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How (Not) to Regulate Assisted Reproductive Technology: Lessons from “Octomom”

RADHIKA RAO*

I. Introduction

On January 26, 2009, Nadya Suleman gave birth to octuplets by means of in vitro fertilization (IVF). Initially heralded as a medical miracle, this event ultimately exposed Suleman to intense public anger and outrage as the details of her life began to surface—that she was an unemployed single mother who already had six children, and was supporting herself with worker’s compensation and disability benefits.¹ Nadya Suleman has been widely demonized as the “Octomom”²—a clever juxtaposition of octuplets and mother that conjures up images of a sinister octopus-like figure with eight squirming tentacles, reminiscent of the evil sea witch in Disney’s *Little Mermaid* movie.

An article in the medical journal *Fertility and Sterility* characterized the birth of the Suleman octuplets as a “truly transformative event” because it incited so much controversy and because it “served as a catalyst to examine a range of clinical and ethical decisions.”³ After these births, the American Society for Reproductive Medicine (ASRM) and the Society

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1. Jessica Garrison, Kimi Yoshino & Catherine Ho, Op. Ed., *Octuplets’ Birth Spawns Outrage from Public*, L.A. TIMES, Feb. 7, 2009; available at <http://articles.latimes.com/2009/feb/07/local/me-octuplets7>; Rong-Gong Lin II & Jessica Garrison, *California Medical Board Revokes License of “Octomom” Doctor*, L.A. TIMES, June 2, 2011, available at <http://articles.latimes.com/2011/jun/02/local/la-me-0602-octomom-doctor-20110602>.

2. I deliberately use the label “Octomom” in my title to evoke these images, but I do not approve of that epithet, so from now on I will refer to the mother of the octuplets by her actual name, and not as Octomom.

3. Steven Ory, *The American Octuplet Experience: A Transformative Event*, 94 FERTILITY & STERILITY 337 (2010).

for Assisted Reproductive Technology (SART) were besieged by calls from reporters and the general public raising questions about the lack of regulation in the field of fertility treatments.⁴ The public outcry altered the public attitude towards ART and prompted a legislative backlash. Several states proposed new laws to regulate ART.⁵ Both Georgia⁶ and Missouri⁷ proposed, but ultimately did not enact, legislation that would have limited the number of embryos that could be implanted in a woman's womb at the same time. The California Legislature considered a bill that would have placed fertility clinics under the jurisdiction of the Medical Board of California,⁸ although this bill was ultimately vetoed by then-Governor Schwarzenegger.

Some critics of Nadya Suleman focus upon the medical procedures that led to the birth of octuplets, such as the implantation of an excessive number of embryos in her womb.⁹ Yet other critics focus upon Nadya Suleman herself—her identity as a non-white single mother who was unemployed and had been supporting herself with worker's compensation and disability payments for several years. They also question Suleman's mental state, as well as her ability to parent eight more children, when she already had six children under the age of eight, and was living with her

4. *Id.* According to Ory:

The ASRM Public Affairs office received more than 100 queries from various news organizations. Many were seeking background, but several interviewers inferred that ASRM and SART bore direct responsibility, asking questions such as, "what are you going to do about this" and "how did you allow this to happen?" Similar concerns and opinions were publicly and privately expressed by some [ASRM and SART] members.

Id.

5. S. McAffrey, "Octomom" Spawns Bills Limiting Embryo Implants, USA TODAY, Mar. 5, 2009, available at http://usatoday30.usatoday.com/news/nation/2009-03-04-octo-bill_N.htm.

6. The legislation proposed in Georgia, titled "The Ethical Treatment of Human Embryos Act," would have limited the number of embryos that could be transferred to two embryos for women under age forty and three embryos for women age forty and older. It also would have restricted the total number of embryos that could be created in a single cycle to the number that could be transferred in that cycle. S.B. 169, Gen. Assem. (Ga. 2009). See http://www.legis.ga.gov/legis/2009_10/versions/sb169_As_introduced_LC_37_0857_2.htm. These provisions were ultimately removed from the bill due to opposition from a large group of patients and physicians. See Ory, *supra* note 3, at 337.

7. The Missouri bill would have adopted current ASRM-SART Guidelines on the maximum number of embryos to be transferred for women at various ages into state law. H.B. 810, 95th Gen. Assem., 1st Reg. Sess. (Mo. 2009).

8. The bill, SB 674, would have placed fertility clinics and cosmetic surgery providers under the jurisdiction of the Medical Board of California. See Malcolm MacLachlan, "Octomom" Inspires Bill to Regulate Fertility Clinics, CAPITOL WEEKLY, Mar. 5, 2009, available at <http://www.geneticsandsociety.org/article.php?id=4567>.

9. Nadya Suleman initially informed reporters that only six embryos had been implanted in her womb but two had split, resulting in the birth of eight children. However, at the hearing to determine whether or not to revoke his medical license, her physician, Dr. Michael Kamrava, admitted that he had actually implanted twelve embryos in her womb.

parents in a three-bedroom house on the verge of foreclosure.

Suleman's case provides a paradigm, both for how to regulate, and, especially, for how not to regulate, ART. Suleman's case exemplifies the line between status and conduct-based regulation of ART because it has triggered calls for both kinds of regulation. Status-based regulation would limit ART to certain types of people while conduct-based regulation of ART would regulate what may be done but not who may do it. To those concerned with equality, ART regulation should focus upon conduct rather than status, upon what may be done and not who is doing it. Moreover, the concern for equality leads me to prefer direct and visible regulation to indirect, invisible regulation, which tends to be discriminatory and to privilege majoritarian values. Finally, clearly articulated regulations that are enacted by publicly accountable bodies are preferable to ad hoc, discretionary determinations rendered by a patchwork of individual decisionmakers, such as physicians, fertility clinics, professional organizations, or even judges and juries ruling in different cases.

II. Status vs. Conduct Regulation

Suleman's case exemplifies the line between status and conduct-based regulation of ART because it has provoked calls for both kinds of regulation. Status-based regulation would confine ART to certain types of people, for example, married couples rather than single persons, or heterosexuals rather than homosexuals. Status-based regulation might also restrict access to ART based upon factors such as race, sex, socioeconomic class, or disability. Conduct-based regulation of ART, on the other hand, would regulate *what* may be done but not *who* may do it. For example, laws prohibiting certain technologies, such as reproductive cloning, or laws limiting the total number of embryos that can be implanted in a woman's womb at the same time, would regulate conduct in order to prevent potential harm—either to women or to the children born of such technologies. Yet such laws would not limit the kinds of persons that could have access to ART.

I have previously discussed this distinction between status and conduct-based regulation of ART.¹⁰ My approach to constitutional analysis of ART emphasizes reproductive equality rather than reproductive liberty. I argue that there is no general right to use ART as a matter of reproductive autonomy, but there may be a more limited right to use ART as a matter of reproductive equality. Accordingly, the government could prohibit use of a particular technology across the board for everyone. However, once

10. Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO. WASH. L. REV. 1457 (2008).

the state permits use in some contexts, it should not be able to forbid use of the same technology in other contexts. Hence, all persons must possess an equal right, even if no one retains an absolute right, to use ART.

My theory does not bar the government from drawing any lines with respect to ART; instead, it simply circumscribes the state's regulatory power when the lines between what is permitted and what is proscribed are unconstitutional. Lines drawn based upon the status of the persons involved should be judged unconstitutional, whereas lines drawn to differentiate between different acts should be deemed constitutional. Hence, a law that permits ART to be used by married persons, but not single persons, or by heterosexuals, but not homosexuals, should be deemed unconstitutional. However, a law that merely distinguishes between different acts, such as a law that limits the total number of embryos that may be implanted in a woman's womb at any one time, will likely be judged constitutional.

Applying this theory to the *Suleman* case, laws that would limit access to ART based upon the status of the persons involved should be deemed impermissible, but laws that evenhandedly regulate conduct in order to prevent harm should be judged constitutional. This raises the question why so many people feel indignant about the birth of octuplets to Nadya Suleman? Almost everyone appears to disapprove of Nadya Suleman, but the reasons behind their disapproval are remarkably varied. Many critics decry the fact that Suleman sought to have children by means of IVF, even though she was an unemployed, non-white single mother who was receiving government assistance in the form of disability payments. From the perspective of equal liberty, these are impermissible factors upon which to premise regulation because they would limit access to ART based solely upon the individual's position in society.

Setting aside purely status-based factors, such as Suleman's marital state, her ethnicity, or her income level, some of Suleman's critics emphasize the sheer size of her brood. They find it outrageous that Suleman gave birth to octuplets when she already had six children under the age of eight. These critics argue that "eight is enough," and that Suleman's inordinate desire to reproduce in such large quantities is the cause for concern. But what exactly is so objectionable about having eight—or even fourteen—children? U.S. law generally does not limit family size for fertile persons, so can or should we cap family size for the infertile? And if the problem is not the size of Suleman's brood, but rather the fact that she had so many children *as an unemployed, non-white single mother who was receiving disability payments*, then once again, her offense seems to turn upon *who* she is rather than *what* she did. But perhaps the problem is not that Suleman now possesses a total of fourteen children, but rather that she

gave birth to eight children at the same time. In this case, the problem is not that “eight is enough,” but rather that eight at one time is too much. This is because multiple births—especially in such high numbers—pose a grave risk of harm, both to the mother and to the children born as a result of ART. I believe that laws that focus upon this type of behavior and regulate it evenhandedly and across the board for everyone should be deemed constitutional.

Still other critics focus upon Suleman’s actions and what they seem to suggest about her mental capacity. These critics argue that Suleman’s extraordinary desire to have so many children under such extreme circumstances itself provides evidence that she is unhinged or mentally unstable and, thus, unfit to be a parent. But once again, U.S. law does not generally condition a fertile person’s right to have a child upon proof of a certain psychological or mental capacity, so can or should we demand a psychological exam as a prerequisite for infertile persons to have children? Although these criticisms appear to be couched in the language of conduct, I fear that they inevitably turn upon status and may lead to dangerous judgments regarding who is “fit” to be a parent and who is not. For example, would we infer mental instability if the same desire to have a large number of children were manifest in a heterosexual married couple,¹¹ or a fabulously wealthy and famous movie star, such as Angelina Jolie? In light of the tragic history of forced sterilization in the United States,¹² I believe that the power to choose who should reproduce and who should not is too great and the risk to equality is too grave to entrust such dangerous judgments to third parties, whether the government or the medical profession. In this respect, I agree with scholars who argue that infertile persons should be granted equal liberty with fertile persons, so that there should be parallel regulation of coital and noncoital reproduction.¹³

III. Direct vs. Indirect Government Regulation

What are the alternatives to direct government regulation of assisted reproductive technology? Deregulation of ART is a myth—in our Foucauldian world, government is omnipresent. One alternative to direct government regulation is the indirect regulation of ART that already

11. See, e.g., *CHEAPER BY THE DOZEN*, (20th Century Fox 1950) (laudatory depiction of a family with twelve children).

12. Laws authorizing forced sterilization often appear to be linked to various forms of discrimination based upon socioeconomic class, race, or other indicia of powerlessness. See, e.g., *Buck v. Bell*, 274 U.S. 200 (1927); *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

13. See Naomi R. Cahn & Jennifer M. Collins, *Eight Is Enough*, 103 NW. U. L. REV. 501, 512–13 (2009) (stating that “we think families created via ART are not . . . truly analogous to families formed by adoption. Instead, the better comparison is to families created without physical intervention.”).

exists in the form of tort liability and the rules prescribed by family law. The tort system provides one means to regulate the safety of ART by threatening physicians and parents with liability if they engage in negligent conduct that causes harm to offspring.¹⁴ And the family law system employs the allocation of parental rights and the best-interests-of-the-child standard as another mechanism to police the use of ART.¹⁵ I agree with those who charge that direct government regulation of ART poses a tremendous risk to equality because the majority may not be willing to extend equal rights to use ART to members of unpopular minority groups. Italy, for example, for a long time possessed no laws regulating ART, yet when the country ultimately chose to enact such laws, they explicitly confined the use of ART to married or “stable” heterosexual couples who are of the childbearing age and infertile, denying any use of these technologies to single persons and homosexuals.¹⁶ The concern is that ART regulation in the United States would follow a parallel path by explicitly restricting access to married persons and heterosexuals, although such blatantly discriminatory laws would likely ultimately be overturned as unconstitutional in this country. An even more insidious threat to equality lurks in the background rules of tort liability and family law.

Tort liability is a random and haphazard process that overcompensates some, undercompensates others, and costs a huge amount to administer, so that it is incredibly inefficient. Yet some scholars suggest that the torts system may be more desirable than direct government regulation of ART because it avoids—or appears to avoid—the problem of government designation of which controversial uses of ART are undesirable and cause harm to women or to children. For example, imposing tort liability upon parents who genetically select traits in their offspring might appear preferable to explicit government regulation because it sidesteps the vexing problem of eugenics by not requiring the government to determine which genetic traits are undesirable. Thus, a principal virtue of tort liability is that it appears not to be a form of government regulation at all. Yet tort liability does not really imply a lack of government regulation; government has not withdrawn from the field. The government is effectively regulating by permitting tort suits to go forward, as the legislature clearly possesses the power to enact a law that would eliminate liability. Indeed, this is exactly what happened in California in the wake of a ruling that

14. See, e.g., Kirsten Rabe Smolensky, *Creating Children with Disabilities: Parental Tort Liability for Preimplantation Genetic Interventions*, 60 HASTINGS L.J. 299 (Dec. 2008).

15. See, e.g., Mary Crossley, *Dimensions of Equality in Regulating Assisted Reproductive Technologies*, 9 J. GENDER RACE & JUST. 273 (2005) (referring to laws that “prevent some individuals from claiming legal protections relating to the parentage of children born as a result of the use of ARTs” based upon their marital status).

16. See Rao, *Equal Liberty*, *supra* note 10.

authorized the imposition of tort liability for the negligent use of ART. In *Curlender v. Bio-Sciences Laboratory*,¹⁷ a California appellate court allowed a lawsuit to proceed against a medical laboratory, which had negligently conducted blood tests that resulted in the wrongful birth of a child afflicted with Tay-Sachs disease. In dicta, the court also suggested that damages might even be available against parents who negligently conceived or carried to term offspring with a serious genetic disease. This language apparently prompted the California Legislature to enact a law that expressly relieved parents of tort liability for wrongful birth of an impaired child.¹⁸ Thus, the government's failure to prevent the imposition of tort liability may itself be characterized as a form of government regulation.

More fundamentally, the torts system masks the problem of direct government regulation of ART only at the cost of delegating the critical power to make decisions regarding the freedom to reproduce using ART to a patchwork of judges or juries ruling in individual cases. By permitting tort liability, government is not withdrawing from the field. Instead, it is giving judges or juries—uneducated members of the general population—untrammelled authority to decide which physician and parental decisions inflict harm and which do not.¹⁹ This greatly increases the risk of discrimination because such sporadic decisionmakers are likely to enact their own conscious or unconscious biases through the subjective and malleable standards of tort law. Moreover, the lack of transparency would make these types of discretionary decisions incredibly difficult to challenge, effectively insulating them from all oversight.

The *Suleman* case provides an excellent example of the discriminatory character of tort law. After the birth of octuplets to Nadya Suleman, her physician, Dr. Michael Kamrava, was accused of “gross negligence” by the California Medical Board and ultimately lost his license to practice medicine.²⁰ It is not clear exactly why Kamrava was accused of gross negligence—whether it was because of what he did, or whether it was because of the identity of his patient. The first and second causes for discipline alleged in the Medical Board's complaint suggest that he was

17. *Curlender v. Bio-Sciences Laboratories*, 165 Cal. Rptr. 477 (Ct. App. 1980).

18. *Id.* at 486.

19. *Id.* at 489. The *Curlender* court also suggested that the parents of a seriously impaired infant who, with full knowledge of the child's likely condition, “made a conscious choice to proceed with a pregnancy” could be held liable “for the pain, suffering and misery which they have wrought upon their offspring.” *Id.* In response to this suggestion, the California Legislature enacted section 43.6 of the Civil Code, which provides that “[n]o cause of action arises against a parent of a child based upon the claim that the child should not have been conceived or, if conceived, should not have been allowed to have been born alive.” *Turpin v. Sortini*, 643 P.2d 954 (Cal. 1982).

20. Rong-Gong Lin II & Jessica Garrison, *California Medical Board Revokes License of “Octomom” Doctor*, L.A. TIMES, June 2, 2011.

singled out because of his conduct in transferring a number of embryos that far exceeded the guidelines set forth by the ASRM, and in repeatedly initiating a fresh cycle of oocyte retrieval when frozen embryos were available. Yet these actions are far from unique: surveys suggest that many other physicians engaged in precisely the same conduct without facing any consequences. The third cause for discipline alleges that Kamrava was guilty of gross negligence because of his “failure to refer the patient for a mental health evaluation,” even though “N.S. was a single woman who had multiple children, all conceived from IVF [and] [s]hortly after giving birth, N.S. repeatedly returned to Respondent for consultation on more IVF cycles for additional pregnancies, without any period of delay.” These statements suggest that it was not so much Kamrava’s conduct, but rather the identity of his patient that led the California Medical Board to take action against him and, ultimately, to revoke his medical license. I fear that the California Medical Board singled out Nadya Suleman’s physician and accused him of “gross negligence” because he failed to adequately fulfill his role as a gatekeeper by denying access to ART to those who depart from society’s norms—in this case, an unemployed single mother who already had too many children conceived through IVF.

Similarly, indirect government regulation of ART by means of the family law system for allocating parental rights and responsibilities is all too likely to inscribe into law the preferences of majoritarian groups seeking to replicate the “traditional family.” For example, the Uniform Parentage Act protects the parental rights of a married couple undergoing artificial insemination with donor sperm, and provides that the sperm donor is not the legal father of the child. However, the 1973 version of the UPA denied the same protection to a single woman undergoing artificial insemination with donor sperm, and this version of the UPA has been adopted in many states, suggesting that the express rules of family law often privilege the conventional, marital family.²¹

Moreover, such bias may be implicit in the judicial decisions awarding custody to children born of ART, as well. For example, a New Jersey court recently ruled that a gestational surrogate who gave birth to twin girls by means of ART was their legal mother, over the objections of the gay married couple for whom she had agreed to gestate the embryos.²² The court reached this conclusion (and permitted the gestational surrogate to go to trial to obtain primary custody), even though one member of the gay couple had provided the sperm and thus possessed a genetic connec-

21. UNIF. PARENTAGE ACT § 5(b) (1973).

22. See Stephanie Saul, *New Jersey Judge Calls Surrogate Legal Mother of Twins*, N.Y. TIMES, Dec. 30, 2009).

tion to the children that the gestational surrogate lacked, and even though the surrogate had signed a contract agreeing to gestate and then relinquish custody of the children.²³ However, in another gestational surrogacy case in California, the California Supreme Court ruled that an African-American gestational surrogate was not the legal mother of a child when she signed a contract with a straight, married couple to carry a half-white/half-Asian embryo created with the wife's egg and the husband's sperm. Perhaps these contradictory outcomes are actually the result of significant factual or legal differences—diverse jurisdictions may adopt different approaches to the same questions. But perhaps they are the result of the race and sexual orientation of the parties involved. When the precise grounds for such differences are not clearly delineated, they may be difficult to challenge as discriminatory in the realm of family law, effectively insulating them from all oversight. For these reasons, I believe that the indirect, apparently invisible, government regulation that is accomplished under the rubric of family law or tort liability may pose an even greater threat to equality than direct and clearly visible legislative or administrative regulation of ART.

The *Suleman* case also demonstrates the discriminatory potential of family law. Four months after the birth of the Suleman octuplets, a petition seeking the appointment of a guardian for their estates was filed by a man named Paul Petersen.²⁴ The probate court denied Nadya Suleman's motion to dismiss this petition and instead permitted an investigation to proceed, stating that it "invites [SSA] to conduct an investigation and file with the court a report and recommendation concerning the proposed guardianship of the estates of the named minors."²⁵ The California Court of Appeals ultimately dismissed the petition because it was filed by a complete stranger against the mother of the octuplets, and because it failed to allege any facts indicating financial mismanagement or other grounds to warrant judicial intervention into the private realm of family life.²⁶ But this holding offers scant security, because it is quite clear that another court ruling on the same issue would be free to reach a radically different conclusion under the flexible forms of family law.

IV. Public vs. Private Self-Regulation

Another alternative to direct government regulation of ART is self-regulation by the medical profession. However, the evidence suggests that self-regulation will not work because financial and other incentives drive

23. *Id.*

24. *See* Nadya Suleman v. Superior Court, 103 Cal. Rptr. 3d 651 (Ct. App. 2010).

25. *Id.* at 1294.

26. *See id.*

doctors to ignore or flout professional guidelines, and the medical profession lacks the power or the will to effectively enforce these guidelines. Before the birth of octuplets to Nadya Suleman, the ASRM had already established guidelines regarding the maximum number of embryos to be implanted in women at various age ranges, yet her physician flagrantly and repeatedly violated these guidelines. Dr. Michael Kamrava claimed that he departed from the guidelines and implanted the unprecedentedly large number of twelve embryos because Suleman requested him to do so, even though he understood that this would endanger both her health and that of her potential offspring. Concerned about backlash after the birth of the octuplets, the medical profession attempted to make an example of her physician by belatedly enforcing its guidelines against him: Dr. Kamrava was first expelled from the ASRM and later accused of “gross negligence” by the California Medical Board, which forced him to undergo a lengthy hearing and ultimately concluded that he should lose his medical license.

Suleman’s physician is the first person ever to have been disciplined for violating ASRM guidelines, even though studies demonstrate that his conduct of implanting many more embryos than is recommended under the guidelines was not an isolated departure, but a relatively common occurrence. A 2010 article published in *Fertility & Sterility* examined embryo transfer practices in the United States and found that 94% of the clinics surveyed reported routinely following ASRM embryo transfer guidelines.²⁷ However, 55% of these same clinics conceded that they would depart from the guidelines based upon a patient’s request²⁸—precisely the same behavior that caused Dr. Kamrava to be expelled from the ASRM and lose his medical license. Another 55% of the clinics stated that they would deviate from the guidelines for cycles involving the transfer of frozen embryos, while 75% would deviate for patients with previously failed IVF cycles.²⁹ Thus, the data suggests that self-regulation will not work because physicians frequently fail to follow their own professional guidelines and because the medical profession is unable or unwilling to effectively enforce these guidelines against the vast majority of physicians and fertility clinics.

In addition, the financial incentives to flout the guidelines are compelling, as clinics implant many more than the recommended number of embryos in order to inflate their success rates and attract patients. Indeed,

27. Emily S. Jungheim et al., *Embryo Transfer Practices in the United States: A Survey of Clinics Registered with the Society for Assisted Reproductive Technology*, 94 *FERTILITY & STERILITY* 2 (2010), available at [http://www.fertstert.org/article/S0015-0282\(09\)02483-2/fulltext](http://www.fertstert.org/article/S0015-0282(09)02483-2/fulltext).

28. See *id.* at 2.

29. See *id.* at 2–3.

these incentives may actually be exacerbated by the sole federal law regulating the fertility industry, the Fertility Clinic Success Rate and Certification Act of 1992, which creates a system for the accurate reporting of information regarding the efficacy of fertility treatments.³⁰ By requiring clinics to report their success rates, which are calculated based upon the total number of live births, this law perversely encourages clinics to employ techniques that may lead to multiple births in order to maximize the total number of children born using ARTs. Another article in *Fertility & Sterility* suggests that these incentives might be reduced by modifying the definition of “reproductive success” and redefining the birth of triplets or higher-order multiples as a “failure” rather than a “success.”³¹ Perhaps these incentives might also be altered by requiring a higher standard of informed consent, for example, by mandating that patients be given information about the risks of multiple gestation and strongly urged to accept single embryo transfer.

But there is an even more fundamental problem with self-regulation by the medical profession. Self-regulation poses an even greater threat to equality than government regulation because physicians and clinics are likely to regulate in all the wrong ways. Some ART providers may conclude that the lesson to be learned from the outcry over Suleman’s case is not to allow ART to be used by the “wrong” people—single women, gays and lesbians, poor persons, and those with disabilities. Empirical evidence suggests that providers will deny access to ART on a variety of problematic grounds that turn upon the status of the participants rather than the harms posed by their actions.

In fact, a 2005 survey of the screening practices of ART providers revealed rampant discrimination on the basis of marital status, sexual orientation, sex, age, economic circumstances, and health or disability.³² According to the survey, 53% of ART providers stated that they would be extremely likely or very likely to turn away a man who does not have a wife or partner, while 20% would reject a woman who does not have a husband or partner.³³ Along the same lines, 48% would be extremely likely or very likely to turn away a gay couple, while 17% would reject a lesbian couple.³⁴ These statistics demonstrate that ART providers, by their

30. 42 U.S.C. §§ 263a-1 to -7 (2000).

31. Lawrence Grunfeld, M. Luna, T. Mukherjee, B. Sandler, Y. Nagashima, A.B. Copperman, *Redefining in Vitro Fertilization Success: Should Triplets Be Considered Failures?* 90 *FERTILITY & STERILITY* 1064 (Oct. 2008).

32. See Andrea D. Gurmankin et al., *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 *FERTILITY & STERILITY* 61 (2005).

33. See *id.* at 65.

34. See *id.*

own admission, are already discriminating against unmarried persons and homosexual couples. But even within the categories of marital status and sexual orientation discrimination, ART providers appear to be engaging in a form of sex discrimination by exhibiting a marked preference for the provision of services to women over men. Although the survey provides no explanation for this puzzling gender-based disparity, I believe that it probably stems from traditional gender-role stereotypes, which intimately associate women with reproduction and childbearing.

Similarly, economic and age-based discrimination were also quite prevalent; 38% of ART providers acknowledged that they would be extremely likely or very likely to reject a couple on welfare who wishes to pay for ART using social security checks, while 18% conceded that they would turn away a couple if both members were forty-three years old.³⁵ Health or disability discrimination also appears common, with 59% of ART providers stating that they would be extremely likely or very likely to reject HIV-positive women, while 55% would exclude women who have severe diabetes (and for whom pregnancy poses a 10% risk of death), 15% would reject couples with limited intellectual capacity, and 13% would turn away women with severe bipolar disorder.³⁶ Only race discrimination appears to be off-limits, with just 5% of ART providers willing to acknowledge that they would turn away a biracial couple.³⁷

In some states, the discriminatory denial of access to medical services by physicians may be challenged under state public accommodation laws. Indeed, this is exactly what happened in the case of *North Coast Women's Care Medical Group v. San Diego County Superior Court*,³⁸ in which a physician refused to treat a lesbian couple seeking to have a child by means of intrauterine insemination with donor sperm. The couple challenged the denial of services by the physician and the medical group under the Unruh Civil Rights Act, which prohibits discrimination based upon marital status and sexual orientation. The California Supreme Court ultimately rejected the physician's argument that she was exempt from complying with the Unruh Civil Rights Act based upon the rights of religious freedom and free speech guaranteed under the federal and state constitutions. Thus, this ruling promises recourse against the discriminatory denial of access to ART in California, yet in most other states, such denials are completely immune from oversight.

35. *See id.*

36. *See id.*

37. *See id.*

38. *N. Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Sup. Ct.*, 189 P.3d 959 (Cal. 2008).

V. Conclusion

The birth of octuplets to Nadya Suleman was a truly transformative event—it completely changed the regulatory climate in the field of assisted reproduction. Prior to this event, no one seemed concerned about the lack of regulation. However, after the birth of the Suleman octuplets, there has been a legislative backlash—several states proposed new laws to regulate ART. The media attention also placed great pressure upon the medical community, which has responded with a regulatory backlash and belated attempts to enforce professional regulations: Suleman’s physician was the first physician expelled from the ASRM and later faced accusations of “gross negligence” from the California Medical Board, which conducted a hearing and ultimately revoked his medical license.

It is no longer a question of *whether* to regulate ART—the only question is *how* to regulate ART, and *who* should do the regulating. If you are concerned about equality, as I am, then ART regulation should focus upon conduct rather than status, upon what may be done and not who is doing it. Moreover, my concern for equality leads me to prefer direct and visible regulation as opposed to indirect, invisible regulation, which tends to be discriminatory and to privilege majoritarian values. Finally, clearly articulated regulations that are enacted by publicly accountable bodies are preferable to ad hoc, discretionary decisions rendered by a patchwork of individual decision makers, such as physicians, fertility clinics, professional organizations, or even judges and juries ruling in discrete and isolated cases.

