

**“DOC OCK” SHOULD KNOCK OFF THE
KNOCKING-UP: USING DR. MICHAEL
KAMRAVA’S TREATMENT OF NADYA
SULEMAN AS A MODEL FOR TORT
REGULATION IN THE FERTILITY
INDUSTRY**

*Karen E. Schiavone**

TABLE OF CONTENTS

I. BACKGROUND ON IVF AND MULTIPLE BIRTHS.....	601
II. CURRENT STATE OF THE LAW.....	605
A. Federal and State Regulation in the United States.....	606
B. Industry Regulation by Professional Societies	608
C. Regulation on the International Level.....	609
III. KAMRAVA COMMITTED MEDICAL MALPRACTICE.....	611
A. Identifying an Appropriate Plaintiff.....	611
B. Breaking Down the Malpractice Claim.....	612
1. Kamrava Owed a Duty of Care to Suleman’s Babies	612
2. Kamrava Breached the Standard of Care in Performing IVF Treatments.....	614
3. Dr. Kamrava’s Breach Caused the Babies’ Injuries	616
4. The Babies Have Been Injured.....	618
IV. A PROPOSAL TO LIMIT FUTURE LEGISLATIVE REGULATION ...	620
A. Legislation is Feasible	621
B. Legislation is Not Desirable	625

* Executive Editor for Lead Articles, *Albany Law Review*; J.D., Albany Law School, 2010; B.S., Grove City College, 2004. I would like to thank Prof. Alicia Ouellette for her guidance and for offering much-needed advice along the way. I would also like to thank my family and friends for their unwavering love and support, without which I would be lost.

*“Human beings are not dogs or cats; they are not supposed to give birth to litters.”*¹

On January 26, 2009, thirty-three-year-old Nadya Suleman, mother of six, gave birth to octuplets, a process that took forty-six doctors and nurses at the Kaiser Permanente hospital in Bellflower, California.² While originally touted as a medical miracle, it soon became clear that this was no divine intervention. The truth was that Suleman sought out the assistance of fertility specialist Dr. Michael M. Kamrava,³ and while most fertility specialists would have transferred only two embryos—or three at the most—in a standard in vitro fertilization (IVF) procedure,⁴ Dr. Kamrava implanted six embryos, far exceeding industry custom. Two of these embryos split, resulting in the birth of eight premature babies. As Suleman already had six children of her own through five previous IVF procedures, she was not considered “infertile,” and both laypersons⁵ and physicians⁶ have expressed outrage that

¹ Bonnie Steinbock, Opinion, *What is Ethical Here?*, NEWSDAY (N.Y.), Feb. 8, 2009, at A46.

² Jeff Gottlieb & Sam Quinones, *It's Sibling Revelry as Bonus Baby Makes Eight*, L.A. TIMES, Jan. 27, 2009, at 1, available at <http://articles.latimes.com/2009/jan/27/local/me-octuplets27>.

³ Alan Zarembo, *Fertility: A Very Private Practice*, L.A. TIMES, Feb. 14, 2009, at 1, available at <http://articles.latimes.com/2009/feb/14/local/me-fertility14>.

⁴ See Karen Goldberg Goff, *Giving IVF a Bad Name: Fertility Doctors on Defense After 'Octo-Mom,'* WASH. TIMES, Mar. 4, 2009, at B2, available at <http://www.washingtontimes.com/news/2009/mar/04/giving-ivf-a-bad-name/> (quoting Dr. Suheil Muasher, medical director of a fertility clinic with over twenty years of IVF experience, explaining that “the vast majority of reproductive endocrinologists follow the ASRM guidelines,” which require that no more than two embryos be implanted into a woman under age thirty-eight and no more than three embryos be implanted into women between thirty-eight and forty); Stephanie Nano, *Octuplets Controversy: Few U.S. Fertility Clinics Follow Guidelines*, CHARLESTON GAZETTE, Feb. 21, 2009, at 7C, available at http://findarticles.com/p/news-articles/charleston-gazette-the/mi_8022/is_20090221/octuplets-controversy/ai_n43305522/?tag=content;coll (stating that only sixteen percent of IVF procedures involve implanting four or more embryos and these cases most often involve previous failed attempts or unhealthy embryos); see also *infra* Part II.B (discussing the appropriate number of embryos to be transferred in IVF procedures).

⁵ See Steve Booher, *Octo-Mom Gives Us Reasons to Be a Little Resentful*, ST. JOSEPH NEWS-PRESS (Mo.), Feb. 9, 2009, available at <http://www.stjoenews.net/news/2009/feb/09/octo-mom-gives-us-reasons-be-little-resentful/> (“[T]he reaction to Ms. Suleman . . . has run the gamut between disapproval and outrage.”); see also Facebook, Groups, Nadya Suleman, <http://www.facebook.com> (last visited Apr. 14, 2010). Of the many Facebook groups created following the birth of the octuplets, notable group titles include: “Nadya Suleman’s fertility doctor should

any physician would submit to Suleman's wish to have "just one more girl."⁷ Others point to Suleman's socio-economic background—no job, no income, and on welfare—as a reason to condemn her, especially considering the status of our presently decaying economy.⁸ But her background aside, one thing seems clear: Dr. Kamrava violated the fertility industry standard of care with regard to the IVF procedure.

It is my proposition that Suleman's children will one day have a cause of action against Dr. Kamrava for medical malpractice. First, he owed a duty of care not only to Suleman, but to her children as well. Second, he breached that duty by implanting

have his license revoked"; "Appalled at the Mother of the Octuplets and her Fertility Doctors"; "Nadya Suleman—Octomom—is totally WRONG"; "Nadya Suleman disgusts me"; "Outraged by Nadya Suleman"; "Nadya Suleman should be sterilized"; "Taxpayers Against Nadya Suleman (T.A.N.S.)"; and many more not suitable for publication. There are, however, a few groups supporting Suleman including: "Nadya Suleman: Keep the Family Together" and "Pray for Nadya Suleman & her Kids." *Id.*

⁶ Goff, *supra* note 4, at B2 (quoting Dr. Suheil Muasher, expressing that "[m]ost in my specialty are outraged"); see also Scott LaFee, *Octuplet Case Sparks Calls for Fertility-Industry Curbs*, SAN DIEGO UNION-TRIBUNE, Feb. 12, 2009, at A1, available at <http://www.signonsandiego.com/news/2009/feb/12/1n12births233821-octuplet-case-sparks-calls-fertil/> (quoting fertility specialist Dr. Jeffrey Chang as stating that the octuplets case is "an outlier and an outrage").

⁷ Jill Smolowe, *The California Octuplets: A Mom's Controversial Choice*, PEOPLE, Feb. 16, 2009, at 79, 80, available at <http://www.people.com/people/archive/article/0,,20258147,00.html> (including a statement by Angela Suleman, Nadya's mother, explaining that her daughter used the rest of her frozen embryos "in an attempt to have 'just one more girl'").

⁸ See, e.g., John Rogers, Associated Press, *Octo-Outrage: For Suleman, Curiosity Quickly Turned to Anger After Birth of Octuplets*, CHI. TRIB., Feb. 26, 2009, at 3 (quoting Julie Albright, sociologist at University of Southern California, who explains that the octuplets case is "triggering this angry, emotional response in so many people" because "we're in particularly sensitive economic times," and people who might normally overlook such a situation are "worried about losing their jobs and their homes," especially since California is "broke and facing the prospect of paying more than \$1 million in medical bills for Suleman's babies while the state issues IOUs instead of tax refunds"); Jo Stanley, Op-Ed., *Eight Is More Than Enough*, SUNDAY HERALD SUN (Melbourne, Austl.), Feb. 15, 2009, at 67 ("[T]he biggest 'why' sweeping America—why should [Suleman's] country foot the bill... at a time when everyone is struggling? Public outrage has seen accusations fly—it shouldn't be allowed, she's condemning her children to a life of disadvantage, ill-health and neglect."); Kimi Yoshino & Jessica Garrison, *Octuplets Care Could End Up Costing Taxpayers Millions*, L.A. TIMES, Feb. 11, 2009, at 1, available at <http://articles.latimes.com/2009/feb/11/local/me-octuplets11> (stating that prior to giving birth to the octuplets, Suleman was receiving food stamps and supplemental security income for her disabled children).

more embryos than industry standards dictate. Third, but for his conduct, the octuplets would not have been born prematurely and with low birth weight. Fourth, considering the high incidence of problems associated with prematurity and low birth weight, it is probable that the children will be disabled in some way, and so there will likely be a showing of physical damages. As such, Dr. Kamrava was negligent in transferring so many embryos to Suleman's womb.

Reproductive technologies in the United States, however, including IVF procedures, are virtually unregulated by the state and federal governments. Rather, IVF clinics and fertility specialists operate according to guidelines set by the industry's professional societies. Fertility specialists fear that further oversight and regulation from the government would decrease success rates and "deter patients from getting the best treatment possible."⁹ The Nadya Suleman case represents an extraordinary exception to customary IVF treatments, and enacting legislation to limit the embryos transferred so soon after the dust has settled may not be the best way to prevent this type of physician conduct in the future. In order to protect women's rights to procreation and reproductive liberty, rather than passing legislation that will inhibit or completely eliminate some women's abilities to have children, I believe that the tort system is much better suited to handle these extreme exceptions on a case-by-case basis.

Part I of this article will offer an explanation of the IVF procedure, the high risks associated with multiple births, and the specific case of Nadya Suleman and her doctor. Part II will examine the current state of law in the United States, including federal and state law, as well as a brief overview of international law on human reproduction. Part III will outline the elements of professional negligence and explain how Dr. Kamrava's conduct with regard to Suleman's treatment amounts to a medical malpractice cause of action against him. Finally, Part IV will propose the best solution to dealing with future conduct similar to Dr. Kamrava's: relying on the tort system to enforce adherence to the industry standard of care, rather than enacting legislation which will inhibit a woman's ability to have a child.

⁹ *Id.* (quoting Dr. Stephen R. Lincoln, a reproductive endocrinologist with the Genetics and IVF Institute in Fairfax, Virginia).

I. BACKGROUND ON IVF AND MULTIPLE BIRTHS

In vitro fertilization is a type of assisted reproductive technology (ART) in which a physician extracts an egg from a female and then fertilizes the egg in the laboratory for reimplantation into the uterus through the cervix.¹⁰ The ovaries are hormonally stimulated in order to retrieve multiple eggs; that way, multiple embryos are produced upon fertilization.¹¹ During a single IVF cycle, one or more embryos can be transferred into the uterus, and the remaining embryos are frozen for later IVF cycles—or they are often discarded.¹² Recent studies show that “only two to four well-chosen embryos need [to] be implanted in order to achieve maximal success rates,”¹³ and most IVF clinics transfer two or three embryos per cycle.¹⁴ Some clinics, however, have been reported to transfer more than seven embryos in one cycle and, accordingly, have a multiple birth rate of thirty-three percent.¹⁵

The IVF process, while common today, still carries with it high risks both to the mother and to the baby or babies she carries, and these risks are aggravated in the case of multiple fetuses. Reported harms to the mother during IVF have included: death

¹⁰ CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2006 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 3 (2008), available at <http://www.cdc.gov/art/ART2006/508PDF/2006ART.pdf> [hereinafter CTRS. FOR DISEASE CONTROL].

¹¹ John A. Robertson, *Assisting Reproduction, Choosing Genes, and the Scope of Reproductive Freedom*, 76 GEO. WASH. L. REV. 1490, 1498 (2008).

¹² *Id.* at 1498–99.

¹³ PHILIP G. PETERS, JR., HOW SAFE IS SAFE ENOUGH?: OBLIGATIONS TO THE CHILDREN OF REPRODUCTIVE TECHNOLOGY 214 (2004).

¹⁴ Nano, *supra* note 4, at 7C; see, e.g., Malpani Infertility Clinic, How Many Embryos Should I Transfer?, <http://www.drimalpani.com/embryo-transfer.htm> (last visited Apr. 14, 2010) (noting that in most clinics in the United States, only two embryo transfers are allowed); Advanced Fertility Center of Chicago, Embryo Transfer Procedure for In Vitro Fertilization, <http://www.advancedfertility.com/embryotransfer.htm> (last visited Apr. 14, 2010) (noting that the clinic typically transfers only two embryos, but given the age of the woman, three to four embryos may be transferred).

¹⁵ PETERS, JR., *supra* note 13, at 210; see also Rosemary Ford, *Local Doctors Say Octomom's Physician Was Reckless*, EAGLE-TRIB. (N. Andover, Mass.), Mar. 15, 2009, available at http://www.eagletribune.com/punews/local_story_074014959.html/resources_printstory (reporting an informal survey finding that of the women in a local support group who had four or more embryos implanted, 82% resulted in pregnancies of three or more children and relating an instance of a woman being “asked by her doctor if she wanted to have 10 embryos implanted”).

due to “accidental failure to deliver oxygen during general anesthesia, visceral injur[y] during egg retrieval[s], pelvic abscess[], serious infection[], . . . serious vascular complication[] . . . , torsion of the ovary, and cancer[] discovered during or after treatment.”¹⁶ Recent studies that link fertility treatment and drugs to cancer have caused many in the medical community to question the implications of non-therapeutic fertility treatments.¹⁷ Furthermore, these women are exposed to unnecessary risk because the fact of the matter is that not every IVF cycle will result in a successful pregnancy carried out to term, producing a healthy child. Most women must endure several IVF cycles before a pregnancy occurs, or, in the alternative, they forego further treatment.¹⁸ In 2007, for example, almost forty-six percent of IVF cycles in women under age thirty-five resulted in pregnancies; however, thirteen percent of those pregnancies did not result in a live-birth.¹⁹

Multiple births are fairly common, although not the goal, in IVF procedures. About one-third of IVF births in the United States are twins, but twins are less healthy and more often premature than singletons.²⁰ “In fertility medicine, any pregnancy greater than twins is considered a poor outcome because of the danger it poses to the mother and the babies.”²¹ One fertility specialist says that he tells his patients that “it’s not OK to end up with triplets or even twins.”²² In multiple pregnancies, not only is “maternal morbidity . . . seven times

¹⁶ Michele Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657, 1724 (2008) (quoting Sandra Coney, *Long-Term Effects of Assisted Conception*, 345 LANCET 976, 976 (1995)).

¹⁷ *Id.* at 1725 (asserting that fertility treatments may be linked to incidences of cancer in both women and fetuses).

¹⁸ *See, e.g., id.* at 1731–32 (noting that even after the significant financial investment made by couples, there is still a high failure rate, and, in fact, there is a limited probability of success, especially in older women).

¹⁹ *See* Ctrs. for Disease Control & Prevention, Dep’t of Health & Human Servs., Assisted Reproductive Technology (ART) Report: National Summary 2007, <http://apps.nccd.cdc.gov/ART/NSR.aspx?SelectedYear=2007> (last visited Apr. 18, 2010). In 2006, only 35% of all IVF cycles resulted in a pregnancy, and 18% of those pregnancies did not result in a live birth. CTRS. FOR DISEASE CONTROL, *supra* note 10, at 17.

²⁰ Robertson, *supra* note 11, at 1501.

²¹ Kimi Yoshino et al., *Octuplets Doctor Has Quads Case; He Transferred at Least 7 Embryos to a Woman Now Pregnant with 4*, L.A. TIMES, Feb. 13, 2009, at B1 [hereinafter Yoshino, *Quads Case*] (quoting Dr. Mousa Shamoni, director of IVF at the University of California).

²² Nano, *supra* note 4, at 7C.

greater,” but there are numerous risks to the infants, all associated with prematurity and low birth weight.²³ Likely risks to babies born with low birth weight—due to their prematurity—include: death; “cerebral palsy; vision and hearing problems; . . . long-term motor, cognitive, behavior, social-emotional, health, and growth problems”; and chronic lung disease.²⁴ In fact, prematurity is linked to over “one-third of all . . . infant deaths” in the United States.²⁵ Thus, multiple births are never the goal in the majority of IVF procedures, at least in most cases.

Dr. Michael Kamrava is the exception to the rule. He provided fertility treatments to Nadya Suleman from 1997 to 2008, resulting in the birth of fourteen children.²⁶ Beginning when she was a teenager, Suleman tried for years to have a baby.²⁷ Because of her self-proclaimed “dysfunctional childhood,” she was deeply depressed and felt suicidal, and she also became obsessed with having babies.²⁸ During that time, she suffered three miscarriages and tried artificial insemination and fertility drugs but was never successful in having a child.²⁹ Suleman, along with Dr. Kamrava, decided that IVF was the only way for her to have a live-birth, and she was successful. Her first six children

²³ Marsha Garrison, *Regulating Reproduction*, 76 GEO. WASH. L. REV. 1623, 1644 (2008). Babies born weighing less than 1,500 grams, or 3 pounds, 4.9 ounces, are considered to be of “very low birth weight.” *Id.*

²⁴ *Id.* at 1644–45. According to some studies, “12% of IVF singletons, 55% of IVF twins, and 94% of IVF triplets or higher-order births result in low birth weight.” *Id.* at 1644. “[O]ne-third of triplets and higher-order births result in very low birth weight.” *Id.* Of babies born with low birth weight: 20% have serious disabilities or major functional impairment; up to 50% scored low on standardized intelligence tests; 21% are mentally retarded; 9% have cerebral palsy; 25% have severe vision problems; and 45% are enrolled in special education programs. *Id.* at 1645. Finally, and shockingly, “the chance of a triplet pregnancy resulting in a baby with cerebral palsy is forty-seven times greater than . . . a singleton pregnancy.” *Id.*

²⁵ *Id.* at 1644.

²⁶ Accusation at 3, *In re* Accusation against Kamrava, No. 06-2009-197098 (Med. Bd. Cal. Dep’t Consumer Affairs Dec. 22, 2009), available at <http://www.latimes.com/includes/misc/kamravaaccusation.pdf>.

²⁷ Kimi Yoshino et al., *Before the Octuplets; She Wanted Babies as a Teenager. Then Came Miscarriages, Injury, Wild Mood Swings and Divorce*, L.A. TIMES, Feb. 6, 2009, at A1.

²⁸ *Id.* (reporting that Suleman claims her “dysfunctional” childhood and a longing for close relationships gave rise to her desire to have a large family, and that depression and suicidal thoughts arose following initial failed attempts at pregnancies).

²⁹ *Id.*

were born from five pregnancies, and during each IVF cycle, Dr. Kamrava implanted six embryos.³⁰ When she became pregnant in 2008, Dr. Kamrava had once again implanted six embryos, and this time they all took—two of them twinning—and thus eight babies were born in January 2009.³¹ The octuplets weighed in the range of one pound eight ounces to three pounds four ounces.³² Thus all of them were within the very low birth weight range.³³ Suleman herself stated “that she was aware of the risks of multiple births, but that she wanted to use all [of] the embryos available to her.”³⁴

In fact, Dr. Kamrava has one of the worst live-birth rates among fertility specialists in the United States. His clinic had one of the highest rates of embryos transferred in the country—“3.5 versus the national average of 2.3”—an indication that he is being overly aggressive in attempting to increase his number of pregnancies.³⁵ Despite his claims that he has invented a new procedure that increases success rates,³⁶ his live-birth rate is one of the lowest in the nation: of fifty-six IVF procedures performed in 2006, only two of these resulted in women giving birth.³⁷

Nadya Suleman is not the only woman to whom Dr. Kamrava has transferred a high number of embryos. Recently, he transferred at least seven embryos into another patient in her late forties with three grown children.³⁸ Newly married, this

³⁰ See Tracy Garcia, *Octomom Fertility Doctor Accused of Negligence*, WHITTIER DAILY NEWS, Jan. 4, 2010 (reporting Suleman’s assertion that “six embryos were implanted for each of her six pregnancies, including four single births and one set of twins”).

³¹ *Reproductive Health: Fertility Expert Calls Birth of Octuplets “Criminal,”* OBGYN & REPROD. WEEK, Feb. 23, 2009, at 249 [hereinafter *Fertility Expert*].

³² Ashley Surdin, *Octuplet Mother Also Gives Birth to Ethical Debate*, WASH. POST, Feb. 4, 2009, at C1.

³³ See Garrison, *supra* note 23, at 1644.

³⁴ Stephanie Saul, *Birth of Octuplets Puts Focus on Fertility Industry and Risks*, N.Y. TIMES, Feb. 12, 2009, at A1.

³⁵ See *id.* (stating that embryo transfer rates this high “are sometimes an indication that a doctor is being too aggressive in trying to raise the number of pregnancies”).

³⁶ Alan Zarembo et al., *Fertility Clinic in Octuplets Case Has Low Pregnancy Rate*, L.A. TIMES, Feb. 10, 2009, at 1 available at <http://articles.latimes.com/2009/feb/10/local/me-octuplets10>.

³⁷ Saul, *supra* note 34, at A1. Of the two successful births, one of them was to Nadya Suleman.

³⁸ Yoshino, *Quads Case*, *supra* note 21, at B1; Lorena Mongelli & Jeremy Olshan, *Doc “Oc” Woe Strikes a 2nd Time*, N.Y. POST, Feb. 13, 2009, at 7, http://www.nypost.com/p/news/national/item_sp7Fun3Gm0i9czCkOAX2iMj;jsessionid=1E000D3FFA6023777259A0A60A90F3041 (“He IVF’d up again.”).

mother wanted one more child with her second husband who had no previous children.³⁹ At five months pregnant with quadruplets, she was hospitalized and placed on bed rest until they were born.⁴⁰

Because of his recent conduct, the Medical Board of California is investigating Dr. Kamrava and his practice to evaluate whether he should keep his license to practice medicine.⁴¹ Additionally, the American Society for Reproductive Medicine is also investigating his practice of implanting greater numbers of embryos than its standards would allow.⁴²

II. CURRENT STATE OF THE LAW

Currently, there is no federal law in the United States which controls the number of embryos to be implanted during an IVF procedure.⁴³ No state regulates the number of embryos transferred.⁴⁴ Legislators resist putting caps on the number of embryos to transfer because there are too many variables that would differ from case to case like “the patient’s age, the number of previous failed attempts, [or] the condition of the embryos.”⁴⁵

³⁹ Yoshino, *Quads Case*, *supra* note 21, at B1.

⁴⁰ *Id.*

⁴¹ See Steven I. Kern, “*Octomom*” *Case Shines Light on Standards of Care*, MED. ECON., Apr. 3, 2009, available at <http://medicaleconomics.modernmedicine.com/memag/Modern+Medicine+Now/Octomom-case-shines-light-on-standards-of-care/ArticleStandard/Article/detail/590413> (explaining that Dr. Kamrava’s decision to implant six eggs into Nadya Suleman could result in disciplinary action by the Medical Board of California). At the time of publication, the executive director of the Medical Board of California had formally accused Dr. Kamrava of gross negligence in transferring too many embryos, in repeatedly initiating a fresh cycle of egg retrieval when frozen embryos were available, and in failing to refer Suleman for a mental health evaluation. Accusation at 1, 6–9, *In re* Accusation against Kamrava, No. 06-2009-197098 (Med. Bd. Cal. Dep’t Consumer Affairs Dec. 22, 2009), available at <http://www.latimes.com/includes/misc/kamravaaccusation.pdf>.

⁴² Yoshino, *Quads Case*, *supra* note 21, at B1.

⁴³ *Id.*

⁴⁴ See Helen M. Alvaré, *The Case for Regulating Collaborative Reproduction: A Children’s Rights Perspective*, 40 HARV. J. ON LEGIS. 1, 31 (2003) (“No law limits the number of embryos that may be implanted simultaneously in a woman’s uterus . . .”). This remains true today, at least in the United States. See Yoshino, *Quads Case*, *supra* note 21, at B1 (stating that although the American Society for Reproductive Medicine has guidelines limiting the number of embryos that can be transferred, as of 2009, “[n]o law governs this issue.”).

⁴⁵ PETERS, JR., *supra* note 13, at 212. Peters goes on to state that “[t]he optimum number [of embryos] is subject to change as clinicians develop better methods for evaluating embryo condition prior to transfer and for improving the likelihood of implantation.” *Id.*

But there are other sources of regulation, including fertility industry standards provided by professional societies, that guide the human reproduction arena and would support a finding against Dr. Kamrava.

A. Federal and State Regulation in the United States

The United States Supreme Court has long held that people have a fundamental right to procreation, as “procreation [is] fundamental to the very existence and survival of the race.”⁴⁶ The Court has further framed this issue as one of privacy, stating that “[i]f the right of privacy means anything, it is the right of the individual . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁴⁷ Procreation rights, however, are not absolute.⁴⁸ The Supreme Court has consistently held that states may intrude upon one’s

⁴⁶ *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

⁴⁷ *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

⁴⁸ Exceptions have been made in both statutory and case law for the mentally incompetent, for prisoners, and for probationers. *See, e.g.*, COLO. REV. STAT. § 27-10.5-130 (West 1996) (allowing sterilization of the incompetent in cases of medical necessity); N.C. GEN. STAT. ANN. § 35A-1245 (Michie 2000) (allowing sterilization of the incompetent in cases of medical necessity); *Gerber v. Hickman*, 291 F.3d 617, 623 (9th Cir. 2002) (“[T]he right to procreate while in prison is fundamentally inconsistent with incarceration.”); *Goodwin v. Turner*, 908 F.2d 1395, 1400 (8th Cir. 1990) (finding that a restriction on inmate procreation was reasonably related to “furthering the legitimate penological interest of treating all inmates equally, to the extent possible”); *In re C.D.M.*, 627 P.2d 607, 608, 612–14 (Alaska 1981) (authorizing sterilization of a nineteen-year-old woman with Down’s Syndrome if it was proven by clear and convincing evidence that it was in the best interests of the incompetent, but remanding to the lower court for reconsideration of whether a less drastic method of birth control was feasible); *In re Angela D.*, 83 Cal. Rptr. 2d 411, 413, 417, 420–22 (Cal. Ct. App. 1999) (authorizing the sterilization of an incompetent female where alternate forms of contraception and full-time supervision were not available, and where she was likely to engage in sexual activity in the future); *In re Grady*, 426 A.2d 467, 481–83 (N.J. 1981) (holding that, under the doctrine of *parens patriae*, the lower court has the power to authorize sterilization for incompetent persons so long as there is clear and convincing proof that sterilization is in the incompetent person’s best interests); *State v. Kline*, 963 P.2d 697, 698–99 (Or. Ct. App. 1998) (finding valid a probation condition requiring that a father seek prior written approval by the court before fathering any child where he had physically abused his two-and-a-half-month-old daughter and had previously broken his son’s arm); *State v. Oakley*, 629 N.W.2d 200, 201–02 (Wis. 2001) (holding that the fundamental right to procreate was not impinged upon where a condition of the defendant’s probation that he must avoid having further children unless he showed that he was able to support those children and his current children).

fundamental rights, including the right to procreate, when the state has a compelling interest in doing so.⁴⁹

While most states, including California, do regulate other aspects of human reproduction,⁵⁰ no state yet regulates the number of embryos to be transferred in an IVF cycle.⁵¹ In light of the Suleman case, however, a few states have begun attempts to control this aspect of human reproduction. In an effort to “prevent a repeat,”⁵² a bill was introduced to the Georgia State Senate that would limit the number of embryos that could be implanted in a woman during in vitro procedures.⁵³ The bill that eventually passed the senate, however, did nothing to restrict the actual number implanted.⁵⁴ A similar bill was introduced and passed in the Missouri House of Representatives, although the requirements proposed there were much less stringent than in Georgia’s bill.⁵⁵ The examples in these states give an indication as to how legislators are feeling about the Suleman case right now, but, at the same time, there is obvious hesitation due to potential limitation of reproductive liberties.⁵⁶

⁴⁹ See, e.g., *Carey v. Population Servs. Int’l*, 431 U.S. 678, 684–86 (1977).

⁵⁰ See CAL. HEALTH & SAFETY CODE § 125305 (West 2010) (regulating research on the human fetus and human embryo); CAL. HEALTH & SAFETY CODE § 24185 (West 2010) (banning human reproductive cloning); CAL. HEALTH & SAFETY CODE § 125119 (West 2010) (allowing research on human embryonic stem cells).

⁵¹ See Alvaré, *supra* note 44, at 31; see also Naomi R. Cahn & Jennifer M. Collins, *Eight is Enough*, 103 NW. U. L. REV. 501, 507–08 (2009) (asserting that there is little to no government regulation of reproductive technologies).

⁵² Elizabeth Cohen & Doug Gross, *Georgia ‘Octomom Bill’ Would Limit Embryo Implants*, CNN, Mar. 3, 2009, <http://www.cnn.com/2009/US/03/03/georgia.octomom.bill/>.

⁵³ S.B. 169, 150th Gen. Assem., Reg. Sess. (Ga. 2009) (as introduced) (proposing multiple restrictions on embryo research and IVF treatment cycles, including implantation requirements more stringent than the guidelines established by the American Society for Reproductive Medicine).

⁵⁴ S.B. 169/CFSA/2, 150th Gen. Assem., Reg. Sess. (Ga. 2009) (as passed Senate).

⁵⁵ H.B. 810, 95th Gen. Assem., 1st Reg. Sess. (Mo. 2009) (as passed House) (“When treating infertility, physicians within the state of Missouri shall not implant more embryos into a human than the current recommendations set forth by the American Society for Reproductive Medicine, or its successor.”); see also Missouri House of Representatives, Bill Summaries for HB810, *available at* <http://www.house.mo.gov/content.aspx?info=/bills091/bills/HB810.HTM> (reflecting that the last action taken on the bill was in the House Committee, no proceeding hearing is scheduled, and the bill is currently not on the calendar).

⁵⁶ See Alvaré, *supra* note 44, at 33–34 (considering arguments that the Constitution safeguards reproductive liberties); Cahn & Collins, *supra* note 51, at 505 (“ART involves extraordinarily personal social and medical choices, and raises critical issues related to patient autonomy and freedom of reproductive

Regardless of these recent attempts, we are still left with no state legislation on this particular issue.

B. Industry Regulation by Professional Societies

Professional societies currently regulate the IVF industry more so than any other official body in the United States.⁵⁷ Most potential patients look to IVF clinics that are members of the American Society for Reproductive Medicine (ASRM) or the Society for Assisted Reproductive Technology (SART) when choosing a fertility specialist.⁵⁸ The member requirements for these organizations are rigorous; for example, membership in SART requires that clinics report their pregnancy data annually, consent to having their data audited, have biannual inspection and certification of their facilities, and “[a]bide by all practice, laboratory, ethical, and advertising guidelines.”⁵⁹ The ASRM provides guidelines on the number of embryos transferred “[i]n an effort to reduce the incidence of high-order multiple gestations.”⁶⁰ The following table illustrates the number of

choice.”); Alicia Ouellette et al., *Lessons Across the Pond: Assisted Reproductive Technology in the United Kingdom and the United States*, 31 AM. J.L. & MED. 419, 433 (2005) (“The lack of regulation at the federal level is a direct result of U.S. emphasis on personal autonomy and the sanctity of privacy.”). See generally *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (“[P]rocreation [is] fundamental to the very existence and survival of the race.”).

⁵⁷ See Ouellette, *supra* note 56, at 419–34 (noting the relatively minimal roles of the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), and the Department of Health and Human Services (HHS), and the comparatively large roles of professional organizations like the American Society for Reproductive Medicine (ASRM), the Society for Assisted Reproductive Technology (SART), and the American College of Obstetrics and Gynecology (ACOG)). “With the exception of quality control regulation . . . the market and professional societies regulate the industry.” *Id.* at 444; see also Cahn & Collins, *supra* note 51, at 507 (“The fertility industry mostly self regulates through nonbinding guidelines and suggested ethical practices . . .”).

⁵⁸ See, e.g., Advanced Reproductive Care, *Choosing a Fertility Specialist*, http://www.arcfertility.com/infertility/fertility_specialist.html (last visited Apr. 17, 2010); Pamela Guthrie O’Brien, *How to Choose a Fertility Specialist*, CONCEIVE, 2004, available at <http://www.conceiveonline.com/seeing-a-specialist-infertility/choose-a-reproductive-specialist/> (suggesting that patients look for a fertility clinic that is certified by the state and by a national organization such as the ASRM).

⁵⁹ Society for Assisted Reproductive Technology, *Frequently Asked Questions*, <http://sart.org/FrequentlyAskedQuestions.html> (last visited Apr. 17, 2010). Examples of these guidelines include: “ovarian stimulation, numbers of embryos to transfer and appropriate use of donor gametes.” *Id.*

⁶⁰ ASRM Practice Committee, *Guidelines on Number of Embryos Transferred*, 90 FERTILITY & STERILITY 1518, 1518 (2008).

embryos to be transferred depending on the woman's prognosis:

A. Cleavage-Stage Embryos					B. Blastocysts			
Prognosis	Age <35	Age 35–37	Age 38–40	Age >40	Age <35	Age 35–37	Age 38–40	Age >40
Favorable	1–2	2	3	5	1	2	2	3
All others	2	3	4	5	2	2	3	3

Unfortunately, the ASRM guidelines act as just that—guidelines—and carry little weight in the law.⁶²

C. Regulation on the International Level

Not unlike other areas of human reproduction, the number of embryos to be implanted is greatly regulated in other areas of the world. Belgium, Germany, Italy, Sweden, the United Kingdom, and even Singapore all limit the number of embryos a physician may implant in an IVF procedure.⁶³ Some of these countries

⁶¹ *Id.* at 1519 (adapting Table 1 from the article). A favorable prognosis is indicated when it is the first IVF cycle, the embryos are of good quality, there are excess embryos available for cryopreservation, or there was a previous successful IVF cycle. *Id.* at 1518. Cleavage-stage embryos are those implanted “two or three days after fertilization” and blastocysts are those implanted “five to six days after fertilization.” *Id.* As indicated by the ASRM, a woman of Suleman’s age and prognosis should have had only two embryos implanted. *See id.* (asserting that no more than two embryos should be implanted into a patient with a favorable prognosis who is under age thirty-five).

⁶² *See id.* (“ASRM and SART have developed [these] guidelines for the purpose of assisting ART patients and programs in determining the appropriate number of cleavage stage . . . embryos or blastocysts to transfer.”); *see also* Cahn & Collins, *supra* note 51, at 508 (“Although most reproductive endocrinologists follow these standards, they are not, as the Suleman case so nicely illustrates, binding.”). These guidelines, however, do provide a standard of care for the IVF industry, which does carry weight in the tort law system, as discussed *infra* Part III.B.2.

⁶³ *See, e.g.,* Belgium: *International Federation of Fertility Societies Surveillance 07*, 87 FERTILITY & STERILITY S19, S20 (2007) [hereinafter IFFS] (stating that no more than one embryo may be transferred for women under thirty-six undergoing their first treatment cycle); Germany: Gesetz zum Schutz von Embryonen [Embryo Protection Act], Dec. 13, 1990, BGBl. I at 2746, § 1 (1) (F.R.G.), available at <http://www.bmj.bund.de/files/-/1147/ESchG%20englisch.pdf> (limiting total embryos transferred per cycle to three); Italy: *see* IFFS, *supra*; *see also* Institute on Biotechnology & the Human Future, Assisted Reproductive Technology, http://www.thehumanfuture.org/topics/reproductive_

further limit the number of embryos a physician may create in the first place.⁶⁴ For example, Germany limits the number of embryos a physician may create to the number that a physician can implant in one IVF cycle.⁶⁵ Since Germany also sets a cap at three embryos implanted per IVF cycle,⁶⁶ a physician can create no more than three embryos per cycle. Italy further proscribes that the only people who may participate in ARTs are “heterosexual couples in stable relationships.”⁶⁷ Dr. Karl Nygren, the former head of an IVF monitoring committee for the European Society of Human Reproduction says that in Sweden they have a saying: “One at a time.”⁶⁸ In 2005, seventy percent of IVF procedures performed in Sweden involved transferring only a single embryo, whereas in the United States in 2006, a mere eleven percent of procedures had a single embryo transfer.⁶⁹ One thing to consider, however, is that in Europe—unlike in the United States—the cost of IVF is covered by government health programs; if the first IVF cycle is unsuccessful, an infertile woman may try again at no additional cost.⁷⁰ But these severe limitations significantly limit women’s reproductive liberties.

technology/policy.html (last visited Apr. 13, 2010) (citing Law 40/2004, Feb. 19, 2004, 2004 Gazz. Uff. No. 45 (Feb. 24, 2004)) (explaining that the maximum number to transfer per cycle is three); Singapore: IFFS, *supra*, at S20–21 (stating a limit of three that increases to four if a level III neonatal unit is available and there have been two previously failed IVF attempts, or if the patient is over thirty-five); Sweden: *id.* at S19, S20–21 (stating no more than one embryo may be transferred, except for older women who may have two transferred); United Kingdom: *see id.* (stating that no more than two embryos may be transferred).

⁶⁴ *See, e.g.*, Gesetz zum Schutz von Embryonen, Dec. 13, 1990, BGBI. I at 2764, § 1 (1) (FRG) (barring physicians from creating more embryos than they can implant in one cycle); *see also* Rachel Anne Fenton, *Catholic Doctrine Versus Women’s Rights: The New Italian Law on Assisted Reproduction*, 14 MED. L. REV. 73 (2006) (referencing the requirement in Italy Law 40/2004 that all embryos that are created must be implanted simultaneously).

⁶⁵ Gesetz zum Schutz von Embryonen, Dec. 13, 1990, BGBI. I at 2746, § 1 (1) (F.R.G.).

⁶⁶ *Id.*

⁶⁷ Institute on Biotechnology & the Human Future, *supra* note 63 (citing Law 40/2004, Feb. 19, 2004, 2004 Gazz. Uff. No. 45 (Feb. 24, 2004)).

⁶⁸ Nano, *supra* note 4, at 7C.

⁶⁹ *Id.*

⁷⁰ *Id.* In the United States, each IVF cycle costs roughly \$12,400, and patients are stuck with paying it out-of-pocket because most insurers do not cover IVF procedures. *Id.*

III. KAMRAVA COMMITTED MEDICAL MALPRACTICE

With the lack of enforceable rules in the United States, we have no direct method of regulating these fertility specialists in how many embryos they are allowed to transfer. As such, it is only natural to turn to the tort law system—and common law—to indirectly regulate physicians' conduct when it cannot, and maybe should not, be enforced by statutory law.⁷¹ In order to find Dr. Kamrava liable for medical malpractice, a threshold issue is to determine who will have standing to bring an action against him.

A. Identifying an Appropriate Plaintiff

If an action against Dr. Kamrava is commenced while Suleman's children are under the age of majority, someone else must bring the action on their behalf.⁷² Suleman cannot recover against Dr. Kamrava on behalf of her children because she consented to the procedure.⁷³ The only way she could sue directly would be if there was an issue of informed consent—that he did not properly disclose to her the risks of a multiple pregnancy—but in this case, she has stated that she knew full well the risks associated with multiple births, and she consented to the procedure regardless.⁷⁴

A guardian ad litem, however, may be “appointed by the court to appear in a lawsuit on behalf of a[] . . . minor party.”⁷⁵ Usually a lawyer, the purpose of a guardian ad litem is to protect the rights of the person or persons the guardian is appointed to

⁷¹ See discussion *infra* Part IV. For a discussion on other social problems that have been addressed by tort litigation, including lawsuits aimed at reducing smoking-related illness, gun violence, and obesity, see Timothy D. Lytton, *Using Tort Litigation to Enhance Regulatory Policy Making: Evaluating Climate-Change Litigation in Light of Lessons from Gun-Industry and Clergy-Sexual-Abuse Lawsuits*, 86 TEX. L. REV. 1837 (2008). These lawsuits often ignite policy changes in the form of legislative regulations. *Id.* at 1837. Professor Lytton concentrates on gun-industry and clergy-sexual-abuse litigation and how it may serve as a framework for addressing future climate-change litigation. *Id.* at 1838.

⁷² See, e.g., *Am. Alternative Energy Partners II v. Windridge, Inc.*, 49 Cal. Rptr. 2d 686, 690–91 (Cal. Ct. App. 1996).

⁷³ See *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (noting that under California law, “if the patient is a minor or incompetent, the authority to consent is transferred to the patient’s legal guardian or closest available relative”).

⁷⁴ Saul, *supra* note 34, at A1.

⁷⁵ BLACK’S LAW DICTIONARY 706 (8th ed. 2004).

represent.⁷⁶ Because Suleman's children must be represented, but cannot be represented by their mother, the court should appoint a guardian ad litem on their behalf in order for them to be able to sue Dr. Kamrava to recover for their injuries resulting from his negligence.

B. Breaking Down the Malpractice Claim

Malpractice is "an instance of negligence or incompetence on the part of a professional."⁷⁷ For negligence claims against physicians, four elements must be established: (1) the physician owed a duty of care to the patient; (2) the standard of care was breached; (3) the physician proximately caused the injury; and (4) an injury resulted.⁷⁸

1. Kamrava Owed a Duty of Care to Suleman's Babies

A finding of a doctor-patient relationship will generally give rise to a duty of care. Specifically, there must be a direct doctor-patient treatment relationship between the plaintiff and the physician in order to establish that the physician owed a duty of care to the plaintiff.⁷⁹ Obviously, Suleman herself is a patient and Kamrava owed her a duty of care. But sometimes, the physician's duty of care is extended to third parties—for instance, when immediate family or other persons are foreseeably at risk because of their relationship with the patient.⁸⁰ While it may first appear that in the Suleman case the children are, in this regard, third parties rather than the primary patient, the mother, it is commonly recognized in the obstetrics field that the

⁷⁶ See *In re Christina B.*, 23 Cal. Rptr. 2d 918, 926 (Cal. Ct. App. 1993) (stating that the guardian ad litem has the responsibility "to protect the rights of the incompetent person" and "the right to control the litigation on behalf of the incompetent person").

⁷⁷ BLACK'S LAW DICTIONARY 959 (8th ed. 2004).

⁷⁸ See, e.g., *Hanson v. Grode*, 90 Cal. Rptr. 2d 396, 400 (Cal. Ct. App. 1999).

⁷⁹ See, e.g., *Greenberg v. Perkins*, 845 P.2d 530, 534 (Colo. 1993) (stating that when "a physician undertakes to treat or otherwise provide medical care to another . . . a physician-patient relationship exists, and the physician's contractual obligations create the matrix from which an independent tort obligation arises"); see also Karen E. Schiavone, *Playing the Odds or Playing God? Limiting Parental Ability to Create Disabled Children Through Preimplantation Genetic Diagnosis*, 73 ALB. L. REV. 283, 321 (2009).

⁸⁰ See, e.g., *Tenuto v. Lederle Labs.*, 687 N.E.2d 1300, 1302–03 (N.Y. 1997) (holding that a physician owes a duty of care "to his patient and to persons he knew or reasonably should have known were relying on him for [his] service to his patient").

physician has more than one patient: the mother and the fetus or fetuses.⁸¹ Moreover, most courts have agreed that a duty of care is owed to *future persons* whenever the risk to them is foreseeable.⁸²

In *Johnson v. Thompson*, for example, the Georgia Court of Appeals allowed a child to sue an obstetrician for an act of medical malpractice committed while the child was in utero—only a fetus.⁸³ The mother’s obstetrician failed to diagnose the child as unusually large for his gestational age several months before the child’s birth.⁸⁴ As a result of the misdiagnosis, the obstetrician did not recommend a cesarean section, and the child suffered physical injuries during a vaginal birth.⁸⁵ The court held that it was “beyond dispute that both the fetus and the mother are patients of the obstetrician and that the obstetrician owes a duty of care to both of them.”⁸⁶ So even though “the identity of the individuals who will be harmed is not yet known and even though some of them may not yet exist,” the duty of care exists.⁸⁷ If this duty extends to a non-viable fetus, should it not also extend to a non-viable embryo that the fertility specialist undertakes to create and implant into the womb?⁸⁸ Dr.

⁸¹ See Anne Drapkin Lyerly & Peter Schwartz, *Is the Patient Always Right?*, 34 HASTINGS CENTER REP. 13, 14 (2004).

⁸² See PETERS, JR., *supra* note 13, at 214–15 (finding that “courts are likely to uphold a reasonable cap on the number of embryos transferred . . . [because] the state has a compelling . . . [reason to] prohibit[] . . . treatments that often result in dangerous multiple pregnancies.”); see, e.g., *Burgess v. Superior Court*, 831 P.2d 1197, 1202 n.7 (Cal. 1992) (recognizing that “by virtue of [the physician’s] physician-patient relationship with [the mother], [he] assumed a duty of care to [the mother], the scope of which extended to providing competent medical treatment for both [the mother] and her fetus”); *Johnson v. Thompson*, 650 S.E.2d 322, 324 (Ga. Ct. App. 2007) (stating that “it seems beyond dispute that both the fetus and the mother are patients of the obstetrician” and holding that the obstetrician owes a duty of care to both); *Broadnax v. Gonzalez*, 809 N.E.2d 645, 648 (N.Y. 2004) (stating that “in treating a pregnancy, medical professionals owe a duty of care to the developing fetus”); *HCA, Inc. v. Miller ex rel. Miller*, 36 S.W.3d 187, 195 n.21 (Tex. App. 2000) (“Provided it is subsequently born alive, even an unborn fetus is a ‘patient’ to whom a doctor treating the mother owes a duty of care.”).

⁸³ *Johnson*, 650 S.E.2d at 323.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.* at 324.

⁸⁷ PETERS, JR., *supra* note 13, at 13.

⁸⁸ See Schiavone, *supra* note 79, at 322. *But see* *Andrews v. Keltz*, 838 N.Y.S.2d 363, 370 (N.Y. Sup. Ct. 2007) (declining to recognize that a duty of care is owed to a developing fetus, where the alleged negligence occurred before the individual was even in utero).

Kamrava owed the children a duty of care not only because of the foreseeable risk to them due to their relationship with Suleman, but also because the babies themselves, as future persons, are recognized as patients.

2. Kamrava Breached the Standard of Care in Performing IVF Treatments

In the State of California, “[t]he standard of care in a medical malpractice case requires that medical service providers exercise that . . . degree of skill, knowledge, and care ordinarily possessed and exercised by members of their profession under similar circumstances.”⁸⁹ Simply stated, a court must determine what the physician knew or should have known, and what he did or failed to do in light of that knowledge.⁹⁰ The standard of care in the United States fertility industry for implanting embryos is best outlined by the ASRM.⁹¹ For a patient of Suleman’s age, thirty-three years old, a physician adhering to industry custom would have implanted only one or two embryos—one embryo if there was a favorable prognosis, and two embryos if unfavorable.⁹² Suleman’s prognosis is debatable; while she has had many previous successful IVF cycles resulting in pregnancies and live births, the embryos may not have been of good quality if they had been previously frozen.⁹³ There would have been excess embryos available to freeze (had Dr. Kamrava implanted the proper amount), so considering Suleman’s difficulties in conceiving, one might term her prognosis unfavorable. Even so, the maximum number of embryos to transfer to Suleman should

⁸⁹ *Barris v. County of L.A.*, 972 P.2d 966, 971 n.1 (Cal. 1999).

⁹⁰ *See also Folk v. Kilk*, 126 Cal. Rptr. 172, 178, 181 (Cal. Ct. App. 1975) (noting that physicians must only “exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by doctors under similar circumstances in diagnosis and treatment” and that doctors are not responsible for every “untoward” result that may occur from medical treatment).

⁹¹ *See ASRM Practice Committee, supra* note 60, at 1518 (stating that standards put forth by ASRM are guidelines that can be modified “according to individual clinical conditions”); *see also supra* Part II.B. tbl.1.

⁹² ASRM Practice Committee, *supra* note 60, at 1518.

⁹³ *Id.*; *see also* Accusation at 3–6, 8, *In re* Accusation against Kamrava, No. 06-2009-197098 (Med. Bd. Cal. Dep’t Consumer Affairs Dec. 22, 2009), *available at* <http://www.latimes.com/includes/misc/kamravaaccusation.pdf>. According to the formal accusation, Dr. Kamrava began each of Suleman’s IVF cycles with fresh embryos, even though Suleman had plenty of previously frozen embryos. *Id.* at 4–6.

have been no more than two.⁹⁴ Some clinics would transfer three, but for a thirty-three-year-old woman, almost no clinics would have implanted more than three embryos in one IVF cycle.⁹⁵ Dr. Kamrava implanted six embryos into Suleman, far over the industry custom. In doing so, he also failed to consider that the embryos would twin. Fortunately, only two embryos twinned in Suleman's case, but the results had the potential to be far more disastrous.

Moreover, some argue that because Suleman already had six children under the age of seven, she was not infertile, and therefore, a physician should not have agreed to give her the IVF treatments she desired.⁹⁶ Others said that due to her background as an unemployed, single mother, they seriously questioned performing Suleman's IVF procedure in the first place, let alone implanting such a high embryo count.⁹⁷ While certainly not all fertility specialists subscribe to this view, many do.⁹⁸ Normally, if there are multiple methods of treatment for a particular condition, and all the methods are accepted by the medical profession, the physician's choice of treatment is not negligent, so long as it is approved of by at least a respectable minority.⁹⁹ Non-treatment (in Suleman's case) and implanting fewer embryos are both accepted by the profession.¹⁰⁰ But almost all agree that Dr. Kamrava's conduct is not approved of by

⁹⁴ See ASRM Practice Committee, *supra* note 60, at 1518; see also *supra* Part II.B. tbl.1.

⁹⁵ Nano, *supra* note 4, at 7C.

⁹⁶ Steinbock, *supra* note 1, at A46 (quoting bioethicist Arthur Caplan as stating that "even the fact that Suleman was accepted as a fertility patient represents a huge ethical failure, because she already had six children, also by IVF.").

⁹⁷ *Fertility Expert*, *supra* note 31, at 249.

⁹⁸ Along these same lines, family law encourages two-parent families in order to prevent harm to the children; "in addition to economic disadvantages, children in single parent households struggle with a lack of regular parental involvement and supervision; difficulties accessing community resources; and disruptions in ongoing relationships with peers, teachers, and others." Alvaré, *supra* note 44, at 52 n.355 (citing Sara McLanahan, *The Consequences of Single Motherhood*, in *SEX, PREFERENCE, AND FAMILY: ESSAYS ON LAW AND NATURE* 309, 310 (David M. Estlund & Martha C. Nussbaum eds., 1997)).

⁹⁹ *Ouellette v. Subak*, 391 N.W.2d 810, 815 (Minn. 1986).

¹⁰⁰ See, e.g., Judith Graham, *Wishes vs. Risky Treatment: Birth of Octuplets to California Woman Spotlights the Ethical Questions Fertility Doctors, Their Patients Face*, CHI. TRIB., Feb. 5, 2009, at C1 (discussing several doctors noting that they would be cautious in providing service to a woman who was unemployed with several young children).

anyone.¹⁰¹

Professor Philip Peters argues that physicians have a “[duty] to use the safest procreative method reasonably available.”¹⁰² He further states:

[O]bligation arises when parents and providers have a choice between a risky route and a safer one. When the participants choose the risky route (as providers might in order to maximize profits or couples might in order to maximize the odds of conception), they threaten the welfare of future children. To maximize the welfare of future children, parents and providers should choose to bear the child who is likely to suffer the least.¹⁰³

Dr. Kamrava’s conduct in implanting so many embryos was clearly the risky route¹⁰⁴—designed to increase his success rates in his failing fertility practice.¹⁰⁵ He did not consider the welfare of the future children in proceeding with this IVF treatment.

For all of these reasons, Dr. Kamrava breached the standard of care. Not only did he implant more embryos into Suleman’s uterus than recommended by the industry standard of care, but he also failed to recognize the fact that Suleman already had six children by his own doing, a fact that most other fertility specialists would have taken into consideration when deciding whether an IVF procedure was appropriate for a particular patient.

3. Dr. Kamrava’s Breach Caused the Babies’ Injuries

In California, a plaintiff to a medical malpractice action must prove that the physician’s negligence was both a cause-in-fact¹⁰⁶ and a proximate cause of injury.¹⁰⁷ A simple three-pronged

¹⁰¹ See, e.g., *id.* Dr. Norbert Gleicher, medical director of the Center for Human Reproduction, calls it “[a] medical catastrophe.” *Id.* Dr. John Lantos, chairman of bioethics at the Center for Practical Bioethics of Kansas City, Missouri, calls Dr. Kamrava’s conduct “[p]rofessional negligence.” *Id.* Dr. Ralph Kazer, chief of reproductive endocrinology and infertility at Chicago’s Northwestern Memorial Hospital, says that “[s]omething went very wrong in the care of this patient.” *Id.*

¹⁰² PETERS, JR., *supra* note 13, at 28 (emphasis omitted).

¹⁰³ *Id.*

¹⁰⁴ See Alison Stateman, *The Fertility Doctor Behind the “Octomom”*, TIME, Mar. 7, 2009, <http://www.time.com/time/nation/article/0,8599,1883663,00.html> (characterizing Dr. Kamrava’s actions as “dangerous.”).

¹⁰⁵ See *id.* (noting that Dr. Kamrava’s overall success rate with embryos was low despite using more embryos than most doctors).

¹⁰⁶ *Jennings v. Palomar Pomerado Health Sys., Inc.*, 8 Cal. Rptr. 3d 363, 369 (Cal. Ct. App. 2003).

¹⁰⁷ *Bushling v. Fremont Med. Ctr.*, 11 Cal. Rptr. 3d 653, 664 (Cal. Ct. App.

analysis establishes “but for” cause or cause-in-fact.¹⁰⁸ First, one must identify clearly and as precisely as possible the injury or loss to be compensated.¹⁰⁹ Second, one must identify the particular act of the physician’s malpractice.¹¹⁰ Third, if the act of malpractice did not occur—meaning that the physician adhered to the standard of care—one must determine whether the injury or loss would still have occurred.¹¹¹ In the case of Suleman’s children, most of the injuries have not yet been determined.¹¹² Some disabilities in children of multiple births do not appear until the children are much older, around two years of age, especially with cognitive disorders and learning disabilities.¹¹³ But considering the high likelihood of injury to these children, and for purposes of this article, we can assume that some, if not all, of Suleman’s eight children will suffer a measureable injury to be compensated.¹¹⁴ Dr. Kamrava committed malpractice when he implanted six embryos instead of following industry standard—implanting two embryos. If he had adhered to the standard of care, eight babies would not have been born. At the most, if the two embryos had twinned, a total four babies could have been born. This is not to say that no injury would occur to quadruplets, but the potential risks to multiple-birth babies greatly increase with each additional fetus occupying the womb.¹¹⁵ Because Dr. Kamrava chose to implant six embryos, he practically guaranteed that in the instance of a higher order pregnancy, the children would end up with some sort of birth defect. Therefore, Dr. Kamrava’s breach of the standard of care is a “but-for” cause of any injuries currently present in the children and those injuries that will not appear until the children are older. But for his negligence in

2004).

¹⁰⁸ See, e.g., *Herskovits v. Group Health Coop.*, 664 P.2d 474, 477 (Wash. 1983).

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² The smallest baby, born weighing only one pound, eight ounces, has a cleft lip that will have to be operated on in a few months. Associated Press, ‘*Maybe It Was Selfish, Octuplets’ Mom Says*, SAN JOSE MERCURY NEWS, Apr. 8, 2009, at 4A. This is only the first of many obstacles he will likely face.

¹¹³ Garrison, *supra* note 23, at 1644–45.

¹¹⁴ This is especially true, considering that three of her older children are already suffering from some sort of disability—genetics don’t lie.

¹¹⁵ See Garrison, *supra* note 23, at 1645; *supra* notes 16–25 and accompanying text.

transferring six embryos, eight babies would not have been born prematurely and with very low birth weight, and the children would not suffer from disabilities created by this multiple fetus pregnancy.

Proximate cause is a tool used to limit liability.¹¹⁶ In California, to establish proximate cause in a medical malpractice action, the plaintiff must show that the physician's breach of the standard of care was the cause, within a "reasonable medical probability," of the plaintiff's injury.¹¹⁷ The plaintiff must show sufficient evidence that would allow an inference that the physician's negligence probably caused the injury—mere possibility is not enough.¹¹⁸ The plaintiff's evidence of proximate cause must be proven by expert testimony.¹¹⁹ While issues of common knowledge may be determined by laypersons, where complex and unusual medical processes are involved, expert testimony is required to establish whether the injury was the result of the physician's negligence.¹²⁰ The IVF process is a "complex medical process" and in this case, expert testimony would be necessary. The expert must establish that when Dr. Kamrava breached the standard of care by implanting six embryos, he *probably* caused the children's resulting injuries. In this case, it is not only possible, but most probable that Dr. Kamrava caused the children's injuries. The injuries were foreseeable, due to the extreme likelihood of injury associated with multiple births, and the injuries were directly caused by his negligence, because no one else's conduct acted to increase the risk of a multiple birth pregnancy. Thus, proximate cause is established.

4. The Babies Have Been Injured

In tort law, a tangible, physical harm must be established, because a person may not assert liability unless he or she can prove an injury that can be compensated.¹²¹ In the Suleman

¹¹⁶ See *Saratoga Fishing Co. v. J.M. Martinac & Co.*, 520 U.S. 875, 884 (1997).

¹¹⁷ *Bushling v. Fremont Med. Ctr.*, 11 Cal. Rptr. 3d. 653, 664 (Cal. Ct. App. 2004).

¹¹⁸ See, e.g., *Jennings v. Palomar Pomerado Health Sys., Inc.*, 8 Cal. Rptr. 3d. 363, 369 (Cal. Ct. App. 2003).

¹¹⁹ See, e.g., *id.* at 368–69.

¹²⁰ *Curtis v. Santa Clara Valley Med. Ctr.*, 2 Cal. Rptr. 3d. 73, 76 (Cal. Ct. App. 2003).

¹²¹ See RESTATEMENT (SECOND) OF TORTS § 433B cmt. a (1965) (stating that

case, it is still too early to know what the exact damages—and how extensive the injuries—will be for the octuplets. But considering the wealth of data on the incidence of birth defects among children born from multiple births, the odds are not in their favor.¹²² Some of the most typical problems cannot be diagnosed for another few years, like learning disabilities.¹²³ As of now, we know that the babies were born nine weeks premature and were of very low birth weight. We also know that the smallest of the eight, Jonah, was born with a cleft lip that will be operated on in the coming months. Almost certainly, this is only a preview of the many difficulties that lie ahead, so there will be assessable damages in this case.

At first glance, this may look like a “wrongful life” claim, because the children would seemingly allege that had Dr. Kamrava adhered to industry standard of care, they would not have been born with birth defects.¹²⁴ This presents somewhat of a problem, for the alternative to not being born with a defect is to not be born at all, and this is not a measurable injury.¹²⁵ In this kind of a case, courts are unwilling to award damages, because they do not wish to assign value to living versus not living at all.¹²⁶ These concerns are dispelled for the following reasons:

First, while the California Supreme Court is unwilling to award general damages for pain and suffering when a plaintiff predicates an award of damages on the basis that his or her life itself is worse than being alive at all,¹²⁷ it is one of the only states to award special damages for extraordinary expenses necessary to treat a medical ailment arising from a physician’s

the burden of proof to show harm falls on the plaintiff); *see also* Kulawik v. ERA Jet Alaska, 820 P.2d 627, 637 (Alaska 1991) (comparing tort action to the wrongful death act in noting that the damages are based on the proximate cause of injuries that are compensated).

¹²² *See supra* note 24 and accompanying text.

¹²³ *See id.*

¹²⁴ A wrongful life action is an ancillary claim to a medical malpractice action brought by the child against the physician—usually in cases where the child is born with a hereditary disability or other genetic disorder—alleging that if the physician had performed her job correctly, the plaintiff would not have been born with his impairment because he would not have been born at all. *E.g.*, Willis v. Wu, 607 S.E.2d 63 (S.C. 2004).

¹²⁵ *See* Deana A. Pollard, *Wrongful Analysis in Wrongful Life Jurisprudence*, 55 ALA. L. REV. 327, 332 (2003) (citing Gleitman v. Cosgrove, 227 A.2d 689, 692 (N.J. 1967), *abrogated by* Berman v. Allan, 404 A.2d. 8, 9, 15 (N.J. 1979)).

¹²⁶ *Id.* at 328–29.

¹²⁷ Turpin v. Sortini, 643 P.2d 954, 961–62 (Cal. 1982).

failure to perform his job correctly.¹²⁸ In *Turpin v. Sortini*, the physician's failure to diagnose a hereditary ailment placed both a medical and financial burden on the plaintiff, and the court found this to be a measurable damage.¹²⁹ Dr. Kamrava's negligence has already placed—and will continue to place—huge medical and financial burdens on the octuplets for the remainder of their lives. Once the injuries are fully manifest, the damages to be awarded to these innocent children will be quite measurable.

Second, regardless of the state's position on awarding damages in this type of claim, the nonexistence or nonidentity problem does not even apply in this context. If Dr. Kamrava had adhered to the standard of care by only implanting two embryos, four embryos would have remained frozen. These embryos would have been unharmed in their frozen state, and they could have been implanted safely in another IVF cycle. Instead, Dr. Kamrava's actions are likely to turn the healthy embryos into unhealthy children.

IV. A PROPOSAL TO LIMIT FUTURE LEGISLATIVE REGULATION

“One of the purposes of tort law is to deter future harm.”¹³⁰ In order to prevent future conduct similar to Dr. Kamrava's, we should rely on the tort system to litigate and punish those that do not adhere to the industry standards outlined by the American Society for Reproductive Medicine. Reliance on tort litigation is more favorable than enacting rigid legislation, because such regulation would, in some instances, act as a complete barrier to reproducing a genetic child. For couples who cannot afford to pay for several IVF cycles, as those in the United States are forced to do in most states, it would not make sense to adopt a model comparable to international modes of regulation. Unlike in the United States, governmental health programs in other countries pay for multiple IVF cycles, and so there is less pressure to have a successful live birth on the first attempt. Physicians in the United States facing such pressure end up somewhat evading the guidelines,¹³¹ but some deviation is

¹²⁸ *Id.* at 966.

¹²⁹ *Id.* at 965.

¹³⁰ *Burgess v. Superior Court*, 831 P.2d 1197, 1206 (Cal. 1992).

¹³¹ Nano, *supra* note 4, at 7C (including such reasons as “pressure from patients who want to use more embryos to improve their chances of getting pregnant; financial concerns from those who are pay for treatment out of their own pockets; and the competition among clinics to post good success rates”).

appropriate. Dr. Kamrava's conduct was an extreme exception to the industry standard, however, and for cases like this, perhaps the tort system is the more appropriate avenue for regulation, so as to not infringe upon fundamental reproductive freedoms.

A. Legislation is Feasible

Because regulating the number of embryos transferred directly impacts human reproduction, any legislation or regulatory scheme that is found to impinge upon the fundamental right of procreation must serve a compelling state interest, must be narrowly tailored to achieve that purpose, and must use the least restrictive means to achieve that interest.¹³² While the right to procreate is determinedly fundamental,¹³³ it remains unclear as to whether using IVF—as a means to procreate—is a fundamental right.¹³⁴

¹³² ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 541, 792 (3d ed. 2006).

¹³³ Compare JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 22–42 (1994) (arguing that the right to procreate is a negative right against state interference and it involves “the freedom to engage in a series of actions that eventuate in reproduction and usually in child rearing,” and that the same level of strict scrutiny should apply to restrictions placed on traditional coital reproduction and those placed on noncoital reproductive technologies “[b]ecause the same procreative goals are involved”), with Radhika Rao, *Constitutional Misconceptions*, 93 MICH. L. REV. 1473, 1474 (1995) (reviewing ROBERTSON, *supra*) (arguing that the right to procreate cannot be considered without also incorporating rights to privacy, including body integrity and parental autonomy, and that the right to reproductive technologies is not founded in constitutional law).

¹³⁴ Compare ROBERTSON, *supra* note 133, at 100 (arguing that a law banning IVF altogether “would no doubt be found unconstitutional because it directly impedes the efforts of infertile married couples to have offspring, thus interfering with their fundamental right to procreate”), and Lori B. Andrews & Nanette Elster, *Regulating Reproductive Technologies*, 21 J. LEGAL MED. 35, 45 (2000) (stating that the “right to make reproductive decisions includes the right of an infertile couple to utilize medically assisted reproduction, such as *in vitro* fertilization” (emphasis in original)), and Judith F. Daar, *Assisted Reproductive Technologies and the Pregnancy Process: Developing an Equality Model to Protect Reproductive Liberties*, 25 AM. J.L. & MED. 455, 464 (1999) (arguing that the language in Supreme Court reproductive jurisprudence explicitly protects the right to procreate, which includes noncoital reproduction methods, such as IVF), and Lyria Bennett Moses, *Understanding Legal Responses to Technological Change: The Example of In Vitro Fertilization*, 6 MINN. J. L. SCI. & TECH. 505, 521 (2005) (arguing that even though Supreme Court jurisprudence is not directly on point, it is likely that the Court would find the right to use IVF as fundamental, and thus, laws prohibiting or severely restricting IVF would be found unconstitutional), with Radhika Rao, *Equal Liberty: Assisted Reproductive Technology and Reproductive Equality*, 76 GEO.

At least one court has found access to non-traditional means of procreation to be a fundamental right. In *J.R. v. Utah*,¹³⁵ the Utah District Court held that the genetic and biological parents of children carried by a gestational carrier surrogate birth mother had fundamental liberty interests applicable to the parent-child relationship with those children.¹³⁶ In that case, a married couple was medically unable to have children on their own, and so they contracted with a surrogate mother for a child to be conceived in vitro by the biological parents.¹³⁷ For these parents, gestational surrogacy was their only chance to have a child that “would truly be *theirs*, a true genetic and biological child of the marriage.”¹³⁸ Likewise, Nadya Suleman had tried many other ways to have genetic offspring, but she was unsuccessful.¹³⁹ So for Suleman—and for purposes of this article—I will assume that there does exist a fundamental right to use IVF as a method of procreation.

Thus, assuming that the rights infringed upon are fundamental, strict scrutiny must be applied in evaluating whether to let stand or strike down the state’s regulatory scheme.¹⁴⁰ In order for the state to be allowed to impinge upon the right to procreate, there must first be a compelling interest of the government.¹⁴¹ The state—here, California—has interests in preserving life, protecting innocent third parties, and preserving the ethical integrity of the medical profession.¹⁴² By limiting the

WASH. L. REV. 1457, 1462 (2008) (“[I]t is doubtful that there is a fundamental right to use technologies such as IVF . . . because the technologies themselves have been in existence for too short a time for there to have developed any tradition of legal protection.”), and Sonia M. Suter, *The “Repugnance” Lens of Gonzales v. Carhart and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1525 (2008) (stating that the presumption that “procreative liberty includes the right to IVF” is not grounded in any Supreme Court precedent, and that when the court declared in *Skinner v. Oklahoma* that procreation was “fundamental to the very existence and survival of the race,’ . . . IVF was not only an impossibility, but barely even a concept” (quoting *Skinner v. Oklahoma*, 361 U.S. 535, 541 (1942))).

¹³⁵ 261 F. Supp. 2d 1268 (D. Utah 2002).

¹³⁶ *Id.* at 1296.

¹³⁷ *Id.* at 1270.

¹³⁸ *Id.* at 1274 (emphasis in original).

¹³⁹ Accusation at 3, *In re* Accusation against Kamrava, No. 06-2009-197098 (Med. Bd. Cal. Dep’t Consumer Affairs Dec. 22, 2009), available at <http://www.latimes.com/includes/misc/kamravaaccusation.pdf>.

¹⁴⁰ CHEMERINSKY, *supra* note 132, at 792.

¹⁴¹ *Id.* at 541.

¹⁴² *Thor v. Superior Court*, 855 P.2d 375, 382 (Cal. 1993). Another commonly

number of embryos transferred, either by statute or by enforcement through tort law, the state is acting to preserve life, because reducing the number implanted will also reduce the likelihood of higher-order pregnancies. This will reduce the selective reduction rate, thereby ensuring that no fetuses are killed in the womb, and it will further eliminate the chance that the remaining fetuses die due to complications from the first selective reduction.¹⁴³

In the interest of protecting innocent third parties, limiting the embryos to be transferred protects the children that are to be born. As discussed above, much harm can come to children born from multiple births.¹⁴⁴ The California Supreme Court has repeatedly acknowledged that “the welfare of a child is a compelling state interest that a state has not only a right, but a duty to protect,”¹⁴⁵ and it has also recognized that “the state’s interest[] in protecting the health of minors . . . [is an] extremely important interest[] that rise[s] to the level of ‘compelling interest[]’ for purposes of constitutional analysis.”¹⁴⁶ The state’s interest in protecting children from future mental or physical disability is at least as important as California’s proclaimed interests in protecting the health and welfare of children, which justifies taking action to limit embryos transferred in order to decrease the rate of multiple births. So by acting now, either through legislation to limit the embryos implanted or enforcement by the courts, the state can protect these innocent children.

Finally, the state has an interest in preserving the ethical integrity of the medical profession.¹⁴⁷ By limiting the embryos

cited state interest is prevention of suicide, *id.*, but that has no application in the Suleman case.

¹⁴³ See Amy Barrett, *When One is Enough*, N.Y. TIMES, July 18, 2004, § 6 (Magazine), at 58, available at <http://www.nytimes.com/2004/07/18/magazine/lives-when-one-is-enough.html?pagewanted=1>.

¹⁴⁴ See *supra* notes 20–25 and accompanying text.

¹⁴⁵ *In re Marilyn H.*, 851 P.2d 826, 833 (Cal. 1993) (holding that a parent’s fundamental interest in the companionship, care, custody, and management of his or her children must be balanced with the child’s fundamental right to be protected from abuse and neglect).

¹⁴⁶ *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 800, 823 (Cal. 1997) (invalidating a legislative requirement that pregnant minors must have parental consent or judicial bypass before getting an abortion because it intruded on the fundamental privacy interests of pregnant minors and the state did not show that the intrusion was necessary to protect the health of minors).

¹⁴⁷ *Thor*, 855 P.2d at 383.

transferred, the medical profession would be free of future situations like the Suleman case—where Dr. Kamrava has disgraced the profession, and the entire population looks upon Suleman and Dr. Kamrava with disapproval and outrage.¹⁴⁸ One fertility specialist, Dr. Suheil Muasher, says that what Dr. Kamrava did “really reflects badly on us.”¹⁴⁹ Many IVF physicians are now fearful that the publicity surrounding the octuplets will “negate their hard work to build a practice high on ethics and success rates and low on higher-order multiple births.”¹⁵⁰ Dr. Stephen Lincoln admits that while previously the industry was not very good at IVF, having to transfer four, five, or more embryos at a time, there has been a significant reduction in multiple births of triplets or higher-order.¹⁵¹ Now Dr. Muasher is concerned that the Suleman case will cause some patients to avoid IVF because of a fear that they will have seven or eight babies.¹⁵² Dr. Kamrava’s act of malpractice was “very much the exception to treatment.”¹⁵³ Having caused so many people—including potential IVF patients—to question the practice of using IVF to procreate, the state may act to prevent such medical conduct from occurring again in order to maintain integrity in the field.¹⁵⁴

Taking action to limit the number of embryos that can be implanted in a woman’s uterus is also narrowly tailored to achieve the state’s interests. No one is asking that the IVF process be barred altogether, just that the process is limited in some way in order to protect all interested parties, including the lives of the mother and her children. The state’s goal is to prevent multiple births. Through direct regulation (via legislation) or indirect regulation (via the courts), limiting the number of embryos to be implanted is the least restrictive means to prevent multiple pregnancies. Stated succinctly:

¹⁴⁸ See Booher, *supra* note 5; Goff, *supra* note 4, at B2; LaFee, *supra* note 6, at A1.

¹⁴⁹ Goff, *supra* note 4, at B2 (reporting Dr. Suheil Muasher statements that “[m]ost in my specialty are outraged” and that “whatever was done here was outside the guidelines.”).

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.* And seven or eight babies would be a highly improbable, if not impossible, occurrence if physicians were to follow the ASRM guidelines.

¹⁵³ *Id.* (quoting Dr. Lincoln).

¹⁵⁴ See also Frank H. Boehm, *Most Doctors Will Follow Guidelines*, TENNESSEAN, Mar. 17, 2009 (“[T]he entire story was an example of how one unethical, unprofessional doctor can give many other doctors a bad name.”).

Although infertile patients may (and should) be deemed to have a fundamental right to use a fertility treatment that enables them to bear a child conceived using their gametes, the courts are likely to uphold a reasonable cap on the number of embryos transferred on the grounds that reasonable caps do not impose an undue burden on reproductive opportunity and that the state has a compelling justification for prohibiting the use of treatments that often result in dangerous multiple pregnancies.¹⁵⁵

Therefore, even under a strict scrutiny analysis, the most stringent of all forms of judicial review,¹⁵⁶ the right to procreation may not be impinged upon by a limitation on transferred embryos.

B. Legislation is Not Desirable

Just because state or federal legislation may be feasible does not mean that it is the appropriate solution for dealing with such extreme cases, as is the case with Dr. Kamrava's treatment of Nadya Suleman. Such an extreme remedy may foreclose the opportunity to reproduce genetic children for some women. Women in the United States may not have the same access to assisted reproductive technologies as do women in other countries,¹⁵⁷ and, therefore, we should not attempt to craft regulations modeled after foreign legislation that has been successful at deterring fertility doctors from implanting too many embryos. While women in other countries are able to try again with little consequence if the first IVF cycle does not yield a pregnancy,¹⁵⁸ women in the United States are typically limited to one cycle if their insurance companies do not cover IVF treatments.¹⁵⁹ If there was legislation further limiting a physician's ability to properly assess each patient's needs, successful IVF pregnancy rates would deteriorate because no two

¹⁵⁵ PETERS, JR., *supra* note 13, at 214.

¹⁵⁶ CHEMERINSKY, *supra* note 132, at 541.

¹⁵⁷ See *supra* note 70 and accompanying text; see also Marcia C. Inhorn, *Right to Assisted Reproductive Technology: Overcoming Infertility in Low-Resource Countries*, 106 INT'L J. GYNECOLOGY & OBSTETRICS 172, 173 (2009) (discussing the low number of women in the United States who utilize ARTs).

¹⁵⁸ See *supra* note 70 and accompanying text.

¹⁵⁹ See James Goldfarb et al., *Clinical Assisted Reproduction: Factors Influencing Patients' Decision Not to Repeat IVF*, 14 J. ASSISTED REPROD. & GENETICS 381, 381 (1997) (concluding that the major reason women did not pursue a second IVF cycle was because of finances); Jim Hawkins, *Financing Fertility*, 47 HARV. J. ON LEGIS. 115, 115–16 (2010) (expressing the prohibitive cost of IVF without insurance coverage).

patients are exactly alike. Implanting one embryo may work for a woman of twenty-seven years, but a physician should be free to transfer two or three embryos if the woman is thirty-seven years of age or has had previous unsuccessful cycles so as to yield a positive result.

By relying on the tort system to cull out those who would resort to such extremes, the fertility industry is not left unregulated, and those physicians adhering to the standard of care will not be limited to rigid, inflexible rules. While some deviation from the standard of care is appropriate, Dr. Kamrava's conduct was unacceptable. Future conduct by other fertility doctors and clinics should be subject to indirect regulation through the tort system by depending on industry guidelines, namely ASRM best practices, to dictate the industry standard of care. In doing so, individuals' rights to procreation and reproductive liberty will not be sacrificed in an attempt to regulate the practices of physicians, as they would with further legislation in this area.