion decisions. The first is Janet, a twenty-four-year old married Catholic, pregnant again two months following the birth of her first child. Her dilemma arises over the issue of justification for taking a life:

> I can't cover it over, because I believe this, and if I do try to cover it over, I know that I am going to be a mess. It will be denying what I am really doing.' Asking herself, 'Am I doing the right thing; is it moral?' Janet counterposes her beliefs about abortion to her concern with the consequences of continuing the pregnancy. Concluding that she cannot be 'so morally strict as to hurt three other people with a decision just because of my moral beliefs,' she finds that the issue of goodness still remains critical to her resolution of the dilemma.

Gilligan, *supra* note †, at 83-84. "At the end, Janet says, 'God can punish, but He can also forgive.' What remains in question for her is whether her claim to forgiveness is compromised by a decision that not only meets the needs of others but also is 'right and best for me.'" *Id.* at 85. Sandra, a twenty-nine-year-old Catholic nurse, also expresses concern with selfishness and its equation with immorality. Although Sandra views abortion as murder, she had previously given up one child for adoption and it was a psychologically draining experience that she did not think she could relive. "The decision thus reduces in her eyes to a choice between murdering the fetus or damaging herself. The choice is further complicated by the fact that to continue the pregnancy would hurt not only herself but also her parents, with whom she lives." *Id.* at 85-86.

106. The reasoning of women who justify selective reduction echoes that in the abortion study. For example, one woman, Christine, decided to reduce her pregnancy from five to two. "'I've spent more time crying than being happy about being pregnant.' A Catholic, she can't see these abortions as a sin. 'There's no way I could have five children. I don't feel I am doing anything wrong.'" Allen, *supra* note 12, at 315. Similarly, Marie, who harbors regret over her two lost quadruplets, said, "Morally, I think [the reduction] was wrong. You're playing God. But then, you're playing God when you use the drugs in the first place. I didn't feel good about it, but I felt it was necessary." *Id.* at 319.

107. *See* discussion *supra* notes 105 & 106.

108. Gilligan, *supra* note †, at 74.

109. *See* Carol Gilligan, *Hearing the Difference, Theorizing Connection*, 10 HYPATIA 120, 122 (1995) [hereinafter Gilligan, *Hearing the Difference*].

so pervasive and so powerfully voiced in the public discourse."[110] The selective reduction discourse involves not only the opposition of self and other, but the opposition of other and other.[111] Moreover, nowhere are visions of feminine self-sacrifice more apparent than in the physical torment endured by women who have opted to carry multiple fetuses to term, even though Bobbi McCaughey and Nkem Chukwu are portrayed in the media as having wanted this decision for themselves.[112] Bobbi McCaughey, for one, is described as having had difficulty gaining enough weight for her seven fetuses; her waist was fifty-two inches when she had only gained twenty-five pounds.[113] Nkem Chukwu spent the last two and a half weeks of her pregnancy bed-ridden at an upside-down tilt in order to increase the chance of the fetuses remaining in utero for as long as possible.[114]

In sum, the ethic of selfishness versus the ethic of responsibility and the ultimate question of what is selfish and what is responsible, are indeed different from a discussion of rights versus murder. It is true that injecting potassium chloride into the heart of a fetus kills that fetus, and is thus viewed as murder by some.[115] To focus merely on the act itself, however, cuts the debate short and precludes an analysis of the particular woman, her situation, and her decision. While being bed-ridden upside-down may be seen as the ultimate act of self-sacrifice, putting one's overarching desire to reproduce before other considerations, and bringing multiple unhealthy infants into the world may both be seen as inherently selfish acts.[116] Herein lies the tension that so permeates the selective reduction debate and distinguishes it from the abortion context: while the labeling of a particular decision as selfish or selfless varied in the abortion study, both labels seem to collide in the selective reduction context.

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110. *See id.* at 121.

> It was as if women's experience of connection was unnatural, unhealthy or unreal. But it was also ironic, because the Supreme Court had given women a legal voice in a matter of relationship and at the same time had framed that voice within a discourse of rights which made it impossible to speak about relationship except in terms of justice—equality, fairness, reciprocity—or in terms of contractual obligation, neither of which had much bearing on many women's situation.

Id.

111. *See* discussion of the rights of fetus versus fetus, *supra* note 50 and accompanying text.

112. *See supra* notes 103, 104.

113. *See* John McCormick & Barbara Kantrowitz, *The Magnificent Seven*, NEWSWEEK, Dec. 1, 1997, at 44.

114. *See* Mark Babineck, *Mom Heading Home—Surviving Octuplets Stay in Hospital* (visited Dec. 30, 1998) <http://www.abcnews.go.com/sections/us/Daily/News/octuplets981230.html> ("Chukwu, a Nigerian immigrant, entered the hospital early in October and spent the last two and one-half weeks of the pregnancy in bed with her head inclined toward the floor. 'It wasn't easy, but I did it for the love I have for them,' said Chukwu, 27, who delivered the first of the babies [on] December 8th and the remaining seven by Caesarian section December 20th. 'I knew one day it will be over.'").

115. *See* Jay Johansen, *The McCaughey Case: Selective Reduction* (visited Feb. 20, 2000) <http://www.ohiolife.org/aborters/mccaugh.htm>.

116. *See supra* note 20; *see also infra* notes 131 & 132 about the health problems faced by the McCaughey septuplets and the surviving Chukwu octuplets.

4. Psychological Impact of the Decision

The decision to selectively reduce, like the decision to abort, does not occur in a vacuum, but instead, psychologically impacts the woman making it. Psychological trauma following a decision to undergo legal abortion has been identified;[117] this includes "depression [and] repression, a sense of loss, guilt, sleeping disorders, anniversary reactions, disturbed relationships with men, obsessive-compulsive behavior, suicide attempts, and psychotic and conversion reactions."[118] It is important to remember that it is not only the decision to have an abortion that can be psychologically damaging: so too can the decision to have a child. Gilligan describes adverse reactions to continuing an unwanted pregnancy, and notes a pervasive "feeling of despair" expressed by one fifteen-year-old named Lisa.[119] Lisa is described as having "become unrecognizable to herself."[120] "Caught in a cycle of despair, finding no way to go back to school and, without school, no way to support herself and the child, 'just confused about everything because I can't get him out of my mind,' she is unable to see how an act of love could have led to such desolation and loss.'"[121] In addition to desolation and loss is the required overall adjustment to what can be an overwhelming change in a woman's life.[122] Interestingly, the language of *Roe v. Wade* itself overtly recognizes the psychological impact of being denied an abortion and of having a possibly unwanted child: "Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care."[123]

The decision to selectively reduce can similarly lead to tremendous feelings of loss, even when one or more healthy babies have resulted from the preg-

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117. *See* Thomas Eller, *Informed Consent Civil Actions for Post-Abortion Psychological Trauma*, 71 NOTRE DAME L. REV. 639, at 668 (1996).

118. *Id.*

119. *See* Gilligan, *supra* note †, at 123-24.

120. *Id.* (quoting Lisa: "I am not the same person I was a year and a half ago. I was a very happy person then. I am just not myself anymore . . . Before I had the baby, I was free. I had a lot of friends. I was fun to be with. I was happy. I enjoyed a lot of things, and I am just different now. I'm lonely. I'm quiet. I'm not like I was anymore. I have changed completely.").

121. *Id.*

122. *See* M. Righetti-Veltema et al., *Risk Factors and Predictive Signs of Postpardum Depression*, 49 J. AFFECTIVE DISORDERS 167 (1998); Laurence Kruckman & Susan Smith, *An Introduction to Postpardum Illness* <http://www.iup.edu/an/postpardum/preface.html>. Veltema describes postpartum depression, noting,

> The very term used to describe the disease—'depression'—has deep experimental and emotional meanings in Western culture, and has been applied rather imprecisely to both mild, temporary forms of depression which are quite common in the first postpartum days, as well as to the more severe psychotic reactions which are quite rare. Typically, the syndrome is characterized by feelings of sadness in the new mother, extreme emotional instability, weeping, irritability and fatigue.

Id. See also Coping After Birth (visited Feb. 28, 2000) <http://www.schuylerhospital.org/stress.html> ("[H]aving a baby, whether it's the first or the fifth child, causes many significant changes in your life. These changes, both physical and emotional, can be more intense than expected, and can leave you feeling overwhelmed, confused, and frightened."); *Postpardum Board Home Page* <wysiwyg://6/http://rainforest.pare. . .ce.com/dialog/get/fpostpardum.html> ("You're exhausted, your house is a mess, this breastfeeding thing is really hard, you're thirsty and too tired to get a drink, and all you can do is cry. Welcome to the postpardum adjustment bulletin board!").

123. Roe v. Wade, 410 U.S. 113, 153 (1973).

nancy.[124] "[I]t is important that physicians not minimize the grief process that parents undergo when either a 'selective reduction' procedure is undertaken or an accidental loss occurs early or late in a multiple pregnancy."[125] As described by one woman who underwent a selective reduction, "I felt that the fertility doctors told me, 'If you get too many babies, you just have a reduction and everything is OK.' But it wasn't OK."[126] The decision to carry a multi-fetal pregnancy to term can also have psychological consequences, especially given the vulnerability of the babies, and the health problems to which they are all so susceptible given their prematurity and low birth weights.[127] For example, of Nkem Chukwu's octuplets, the smallest weighed eleven ounces and the largest weighed one pound, eleven ounces,[128] with the smallest ultimately dying within a week of her birth.[129] The chief neonatal specialist at the hospital where the oc-

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124. In fact, there is even a support network for families facing these issues: Centers for Loss in Multiple Birth (CLIMB), Inc.: e-mail at climb@pobox.alaska.net. *See also* Allen, *supra* note 12, at 318 (describing the experience of one woman 'Marie' of Silver Springs, Maryland: "Marie . . . is still haunted by a final sonographic glimpse of her quadruplets before the reduction at Philadelphia's Thomas Jefferson medical Center . . . Now, the mother of healthy two-year-old twins, she says, 'Every time I read a newspaper article about a large delivery, it makes me sad. I think it would have been wonderful to have four.'"); Sills & Perloe, *Eight is Enough* (visited Jan. 21, 2000) <http://www.obgyn.net/english/ pubs/features/eight-is-enough.htm> (describing the experience of selective reduction as "extremely traumatic").

125. Elizabeth A. Pector, *Letter to the Editor: Dealing with Loss in Multiple Pregnancies*, AM. FAM. PHYSICIAN, Dec. 1, 1998 ("[A]ttempts to reassure parents that they will 'at least' have one or more survivors from the pregnancy will damage the physician's relationship with them."); *see also* Berman, *Loss and Multi-Fetal Pregnancies* (visited Jan. 22, 2000) <http://www.hygeia.org/poems20.htm>. Berman acknowledges the emotional trauma accompanying selective reduction even when it results in the birth of at least one healthy baby:

> Caregivers must recognize that the birth of a healthy baby will be a time of sorrow as well as joy. We must be careful not to adopt the attitude of 'don't complain, be grateful—at least you got one healthy baby.' We must take the time to acknowledge and affirm the appropriateness of the couple's emotions of loss while letting them see that they have much to be thankful for.

Id.

126. Allen, *supra* note 12, at 319.

127. *See* discussion, *supra* note 20; *see also* Melinda Sacks, *'Micro-Preemies' Come with Big Price Technology That Gives Life Takes Toll on Families*, ARIZ. REPUBLIC, Apr. 7, 1999, at D8 ("While attention has focused on the miracle of the Houston octuplets, rarely discussed is the reality of caring for babies so small that many eventually die or suffer lifelong complications."). It is more common than not for babies born of multifetal pregnancies to have serious health problems:

> The McCaughey septuplets may be healthy now . . . but if they stay that way, they'll be the exception, not the rule. A far more likely scenario is the experience of Sam and Patti Frustaci, who made the cover of *People* when six of their septuplets were born in May, 1985 (the seventh was stillborn). Five years later, three of the other babies had died and the other three had been diagnosed with a variety of medical and developmental problems.

Allen, *supra* note 12, at 287. The live birth of sextuplets in California, *see supra* note 1, was trumpeted by the press as a triumph, although the death of three of the six received less publicity. Two of the survivors are disabled. *See* Rorty and Pinkerton, *supra* note 10, at 62.

128. *See* Mark Babineck, *Eight Babies for Houston Woman—Tiniest Infant Weighs Eleven Ounces*, CHICAGO SUN-TIMES, Dec. 21, 1998, at 23.

129. *See* Babineck, *Mom Heading Home—Surviving Octuplets Stay in Hospital* (visited Dec. 30, 1998) <http://www.abcnews.go.com/sections/us/Daily/News/octuplets981230.html>; *see also* Reuters, *Three Texas Octuplets to Go Home This Week* (visited Mar. 3, 1999) <wysiwyg://16/http://

tuplets were born noted that "potential lung and heart problems are the immediate worries. After that, metabolic problems and infections are a danger."[130] Thus, both the McCaughey septuplets[131] and the surviving Chukwu octuplets[132] face an uncertain medical future. If fifteen-year-old Lisa, who was interviewed by Gilligan, could not believe how much her life had been altered by one baby, one can only imagine how having seven or eight babies with medical and/or developmental problems could alter a woman's life.

In sum, although the abortion and selective reduction decisions can be distinguished by a difference in intent,[133] the decisions to abort or carry to term, to reduce or have a large pregnancy all have significant psychological ramifications. These are often not decisions that are made and then simply forgotten about, especially when children are brought into the world, or when much-desired children are lost.

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nt.excite.com/news/r/990303/00/news-octuplets> (noting that the smallest octuplet, a girl named Odera, weighed just 11.3 ounces at birth and died on December 27, 1998, a week after birth); Associated Press, ARIZ. REPUBLIC, *Two More of Houston Eight Sent Home from Hospital*, Apr. 9, 1999, at A10.

130. Babineck, *supra* note 128.

131. *See* Elizabeth Kastor, *Bringing Up Babies*, GOOD HOUSEKEEPING, May 1999, at 110 ("[T]hree of the septuplets continue to struggle with medical problems as a result of their premature births."). Kastor notes that there have been other problems as well:

> For Natalie and Alexis, the two septuplets with the most troubling medical problems, eating has been a painful ordeal their entire lives. Both have severe reflux, a condition similar to but much more serious than adult heartburn. For months, they would eat only to spew out the formula—projectile vomiting. The girls have had esophageal operations intended to make it more difficult for them to vomit, but both have so far managed to overcome medical science, and the problem persists . . . For now, both girls are fed through tubes in their stomachs. Alexis lies in a cradle for one hour of every four, formula dripping from an IV bag into her belly . . . Kenny had to have eye surgery when he was only 2 months old to correct damage related to his premature birth. Joel has his glasses. Alexis is the smallest of the seven, and she looks closer to 6 months old than to 12 months . . . And she seems very far from sitting up, let alone crawling. She has never consistently taken a bottle. 'If you put half a Cheerio in her mouth, she gags and chokes,' says Bobbi.

Id. at 182. *See also* Justin Gillis, *MedImmune Fights Off a Virus*, WASH. POST, Mar. 22, 1999, at F12 ("Every month this winter, the McCaughey septuplets of Carlisle, Iowa, got a shot to protect them from a respiratory disease that can kill premature babies."); UPI, *McCaughey Septuplets Grow At Own Pace* (visited Apr. 25, 1999) <wysiwyg://22?http://nt.excite.com/news/u/990425/16/health-septuplets> ("[T]wo of the McCaughey ("McCOY") septuplets are being monitored for cerebral palsy. The Des Moines Register says physical therapists have been visiting the McCaughey home twice a month since October to work with 18-month-old Nathan and Alexis, who are unable to sit up unassisted.").

132. See *Octuplet's Condition Improves*, AUSTIN AMERICAN-STATESMAN, Mar. 19, 1999, at B15 ("The weakest of the seven surviving Houston octuplets has been upgraded to serious condition and is out of the neonatal intensive care unit . . . ."); *1 of Houston 8 Upgraded to 'Serious'*, ARIZ. REPUBLIC, Mar. 19, 1999, at A5; Associated Press, *Home At Last*, HOUS. CHRON., Apr. 9, 1999, at 31 ("Two of the [octuplets], Ikem and Gorom, remain in serious condition at Texas children's."); Associated Press, *Two More of the Octuplets Released From Hospital*, Apr. 8, 1999 ("The two Chukwu babies remaining at Texas Children's Hospital—Gorom and Ikem—were in serious condition Thursday night. Hospital spokeswoman Tina Foster said Gorom, the youngest of the infants, and Ikem, the firstborn boy, both have had successful abdominal surgery and are closer to going home."); *Two of Houston Octuplets Join Three Siblings at Home*, ORLANDO SENTINEL, Apr. 9, 1999, at A12.

133. *See supra* notes 34-37.

III. PROBLEMS UNIQUE TO SELECTIVE REDUCTION

A. Size, Wide Usage and Lack of Regulation of the Fertility Industry

While the abortion decision is made in a climate that is increasingly hostile to it,[134] selective reduction occurs in the context of the vast,[135] widely-used[136] and largely unregulated fertility industry.[137] The fertility industry is itself colored by the "perception that doctors in this field have strong incentives not to work in their patients' best interests."[138] Thus, one reason offered to explain why fertility doctors do not make every possible effort from the outset to avoid creating multiple pregnancies is that "in the fiercely competitive world of infertility medicine, clinics with the highest pregnancy rates tend to attract the most patients."[139] Pregnancy rates are themselves manipulated and improved upon by clinics either by selecting patients with a high likelihood of getting pregnant,[140] and/or by implanting a higher number of embryos.[141] It is important to note, however, that doctors and clinics are not the only ones with a vested stake in the outcome of fertility treatments.[142] For the patient, the investment is not only financial,[143] but an emotional one as well.[144] Hence, the selective reduction decision is one that is

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134. *See supra* notes 51 & 52.

135. *See* Judith F. Daar, *Regulating Reproductive Technologies: Panacea or Paper Tiger?*, 34 HOUS. L. REV. 609, 609 (1997) (noting that the United States now boasts over three hundred reproductive medicine clinics; they represent an estimated $350 million a year industry).

136. *See id.* (stating that reproductive medicine clinics in the United States attract over one million patients each year); *see also* Begley, *supra* note 70, at 39 (placing the number even higher, and noting that "more than 3 million couples will seek help for infertility this year"); Rick Weiss, *When Does Assisting Clients Become Experimentation? Some Experts Question the Ethics of an Unregulated Industry That Sometimes Gives Vulnerable Patients Only Part of the Truth*, L.A. TIMES, Mar. 30, 1998, at S7 ("[M]ore than 1,000 women undergo in vitro fertilization procedures every week in this country, and countless others receive other kinds of fertility treatments.").

137. *See* Daar, *supra* note 135, at 639 ("A review of federal and state laws pertaining to the practice of reproductive technologies reveals that practitioners in our country enjoy a nearly regulatory-free environment. A single inactive federal program and a handful of state laws comprise the total regulatory scheme surrounding ART."); *see also* Keith Alan Byers, *Infertility and In Vitro Fertilization: A Growing Need for Consumer-Oriented Regulation of the In Vitro Fertilization Industry*, 18 J. LEG. MED. 265, 289 (1997).

138. Note, *In Vitro Fertilization and Consumer Protection*, 109 HARV. L. REV. 2092, 2104 (1996).

139. Allen, *supra* note 12, at 318; *see also* Finkel, *supra* note 19 (describing "a technology being steered largely by for-profit fertility centers that depend on success rates to attract more business").

140. *See* Genetics & IVF Institute, *"What's Your Success Rate?": Understanding Pregnancy Statistics* (visited 1998) <http://www.givf.com/success1.html> (noting that positive selection by clinics involves favoring patients who are most likely to get pregnant in order to enrich the statistically reported patient population; some clinics also practice negative selection, which involves screening out the most hopeless cases).

141. Multiple inseminations increase the numerical odds of pregnancy with each cycle, but they also increase the odds of multifetal pregnancies warranting reduction. *See* Allen, *supra* note 12, at 318.

142. *See* Lerner, *supra* note 6, at 1A ("[D]octors know how to lower the risk of multiple births—but they, or their patients, are not always willing to do it.").

143. *See supra* note 70 (discussing the cost of treatments).

144. *See* Sills & Perloe, *Eight is Enough* (visited Jan. 21, 2000) <http://www.obgyn.net/english/pubs/features/eight-is-enough.htm> ("If such treatments [for infertility] produce too many eggs or the estrogen level is too high, the treatment cycle should be canceled . . . But there are forces (desire

made usually after a lot of time, money and anguish have been invested into the project of having a child, which is what sets this apart from the abortion decision.[145] Given the extreme financial and emotional investments, this is an area where the end result of a take-home baby is seen as justifying the means: "For couples lucky enough to become the parents of reasonably healthy children, there is something grounding about the children themselves that seems to dispel doubts about the process that produced them."[146]

Future law and policy about selective reduction should take into account not only the psychological factors described above but also the fact that the decision is made in a context where both doctors and infertile patients have a great deal at stake. Moreover, it should consider that the lack of government regulation leaves women, the largest users of the fertility industry,[147] grossly underprotected.[148]

B. The Particular Problem of Money-Back Guarantees

Money-back guarantees can be seen as fueling the fire to implant a high number of embryos. Offered by fertility clinics in order to attract a wider customer pool, [149] they provide couples with the option of paying a set fee in return for a specified number of cycles (typically three).[150] These guarantees offer an inherent incentive to doctors to undertake risky and unsafe procedures, like multiple inseminations, as a means to increase the odds of pregnancy with each

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for conception as well as time and money invested) working against such restraint."); *see also* Lisa A. Rinehart, *Infertility, the Market, the Law, and the Impact*, 35 JURIMETRICS J. 77, 106 (1994) ("Infertility patients are not only survivors; they are adventurers. They pursue treatments already available and seek out new ones based on the slimmest of hopes that there will be an answer—a baby for them to take home. Technology has become their talisman.").

145. *See* Ellen Hopkins, *Tales from the Baby Factory*, N.Y. TIMES, Mar. 15, 1992, § 40 (Magazine), at 80. Hopkins comments on the emotion trauma associated with infertility:

> IVF, of course, didn't invent the sorrow of infertility. But it—and all other assisted reproductive technologies—has certainly added a unique and perverse dimension to that pain. By its very nature, the pain has always had a cruel dynamic of hope that is dashed on a monthly basis as the woman gets her period once again.

Id.

146. Allen, *supra* note 12, at 319.

147. *See* Weiss, *supra* note 136, at 8 ("[M]ore than 1,000 women undergo in vitro fertilization procedures every week in this country, and countless others receive other kinds of fertility treatments.").

148. *See id.* at 7 (noting that minimal regulation has invited the practice of "using women as guinea pigs"); *see also* Peres, *supra* note 37, at 9 ("'You have more protection to have a tattoo or get your hair color changed than you do to have an IVF procedure,' said Richard Rawlins, director of the assisted reproduction labs at Rush-Presbyterian-St. Luke's Medical Center."). *But see* the rejection of a legislative approach *infra* notes 166 & 167. Moreover, it is important to note that legislation in this context could be tantamount to a reimposition of a patriarchal framework on the women it seeks to protect.

149. *See, e.g.*, *NBC Nightly News: Fertility Clinics with a Money-Back Guarantee* (NBC television broadcast, Aug. 1, 1998); Claudia Morain, *Money-Back Guarantee*, AM. MED. NEWS, June 1, 1998, at A25; Debra Gordon, *A Baby, or Your Money Back—Medicine: Fertility Clinics Say the Offer Assures Couples They Won't Lose Money, but Critics Call Their 'Guarantees' Unethical*, ORANGE COUNTY CAL. REG., Mar. 26, 1998, at A1.

150. *See* Byers, *supra* note 137, at 287.

IVF cycle.[151] Participating patients may be compelled to withstand risky procedures that are forced upon them as program protocol. One patient quoted in a recent article expressed that "her hands were tied by the money-back agreement. 'You have to do exactly what they say.'"[152] Here, the loss of voice identified by Gilligan is glaring.[153]

Fertility clinics profit most on money-back schemes if a woman becomes pregnant after one treatment, as opposed to undergoing several treatments before becoming pregnant. These financial considerations, may, as alluded to above, encourage physicians to over-prescribe fertility drugs or to implant too many embryos,[154] leading to risky multi-fetal pregnancies.[155] The link between money-back guarantees and selective reduction is not a difficult one to draw, especially given the incentives these money-back guarantees provide to physicians to tinker with increasing the odds of pregnancy.

A second problem posed by money-back guarantees is the illusion created by the use of the word "guarantee"; it tends to imply that successful outcomes from the treatments are guaranteed, thereby making false promises and generating unrealistic expectations.[156] Additionally, not only is there a problem with the apparent promise of success, but a problem lies in the way that success is itself defined: clinics can keep the money paid to them if a pregnancy results, and the refund is not conditioned upon the actual birth of a baby.[157] If, for example, fertility treatments produce a multi-fetal pregnancy that is selectively reduced to twins, and those twins are ultimately miscarried,[158] this is still absurdly defined as "success" under money-back guarantee plans.

IV. A CONTEMPLATION OF POSSIBLE SOLUTIONS AND CONCLUSION

The thought of injecting potassium chloride into the heart of one or several fetuses, and then having the woman carry around a dead fetus or several dead fetuses for weeks to months is not a pleasant one. Neither is the thought of a one-year-old septuplet being fed formula through her belly,[159] and facing an uncertain medical future. The decision to selectively reduce or carry multiple fetuses to term is not simple, and neither are its consequences. In fact, it is the presence of these stark medical realities that distinguishes selective reduction from the abortion decision and that raises the attendant levels of discomfort.

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151. *See* Gordon, *supra* note 149, at A1.

152. Susan Ince, *Seven Things a Fertility Doctor May Not Tell You*, GLAMOUR, Dec. 1998, at 56.

153. *See supra* Part III.3.b.

154. *See* Gordon, *supra* note 149, at A1 (describing one clinic that implanted nine fertilized embryos in a woman who had chosen the money-back option, and observing that this is an unusually high number given the age of the woman, for whom the average of implanted embryos would have been 3.95).

155. *See* discussion of risks *supra* note 20.

156. *See* Morain, *supra* note 149, at 25.

157. *See* Byers, *supra* note 137, at 287-88.

158. After selectively reducing a multifetal pregnancy down to twins, there is a slightly increased risk that the remaining twins could be miscarried: a one in seven chance, compared to one in eleven for normal twin pregnancies. S*ee* Allen, *supra* note 12, at 287.

159. *See* Kastor, *supra* note 131, at 182.

The possible outcomes include not just baby or no baby, but one baby, some babies, no babies, or many ill or disabled babies.

Given the inherent discomfort, it is clear that multiple births and selective reduction of multi-fetal pregnancies generate strong reactions in the parties involved,[160] and in the public debate.[161] One reason for the persistent discomfort, debate and discussion is that "[w]e . . . don't like a problem for which there is no immediate solution."[162] Despite this absence of obvious, immediate solutions, some possibilities do exist. In exploring these possibilities, the non-judgmental tone of Gilligan's abortion study is helpful, since one of the risks of examining multiple births and selective reduction is that "everyone feels free to judge how people create families, feels free to judge mothers. And that's dangerous."[163]

Legislation limiting the number of embryos that can legally be implanted is one means of combating and preventing, or at least curtailing, the dilemma posed by multi-fetal pregnancies and subsequent selective reduction. Some have suggested that "the number of embryos transferred be limited to two,"[164] and legislation could be one way of enforcing such a limit. British law, for example, limits the number of transferred embryos to three.[165] However, such an approach has been overtly rejected by many,[166] including the New York State Task Force on Life and Law.[167] This panel refrained from recommending legislation to enforce a limit on the number of embryos that could be implanted by a

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160. *See supra* notes 124-126. It is interesting to note that Kenny McCaughey has quit his job as a billing clerk at a Chevrolet dealership and plans to hit the lecture circuit to counsel women against selective reduction. *See, e.g.*, *New Job for Dad*, CINCINNATI POST, Mar. 24, 1999, at 14A; *Features—People*, INT'L HERALD TRIBUNE, Mar. 25, 1999, at 24.

161. *See* discussion regarding the controversy generated by multiple births *supra* note 6.

162. McNamara, *supra* note 6, at E1.

163. *Id.*

164. BLANK & MERRICK, *supra* note 20, at 92.

165. *See* Human Fertilisation and Embryology Act 1990, ch. 37; *see generally* Arlene Judith Klotsko, *Infertility, Inability and Rights: An English Case Study in* CREATING THE CHILD: THE ETHICS, LAW AND PRACTICE OF ASSISTED PROCREATION 341 (Donald Evans ed., 1996); Lee Kuo, *Lessons Learned from Great Britain's Human Fertilization and Embryology Act*: *Should the United States Regulate the Fate of Unused Frozen Embryos?*, 19 LOY. L.A. INT'L & COMP. L.J. 1027 (1997); Elizabeth Ann Pitrolo, *Comment—The Birds, the Bees, and the Deep Freeze: Is There International Consensus in the Debate Over Assisted Reproductive Technologies?*, 19 HOUS. J. INT'L L. 147, 173-77 (1996) (providing an overview of the history of the United Kingdom's law governing assisted reproductive technologies); Robert L. Stenger, *The Law and Assisted Reproduction in the United Kingdom and United States*, 9 J.L. & HEALTH 135 (1994-95); Judy Peres, *Setting Limits on High-Tech Babymaking—The Law Has Not Kept Up with Reproductive Science, Partly Because the Issues Are Difficult to Discuss*, CHICAGO TRIBUNE, July 26, 1998, at 1.

166. *See, e.g.*, Jean Macchiaroli Eggen, *The 'Orwellian Nightmare' Reconsidered: A Proposed Regulatory Framework for the Advanced Reproductive Technologies*, 25 GA. L. REV. 625, 688 (1991) ("[G]overnmental intrusion into the bedrooms of those who choose affirmatively to procreate is . . . unacceptable."); *id.* ("[A] regulation could become irrelevant, obsolete or unfairly restrictive a short time after its promulgation."); McNamara, *supra* note 6, at E1 ("While certainly monitoring within the profession should be encouraged, regulating baby making, even high-tech baby making is not a great idea."); Peres, *supra* note 165, at 1 ("U.S. fertility specialists say the British law limiting the number of transferred embryos to three is a dangerous intrusion by government into the practice of medicine. That restriction, they contend, does not allow for individual patient differences. For example, a woman over 40 who has had several failed attempts to get pregnant has very low odds of success with only three embryos.").

167. *See* Gianelli, *supra* note 11, at 3.

physician. While it shunned legislation, the panel did not embrace the practice of selective reduction, noting that its availability "should not be used as a justification for creating a significant likelihood of high-order multiple gestation."[168] The panel ultimately viewed legislation as "an inappropriate vehicle for making medical decisions, particularly those involving complex and evolving variables."[169]

In addition to being unable to adequately address the complexity of infertility, legislation in this context could hurt the very people it seeks to protect. By listening to the voices of the women described herein, it is apparent that they desperately wanted to be pregnant and to increase their odds both of conceiving and of carrying a healthy baby (or babies) to term. Such motivations are not unique to the women who opted to selectively reduce. Surely Bobbi McCaughey and Nkem Chukwu were also motivated by the health of their babies, or else they would likely not have agreed to be bed-ridden to increase the chances of the babies remaining in utero longer.[170] Instead of legislative restrictions, one suggestion is that "parents who express concerns about the moral acceptability of selective fetal reduction prior to treatment should not be given the most powerful fertility drugs, which can stimulate production of multiples."[171] This is one way to stop the problem before it starts, but it can also be seen as limiting reproductive possibilities based on beliefs about abortion, which, while logical in this context, is inherently problematic.

Another viable alternative lies in the use of professional guidelines. In fact, the New York State Task Force on Life and Law called on professional societies to set "strict upper limits."[172] Professional guidelines can thus address the number of embryos implanted in the womb;[173] they can also prompt doctors to monitor the number of eggs made available through fertility drugs, encouraging doctors to halt treatments if, in a given month, the drugs cause too many egg-producing follicles to mature.[174]

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168. *Id.*

169. *Id.*

170. *See* McCormick & Kantrowitz, *supra* note 113, at 62. *See also* Babineck, *Mom Heading Home—Surviving Octuplets Stay in Hospital* (visited Dec. 30, 1998) <http://www.abcnews.go.com/sections/us/Daily/News/octuplets981230.html>.

171. Sills & Perloe, *Eight is Enough* (visited Jan. 21, 2000) <http://www.obgyn.net/english/pubs/features/eight-is-enough.htm>.

172. Gianelli, *supra* note 11, at 3.

173. *See* Lerner, *supra* note 6. at 1A (describing one clinic in the Midwest that had "adopted guidelines in 1995 to control the number of fertilized eggs used in in-vitro fertilization—two eggs for women younger than 30, three for women older than 30. They're not strict limits . . . but most couples abide by them—and the clinic's success rates have only improved since then.").

174. *See* Manier, *supra* note 22, at 1. Manier comments further on how monitoring the woman's egg-production can reduce multi-fetal pregnancies:

> [M]onitoring the number of mature follicles is relatively easy if done by a qualified professional. Ultrasound readings show how many follicles have grown and matured within the ovaries. At the University of Chicago Hospitals, doctors say they do not give the drugs that release the eggs if more than three or four follicles have matured. Although that means the couple must wait another month and try another round of drugs that can cost more than $1,000 per treatment, most doctors say the expense and frustration is minimal compared with the estimated $2 million it will cost to care for the Houston octuplets.

Id.

Rapidly advancing technology is yet another means of combating the problem posed by multiple births and selective reduction. Common practice typically involves transferring, on average, four embryos, with the range usually spanning anywhere from one to six.[175] However, recent advances now allow doctors to transfer on the fifth day of growing fertilized embryos outside of the womb,[176] instead of on the third day. This allows for implantation of the two or three embryos that appear most likely to thrive in the womb.[177] Obviously as reproductive technology continues to evolve, so too will the possible medical solutions to the problems exposed herein.

A final solution involves changing not the actual practices or procedures of fertility treatments, but the very nature of the physician-patient relationship itself. This change involves shifting from a model of cure-giving, based on notions of "doctor knows best" and the patient following "doctor's orders," to one of care-giving, based on employing personal powers in the "art" of medicine.[178] "Caregiving might include, for example, asking questions about the body that take into account the patient's meanings; or, for instance, promoting the expression of feeling by patients to enhance psychological well-being."[179] This approach is desirable for two reasons. First, it validates patient feeling states and responses, thereby allowing room for parents to properly grieve the loss of the desired child that was selectively reduced.[180] "Patients want and need to hear that their physician is concerned about their adjustment to such a loss. Simple gestures, such as asking how they're coping when they bring surviving children to the physician's office . . . or mentioning the deceased child by name," are means of enhancing the quality of the doctor's professional relationship with families who underwent selective reduction.[181] A care-giving approach wel-

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175. *See* Liselotte Mettler & H. W. Michelmann, *In Vitro Fertilization and Embryo Transfer*, 10 AM. J. REPRODUCTIVE IMMUNOLOGY & MICROBIOLOGY 111, 112 (1986) (noting that since pregnancy rates increase with the number of embryos transferred, up to six embryos have been transferred at a time); Shirley J. Paine et al., *Ethical Dilemmas in Reproductive Medicine*, 18 WHITTIER L. REV. 51, 55 (1996).

176. *See* Manier, *supra* note 22, at 1.

177. *See id. See also* Toni Gerber Hope, *The Ultimate Fertility Guide*, REDBOOK, Nov. 1, 1998, at 146. Hope comments on the benefit of checking the quality of the embryos prior to implantation:

> You can avoid the risk of multiple births by limiting the number of embryos that are transferred back to the mother. But then you also cut the chances of success. Is there a happy medium, so to speak? Going beyond mere numbers, some specialists believe that checking the quality of embryos might be the ticket.

Id. See generally Peres, *supra* note 37, at 1. Peres reports that new technology allows doctors to cultivate embryos longer in the lab, allowing them to check the embryos' quality before implantation:

> [S]cientists can now culture embryos longer in the lab, to a stage where they can tell which ones are likely to survive in the uterus. 'Doctors used to put back four or five embryos on Day Three (after fertilization), when they're just eight cells and you can't tell which ones are good,' [the director of the assisted reproduction labs at Rush-Presbyterian-St. Luke's Medical Center] said. 'Now they can put back two or three on Day Five—and often, with just two, you still get twins.

Id.

178. *See* Michael H. Cohen, *Toward a Bioethics of Compassion*, 28 IND. L. REV. 667, 668 (1995).

179. *Id.* at 668.

180. *See* Pector, *supra* note 125, at 1969 ("Properly grieving the loss of the equally desired child promotes healthy development of surviving children from the same pregnancy, in addition to children who were born previously or subsequently.").

181. *Id.*

comes and encourages such gestures. On the other hand, a cure-giving model, representative of "a larger societal failure to honor patient feeling states and responses" in a society where medical care is dominated by technology,[182] would seem to stifle such grief. Second, a care-giving model could combat the patient's loss of voice, as its concern with patient feelings and responses serves to reintroduce voice into medical treatment. Nowhere are the loss of voice and loss of choice more apparent than in the words of one woman who participated in a money-back guarantee plan, who noted, "You have to do exactly what they say."[183] Care-giving shifts away from the notion of blindly following doctor's orders, as it recognizes "compassion, fidelity and humanity as common denominators, across time and cultures, in the ethical aspirations of healing professionals."[184]

In conclusion, whether or not one adheres to a view of relational feminism, and whether or not one agrees with the analogy between selective reduction and abortion are beside the point. Whether or not one is a staunch advocate of reproductive rights is also beside the point, since selective reduction raises such complex issues of human costs. What matters is that selective reduction is clearly a problem that needs to be addressed, both in the public and private realms. No acceptable solution can be devised without taking into account the experiences of women who want so badly to have a child, and who find themselves pregnant with multiple fetuses. Gilligan's work underscores the importance of listening to women's voices here, and of refraining from dismissing them as inconsequential[185] or from framing their underlying decision as a "piece of cake."[186]

In spite of the proposed solutions discussed above, this Article will not conclude with one neat, all-encompassing solution to the problems identified herein, in large part because such a solution seemingly does not exist. Professional guidelines, technology and physician attitudes are all important areas for change and even, perhaps, is cautious legislation. The purpose of this Article, however, is not to resolve this dilemma, not to end the discussion, but instead to pose more questions[187] in order to begin a deeper contemplation of where we, as a society, can possibly go from here.

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182. Cohen, *supra* note 178, at 668.

183. Ince, *supra* note 152, at 56.

184. Cohen, *supra* note 178, at 677.

185. *See* Gilligan, *Hearing the Difference*, *supra* note 109, at 123 ("Listening to women's voices clarified the ethic of care, not because care is essentially associated with women or part of women's nature, but because women for a combination of psychological and political reasons voiced relational realities that were otherwise unspoken or dismissed as inconsequential.").

186. Allen, *supra* note 12.

187. *See* DONNA J. HARAWAY, MODEST_WITNESS@SECOND_MILLENIUM.FEMALEMAN_MEETS_ ONCOMOUSE: FEMINISM AND TECHNOSCIENCE 187 (1997). Haraway maintains that addressing the question of where babies come from is still important:

> Like it or not, as if we were children dealing with adults' hidden secrets, feminists could not avoid relentlessly asking where babies come from. Our answers have repeatedly challenged the reduction of the original and originating question to literalized and universalized women's body parts. It turns out that addressing the question of where babies come from puts us at the center of the action in the New World Order.

Id.