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DANGEROUS RELATIONS: DOCTORS AND EXTRACORPOREAL EMBRYOS, THE NEED FOR NEW LIMITS TO MEDICAL INQUIRY

What is man that thou are mindful of him, and the son of man, that thou dost care for him?

For thou hast made him little less than God, and dost crown him with glory and honor.

Psalms 8:4-5

I. INTRODUCTION

Since the birth of Louise Brown on July 25, 1978, the science of in vitro fertilization (IVF) has been hailed as a remedy for infertility. It is estimated that between ten and twenty percent of couples desiring to have children are unable to do so because of infertility. The number of potential candidates for IVF increases when one includes those couples seeking to modify their procreative choices out of concern for passing on deleterious inherited traits. Although the current lucrative market in IVF therapy was created in response to a compelling human need, it does not address the biological

4. Id. This procedure is referred to as Artificial Insemination, Donor (AID), and is usually achieved by “impregnating the woman with semen from a man not her husband in a simple procedure that can be accomplished with a syringe.” Wadlington, Artificial Conception: The Challenge for Family Law, 69 VA. L. REV. 465, 468 (1983) (footnote omitted). This procedure is often carried out in conjunction with IVF. Id. at 474. These modern technologies also raise the specter of creating genetically superior humans as opposed to avoiding congenital defects. See Chen, Sperm Bank Donors All Nobel Winners, L.A. Times, Feb. 29, 1980, at 1, col. 1.
5. Professor Harry D. Krause has stated that “a child is not medication to be prescribed lightly to frustrated parents.” Krause, Artificial Conception: Legislative Approaches, 19 FAM. L.Q. 185, 206 (1985). Yet, all indicators are that the procedure is widely used. The cost for an
causes of infertility.⁶

As recently as 1983, IVF was considered an experimental procedure.⁷ Even with all its modern permutations and advances,⁸ IVF only bypasses a physical incapability that may exist in either the woman or the man.⁹ While circumventing infertility through assisted reproduction can be rewarding for the heretofore infertile couple, realizing their dream of conceiving a child who shares their exact genetic makeup,¹⁰ IVF therapy creates an immediate conflict in the context of doctor-patient relationships because the medical

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⁶. D. Giesen, supra note 3, at 629 ("Ever willing to accommodate, medical science views not only the cause of infertility as a medical disorder, but its effect, namely childlessness, as a disease in need of cure.").


⁹. D. Cusine, New Reproductive Techniques 6-7 (1988). Among the problems facing infertile men is the failure of spermatogenesis, which may take the form of oligospermia (sub-fertility), azoospermia (absence of sperm), and necrospermia (dead sperm). Problems associated with impotence and blockage of the vas deferens may also be circumvented by IVF without resort to donor sperm. The woman who has a fallopian or cervical blockage is also a candidate for IVF therapy. Id. at 7. For the sake of this Comment, reference will be made for simplicity to the married couple who uses IVF therapy by donating their own sperm and ovaries. There are a host of possibilities that can exist when using one or more donated gametes. For an informative and easy to understand treatise on the many varieties and combinations of reproductive technology, see generally D. Cusine, supra.

¹⁰. See generally Ubell, You Don’t Have to be Childless, PARADE, Jan. 14, 1990, at 14.
community refuses to acknowledge responsibility for the potential life that results from the IVF process.\textsuperscript{11}

Writing in 1972, when in vitro fertilization technology had yet to pass from the purely experimental to the medically acceptable,\textsuperscript{12} Leon R. Kass, a leading ethicist and physician, predicted that the issue of defining "protectible life" would dominate "ethical questions surrounding attempts to generate a normal child by transferring a laboratory-grown human embryo into the uterus of an infertile woman."\textsuperscript{13} In attempting to "solve" infertility, an IVF-created embryo is inevitably treated as an object or commodity for use by the medical community. This "trivialization"\textsuperscript{14} of human life is reflected in a 1989 General Accounting Office (GAO) study of human embryo laboratories.\textsuperscript{15} According to the GAO study, it is standard practice for the number of embryos "produced during an IVF treatment cycle" to exceed the number "immediately replaced in the patient," with eighty-three percent of the surveyed facilities freezing these excess embryos for storage.\textsuperscript{16} Unfortunately, forty-one percent of the laboratories eventually destroy these excess embryos, while thirty-six percent use them for research or "diagnostic purposes."\textsuperscript{17} While some commentators argue that the benefits of IVF may justify the practices described above,\textsuperscript{18} there is a very real danger that

\textsuperscript{11} This conflict is exemplified in the text of the American Medical Association's (AMA) 1989 Principles of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs, reprinted in Codes of Professional Responsibility 189 (R. Gorlin ed. 1990). Section 2.14, addressing the issue of IVF, is composed of two paragraphs. The first paragraph states that "any fertilized egg that has the potential for human life and that will be implanted in the uterus of a woman should not be subjected to laboratory research." \textit{Id.} at 199. The statement appears to define clearly a relationship between the doctor and the embryo. However, paragraph two sanctions research on those "fertilized ova not utilized for implantation," with the physician admonished to adhere to the principles outlined in § 2.10 covering fetal research. \textit{Id.} The third guideline of § 2.10 states: "In fetal research projects, the investigator should demonstrate the same care and concern for the fetus as a physician providing fetal care or treatment in a non-research setting." \textit{Id.} at 196. If professional care was apportioned equally in the therapeutic and research settings, the interventions allowed under paragraph two of § 2.14 could not stand—the research trials would invariably lead to the destruction of the embryo.


\textsuperscript{13} \textit{Id.} at 32. Kass stated that the current boundaries for defining protectible human life are "gerrymandered for the sake of abortion—namely, birth or viability—... but they will not survive the coming of more sophisticated technologies for making babies." \textit{Id.} at 33-34.


\textsuperscript{15} \textit{General Accounting Office, Human Embryo Laboratories: Standards Favored to Ensure Quality} (1989).

\textsuperscript{16} \textit{Id.} at 9.

\textsuperscript{17} \textit{Id.} at 10.

\textsuperscript{18} See, e.g., Fletcher, \textit{In Vitro Research Benefits May Outweigh Risks, Ethicist Says}, 13
physicians and researchers will become inured to the taking of human life.\textsuperscript{19}

Assuming with IVF that the "genies have been let out of the bottle,"\textsuperscript{20} a central concern is to ensure that artificial reproduction "remains our servant and does not become our master."\textsuperscript{21} Maintaining control over IVF technology cannot come solely through plans for self-regulation by the medical community.\textsuperscript{22} Codes of medical conduct never contemplated a relationship between the physician and the embryo existing ex utero, and current definitions for a protectible legal interest offer no guidance to the medical community.\textsuperscript{23} Rather, the traditional roles that have been applied in medical relationships provide a more coherent pattern of values and ideological principles to guide practitioners in assuming greater control of the IVF issue.

The purpose of this Comment is to demonstrate that the medical community currently does not have the capability to moderate the intense debate surrounding the disposition of fertilized embryos existing ex utero.\textsuperscript{24} This Comment argues that current adventures by medical practitioners and researchers into fertilized embryo technologies confuse the standard of care practiced not only in the IVF context, but also in everyday doctor-patient relationships.\textsuperscript{25} IVF presents the prime example of how the boundaries be-

\begin{thebibliography}{99}
\bibitem{19} This thesis is supported if one believes that an embryo is a human life or represents a potential for life. A myriad of factors, "including the demands of patients, scientists' yearning for discovery, physicians' interest in satisfying patients' needs, lucrative possibilities, and public fascination with technology," Bonnicksen, \textit{Embryo Freezing: Ethical Issues in the Clinical Setting}, 18 HASTINGS CENTER REP. 26, 30 (Dec. 1988), all contribute to unjustified paternalistic medical intervention. Doctors Edmund Pellegrino and David Thomasma decry this "strong paternalism" because it "violates the architectonic aim of medicine, which is to heal the one who is ill." \textsc{E. Pellegrino & D. Thomasma, For the Patient's Good: The Restoration of Beneficence in Health Care} 23 (1988).
\bibitem{20} D. Giesens, \textit{supra} note 3, at 665.
\bibitem{21} \textit{Id}.
\bibitem{22} The American College of Obstetricians and Gynecologists (ACOG) and The American Fertility Society (AFS) have announced the establishment of a "national advisory board to set guidelines and implement peer review procedures for activity in preembryo and fetal tissue research." ACOG, News Release (Jan. 7, 1991). Interestingly, these organizations look to self-regulation as a way to justify greater, rather than more limited, research.
\bibitem{23} D. Giesens, \textit{supra} note 3, at 666.
\bibitem{25} IVF is contrary to the traditionally accepted view that medical practice contemplates "interventions that are designed solely to enhance the well-being of an individual patient or
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between medical practice and research have become blurred. These two functions must be kept separate in order to ensure the patient's well-being, which is enhanced only when his or her interests are aligned with the doctor's goal of care-giving.

If doctors are to continue to practice medicine within the parameters of informed consent and thoroughgoing loyalty to the interests of their patients, there must be "limits to the uninhibited pursuit of the fashionable." To this end, current standards of medical-professional responsibility

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26. Medical practice employs "existing knowledge to treat a patient, while research involves the testing of hypotheses, which may reveal new knowledge." Gaze & Dawson, Who is the Subject of the Research?, in Embryo Experimentation, supra note 2, at 111.

27. See Fletcher, supra note 25, at 2-4. This issue is considered in the context of a slippery-slope; a loosening of respect at the core of relationships of trust leads to a general decline in standards of conduct—applicable in this case to all interactions between doctor and patient. See Lebacqz, Prenatal Diagnosis and Selective Abortion, 40 Linacre Q. 109, 114 (1973) (cautioning against the use of selective abortion and criticizing the eugenic effect of "eliminating deleterious genes from the gene pool").

28. In 1949 the World Medical Association drafted the International Code of Medical Ethics. The section addressing a doctor's duties to the sick states:

A doctor must always bear in mind the obligation of preserving human life. A doctor owes to the patient complete loyalty and all the resources of his science . . . . A doctor shall preserve absolute secrecy on all he knows about his patients because of the confidence entrusted in him.

D. Gieson, supra note 3, at 672.

29. Id. at 666 (footnote omitted). As of December 1990, the Federal Republic of Germany criminalized all interventions not promoting the preservation of human embryos. The law specifically provides for imprisonment if anyone "attempts to fertilize artificially an egg cell for any purpose other than bringing about a pregnancy of the woman from whom the egg cell originated." Law for Protection of Embryos § 1(1)(ii), reprinted in 64 Bull. Med. Ethics 9 (Dec. 1990). The law also prohibits artificial fertilization after the death of a gamete donor (§ 4), artificial alteration of human germ line cells (§ 5), cloning (§ 6), and the creation of hybrid embryos containing "different genetic information from the embryo cells." (§ 7). Id. at 10.
cannot support unlimited research on extracorporeal embryos and should be employed to curtail the creation of life in vitro. This analysis argues that responsibility must be allocated in behalf of the laboratory embryo. Only in this way will the respect accorded an extracorporeal embryo (incapable of even presumptive consent) be equal to that accorded a mature, sentient patient (capable of giving informed consent to medical procedures). Medical and legal responsibility in behalf of the embryo is supported if it is assumed either that life begins at conception or that the embryo represents potential life.

Proceeding from the perspective of the doctor-patient relationship, this Comment analyzes the need for limits on the use of IVF technology. Physicians are faced with two concerns. First, the law does not provide an acceptable guide for defining a physician's duty because the ex utero embryo does not conform to the traditional conceptions of a life-in-being. This problem is addressed from the perspectives of viability and autonomy. While the medical community has developed degrees of professional responsibility in both contexts, those standards are inadequate when applied to the extracorporeal embryo. Second, doctors who practice IVF necessarily find themselves conducting unwarranted medical experimentation that is unsupported by informed consent. This Comment concludes that IVF can continue within limited bounds without harming the standard of care practiced in all doctor-patient relationships.

II. DILEMMAS AT THE BEGINNING OF LIFE

The medical community currently lacks the capacity to make appropriate

30. Dr. Giesen asserts that in vitro fertilization, which involves “treating and transferring embryos, ... constitutes experimentation on human beings without the capacity to consent.” Giesen, Developing Ethical Public Policy on Reproduction and Prenatal Research: Whose Interests Deserve What Protection?, 8 MED. & L. 553, 553 (1989). Compare Silverman, Methodologic Controversies in Clinical Research: Consent for Experimentation Involving Neonates, 296 AM. J. MED. SCI. 354 (1988). The disturbing tone of Silverman’s research-oriented perspective needs little elaboration: “From the perspective of 1988 in neonatal medicine, it is discouraging to see that, despite the absence of objective information about social impact, the dogma of informed consent in clinical trials has become deeply entrenched.” Id. at 356.

31. It is the conflict represented by these two views that doctors must avoid. While differing views about the origins of life are strongly held, doctors should be careful to guard zealously the new professional respect that has been attained through patient self-awareness. The progression from days of patient ignorance and a professional “guild” mentality “with no critical ethical reflection,” Fletcher, supra note 25, at 2, has been replaced by a new paradigm of medicine where doctors and patients are partners in ending sickness. Any notion that the doctor and his patient share a common enterprise is based on the concept of a patient’s right to self-determination, thereby minimizing the effect of medical paternalism. Veatch, Three Theories of Informed Consent: Philosophical Foundations and Policy Implications, in THE BELMONT REPORT, supra note 25, at Appendix (Volume II, Chapter 26).
decisions about the disposition of frozen embryos. This inability is due to the failure of medical-ethical constructs to evolve with the development of IVF and its frozen embryo technological counterpart. The problem is compounded by the absence of legal principles that fail correspondingly to offer guidance to the new technologies. Since the legal community has yet to offer a comprehensive or systematic approach to these issues, an analysis of current law must be applied analogically to the dilemma of a doctor’s duty to extracorporeal embryos. Any discussion of allocating the doctor’s duty must derive from an understanding of when that duty arises. The determining point, then, is that time when life begins. The following sections are designed to explicate two views about the beginning of life. The first view is discussed in terms of viability; the second view proceeds from the notion that life begins at conception. Primary emphasis is placed on the dialogue between these views and the corresponding theories about the relationship between decisionmakers and the embryo existing ex utero.

In the first section, the United States Supreme Court’s abortion decisions offer a perspective of when life begins. The question of viability in this

32. D. Giesen, supra note 3, at 649. Of particular importance to Giesen’s call for limitations on the use of IVF and cryopreservation is his acute awareness of what actually supports our current enjoyment of IVF as an acceptable medical procedure. Giesen reports that 40%-60% of embryos were destroyed just in the process of testing new techniques of cryopreservation. It is not ethically justifiable that many of these lost “ice-babies” were created expressly for the purpose of testing the technique of deep-freezing. Cryopreservation, as a procedure, obviously involves room for human error, and thus considerable risk for the embryos. It can therefore be justified only if immediate implantation is impossible. The physician therefore has a duty not to fertilize more ova than ought reasonably be implanted at one time.

Id. (footnote omitted).

33. John A. Robertson argues that the moral and legal status of extracorporeal pre-embryos can be reconciled through an analysis of the intent to transfer or not to transfer these entities for implantation in utero. There is merit to Robertson’s general premise that some duty arises, but there cannot be a “linking” between moral and legal principles as they exist today. Therein lies the problem for medical professionals and those seeking legal reform. Robertson, Extracorporeal Embryos and The Abortion Debate, 2 J. Contemp. Health L. & Pol’y 53, 60-62 (1986). Robertson’s theory and the thesis of this Comment, however, both seek to harmonize moral principles whereby legal action actually serves these ends, instead of the current state where the law finds itself unable to act in an area requiring immediate attention.


area, however, has been confused because of its relationship to the balancing of a woman's liberty in her reproductive health and the state's interest in protecting human life. Moreover, the viability test is inadequate; the analysis should be based on a relationship of respect for a potential life. In the second section, an approach advocating full rights of personality for the embryo is applied to a relationship based on reverence for an individual life.

A. Viability Definitions

While the line of Supreme Court cases dealing with abortion appears to enshrine the concept of viability as a static determiner of when life begins, advances in medical science have weakened the viability concept, creating uncertainty for doctors seeking to follow the Court's rulings. If nothing else, the Court's decisions have established a sliding scale whereby viability is determined by the particular setting and the specific level of technology available to the doctor. Many would apply the sliding scale approach to


36. Roe, 410 U.S. at 154. The debate that followed this decision often proceeded from an incorrect assumption of what the Supreme Court stated in the Roe opinion. The Court refused to define when life begins, but instead sought to define the maturation of a protectible interest in the pre-term fetus. Id. at 154-55.

37. Unfortunately, doctors who employ IVF and currently perform experiments on extracorporeal embryos borrow the viability standard from the abortion context, which was intended to balance rights of survival between a mother and fetus. This application to research is illogical because the potential life-in-being has the ability to be brought to term if provided with a willing mother's uterus. The assertion by the ethics committee of the American Fertility Society, that the embryo used in IVF is a "preembryo" and should not be treated as a person, because it has not yet developed . . . and may never realize its potential," Ethical Considerations of the New Reproductive Technologies, 46 FERTILITY & STERILITY 84 (Supp. 1986), begs the viability issue because the embryo's situation ex utero (the absence of viability) is a result of actions by the very parties who seek to benefit by a classification that does not recognize a life interest.

38. This section will analyze the maximization of the principle of respect for autonomy in medical practice and how the principles of nonmaleficence and beneficence lead to unwarranted paternalism by doctors involved in IVF. See generally T. Beauchamp & J. Childress, PRINCIPLES OF BIOMEDICAL ETHICS (1989) [hereinafter Beauchamp & Childress].

39. The Roe Court stated that "viability" occurred at that time when the fetus had "the capability of meaningful life outside the mother's womb." 410 U.S. 113, 163 (1973). However, there is no definition for "meaningful life" in the opinion.

40. Special Project, Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth, 39 VAND. L. REV. 597, 629 (1986) [hereinafter Special Project]. Modern perinatal care continues to increase the time that the fetus can survive outside the mother. Id. "Perinatal" defines that period between the twenty-eighth week of pregnancy and the first seven days after birth. Id. (citing STEDMAN'S MEDICAL DICTIONARY 1055 (24th ed. 1982)).

41. H.T. Engelhart, Medicine and the Concept of Person, Concepts of Personhood 94-101 (1976). Engelhart correctly proposes that there is an "arbitrary line" drawn between what we identify as a fetus and an infant. He says: "We recognize . . . that some
the current debate regarding frozen embryos if only because medical technology is unable to simulate the delicate placental tissue necessary for fetal respiration. Although the analytical framework established in *Roe v. Wade* permits state intrusion in the context of "protecting the health of the pregnant woman" and the "potentiality of human life" in utero, the creation of life—ex utero—falls outside these two parameters because *Roe* only addressed the potentiality of human life within the scope of a woman's reproductive autonomy.

*Roe v. Wade* was the Supreme Court's first attempt to define a protectible human interest. Although the decision was reached from a perspective of protecting the right of a woman to terminate her pregnancy within the bounds of a general privacy interest, the Court recognized the role of a physician as a guardian of the state's compelling interest in fetal life at the beginning of the third trimester. While the Court held that abortions could be procured with little or no state intervention during the first trimester, it rejected a proposition that privacy rights were absolute and entitled a woman to choose an abortion at any time.

By placing the role of the doctor—as guardian—at the center of the post-trimester abortion controversy, the *Roe* Court ran counter to traditional rules established by the medical profession for the protection of patients. The Court focused on the following part of the Hippocratic Oath which states, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy." Unaware of a perceived history in the medical commun-

human biological life is treated as human personal life even though it does not involve the existence of a person in the strict sense." *Id.* at 99.

42. Special Project, *supra* note 40, at 630.
44. *Id.* at 162.
45. Dr. Leon R. Kass envisioned that embryos, created ex utero, would redefine the issue of protectible humanity because "nascent lives [were] being deliberately created despite certain knowledge that many of them [would] be destroyed or discarded." Kass, *New Beginnings in Life*, in *The New Genetics and the Future of Man* 34 (M. Hamilton ed. 1972).
47. *Id.* at 163.
48. *Id.* at 166.
49. *Id.* at 155.
50. See *id.* at 130-32 (summarizing ancient critiques of the Hippocratic tradition in proposing that anti-abortion policies did not become part of the medical standard of conduct until the nineteenth century).
51. *Id.* (interpreting A. CASTIGLIONI, *A History of Medicine* 84 (1947)). The Hippocratic Oath places two duties upon doctors—nonmaleficence and beneficence. *Beauchamp & Childress, supra* note 38, at 120 ("I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them."). The principle of nonmaleficence states that "one ought not to inflict evil or harm," while the principle of benefi-
nity of strenuous opposition to abortion, the Court gave consideration to mainstream representatives of the profession who recognized a modern trend within the American Medical Association (AMA) sanctioning abortion within the context of regulated and accepted medical procedures.

By recognizing this modern trend, the Court, in effect, supported the medical community's attempt at self-regulation by acknowledging the value of "informed patient consent" and "sound clinical judgment" about the decision to perform an abortion. Yet, even in sanctioning abortion, the Court acknowledged that the right could be qualified, recognizing that a doctor could exert some influence over a woman's choice for abortion during the first trimester—presumably where the woman's right is paramount. The putative concerns of maintaining professional standards, however, were in conflict with the very definition of life imposed by the Court; the holding of Roe v. Wade has determined how doctors and researchers approach life issues.

As a result of the Court's attempt to define a protectible interest in life, a doctor is entitled to protect the unborn only when the fetus is "potentially

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52. More emphasis should have been given to those members of the medical community who conscientiously allowed abortion therapy out of a concern for the best interest of their patients.

53. Roe, 410 U.S. at 143 (citing proceedings from the AMA House of Delegates (June 1970)).

54. Id.

55. The Roe Court specifically recognized the context of the woman's relationship to state regulation: "[A] State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life." Id. at 154.

56. Id. at 143-44. The Court looked to that part of a June 25, 1970, American Medical Association resolution which stated that an abortion, "like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demand." Id.
able to live outside the mother's womb, albeit with artificial aid."

The Court fashioned a superior right of a woman to control her reproductive health prior to the viability of the fetus. In this respect, however, the sliding scale does not provide an authentic balance if the two competing parties do, in fact, assert equally recognized values in personal autonomy. Nonetheless, the Court's post-

In Planned Parenthood v. Danforth, the Court struck down a Missouri abortion statute requiring a doctor to preserve the life and health of the fetus at any stage of pregnancy. In that instance, the Court recognized the duty owed by the doctor to the fetus only after the point of viability. Although not directly addressed in Danforth, of central importance to the issue of frozen embryos was the Court's recognition that the standard of viability is a "medical term." Justice Blackmun's majority opinion framed the policy concerns as follows:

[I]t is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is ... a matter for the judgment of the responsible attending physician.

The Danforth majority also modified its definition of viability by upholding a provision of the state law defining viability as the ability to survive outside the mother for an "indefinite" period of time.

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57. Id. at 160; see also Special Project, supra note 40, at 630 (discussing advancements in neonatal care).

58. D. GIESEN, supra note 3, at 645. Dr. Giesen suggests that the United States example of a right to abortion would not survive constitutional challenge under the German constitution of 1949, which protects life at its earliest stages. Id. at 645 n.79. In Germany, the right to life of the fetus is recognized without regard to the considerations of viability that trigger the maturation of a compelling state interest within the American framework.

59. It is here that the analysis takes on a more analogic tone because there are few cases on point that discuss the viability issue in the context of the embryo existing ex utero.

60. 428 U.S. 52 (1976).

61. Id. at 83.

62. Id. Contrary to the Supreme Court's later assertion in Webster v. Reproductive Health Services that Roe v. Wade should be limited in the future to a perceived liberality in the ability for a woman to obtain an abortion, another Missouri statute declaring that the "life of each human being begins at conception," and that "unborn children have protectable interests in life, health, and well-being," MO. REV. STAT. §§ 1.205.1(1), 1.205.1(2) (1986), was effectively nullified by the Webster Court's affirmation of the viability approach. 109 S. Ct. 3040, 3058 (1989).

63. Danforth, 428 U.S. at 64.

64. Id. at 63. The Missouri abortion statute also provided that, while no specific time
The impact of the sliding scale in defining the beginning of life was demonstrated again in *City of Akron v. Akron Center for Reproductive Health.* In deciding that a comprehensive state regulatory plan was overbroad and had the effect of chilling access to an abortion, the Court stressed the importance of the physician in consulting with the woman seeking an abortion. This holding was strengthened by the Court's rejection of the state's requirement that the doctor inform his patient that life begins at conception and that an abortion is a "major surgical procedure" with serious physical and emotional consequences. A similar state statute was rejected by the Court in *Thornburgh v. American College of Obstetricians & Gynecologists,* where the Pennsylvania legislature attempted to dictate the physician's role by insisting that he or she provide specific information to a woman seeking an abortion. Perhaps the most objectionable provision of the statute was the delineation of specific criteria necessary to relieve the physician from liability for failure to inform his patient of the attendant risks of the abortion procedure. The *Thornburgh* Court was unwilling to allow the consultation role of the physician, spoken of in *Danforth* and *Akron* and defined by the parameters of a relationship based on informed consent, to be transmuted into a vehicle for promoting a specific state policy.

limit would be used to determine viability, an infant who survived "an attempted abortion . . . not performed to save the life or health of the mother" became a ward of the state. Mo. Ann. Stat. § 188.040 (Vernon 1976). By not defining a specific time limit, the statute exemplified the sliding scale.

66. Id. at 434.
67. Id. at 447. The Court stressed "the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out." Id. (citing Colautti v. Franklin, 439 U.S. 379, 387 (1979)).
68. Id. at 444-45.
70. Section 3205 of the Pennsylvania Abortion Control Act required that the woman give her "informed consent" to the procedure. Yet, the Court found that the chilling effect of the statute was similar to that found in *Akron.* Id. at 760.
71. Rather than contributing to the woman's informed consent, the Court found that the criteria required by the state were designed to "influence" her choices. *Thornburgh,* 476 U.S. at 760. Several criteria are plainly violative of the privacy concerns at the core of informed consent—e.g., requiring that certain print material be provided for patient review containing information on (i) the possible alternatives to abortion, (ii) the availability of private agencies willing to help the woman carry her child to term, and (iii) the "probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, including any relevant information on the possibility of the unborn child's survival." Id. at 761.
73. For views critical of physician participation in the context of "therapeutic abortion" in the United Kingdom, see generally Grubb, *Abortion Law in England: The Medicalization of
A more restrictive statutory scheme was previously rejected in Colautti v. Franklin. The Court found that autonomous decisionmaking by a woman was absolute prior to viability of the fetus. Section 5(a) of the Pennsylvania Abortion Control Act imposed criminal liability upon the doctor for failing to safeguard the life of the pre-term fetus upon a finding of viability or a "sufficient reason to believe that the fetus may be viable." As in Akron, the Pennsylvania statute's imposition of a new standard of care confused the doctor's duty of loyalty. The Court wisely found the statute void for vagueness because it was uncertain whether it allowed the doctor "to consider his duty to the patient to be paramount to his duty to the fetus or whether it require[d] the physician to make a trade-off between the woman's health and additional percentage points of fetal survival."

The state requirements struck down in Colautti, Akron, and Thornburgh violated traditional notions of informed consent because the subject of the doctor-patient relationship lost the ability to make an "autonomous authorization" for particular medical treatment, free of legislative bias conveyed through the physician. Like the state requirements, the unrestricted use of IVF and its attendant technologies further erodes the already fragile assumptions that are the basis of informed consent because the extracorporeal embryo does not possess the ability for self-determination.

It is more convenient for those who advocate that the use of IVF is acceptable for medical experimentation if the embryo is deemed not to possess rights of personality. The Supreme Court's latest pronouncement on abor-
tion, however, may call into question such a facile determination of protectable life. *Webster v. Reproductive Health Services*[^83] has left open the possibility for more restrictive state regulation of abortion by upholding a Missouri statute premised on the belief that “[t]he life of each human being begins at conception” and that “[u]nborn children have protectable interests in life, health, and well-being.”[^84] While the Eighth Circuit Court of Appeals in *Webster* held that policy statements regarding when life begins could not be used to “justify” an otherwise unconstitutional regulation of abortion,[^85] a plurality of the Supreme Court would not rule on whether the provision created rights in the unborn under other state laws.[^86] By this evolution of abortion law, extracorporeal embryos could be accorded a different status than their in utero counterparts, particularly because IVF does not present the “two-lives-in-one body conflict.”[^87] Such a result is legally sustainable because the viability approach has only been applied to fetal life existing in utero.[^88] Thus, in an post-*Webster* environment, when questions about the beginning of life are presented in a non-abortion setting, extracorporeal em-

[^83]: Rep. 5 (June 1982); Jones, *The Ethics of In Vitro Fertilization*—1982, 37 *Fertility & Sterility* 146 (1982). Physicians should be circumspect of those who advocate that an embryo lacks the characteristics of personhood and, therefore, is not entitled to protection. See generally Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, 2 Hastings Center Rep. 1, 1-2 (Nov. 1972) (listing, *inter alia*, the following criteria to define “humaness:” minimal intelligence, self-awareness, self-control, sense of time, sense of futurity, sense of the past, capability to relate to others, and control of existence).


[^86]: Id. at 3050 (“The Court has emphasized that *Roe v. Wade* ‘implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion.’ *Maher v. Roe*, 432 U.S. 464, 474 ([1977]).”).

[^87]: D. Giesen, *supra* note 3, at 646.

With IVF there is never any doubt as to whether fertilization has taken place, but at present the embryo must be implanted in utero in order to develop past the early stages of cleavage. Some scholars make use of this fact to argue that the embryo should enjoy protection only after implantation; others feel that the life of the embryo deserves respect only after a certain stage of maturity (e.g. after sentience has set in). However, in law, there is no room for differentiation between human life and human life. The human embryo enjoys legal protection from the moment it comes into existence.

[^88]: Annas, *Webster and the Politics of Abortion*, 19 Hastings Center Rep. 36 (Mar./Apr. 1989). Annas states that the trimester approach for abortion is “a technologically based decision, relying as it does on the safety of medical techniques to ascertain the stage of pregnancy when abortion is safer than carrying the fetus to term, and a determination of ‘viability’
bryos could receive a status different than that of their in utero counterparts, and, consequently, a physician's duty of care to IVF embryos may be greater than previously thought.

As seen above, the standard of viability established by the Supreme Court creates a medical obligation for the physician to the woman seeking an abortion, thus weakening state efforts to intrude upon the privacy relationship between doctor and patient. This relationship, defined by the respect for patient autonomy, is discussed again in the following section. However, the Court's treatment of viability does not offer a guide for physician standards of conduct toward the embryo because advances in technology are now making these traditional legal determinations of viability more difficult.  

It appears that Leon Kass' prediction regarding the confusion of definitions of life has been realized in the debate generated by the issues of abortion and in vitro fertilization.  

B. The Case For Autonomy Of The In Vitro Subject

The Second Vatican Council stated in its pastoral constitution, Gaudium et Spes, that God's absolute commandment to "love thy neighbor as thyself" makes clear His plan that humankind be mindful of preserving the communitarian nature of life. This general plan applies to all lives in being and supports the Church's official teaching that the destruction of an embryo, no matter how undifferentiated in development, is murder. However, the application of these morally consistent principles engenders great confusion when a physician is faced with the option of creating in vitro embryos for the purpose of implantation and eventual birth. The Church's moral imperative, when applied to the United States experience of medical ethics and physician duty, yields to a duality associated with the rights of autonomy (in this case, those of the embryo) and a community interest in fostering a general attitude of respect for life.

by physicians and scientists for choosing this as a constitutionally relevant boundary." Id. at 38. However, these terms provide little protection to the extracorporeal embryo.


90. Kass, supra note 12, at 33.


92. Id. at 223-24.

93. Donovan, Test Tube Killing, 45 Homiletic & Pastoral Rev. 59, 60 (1944) (section entitled Answers to Questions).

94. There is an important distinction to make when discussing "autonomy." The concept is often confused with an unlimited notion of "sovereignty" that is counter to the necessity of balancing individual liberties with the domain of those decisions that primarily and directly offset only the interests of the decisionmaker. Feinberg, Autonomy, Sovereignty, and Privacy: Moral Ideals in the Constitution?, 58 Notre Dame L. Rev. 445, 446-64 (1983). If autonomy
Justice O'Connor recognized a definition of viability which could ultimately require respect for both autonomy and for human life to ensure preservation of the extracorporeal embryo. In her Akron v. Akron Center for Reproductive Health dissent she wrote:

As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception. Moreover, it is clear that the trimester approach violates the fundamental aspiration of judicial decisionmaking through the application of neutral principles . . . .

The application of a blanket assumption that life begins at conception demonstrates how inadequately current medical-ethical constructs can accommodate IVF because a life in being must be allowed the opportunity for complete development, regardless of any custodial or contractual obligations surrounding fertilization. Doctors implicate themselves in a maze of issues concerning their responsibility when embryos are regarded as individuals who possess legal rights. A recent case demonstrates how the application of this assumption will limit those in the medical community who demand more access to IVF technology.

I. Davis v. Davis: Life Begins at Conception?

In late September of 1989, the Circuit Court for Blount County, Tennessee (Equity Division) heard the case of Davis v. Davis. This case presented a claim for child custody by a woman who had participated with her husband in the in vitro fertilization procedure. The couple hoped that the process of in vitro fertilization would enable them to produce children who

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is violated by a nonconsensual touching, then it is also violated by the withholding of physical treatment requested by the subject. Id. at 453.


96. See Charlesworth, Community Control of IVF and Embryo Experimentation, in EMBRYO EXPERIMENTATION, supra note 2, at 151 (cautioning that an IVF embryo is, because of its "exposed" position, subject to a greater array of human interventions than its in vivo counterpart).

97. Responsibility is created toward a life in being once it is recognized as such. On a reciprocal level, though, the in vitro subject is limited to a "discretionary competence" in theory because it has no ability to speak for itself. Feinberg, supra note 94, at 454.

98. One doctor who was very active in research on human embryos responded truculently to the Health and Human Services ban on federally-funded projects: "It's irrational. It slows the progress of science. It's very frustrating to me that I cannot get NIH [National Institutes of Health] funds." Ubell, supra note 10, at 15.


100. Davis, slip op. at 4-6, 1989 Tenn. App. LEXIS at *4-9.
shared a genetic bond with them. Before a successful implantation could be achieved, however, the couple was divorced, leaving seven embryos cryopreserved in the office of a local physician specializing in fertility therapy. The claim for custody of the seven embryos was initiated by Mrs. Davis, who still desired to bear children.

In granting Mrs. Davis' petition for custody, the court held that the seven embryos were children and ordered their disposition in the following manner:

[T]he Court finds and concludes that it is to the manifest best interest of the children, in vitro, that they be made available for implantation to assure their opportunity for live birth; implantation is their sole and only hope for survival. The Court respectfully finds and concludes that it further serves the best interest of these children for Mrs. Davis to be permitted the opportunity to bring these children to term through implantation.

The ruling was made over the strenuous objection of Mr. Davis. He contended that the seven embryos were joint property and that the order allowing for the possibility of implantation by his former wife violated his desire not to become a father. Testimony was given by a variety of experts in the field of embryology to the effect that few could agree on a definition for the beginning of life. The judge, however, did find support for his decision by interpreting other statutes in his jurisdiction that involved life issues. He concluded that the State of Tennessee did not intend for its wrongful death or criminal abortion statutes to “declare the rights to be accorded a human embryo, in vitro, in a divorce case.”

The court further found that the common law doctrine of parens patriae would be used to determine the best interests of the children.
Although Davis was overturned on appeal, there are some incongruities raised by the trial court’s decision that appear in similar cases in the United States. First, by declaring that the Davis embryos were created only for the production of the couple’s children, the judge contradicted his earlier holding that human embryos are not property. To be consistent, one would have to side with the position awarding the embryos near perfect rights of autonomy. The Davis ruling, by giving custody of the embryos to the mother, presumably incapable of carrying all embryos to term, merely reverts to a lower standard of respect, treating the “children” as imperiled newborns.

Baby “M,” 217 N.J. Super. 313, 525 A.2d 1128 (1987), for the general principles of the parens patriae power. However, Judge Young’s bald assertion that “[t]he thrust of the equitable nature of this doctrine is that it turns its full focus on the best interests of the child,” without concern “for those who claim rights of the child,” appears more concerned with proving that he actually had dispositional authority over this case from the “Court’s having historic Chancery or equity jurisdiction.” Davis, slip op. at 19, 1989 Tenn. App. LEXIS at *35. The key theoretical difference is that the parens patriae power was used in the Baby M case to terminate parental rights. In Re Baby M, 217 N.J. Super. at 399, 525 A.2d at 1171. The Davis case effectively imposed the “irreversible burdens” of fatherhood on the husband. Robertson, supra note 104, at 9. Another method of determining the “best interests” of the embryos would be to treat them “as though they were fully developed children and subject to the appointment of a guardian ad litem by a court.” Smith, Australia’s Frozen “Orphan” Embryos: A Medical, Legal and Ethical Dilemma, 24 J. Fam. L. 27, 31 (1985-86). Interestingly, this argument, proceeding from a court of equity’s jurisdiction, also supports the imposition of a constructive trust upon the Davis’ fertility doctor. The court could then “prevent acts inconsistent with the perceived intention of the parties in question from occurring.” Id.

108. Davis v. Davis, C/A No. 180, slip op. (Tenn. Ct. App. Sept. 13, 1990), 1990 Tenn. App. LEXIS 642, appeal granted sub nom. Stowe v. Davis, 1990 Tenn. LEXIS 466. Noting that Mary Davis no longer wished to implant the embryos, the Tennessee Court of Appeals noted that “it would be repugnant and offensive to constitutional principles to order Mary Sue to implant these fertilized ova against her will” as well as “order Junior [Mr. Davis] to bear the psychological, if not the legal, consequences of paternity against his will.” Id. at 6, 1990 Tenn. App. LEXIS at *8-9. The reversal was premised on the protection of Mr. Davis’ right “not to beget a child where no pregnancy had taken place.” Id. at 4, 1990 Tenn. App. LEXIS at *6.

109. Two unreported cases with facts similar to those Davis have been filed in Louisville, Tennessee and Cleveland, Ohio. See Boskey, The Law of Alternative Reproductive Technologies, in 4 FAMILY LAW AND PRACTICE 64-A-28 (A. Rutkin ed. 1990).


111. Beauchamp & Childress, supra note 38, at 73. Beauchamp and Childress argue that the principle of respect for autonomy only applies to those individuals who have the ability to assert personal claims. Id.; see Schoendoerff v. Society of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .”) (Cardozo, J.), overruled on other grounds, Bing v. Thunig, 2 N.Y.2d 665, 667, 143 N.E.2d 3, 9 (1957). For an analysis of the legal, medical, and ethical issues concerning nontreatment decisions for critically ill newborns, see generally Imperiled Newborns, 17 HASTINGS CENTER REP. 5 (Dec. 1987). The designation “lower standard of respect” is used in this instance because treatment decisions for critically ill newborns are made often on shifting perceptions of the child’s quality-of-life potential. See Ellis, Letting Defective Babies Die: Who Decides?, 7 AM. J.L. & MED. 393, 407.
Consistency with the judge's ruling demands that all seven of the remaining embryos be implanted in the mother. Failure to act by the fertilization specialist, who currently has the seven frozen embryos stored in a freezer in his office, could lead to varying forms of liability. While these examples are only hypothetical, they do demonstrate that once a duty of care is established, it cannot be ignored because of the particular state of life currently possessed by a moral subject. On the face of the trial court's opinion in Davis, it could be assumed that the wife attained a victory in defeating the husband's petition for the seven embryos not to be implanted (or, effectively, allowed to die). However, the mother's maintenance of the embryos in frozen storage could be considered an "injurious environment" for the children and tantamount to neglect by failing to meet a minimum standard of necessary support.

(1982). However, the ex utero embryo has the potential to develop completely, provided it is transferred to a gestational environment. See Baylis, The Ethics of Ex Utero Research on Spare "Non-Viable" IVF Human Embryos, 4 BIOETHICS 311, 314, 317 (1990).


113. Liability may proceed by way of actions for breach of contract or infliction of emotional distress. See Boskey, supra note 109, at 64-A-30. To date it is unclear whether Louisiana, the only state recognizing the ex utero embryo as a human being, would support a murder charge against a physician, who by act or omission, caused the "death" of a fertilized embryo. See Kasimba, IVF Regulation: The Search for a Legal Basis, in EMBRYO EXPERIMENTATION, supra note 2, at 163.

114. This is the most persuasive use for a deontological theory of responsibility in the medical profession and supports a dramatic curtailment in the current use of IVF. In this paradigm, the categorical imperative would be the preservation of all life, regardless of the condition of the recipient of that care. BEAUCHAMP & CHILDRESS, supra note 38, at 40.

115. However, Mary Davis' position was tenuous in response to her husband's appeal. She had since remarried and no longer desired to use the embryos; she preferred that they be donated to other childless couples. The argument in her appellate brief hardly seems credible: Appellee requests that this case be viewed solely for what it is; a case of a woman who tried desperately for years to become a mother and, upon embarking upon what may be her last chance, has been thwarted by the cruel decision of a husband who changed his mind in midstream.


The appeal of Junior Davis was more consonant with the issue addressed by the Court of Appeals:

Judge Young's decision to give Mary Sue the exclusive control over the use of the embryos weakly promotes his anthropomorphic view that they are "children." His notion that these fertilized, frozen ovum [sic] irreversibly fulfilled the Davis' intention to become parents is alien to the well-settled laws which permit continuing choice until at least the end of the first trimester.


116. H.D. Krause, ILLEGitIMACY: LAW AND SOCIAL POLICY 285 (1971) (showing that parental neglect depends on a finding of fault). Pending the initial decision of Davis v. Davis, a Tennessee attorney petitioned the Circuit Court for Blount County, Tennessee to appoint a
2. York v. Jones: Embryos as Property

In contrast to Davis v. Davis, a federal court in Virginia held that extracorporeal embryos were property within the parameters of a bailor-bailee relationship.¹¹⁷ At issue was the conduct of a large and well-established fertility clinic in Norfolk, Virginia.¹¹⁸ The plaintiffs, Risa and Steven York, were a married couple who had engaged the services of the Jones Institute of Reproductive Medicine, seeking to have “their own genetic child.”¹¹⁹ Over a two-year period, Mrs. York attempted to become implanted with previously fertilized embryos on four occasions. When these efforts failed, the couple sought to have their remaining cryogenically preserved embryo transferred to another fertility clinic. The controversy arose when the Jones Clinic refused to surrender the remaining embryo.¹²⁰

Claiming that the Virginia Human Research Statute limited the York’s dispositional authority over the embryo, the Jones Clinic defended its refusal to act on the grounds that a signed consent form implicitly incorporated the protocols of the state human research committee.¹²¹ The relevant provision of the Cryopreservation Agreement provided for “three fates” for any “prezygotes remaining in frozen storage.” These options were limited to donation to an anonymous infertile couple, donation for approved research, or removal from cold storage “but not allowed to undergo further development.”¹²² However, the court held that the Yorks had a proprietary interest in the frozen embryo that could not be vitiated by the apparently restrictive provisions of the contract.¹²³

In ruling in favor of the Yorks, the court approved two theories relevant to the character of the embryo. First, the contract created a bailor-bailee guardian or temporary custodial parent for the seven Davis embryos. The petition specifically stated that “time [was] of the essence” because the survival rate of in vitro embryos declined with the passage of time and that Mrs. Davis’ actions constituted “constructive abandonment” of the embryos. Petition to Appoint a Guardian/Alternate Temporary Custodial Parent and/or for Change of Temporary Custody, by R.D. Hash, Esq. at 3-4, Davis v. Davis (Tenn. Cir. Ct. Sept. 21, 1989), 1990 Tenn. App. LEXIS 642 (No. E-14496).

¹¹⁷. York v. Jones, 717 F. Supp. 421, 427 (E.D. Va. 1989). While a bailment may be defined “as the rightful possession of goods by one who is not the owner,” S. WILLISTON, LAW OF CONTRACTS 875 (1967), the bailee, nevertheless, “is under a duty to exercise a certain degree of care over the bailed chattel, and to return it to the bailor on demand.” R. BROWN, THE LAW OF PERSONAL PROPERTY 209 (1975).
¹¹⁹. Id.
¹²⁰. Id. at 424.
¹²¹. Id. at 425.
¹²². Id. at 424-25. In Davis v. Davis, the third option was requested by Mr. Davis during the divorce proceeding that granted custody of seven frozen embryos to Mrs. Davis.
relationship because Virginia law did not require a finding of specific intent by both parties to do so. Because the relationship between the parties had been terminated by the Yorks, the Jones Clinic, as bailee, had an “absolute obligation to return the subject matter of the bailment to the bailor.” The court also concluded that an action in detinue would support the plaintiff’s recovery. In dicta, the court noted that the state human research statute did not apply to this contract dispute because the statute’s purpose was to ensure that informed consent is obtained in order to “protect both scientist and subject from the legal claims of the other.” Viewing informed consent as a type of contractual relationship itself, the interests of the embryo in York seem conspicuously unrepresented.

While the fortunate reality of York v. Jones (in contradistinction to Davis v. Davis) was the presence of two parents who both desired to nurture a child, the conflict with the fertility clinic demonstrates the difficulty of aligning duties between responsible parties. Clearly, Dr. Jones’ goals were not always parallel to those of the Yorks because he sought to retain control of the embryo. The Yorks believed that their child was being held “hostage,” while Dr. Jones viewed the embryo as part of a procedure that might have resulted in a successful pregnancy.

3. Synthesis of Concepts To Redefine Physician Loyalty

Fueled by commercial interests, practitioners and researchers, engaged in the “business of initiating new life,” will continue to argue for a relaxation of restrictions on the use of IVF until both the medical and legal communities undertake a systematic and informed resolution about the basic question of when life begins. It is because the subject of this controversy

124. Id. at 425 (“Rather, all that is needed ‘is the element of lawful possession however created, and duty to account for the thing as the property of another that creates the bailment . . . ’ ” (citation and quotation omitted)).
125. Id. (citing Annotation, Bailments, 8 AM. JUR. 2D § 178 (1980)).
126. Id. at 427. The court stated the five elements of a detinue action in Virginia: (1) plaintiff must have a property interest in the thing sought to be recovered; (2) the right to immediate possession; (3) the property is capable of identification; (4) the property must be of some value; and (5) defendant must have had possession at some time prior to the institution of the act.
128. The ethical sense of what is meant “to have a child of one’s own” is usually limited to the parents. Kass, "Making Babies” Revisited, 54 PUB. INTEREST 32, 44 (1979).
130. Jones, supra note 82, at 147.
exists outside the current parameters of understanding protectible life that
two very opposite cases like *Davis v. Davis* and *York v. Jones* can be decided
at virtually the same time. This current scarcity of legal principles wrong-
fully permits the physician to practice IVF with little guidance.  

In testimony before the House of Representatives Committee on Science
and Technology, the attorney who represented Risa and Steven York capa-
bly summarized the lack of legal guidance with these words:

> The medical technologies of . . . embryo freezing and the donation
> of sperm, ova and embryos are being forced into the Procrustean
> bed of existing laws on paternity, fetal research and adoption. The
> result is an insufficient protection of the participants in the new
> conceptions, including the children.

This testimony correctly assigns primary concern to a doctor's duty towards
the extracorporeal embryo by focusing on maintaining general standards of
informed consent. If a physician is unsure whether he or she has laid a
proper foundation for obtaining the informed consent of a patient, society
should limit IVF and live embryo research because it is dangerous to apply
the fiction of "surrogate consent" to the same authority that has disposi-
tional control over the extracorporeal embryo. Indeed, the legal and med-
ical communities must fashion concrete standards governing the relationship
between the doctor and extracorporeal embryo. Current standards are inad-
equate to the task, although some legislative protections could be interpreted
to impose negative duties upon responsible parties by prohibiting specific
dispositional acts relating to previable life. An ancillary provision of the

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ers, there was a consensus that government involvement would only "restrict progress." Id.
133. *Human Embryo Transfer: Hearings Before the Subcomm. on Investigations and Over-
further discussion, see Andrews & Hendricks, *Legal and Moral Status of IVF/ET*, in *Foun-
5, 6 (Sept./Oct. 1989).
(1982) [hereinafter Childress].

Because consent is so important an implication of the principle of respect for persons,
we resort to fictions such as presumed consent . . . Yet we should resort to fictions
. . . only with the greatest care and caution, for under the guise of "consent" they
may imply a more extensive paternalism than is warranted.

*Id.* at 85 (footnote omitted).
(1982); Tex. Penal Code Ann. § 48.02 (Vernon 1989). Seven states prohibit the sale of live
Uniform Anatomical Gift Act also could protect embryos, but to have such a provision would first require that the embryo not have any rights under the law as an individual.137 Either approach would be preferable to the current want of legal guidance.138

Several factors demonstrate that a relationship based on respect for the autonomous person cannot exist between doctor and embryo. First, there is no foundation for obtaining consent. While it is beneficial to follow a rule that non-autonomous individuals or entities do not lose all expectations of privacy,139 there is a different standard of conduct applicable to the non-autonomous subject. Second, the embryo is often treated as a means toward some other goal, rather than as an end in itself.140 Third, there is an inevit-
ble movement away from a perceived course of beneficial therapy directed at the embryo's well-being to a de facto experimental trial by the attending physician.141 Fourth, implied consent142 used to secure "permission" for medical interventions, is not consent at all but merely a construct for action that is perceived to be justifiable while allowing "responsible" parties to divine the subject's approval.143

The following section proposes that the principle of informed consent is weakened when applied to the creation of extracorporeal embryos because an embryo cannot act upon this consent, and because it is dubious whether the process of IVF is sensitive to the promotion of patient benefit.144 In addition, the processes of IVF and cryogenic storage (with the intention for timely embryo implantation) are inherently dangerous and pose an unreasonable risk to the embryo.145

III. A NEW MODEL IN SUPPORT OF BENEFICENT ACTION

The premise that the medical community needs protection from the explosive issues surrounding IVF and cryogenic storage has been viewed from two perspectives. The medical community must first recognize the lack of congruity between legal and medical perceptions of life and realize that these concepts have been applied in different factual settings and under laws with different sanctions. In addition, the medical community must be subject to

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birth, 69 VA. L. REV. 405, 431 (1983). There still exists the specter that embryos could be chosen for special characteristics as part of a program of eugenics. Id.


142. CHILDRESS, supra note 135, at 83.

143. Id.

144. Veatch, supra note 31, at 3.


For an explanation of the potential harmful effects of the procedure on the embryo, see D. GIESEN, supra note 3, at 649 (embryos can only be maintained for about two years in cryogenic storage). As further evidence of possible endangerment to the embryos, it has been demonstrated that the process of cryogenic freezing can damage the cellular mechanisms responsible for cell cleavage, thereby retarding development. Bromwich, Oocyte Donation: Ethical Rather Than Practical Problems Need to Be Solved, 300 BMI 1671, 1672 (1990).
tighter controls over the use of IVF.\textsuperscript{146} Doctors can no longer hide behind the shifting definition of viability as medical technology both increases the survival rate of newborn humans\textsuperscript{147} and makes advances toward the complete artificial incubation of laboratory mammals.\textsuperscript{148} Questions of viability may not be applicable at all if it is recognized that the viability concept was formulated with the balancing of rights between "two lives in one body."\textsuperscript{149} While the doctor's role of loyalty to the mother appears secure,\textsuperscript{150} there is confusion in defining the relationship of medical practitioners to embryos existing ex utero. The result can be unregulated paternalistic action by the doctor when considering the disposition of a viable embryo.\textsuperscript{151}

This paternalistic action was demonstrated in \textit{Del Zio v. The Presbyterian Hospital}.\textsuperscript{152} In this action, the wife submitted to follicle aspiration in order to obtain an ovum for subsequent uterine implantation. The attending physician, who had been conducting in vitro research, combined the collected follicle fluid with the husband's semen in a test tube and proceeded to incubate the mixture.\textsuperscript{153} Prior to implantation, the chief of Presbyterian Hospital's obstetrics and gynecology staff ordered that the mixture be destroyed on the basis of the hospital's prior agreement with the federal government that no IVF would occur at the facility.\textsuperscript{154} The couple asserted claims of emotional distress and tortious damage and alleged conversion of property. The jury found the conversion claim to be too speculative and awarded damages of fifty thousand dollars to the wife and three dollars to the husband for tortious conduct causing emotional distress.\textsuperscript{155} Interestingly, at the time of the trial, the test tube sample was actually frozen by the chief physician as evidence, and no one was able to determine if an embryo had actually

\textsuperscript{147} See Kass, \textit{supra} note 12, at 22.
\textsuperscript{148} D. GIESEN, \textit{supra} note 3, at 646. While Dr. Giesen proposes that the extracorporeal embryo becomes an independent life in being upon separation from a supportive uterus, J.A. Robertson asserts:

\text{[T]he embryo does not have a moral status in and of itself, as it presently is, but does have moral status if it might be transferred to a uterus and thus become a person. When transfer does not occur and no duty is owed, decisions about embryos become occasions to use embryos as a symbol of life or persons generally.}
\text{Robertson, \textit{supra} note 33, 59-60.}
\textsuperscript{150} See \textit{supra} notes 50-56 and accompanying text.
\textsuperscript{151} IDRESS, \textit{supra} note 135, at 55.
\textsuperscript{152} 74 Civ. 3588 (S.D.N.Y. Apr. 12, 1978), as cited in Powledge, \textit{A Report from the Del Zio Trial}, 8 HASTINGS CENTER REP. 15 (Oct. 1978) [hereinafter Powledge].
\textsuperscript{153} \textit{Id.} at 15.
\textsuperscript{154} \textit{Id.}
\textsuperscript{155} D. GIESEN, \textit{supra} note 3, at 662 (footnote omitted).
developed.\textsuperscript{156}

In the previous discussion of the in vitro subject as an autonomous being, the principle of beneficence was contrasted with a general respect for the autonomy of individuals.\textsuperscript{157} While the notion of respect has at its core the mandate to look to the subject's own wishes in an effort to avoid paternalistic behavior,\textsuperscript{158} the medical practitioner is unable to apply this respect in the case of the nonautonomous subject; the principle of informed consent has not been adequately defined for the scenario of the IVF embryo.\textsuperscript{159}

This current lack of definition also is reflected in clinical research policy statements promulgated by representative bodies of the medical community. The Declaration of Helsinki provides recommendations to guide researchers in the use of human subjects in clinical and purely research trials.\textsuperscript{160} The fourth canon of the section covering nontherapeutic research explicitly states that “the interest of science and society should never take precedence over considerations related to the well-being of the subject.”\textsuperscript{161} However, in the case of embryos like those in Davis \textit{v.} Davis, there is a dramatic shift away from such ethical guidelines because the Declaration was never intended to apply to the problems surrounding IVF. The section on clinical research, however, does disapprove of the use of subjects who cannot assert a desire to be removed from the trial.\textsuperscript{162}

In the above analysis two incongruous results for the medical practitioner are possible. The status of an embryo becomes equated with that of a critically ill patient who could be saved with available therapy,\textsuperscript{163} or the embryo's status is shunted to that of an incompetent individual who is subject

\begin{itemize}
  \item \textsuperscript{156} Powledge, \textit{supra} note 152, at 15.
  \item \textsuperscript{157} See \textit{supra} notes 94-98 and accompanying text.
  \item \textsuperscript{158} \textsc{Childress}, \textit{supra} note 135, at 59-66.
  \item \textsuperscript{159} See \textsc{Beauchamp} \& \textsc{Childress}, \textit{supra} note 38, at 79 (describing informed consent as partitioned into five elements, each of which must be present in order for there to be valid consent: competence, disclosure of information, understanding of information, voluntariness, and authorization by the subject).
  \item \textsuperscript{160} See \textsc{Contemporary Issues in Bioethics} 421-23 (T. Beauchamp \& L. Walters eds. 1989) [hereinafter \textsc{Contemporary Issues in Bioethics}].
  \item \textsuperscript{161} \textit{Id.} at 423.
  \item \textsuperscript{162} \textit{Id.} at 422.
  \item \textsuperscript{163} See \textsc{Duff}, \textit{Moral and Ethical Dilemmas in the Special-Care Nursery}, 289 \textsc{New Eng. J. Med.} 890 (1973); \textsc{Engelhardt}, \textit{Ethical Issues in Aiding the Death of Young Children}, in \textsc{Beneficent Euthanasia} 180 (M. Kohl ed. 1975); \textsc{Roth}, \textit{Tests of Competency to Consent to Treatment}, 134 \textsc{Am. J. Psychiatry} 279 (1977). The case that most closely parallels this finding is that which led to the implementation of the Baby Doe regulations and subsequent amendments to the Child Abuse and Treatment Act which defined child abuse as the "withholding of medically indicated treatment" from newborns. 42 U.S.C. § 5106g(10) (1988). The development of the case and laws are chronicled with great clarity in \textsc{Smith}, \textit{Defective Newborns and Government Intermeddling}, 25 \textsc{Med. Sci. \& L.} 44, 44-48 (1985).
\end{itemize}
to medical experimentation through the substituted judgment doctrine.\textsuperscript{164} Given the claims of individual doctors that progress is presently being made in fetal tissue research,\textsuperscript{165} there may be a trend toward ending the Department of Health and Human Services (HHS) ban against federal funding of such research.\textsuperscript{166} To focus the work of doctors and researchers away from the needless creation of surplus embryos, the federal government should encourage limited research in IVF through renewed funding,\textsuperscript{167} thereby giving effect to the strict guidelines that are currently in place.\textsuperscript{168}

\begin{footnotesize}
\begin{enumerate}
\item Substituted judgment evaluates proxy decisionmaking in terms of the choice “which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.” Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 752-53, 370 N.E.2d 417, 431 (1977). The Saikewicz court specifically claimed that the substituted judgment standard “comends itself simply because of its straightforward respect for the integrity and autonomy of the individual.” 373 Mass. at 751, 370 N.E.2d at 431. However, the extracorporeal embryo shatters the substituted judgment paradigm because the embryo theoretically has the potential, through implantation and healthy development, to become competent. In this case, it is the responsibility of the dispositional authority “to keep as many as possible of a child’s central life-options open until the child become an autonomous adult himself.” Feinberg, supra note 94, at 465.
\item See Brahams, Fetal Spare Parts, 1 LANCET 424 (1988) (research should be allowed so long as embryos not created for the sole purpose of research); Mahowald, Silver & Ratcheson, The Ethical Options in Transplanting Fetal Tissue, 17 HASTINGS CENTER REP. 9, 10 (Feb. 1987) (procedures are justified by referencing the needs of treatment for Parkinson’s disease as a method toward supporting the autonomy of the chronically ill); Robertson, Rights, Symbolism, and Public Policy in Fetal Tissue Transplants, 18 HASTINGS CENTER REP. 5, 10 (Dec. 1988) (Respect for the needs of sick patients conflicts with respect for prenatal human life; the final result is “the specter of fetal tissue procurement leading to a commercial market in abortions and in fetal tissue.”).
\item See Krauthammer, Political Malpractice, Wash. Post, Nov. 10, 1989, at A27, col. 3. For an analysis of the events leading up to the HHS ban on federally funded fetal tissue research see Robertson, Fetal Tissue Transplants, 66 WASH. U.L.Q. 443 (1988); see also Palca, U.S. In Vitro Fertilization in Limbo According to OTA, 333 NATURE 388 (1988).
\item Part 45 of the Code of Federal Regulations, Protection of Human Subjects, provides:
\begin{quote}
§ 46.208 Activities directed toward fetuses in utero as subjects.
\begin{enumerate}
\item No fetus in utero may be involved as a subject in any activity covered by this subpart unless: (1) The purpose of the activity is to meet the health needs of the particular fetus and the fetus will be placed at risk only to the minimum extent necessary to meet such needs, or (2) the risk to the fetus imposed by the research is minimal and the purpose of the activity is the development of important biomedical knowledge which cannot be obtained by other means.
\item An activity permitted under paragraph (a) of this section may be conducted
\end{enumerate}
\end{quote}
\end{enumerate}
\end{footnotesize}
However, any solution embodying the principle of autonomy must also account for the subject's well-being. A statute adopted in Minnesota presents a well-balanced approach by providing that an embryo cannot be harmed in any way by the research.\textsuperscript{169} This approach is consistent with the medical reality that IVF technology presents a high degree of risk to the embryo.\textsuperscript{170} Thus, the only conceivable medical inquiry into the ex-

only if the mother and father are legally competent and have given their informed consent, except that the father's consent need not be secured if: (1) His identity or whereabouts cannot reasonably be ascertained, (2) he is not reasonably available, or (3) the pregnancy resulted from rape.

§ 46.209 Activities directed toward fetuses ex utero, including nonviable fetuses, as subjects.

(a) Until it has been ascertained whether or not a fetus ex utero is viable, a fetus ex utero may not be involved as a subject in an activity covered by this subpart unless:

(1) There will be no added risk to the fetus resulting from the activity, and the purpose of the activity is the development of important biomedical knowledge which cannot be obtained by other means, or

(2) The purpose of the activity is to enhance the possibility of survival of the particular fetus to the point of viability.

(b) No nonviable fetus may be involved as a subject in an activity covered by this subpart unless:

(1) Vital functions of the fetus will not be artificially maintained,

(2) Experimental activities which of themselves would terminate the heartbeat or respiration of the fetus will not be employed, and

(3) The purpose of the activity is the development of important biomedical knowledge which cannot be obtained by other means.

(c) In the event the fetus \textit{ex utero} is found to be viable, it may be included as a subject in the activity only to the extent permitted by and in accordance with the requirements of other subparts of this part.

(d) An activity permitted under paragraph (a) or (b) of this section may be conducted only if the mother and father are legally competent and have given their informed consent, except that the father's informed consent need not be secured if: (1) His identity or whereabouts cannot reasonably be ascertained, (2) he is not reasonably available, or (3) the pregnancy resulted from rape.


169. The Minnesota statute provides:

Subdivision 1. Whoever uses or permits the use of a living human conceptus for any type of scientific, laboratory research or other experimentation except to protect the life or health of the conceptus, or except as herein provided, shall be guilty of a gross misdemeanor.

Subdivision 2. The use of a living human conceptus for research or experimentation which verifiable scientific evidence has shown to be harmless to the conceptus shall be permitted.

Subdivision 3. Whoever buys or sells a living human conceptus or nonrenewable organ of the body is guilty of a gross misdemeanor. Nothing in this subdivision prohibits (1) the buying and selling of a cell culture line or lines taken from a nonliving human conceptus . . . .

MINN. STAT. ANN. § 145.422 (West 1986) (emphasis supplied).

tracorporeal embryo could occur in a setting that contemplated the immediate implantation of the IVF embryo.\textsuperscript{171} Louisiana also protects embryos through a statute that effectively prevents embryo abuse by physicians during the period prior to implantation.\textsuperscript{172}

Physicians can be encouraged to explore responsibly the mysteries of human conception without compromising the principle of respect for all life. This principle is founded upon the notion that the embryo ex utero should be considered to have near perfect rights of personality. Such an approach attempts to reconcile those who assert that society can be responsible in managing IVF technology\textsuperscript{173} with fundamental principles governing the ex-

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\textit{Embryo Viability Related to Freezing and Thawing Procedures}, 157 AM. J. OBSTETRICS \\ & GYNECOLOGY 168 (1987) (although frozen-thawed embryos had equal chances of postimplantation viability when compared to the performance of fresh, immediately transferred embryos, these results could be achieved only by selecting those embryos that could withstand cryogenic storage). The advances of this research have no moral foundation since it is possible to fertilize a previously frozen ovum. D. GIESEN, supra note 3, at 640. In this way, the moral dilemma is obviated because no independent legal significance attaches to an unfertilized ovum, or for that matter, to other donated body parts and tissue. See Moore v. Regents of Univ. of Cal., 215 Cal. App. 3d 709, 249 Cal. Rptr. 494 (1988), aff'd in part and rev'd in part, 51 Cal. 3d 120, 793 P.2d 479, 271 Cal. Rptr. 146, reh'g denied, 1990 Cal. LEXIS 2975 (1990).

\textsuperscript{171} D. GIESEN, supra note 3, at 646. Dr. Giesen correctly states that nonimplanted embryos should be protected in the same manner as those existing in utero. \textit{Id}. Interestingly, even Dr. Giesen's conservative approach is capable of conflicting interpretations because an embryo in utero may legally be aborted within the parameters of the \textit{Roe} trimester framework. See text accompanying notes 41-49. This reality begs the question of whether the embryo existing ex utero actually enjoys greater protection; the desire to protect this entity as an independent life is necessary to limit the bounds of possible dispositions by uninterested physicians, researchers, and gamete donors.

\textsuperscript{172} The statute states in relevant part:

\begin{quote}
\textbf{§ 123. Capacity}

An in vitro fertilized human ovum exists as a juridical person until such time as the in vitro fertilized ovum is implanted in the womb; or at any other time when rights attach to an unborn child in accordance with law.

\textbf{§ 126. Ownership}

An in vitro fertilized human ovum is a biological human being which is not the property of the physician which acts as an agent of fertilization, or the facility which employs him or the donors of the sperm and ovum. If the in vitro fertilization patients express their identity, then their rights as parents as provided under the Louisiana Civil Code will be preserved. If the in vitro fertilization patients fail to express their identity, then the physician shall be deemed to be temporary guardian of the in vitro fertilized human ovum until adoptive implantation can occur.

\textbf{§ 127. Responsibility}

Any physician or medical facility who causes in vitro fertilization of a human ovum in vitro will be directly responsible for the in vitro safekeeping of the fertilized ovum.
\end{quote}


\textsuperscript{173} Smith, \textit{Intimations of Life: Extracorporeality and the Law}, 21 GONZ. L. REV. 395, 396 (1985-86) ("If procreation continues to remain at the very center of a marital relationship and, indeed, family the essence of a society that retains its vitality, new and even controversial
tent of physician prerogatives in the research environment.\textsuperscript{174}

IV. CONCLUSION

Only through a recognition by the medical community that IVF does not represent one of many potential avenues for unlimited medical exploration can the entire ethos of respect at the core of all patient-professional relationships be preserved. While current indicators in American law point to a lack of definitional guidance regarding the status of the extracorporeal embryo, those legal concepts applied to other dilemmas at the beginning of life provide a roadmap for future reform. As technology moves toward the creation of an artificial incubator for the term maturation of human life, the temptation to perfect the genesis of human life will lead inevitably to eugenics. While the technology curve has yet to cast a shadow over our respect for the mysteries of life, this potential for midwifery in the test tube must be halted now.

The basis for this endeavor originates in a conviction that the interests of individual liberty and of the accommodation of diverse social views are not always inversely proportional. In the case of relationships between doctors and their patients, the amount of good to be obtained from unlimited use of IVF therapy and research pales before a stronger interest in promoting confidence in the health care system and faith in those who practice medicine. This is achieved by direct government participation in limited research in which embryos are not harmed, rather than by uninvolved silence when the call for encouraging beneficent action is unheard.

The importance of defining the parameters of justifiable action in IVF will impact medical ethics in three ways. First, the trend of assessing a patient’s free choice by a sliding scale based on his or her current condition or level of development will be reversed. Second, the new doctor-patient relationship will yield a more consistent environment of mutual understanding where both parties, or those with proxy responsibility, will be fully aware of the demands that can be made in the clinical environment. Third, a re-evaluated endeavors are necessary in order to assure this sort of marital fulfillment and societal success and, thus, perpetuation.” (footnotes omitted)).

\textsuperscript{174} See CONTEMPORARY ISSUES IN BIOETHICS, supra note 160, at 420. (Code of Nuremberg). The Code of Nuremberg demands that the clinician use subjects for research who have the “legal capacity to give consent.” Id. The possibility of proxy consent in the context of embryos can be justified only if the proxies are obtained from the parents and the medical inquiry is minimized so as not to endanger the embryo. Of central importance is the requirement that all parties intend immediately to implant the embryo. BEAUCHAMP & CHILDRESS, supra note 38, at 170-84; see also Protection of Human Subjects, HEW Support of Human in Vitro Fertilization and Embryo Transfer: Report of the Ethics Advisory Board, 44 Fed. Reg. 35,033, 35,057 (1979).
conception of state interests will no longer result in the unnecessary compromise of individual autonomy for the sake of avoiding the dangerous slide toward the active termination of “unworthy” life.

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