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Hard Choices: Where to Draw the Line on Limiting Selection in the Selective Reduction of Multifetal Pregnancies

Mary A. Scott

Note

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Imagine a hopeful mother, desperate after many failed attempts to become pregnant. She consults a fertility clinic and decides to undergo the invasive and costly process of in vitro fertilization (IVF). The procedure is more than successful—she finds herself pregnant with quadruplets. At less than five feet tall and with a petite frame, she will not be able to carry all four fetuses to term. Her doctor recommends an abortion, but she is unwilling to sacrifice the pregnancy. In 1984, such a patient came to Mark Evans, an obstetrician-geneticist who performed the first procedure now known as selective reduction—the termination of one or more fetuses in a multifetal pregnancy.[1]

As reproductive technology has become more accessible in recent years, the number of multifetal pregnancies has skyrocketed.[2] Due to the risks inherent in multifetal pregnancies,[3]

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1. Liza Mundy, *Too Much To Carry?*, WASH. POST (May 20, 2007), http://www.washingtonpost.com/wp-dyn/content/article/2007/05/15/AR2007051501730.html.

2. *E.g.*, Am. Coll. of Obstetricians & Gynecologists Comm. on Ethics, *Committee Opinion No. 553: Multifetal Pregnancy Reduction*, 121 OBSTETRICS & GYNECOLOGY 405, 406 (2013) [hereinafter *Committee Opinion No. 553*] (noting that the birthrate of twins increased 76% between 1980 and 2009 and the birthrate of triplets increased 400% between 1980 and 1998).

3. *See id.* (noting the risks of prematurity, cerebral palsy, learning disabilities, slow language development, behavioral difficulties, chronic lung dis-

the practice of selective reduction has progressed as the numbers of such pregnancies has increased.[4] These trends mean that when fertility treatment is involved, patients and physicians often find themselves in the difficult position of having to choose which fetus or fetuses to keep. Physicians may select which fetus to terminate based on proximity to the maternal abdominal wall.[5] In other cases, physicians may consider other factors including apparent abnormalities, other findings affecting health of a particular fetus, or the parents' desire to have a child of a particular sex.[6]

As assisted reproduction practices are evolving, so too is the regulation of reproductive rights in the United States. As of 2015, several states have expanded abortion regulation by enacting laws specifically banning abortions based on the woman's motivation for seeking an abortion.[7] While most of these laws target abortions based on the sex of the fetus, an increasing number of states have recently either proposed or passed laws prohibiting abortions based on the presence of a genetic abnormality such as Down syndrome.[8] At least one state prohibited abortions based on the race of the fetus or a parent of the fetus.[9] There is currently no parallel federal regulation, although it has been attempted.[10] Such state laws have been challenged as unconstitutional, but the debate is not yet resolved.[11]

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ease, developmental delay, and death to infants as well as health and economic risks to mothers).

4. *See* Mundy, *supra* note 1. The American College of Obstetricians and Gynecologists distinguishes between selective reduction and multifetal pregnancy reduction: "[i]n multifetal pregnancy reduction, the fetus(es) to be reduced are chosen on the basis of technical considerations, such as which is most accessible to intervention. In selective reduction, fetuses are chosen on the basis of health status or sex." *Committee Opinion No. 553*, *supra* note 2, at 408–09. This Note consistently uses "selective reduction" to refer to both meanings.

5. *See, e.g.*, Judith F. Daar, *Selective Reduction of Multiple Pregnancy: Lifeboat Ethics in the Womb*, 25 U.C. DAVIS L. REV. 773, 781 (1992) [hereinafter Daar, *Lifeboat Ethics*].

6. *See* Mark I. Evans, *The Truth About Multiple Births*, NEWSWEEK, Mar. 2, 2009, at 14.

7. *See, e.g.*, ARIZ. REV. STAT. ANN. § 13-3603.02 (2011); 720 ILL. COMP. STAT. ANN. 510/6 (2010); OKLA. STAT. tit. 63, § 1-731.2 (2011).

8. *See* N.D. CENT. CODE § 14-02.1-04.1 (2013); S.B. 334, 119th Gen. Assemb., 1st Sess. (Ind. 2015); H.B. 439, 98th Gen. Assemb., 1st Sess. (Mo. 2015); H.B. 135, 131st Gen. Assemb., Reg. Sess. (Ohio 2015–2016).

9. *See* ARIZ. REV. STAT. ANN. § 13-3603.02.

10. *See* Prenatal Nondiscrimination Act (PRENDA) of 2012, H.R. 3541, 112th Cong. (2012).

11. After the Arizona law's passage, the National Association for the Advancement of Colored People, Maricopa County Branch (Maricopa NAACP)

While these laws ban selection (based on genetic abnormality, sex, or race) specifically in the context of abortions, most do not purport to ban such selection practices specifically in the context of selective reduction.[12] The assisted reproduction industry in general and the practices associated with IVF, including selective reduction, are nearly entirely unregulated.[13]

While there is extensive literature examining the ethics of selective reduction[14] and critiquing the regulation of sex selection in particular,[15] there is currently a gap in research with respect to how motivation-based abortion prohibitions might intersect with the unregulated assisted reproduction industry and the practice of selective reduction. This intersection raises questions of whether selective reduction falls within the ambit of state abortion laws,[16] whether motivation-based abortion prohibitions could withstand constitutional scrutiny,[17] and

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and the National Asian Pacific American Women's Forum (NAPAWF) brought an equal protection claim asserting that "the Act stigmatizes and denigrates their members on the basis of race and gender," and that the reasons for the Act's passage were based on ill-informed racial stereotypes, discriminating against their members and causing stigmatic harm. NAACP v. Horne, No. CV13-01079-PHX-DGC, 2013 WL 5519514, at *3–4 (D. Ariz. Oct. 3, 2013). The United States District Court for the District of Arizona determined that it lacked subject matter jurisdiction because the plaintiffs "fail[ed] to identify any personal injury suffered by them." *Id.* at *6.

12. Of the states that have enacted motivation-based abortion prohibitions, North Dakota appears to be the only state to explicitly include "the elimination of one or more unborn children in a multifetal pregnancy" in its definition of abortion. N.D. CENT. CODE § 14-02.1-04.1. Otherwise, where such laws do not explicitly encompass selective reduction, it is arguable that selective reduction does not legally constitute abortion. *See infra* Part II.B.

13. *See* Judith F. Daar, *Regulating Reproductive Technologies: Panacea or Paper Tiger?*, 34 HOUS. L. REV. 609, 639 (1997) ("A review of federal and state laws pertaining to the practice of reproductive technologies reveals that practitioners in our country enjoy a nearly regulatory-free environment. A single inactive federal program and a handful of state laws comprise the total regulatory scheme surrounding [assisted reproductive technologies].").

14. *See, e.g.*, *Committee Opinion No. 553*, *supra* note 2; Daar, *Lifeboat Ethics*, *supra* note 5, at 822–28.

15. *Compare, e.g.*, Owen D. Jones, *Sex Selection: Regulating Technology Enabling the Predetermination of a Child's Gender*, 6 HARV. J.L. & TECH. 1, 48–61 (1992) (proposing a possible action plan for regulating sex selection), *with* David McCarthy, *Why Sex Selection Should Be Legal*, 27 J. MED. ETHICS 302, 306–07 (2001) (arguing that the major objections to sex selection do not provide sufficient grounds to limit reproductive liberties).

16. Radhika Rao, *Selective Reduction: "A Soft Cover for Hard Choices?" or Another Name for Abortion?*, 43 J.L. MED. & ETHICS 196, 197 (2015) (arguing that selective reduction and abortion "are points along a continuum that should not be segregated and analyzed in strict isolation").

17. *See* Justin Gillette, *Pregnant and Prejudiced: The Constitutionality of Sex- and Race-Selective Abortion Restrictions*, 88 WASH. L. REV. 645, 649

whether there is a different legal framework that would be more useful in regulating selection in the context of assisted reproduction. Answering these questions is important in light of a political climate in which the continued passage of motivation-based abortion prohibitions and other restrictions on abortion is likely, and the assisted reproduction industry continues to progress with little regulation.

This Note attempts to fill this gap in scholarship by determining if and to what extent the growing number of motivation-based abortion prohibitions may apply to selective reduction. This Note does not engage in the ethical battle over whether selective reduction or selective abortions should be practiced. Rather, it seeks to make a legal argument about whether and how selection should be regulated as a step in the selective reduction procedure. Part I investigates the development and current standing of motivation-based abortion prohibitions, discusses the current state of regulation in the assisted reproduction industry, and introduces the current ethical and legal frameworks used to discuss selective reduction. Part II shows how motivation-based abortion prohibitions could create barriers to women in need of selective reductions by analyzing the constitutionality of motivation-based abortion prohibitions, determining how selective reduction fits within the abortion framework, and investigating how motivation-based abortion prohibitions may apply to various selective reduction scenarios.

Part III argues that motivation-based abortion prohibitions should generally not apply in cases of selective reduction and proposes that state legislatures amend their abortion laws to better protect selective reduction as a necessary procedure. Part III then suggests that state legislatures implement reporting requirements to encourage effective self-regulation practices in the assisted reproduction industry and that states mandate that selection be random only in certain narrowly limited circumstances. While this Note acknowledges that there may be other barriers to selective reduction beyond the scope of this proposed solution, it aims to provide an adequate response to the most pressing obstacle—the increasing number of motivation-based abortion prohibitions.

I. AN OVERVIEW OF SEX SELECTION, ABORTION, AND

(2013) (arguing that motivation-based abortion prohibitions cannot withstand constitutional scrutiny); Annie Moskovian, *Bans on Sex-Selective Abortions: How Far Is Too Far?*, 40 HASTINGS CONST. L.Q. 423, 439–44 (2013) (concluding that sex selection should be constitutionally protected).

SELECTIVE REDUCTION

Sex-selective abortion laws and selective reduction have evolved independently and in response to different concerns. This independent evolution creates two divergent contexts in which selection arises. Whereas recent legislation anticipates selection of fetal characteristics as a motive to seek an abortion, in the context of selective reduction, selection may arise as an option once the decision to reduce has already been made. This Part shows the development of selection practices, the passage of laws in response to those practices, and recent interpretations and applications of those laws. This Part also examines current regulation of the assisted reproduction industry and the ethical and legal frameworks of selective reduction. Specifically, Section A outlines the development of motivation-based abortion prohibitions in response to a perceived need to address discriminatory abortion practices in the United States. Section B then shows that while the constitutionality of these laws has been litigated, the issue has not been resolved. Section C examines self-regulation practices within the assisted reproduction industry. Finally, Section D provides an overview of selective reduction and introduces some of the ethical and legal questions that it presents.

A. THE EVOLUTION OF SEX-SELECTIVE ABORTION LAWS IN THE UNITED STATES

While it is unclear whether sex selection is having widespread consequences on the population of the United States,[18] it is a global issue that has caught the attention of the United States legislature. The recent trend in state laws banning motivation-based abortions has a complex tangential relationship to the national debate over abortion access more generally.[19]

18. *See generally* BRIAN CITRO ET AL., REPLACING MYTHS WITH FACTS: SEX-SELECTIVE ABORTION LAWS IN THE UNITED STATES 15 (2014) (discussing the prevalence of sex selection in the United States).

19. *See, e.g.*, *id.* at 27 ("Laws banning sex-selective abortion purport to combat gender discrimination. However, the text of the laws and the statements made in support of the bans during legislative hearings make it clear that they are intended to place restrictions on abortion services generally."); Jaime Staples King, *Not This Child: Constitutional Questions in Regulating Noninvasive Prenatal Genetic Diagnosis and Selective Abortion*, 60 UCLA L. REV. 2, 74 (2012) ("As states that oppose abortion become savvier about ways to restrict access, their legislative attentions have turned to restricting access to abortion based on the reason the procedure was sought."); Kevin L. Boyd, Comment, *The Inevitable Collision of Sex-Determination by Cell-Free Fetal DNA in Non-Invasive Prenatal Genetic Diagnosis and the Continual Statewide Expansion of Abortion Regulation Based on the Sex of the Child*, 81 UMKC L.

This Section examines both the origins and prevalence of sex selection and the federal and state legislative responses to it.

1. The Development of Selective Abortion Practices

Globally, female children have long been the target of sex selective practices, and the increased accessibility of reproductive technologies may have exacerbated this disparity in recent years.[20] Sex selection and the male gender preference are typically associated with South, East, and Central Asian countries where birth ratios are sometimes as high as 130 males per 100 females.[21] While some argue that sex selection is also prevalent in more developed parts of the world, others have cast doubt on whether such disproportionate selection is occurring at all.[22] As more advanced sex-selective technologies have become available,[23] however, it is clear that the option to select for sex has become more accessible to the United States population generally.[24]

Fertility patients may use a number of techniques to iden-

REV. 417, 453 (2012) ("The Arizona statute is one of the new ways that the anti-choice movement has chosen to attack abortion rights and limit a woman's access to abortion services.").

20. *See, e.g.*, WORLD HEALTH ORG., PREVENTING GENDER-BIASED SEX SELECTION 1 (2011), http://apps.who.int/iris/bitstream/10665/44577/1/9789241501460_eng.pdf; *Sex-Selective Abortion: Gendercide in the Caucasus*, ECONOMIST (Sept. 21, 2013), http://www.economist.com/news/europe/21586617-son-preference-once-suppressed-reviving-alarmingly-gendercide-caucasus (noting that the spread of cheap ultrasound machines have correlated with an increase in the number of sex-selective abortions in eastern European countries including Georgia, Azerbaijan, and Armenia).

21. WORLD HEALTH ORG., *supra* note 20, at v.

22. *Compare* Samuel B. Casey, David B. Waxman & Amy T. Pedagno, *No Girls Allowed: Sex-Selective Abortion and a Guide to Banning It in the United States*, 5 REGENT J.L. & PUB. POL'Y 111, 132–33 (2013) ("[M]ore boys than girls are born in the United States, by a ratio of 1.05 to 1. But among American families of Chinese, Korean and Indian descent, the likelihood of having a boy increased to 1.17 to 1 if the first child was a girl . . . [and] if the first two children were girls, the ratio for a third child was 1.51 to 1—or about 50 percent greater—in favor of boys." (quoting Sam Roberts, *U.S. Births Hint at Bias for Sons in Some Asians*, N.Y. TIMES (June 15, 2009), http://www.nytimes.com/2009/06/15/nyregion/15babies.html)), *with* CITRO ET AL., *supra* note 18 (noting that the findings in the same study were based on outdated data that excluded several population groups and finding that "[t]he overall sex ratio at birth for all Asian Americans in the United States is 1.04").

23. *See, e.g.*, Am. Coll. of Obstetricians & Gynecologists Comm. on Ethics, *Committee Opinion No. 360: Sex Selection*, 109 OBSTETRICS & GYNECOLOGY 475, 476 (2007) [hereinafter *Committee Opinion No. 360*] (describing three general methods of sex selection, including prefertilization, postfertilization and pretransfer, and post-implantation).

24. *See* Boyd, *supra* note 19, at 421–22.

tify and select the sex of a child, and many clinics now advertise the availability of sex selection in the context of IVF.[25] Prior to fertilization, patients may attempt to increase the likelihood of conceiving a child of a preferred sex through pre-implantation sperm sorting, although there is little evidence confirming the safety or effectiveness of this method.[26] In the context of IVF, patients often use pre-implantation genetic diagnosis (PGD) after fertilization to select only male or female embryos for implantation.[27] During pregnancy, patients may select from a number of prenatal methods of sex determination including amniocentesis, ultrasonography, and chorionic villus sampling.[28] Once the sex of a fetus is identified, the mother may then decide whether to continue the pregnancy. If sex is identified prior to implantation, then she need only decide whether and how to proceed with implantation; if sex is identified post-implantation, however, then the only method to select for sex is by abortion.[29] Abortion is the most common method of sex selection[30] and thus has earned the strongest legislative response.

While sex selection for the purpose of "family balancing"[31]

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25. *See, e.g.*, *Gender Selection*, CTR. FOR HUM. REPROD., https://www.centerforhumanreprod.com/services/infertility-treatments/genderselection/program (last visited Nov. 29, 2015); *Gender Selection*, FERTILITY INSTS., http://www.fertility-docs.com/programs-and-services/gender-selection/select-the-gender-of-your-baby-using-pgd.php (last visited Nov. 29, 2015) (advertising "virtually 100% accuracy" of PGD).

26. WORLD HEALTH ORG., *supra* note 20, at 14–15.

27. *See* Boyd, *supra* note 19, at 422. While it may seem that pre-implantation selection methods could eliminate the need to consider sex at the point of selective reduction, not all IVF patients opt for pre-implantation screening, and those that do typically use the process to detect disease-causing genes rather than the sex of the fetus. *See* Gina Kolata, *Ethics Questions Arise as Genetic Testing of Embryos Increases*, N.Y. TIMES (Feb. 3, 2014), http://www.nytimes.com/2014/02/04/health/ethics-questions-arise-as-genetic-testing-of-embryos-increases.html (noting that an international survey found that only "2 percent of more than 27,000 uses of pre-implantation genetic diagnosis were made to choose a child's sex"). Thus, even if PGD is widely used, there will still be many patients who go through the IVF process without selecting for sex prior to implantation.

28. *Id.* at 424–26.

29. *See* WORLD HEALTH ORG., *supra* note 20, at 14.

30. *See* H.R. REP. NO. 112-496, at 7 (2012) (noting that pre-implantation techniques "are not widely available or affordable, and make up a small fraction of sex-selection procedures" and that "most sex-selection takes the form of abortion").

31. "Family balancing" refers to gender selection "for the purposes of achieving a more balanced representation of both genders in a family." *Family Balancing*, GENETICS & IVF INST., http://www.givf.com/familybalancing (last visited Nov. 29, 2015).

generates mixed views in public opinion,[32] the medical community generally considers sex selection to be an acceptable method of avoiding suspected risks of sex-linked genetic disorders.[33] Although the underlying moral and ethical justifications for aborting or reducing a fetus with genetic abnormalities are controversial, this type of selection is common, and almost certainly much more prevalent than selection for sex alone.[34] State legislatures have responded to both types of selection—selection for sex and selection to avoid a genetic abnormality—by enacting laws prohibiting abortions where the woman's motivation is based on the desire for such selection.

2. Legislative Responses to Selective Abortion

In 2012, the United States House of Representatives considered legislation aimed at restricting the practice of sex selection but did not approve it.[35] Known as the Prenatal Nondiscrimination Act (PRENDA), the bill proposed both criminal and civil liability for any person who "knowingly performs an abortion knowing that such abortion is sought based on the sex, gender, color or race of the child, or the race of a parent of that child."[36] While the issue of race was ultimately dropped from the bill, leaving the ban on sex selection alone, the bill ultimately failed for other political reasons.[37] Thus, questions of its

32. *See* Deidre C. Webb, Note, *The Sex Selection Debate: A Comparative Study of Sex Selection Laws in the United States and the United Kingdom*, 10 S.C. J. INT'L L. & BUS. 163, 195–96 (2013).

33. *See Committee Opinion No. 360*, *supra* note 23, at 475–76.

34. *See* Mark Leach, *North Dakota Enacts Law Banning Down Syndrome-Selective Abortion*, DOWN SYNDROME PRENATAL TESTING (Mar. 26, 2013), http://www.downsyndromeprenataltesting.com/north-dakota-enacts-law-banning-down-syndrome-selective-abortion ("[N]ot only is termination following a prenatal diagnosis for conditions like Downs syndrome authorized, it is the choice most often made by those with a prenatal diagnosis and medical guidelines *require* obstetricians to counsel their patient about termination following a prenatal diagnosis."). Although its precision is debated, the traditionally cited rate of termination following a Down syndrome diagnosis is 90%—more recent studies cite a rate closer to 75%. *See* Mark Leach, *More Women Aborting & Continuing Down Syndrome Pregnancies*, DOWN SYNDROME PRENATAL TESTING (Aug. 28, 2014), http://www.downsyndromeprenataltesting.com/more-women-aborting-continuing-down-syndrome-pregnancies.

35. *See* Jennifer Steinhauer, *House Rejects Bill To Ban Sex-Selective Abortions*, N.Y. TIMES (May 31, 2012), http://www.nytimes.com/2012/06/01/us/politics/house-rejects-bill-to-ban-sex-selective-abortions.html.

36. Prenatal Nondiscrimination Act (PRENDA) of 2012, H.R. 3541, 112th Cong. (2012).

37. Casey, Waxman & Pedagno, *supra* note 22, at 140–43; *see also* Steinhauer, *supra* note 35 (noting that on a vote of 246 to 168, the bill fell short of the two-thirds support required to pass, but that "Republicans did not

constitutionality and efficacy were never addressed, leaving an opening for future motivation-based abortion prohibitions at both the state and federal level.

Congress's failure to enact a federal motivation-based abortion prohibition has not stopped states from enacting similar laws. Illinois and Pennsylvania have had such laws since 1985 and 1989, respectively.[38] In 2011, Oklahoma and Arizona enacted selective abortion prohibitions.[39] In 2013, both North Carolina[40] and North Dakota[41] enacted laws prohibiting abortions based on particular fetal characteristics. Other states, including California, Colorado, Florida, Georgia, Idaho, Iowa, Indiana, Kansas, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, New Jersey, New York, Ohio, Oregon, Rhode Island, Texas, Virginia, Wisconsin, and West Virginia, have also proposed similar legislation.[42] The legislatures of Colorado, Indiana, Massachusetts, Missouri, New York, Ohio, Oregon, and Texas have similar bills before them again in 2015.[43] Thus, at the time of publishing this Note, there are at least twenty-two states that have considered or are considering such legislation and at least six states that have already adopted it.

These laws differ from state to state in theories of liability, punishment, application, and subject matter. For example, depending on the state, performing a sex-selective abortion may warrant a conviction ranging from a misdemeanor to a felony.[44]

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anticipate that the legislation would pass, but saw it as an opportunity to force Democrats to vote on an issue with appeal among conservatives").

38. Casey, Waxman & Pedagno, *supra* note 22, at 143.

39. ARIZ. REV. STAT. ANN. § 13-3603.02 (2011); OKLA. STAT. tit. 63, § 1-731.2 (2011).

40. S.B. 353, 2013 Gen. Assemb., Reg. Sess. (N.C. 2013) (prohibiting abortions where the sex of the unborn child is a "significant factor" in the woman's decision to seek the abortion).

41. N.D. CENT. CODE § 14-02.1-04.1 (2013) (criminalizing abortions based solely on the sex, genetic abnormality, or potential genetic abnormality of the fetus).

42. *See* Casey, Waxman & Pedagno, *supra* note 22, at 144; Sital Kalantry, *Sex-Selective Abortion Bans: Anti-Immigration or Anti-Abortion?*, 16 GEO. J. INT'L AFFAIRS 140, 150 (2015).

43. H.B. 15-1162, 70th Gen. Assemb., 1st Sess. (Colo. 2015); S.B. 334, 119th Gen. Assemb., 1st Sess. (Ind. 2015); H.B. 1547, 189th Gen. Ct. (Mass. 2015); H.B. 439, 98th Gen. Assemb., 1st Sess. (Mo. 2015); Bill No. A06545, Reg. Sess. (N.Y. 2015); H.B. 135, 131st Gen. Assemb., Reg. Sess. (Ohio 2015); S.B. 108, 78th Gen. Assemb. (Or. 2015); H.B. 2986, 78th Gen. Assemb. (Or. 2015); H.B. 113, 84th Gen. Assemb. (Tex. 2014).

44. ARIZ. REV. STAT. ANN. § 13-3603.02 (classifying the performance of a sex-selective reduction as a class 3 felony); N.D. CENT. CODE § 14-02.1-04.1 (classifying the performance of a sex-selective reduction as a class A misdemeanor); 18 PA. CONS. STAT. ANN. § 3204 (2011) (classifying the performance

A violation can also result in additional punishments ranging from damages and fines to injunction and license revocation.[45] None of the existing laws impose liability on the woman upon whom the abortion was performed.

While most of these laws apply only in limited circumstances, some may apply more broadly. Importantly, most of these laws include the word "solely."[46] The word "solely" limits the laws' application to circumstances where a particular fetal characteristic is the *only* factor in the decision to seek an abortion. Arizona's law does not contain this limitation. It provides that "if sex is even one of the factors or aspects of the pregnant woman's decision for terminating the pregnancy, whether due to gender-linked disorders or family balancing, the abortion is illegal and cannot be performed, or must be reported if performed."[47] The laws that apply the most broadly only require that the decision to seek an abortion be "*related* to the sex" of the fetus.[48]

Finally, while most of these laws only seek to prevent abortions based on sex, an increasing number also aim to prevent abortions based on genetic abnormality. Such laws have been proposed in Indiana, Missouri, and Ohio and signed into law in North Dakota.[49] Provisions banning both types of selection raise

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of a sex-selective reduction as a third-degree felony); H.B. 1585, 97th Gen. Assemb., 2d Sess. (Mo. 2014) (making a violation of the law a class A misdemeanor or a class D felony if the person has previously pled guilty to or been convicted of a violation).

45. *See, e.g.*, ARIZ. REV. STAT. ANN. § 13-3603.02 (providing a civil cause of action for money damages to either the father of the unborn child if he was married to the mother at the time of the abortion, or to the mother's parents if the mother is under 18); OKLA. STAT. tit. 63, § 1-731.2 (2011) (providing a cause of action for injunctive relief and actual or punitive damages by the woman upon whom the abortion was performed or her family members, healthcare provider, a district attorney, or the Attorney General); Mo. H.B. 1585 (imposing liability for damages, license suspension or revocation, and injunction).

46. *See, e.g.*, OKLA. STAT. tit. 63, § 1-731.2 (imposing liability for "knowingly or recklessly perform[ing] or attempt[ing] to perform an abortion with knowledge that the pregnant female is seeking the abortion *solely* on account of the sex of the unborn child" (emphasis added)); 720 ILL. COMP. STAT. ANN. 510/6 (2010) (prohibiting abortions sought "solely on account of the sex of the fetus"); 18 PA. CONS. STAT. ANN. § 3204 (prohibiting physicians from performing any abortion that is not "necessary" and excluding abortions sought "solely" because of the sex of the unborn child from the definition of a "necessary" abortion).

47. Boyd, *supra* note 19, at 435.

48. *See* N.C. GEN. STAT. ANN. § 90-21.121 (West 2013) (emphasis added).

49. *See, e.g.*, N.D. CENT. CODE § 14-02.1-04.1 (criminalizing abortions based solely on the existence of a genetic abnormality or potential genetic abnormality); S.B. 334, 119th Gen. Assemb., 1st Sess. (Ind. 2015) (prohibiting

constitutional questions regarding a woman's right to a pre-viability abortion and the legitimacy of states' interests in preventing discrimination, which are discussed in further detail in Part II.

B. INTERPRETING AND VALIDATING MOTIVATION-BASED ABORTION PROHIBITIONS

This Section provides the foundation for analyzing how state laws restricting motivation-based abortions would stand up against a constitutional challenge. Part I.B.1 briefly explains the current state of Supreme Court jurisprudence regarding the validity of state abortion laws. Then, Part I.B.2 examines the challenges that have been brought against recently enacted motivation-based abortion prohibitions, finding that none of the laws have been challenged on grounds that give the Supreme Court an opportunity to actually review their constitutionality.

1. Current Judicial Standards for State Abortion Laws

The Court in *Roe v. Wade* established a woman's right to have an abortion prior to fetal viability, but provided that states could "regulate, and even proscribe, abortion [after viability] except where it is necessary . . . for the preservation of the life or health of the mother."[50] In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court expanded states' ability to regulate, based on the "substantial state interest in protecting potential life throughout pregnancy," by allowing pre-viability regulations that do not pose an "undue burden" on a woman's right to have a pre-viability abortion.[51]

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the performance of an abortion on a woman who is seeking the abortion solely because of "a diagnosis or potential diagnosis of the fetus having Down syndrome or any other disability"); H.B. 439, 98th Gen. Assemb., 1st Sess. (Mo. 2015) (prohibiting the performance of an abortion on a pregnant woman who is known to be seeking the abortion "solely because the unborn child has been diagnosed with either Down syndrome or a potential for Down syndrome" or solely because the unborn child has been diagnosed with "either a genetic abnormality or a potential for a genetic abnormality"); H.B. 135, 131st Gen. Assemb., Reg. Sess. (Ohio 2015–2016) (prohibiting the performance of "an abortion on a pregnant woman who is seeking the abortion because of a test result indicating Down Syndrome in an unborn child or a prenatal diagnosis of Down Syndrome in an unborn child"). North Carolina's law could also be interpreted to apply to abortions sought on the basis of genetic abnormality where those abnormalities are sex-linked. *See* N.C. GEN. STAT. ANN. § 90-21.121 (explaining that the woman's decision to seek an abortion need only be "related" to the sex of the fetus).

50. 410 U.S. 113, 164–65 (1973).

51. 505 U.S. 833, 876–77 (1992).

Recently, courts have both upheld[52] and struck down several state abortion regulations under the *Casey* "undue burden" standard.[53]

The Supreme Court's statements in *Casey* suggest that the Court may uphold an abortion ban that applies prior to viability, as long as it is a narrow ban justified by a state interest not considered in either *Roe* or *Casey*.[54] In *Roe*, the Court struck down a Texas statute outlawing abortions at any time except to save the life of the mother, while the *Casey* Court upheld a statutory provision prohibiting a minor from having an abortion without parental consent, unless a court is able to determine that she "is mature and capable of giving informed consent and has in fact given her informed consent, or that an abortion would be in her best interests."[55] In doing so, the Court considered state interests in protecting potential life, safeguarding women's health, and protecting minors.[56] The Court has yet to consider the validity of state interests in eliminating discrimination in the context of abortion.

States justify motivation-based abortion prohibitions as a means of eliminating discrimination.[57] While states' interest in eliminating discrimination has not yet been examined in the context of abortion law, it has been considered in the context of laws affecting expressive associational rights.[58] Because the Supreme Court has upheld statutes that infringed on groups' associational rights based on the states' compelling interest in eliminating sex discrimination, there is a valid argument that

52. *See* Gillette, *supra* note 17, at 661 (noting that the Supreme Court has upheld state laws requiring doctors to inform women of the availability of materials regarding the physical characteristics of the fetus, requiring women to wait twenty-four hours before having an abortion, and requiring minors to obtain parental consent and notification).

53. *See* Thomas J. Molony, Roe*,* Casey*, and Sex-Selection Abortion Bans*, 71 WASH. & LEE L. REV. 1089, 1105–09 (2014) (discussing several recent cases in which federal courts have struck down state "fetal pain" statutes and "fetal heartbeat statutes" on the grounds that they unconstitutionally burdened a woman's right to have a pre-viability abortion).

54. *See id.* at 1111.

55. *Casey*, 505 U.S. at 899; *see also* Molony, *supra* note 53, at 1111–12.

56. Molony, *supra* note 53, at 1113–14.

57. *See* King, *supra* note 19, at 56–62 (identifying a legitimate state interest in social integrity based on the potential social harms resulting from widespread discriminatory selective abortions that would justify the regulation of noninvasive prenatal genetic diagnosis).

58. *See* Molony, *supra* note 53, at 1118–23 (discussing three cases in which the Supreme Court considered whether statutes prohibiting discrimination based on race, religion, sex, and sexual orientation unconstitutionally infringed on groups' associational rights).

the same interest would justify a ban on selective abortions as long as it imposes no more than "a slight infringement on a woman's right to choose."[59] The sex of a fetus alone has little to no relation to the mother's health, the burdens and distresses of raising and caring for a child, or the mother's liberty, so "any infringement that a narrow sex selection ban might impose on a woman's right to choose reasonably [could] be characterized as slight or insubstantial."[60] Thus, it is possible that the Court would reject any future facial challenges to these statutes, because there is a significant state interest in preventing sex discrimination, and eliminating the choice to have a boy as opposed to a girl (or a girl as opposed to a boy) poses no undue burden.[61]

In scrutinizing the constitutionality of state abortion laws, the Supreme Court is also likely to be influenced by traditional canons of interpretation. When ruling on the constitutionality of state statutes, the Supreme Court will adhere to the "cardinal principle" that, before declaring a statute unconstitutional, it will look for any "fairly possible" construction of the statute "by which the question may be avoided."[62] Although the Court has applied this canon inconsistently in abortion cases, it is possible that it will still influence the Court to uphold motivation-based abortion statutes in some form. In *Thornburgh v. American College of Obstetricians and Gynecologists*, Justices O'Connor and White identified "an unprecedented canon of construction under which 'in cases involving abortion, a permissible reading of a statute is to be avoided at all costs.'"[63] But, more recently, the Court adhered to the "cardinal principle" in *Gonzales v. Carhart*, concluding that "[t]he canon of constitutional avoidance . . . extinguishes any lingering doubt as to whether the Act covers [dilation and evacuation]."[64] Justice

59. *Id.* at 1123–24.

60. *Id.* at 1129.

61. This analysis is also likely to apply to some degree to laws prohibiting abortions based on a genetic abnormality of the fetus, given the legitimacy of states' interest in eliminating other forms of discrimination. *See supra* note 49 and accompanying text.

62. Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Trust for S. Cal., 508 U.S. 602, 629 (1993) (quoting Crowell v. Benson, 285 U.S. 22, 62 (1932); Machinists v. Street, 367 U.S.740, 749–50 (1961)).

63. 476 U.S. 747, 829 (1986) (O'Connor, J., dissenting) (quoting *id.* at 812 (White, J., dissenting)).

64. 550 U.S. 124, 153 (2007). Having determined that the law at issue in that case would have been unconstitutional if it prohibited the procedure of dilation and evacuation (D & E), the Court held that "the most reasonable reading and understanding" of the statute was that it did *not* prohibit that

Kennedy opined that this principle had, "in the past, fallen by the wayside when the Court confronted a statute regulating abortion,"[65] but the Supreme Court and circuit courts generally adhered to it in cases subsequent to *Gonzales*.[66] Therefore, the canon of constitutional avoidance is likely to continue to influence the courts when confronted with abortion statutes in future cases.

2. Constitutional Challenges to Existing State Laws Banning Motivation-Based Abortions

In 1993, the United States District Court for the Northern District of Illinois enjoined enforcement of Illinois's ban on sex-selective abortion in cases of pre-viability abortion.[67] While this result suggests that the enforcement of similar laws in other states may also be enjoined, it does not suggest how the Supreme Court might rule. There are few other examples of courts deciding the constitutionality of these laws, particularly in more recent years.

After the Arizona legislature passed the state's current law, the National Association for the Advancement of Colored People (NAACP) and the National Asian Pacific American Women's Forum (NAPAWF) filed a lawsuit challenging its constitutionality.[68] The claim alleged that the Act denied equal protection by perpetuating racially discriminatory stereotypes about Black, Asian and Pacific Islander women, Asian culture, and abortion care.[69] The United States District Court for the District of Arizona dismissed the claim on the grounds that the plaintiffs "fail[ed] to identify any personal injury suffered by

procedure, and therefore it could not be found invalid on its face on those grounds. *Id.* at 153–56.

65. *Id.* at 153.

66. *See, e.g.*, *id.*; Planned Parenthood Minn., N.D., S.D. v. Rounds, 686 F.3d 889 (8th Cir. 2012) (adopting a construction of a suicide advisory provision in a South Dakota statute so as to avoid a constitutional question); Richmond Med. Ctr. for Women v. Herring, 570 F.3d 165, 176–77 (4th Cir. 2009) (upholding a Virginia statute based on a narrow interpretation that the law "criminalizes both the intentional intact D & E and the accidental intact D & E, but only where the necessary scienter is present and no affirmative defense is presented"). *But see* Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583, 588 (5th Cir. 2014) (noting that "whether the Supreme Court applies this rule in the same way in abortion cases is uncertain").

67. Herbst v. O'Malley, No. 84 C 5602, 1993 WL 59142, at *2 (N.D. Ill. Mar. 2, 1993).

68. NAACP v. Horne, No. CV13-01079-PHX-DGC, 2013 WL 5519514 (D. Ariz. Oct. 3, 2013); Complaint, *Horne*, 2013 WL 5519514.

69. *Horne*, 2013 WL 5519514, at *2.

them *as a consequence* of the alleged constitutional error," and thus the court lacked subject matter jurisdiction.[70] The court based its holding on *Allen v. Wright*, which "makes clear that stigmatizing injury alone is not sufficient for standing in equal protection cases," and that plaintiffs must show that they "personally have been denied equal treatment."[71] The Red River Women's Clinic, North Dakota's only abortion clinic, brought a similar challenge against North Dakota's H.B. 1305 banning abortions on the basis of either sex or genetic abnormality.[72] However, the clinic ultimately dropped its claim "because it determined that the law doesn't apply to its practice."[73] In 2013, the *NAACP v. Horne* plaintiffs filed an appeal in the Ninth Circuit.[74] Oral argument is currently scheduled for December 9, 2015.[75]

C. REGULATING ASSISTED REPRODUCTION

While the number of laws affecting reproductive rights in the United States has grown in recent years, they have almost exclusively focused on issues like abortion and birth control,[76] leaving practices in the assisted reproduction industry relative-

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70. *Id.* at *8.

71. *Id.* at *5 (citing Allen v. Wright, 468 U.S.737 (1984)).

72. Jessica Mason Pieklo, *Lawsuit Filed Challenging North Dakota Pre-Viability Ban*, RH REALITY CHECK (June 25, 2013, 2:25 PM), http://rhrealitycheck.org/article/2013/06/25/lawsuit-filed-challenging-north-dakota-pre-viability-ban.

73. Jessica Mason Pieklo, *Red River Clinic Asks Court To Dismiss Its Legal Challenge to Sex-Selection and Fetal Anomaly Bans*, RH REALITY CHECK (Sept. 12, 2013, 1:04 PM), http://rhrealitycheck.org/article/2013/09/12/red-river-clinic-asks-court-to-dismiss-its-legal-challenge-to-sex-and-fetal-anomaly-bans.

74. Brief of Appellants, NAACP v. Horne, No. 13-17247 (9th Cir. filed Mar. 12, 2014), 2014 WL 1153838. Oral argument was scheduled at the time this Note was being published. Appellants' Acknowledgment of Hearing Notice, NAACP v. Horne, No. 13-17247 (9th Cir. filed Oct. 1, 2015). Even if the Ninth Circuit or another federal court later finds motivation-based abortion prohibitions to be unconstitutional, this Note recognizes that states can and likely will modify these laws to comply. *See infra* Part II.A. For example, Arizona and North Dakota might remove the ban on abortions based on race or genetic abnormality, while keeping the provision banning abortions based on sex, and all states may modify their sex-selective abortion laws to apply only prior to viability.

75. *See supra* note 74 and accompanying text.

76. *See* Anne Drapkin Lyerly, *Marking the Fine Line: Ethics and the Regulation of Innovative Technologies in Human Reproduction*, 11 MINN. J.L. SCI. & TECH. 685, 698 (2010); *see, e.g.*, Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014) (addressing the issue of employer opposition to certain methods of insurance-supplied birth control methods).

ly untouched by regulation.[77] The only federal law currently pertaining to assisted reproduction technologies is the Fertility Clinic Success Rate and Certification act of 1992.[78] This law requires fertility clinics to annually report their pregnancy success rates and certification status to the Secretary of Health and Human Services through the Centers for Disease Control.[79]

Some states, including Arizona, California, New Hampshire, Pennsylvania, and Virginia have proposed their own laws pertaining to fertility practices.[80] In 2013, the Arizona legislature produced a bill proposing exhaustive requirements for fertility clinics to report the total number of live births achieved; the rate of live births per transfer; the percentage of live births per completed cycle of egg retrieval; the percentage of transferred embryos that implant; specific information regarding the safekeeping of embryos; the percentage of pregnancies resulting in multifetal pregnancies, broken down by the number of fetuses; the percentage of live births having multiple infants; the number of selective reductions performed, broken down by the number of embryos transferred before the reduction; the percentage of selective reductions that resulted in a miscarriage; the percentage of premature births per single and multiple births; and the percentage of birth defects per single and multiple births.[81] If enacted, this law would have been the broadest external regulation of the ART industry.

Given the considerable variance in clinic success rates, the expense of assisted reproduction, and the potential impact on patient health, some regulation of the ART industry is needed. However, there are also valid arguments against such regulation. First, the industry already self-regulates in many ways.[82] For example, the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART) regularly issue guidelines for the ART industry.[83]

77. *See* Daar, *supra* note 13; Sandra T. Jimenez, Note, *"My Body, My Right": A Look into IVF Regulation Through the Abortion Legal Framework*, 33 WOMEN'S RTS. L. REP. 375, 384–85 (2012) ("Current ART regulation exists in the form of voluntary and legally unenforceable guidelines created collaboratively by the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART) in lieu of federal or state statutes.").

78. *See* Daar, *supra* note 13, at 642.

79. 42 U.S.C. § 263a-1(a) (2012).

80. *See* Daar, *supra* note 13, at 646–50.

81. S.B. 1376, 51st Leg., 1st Reg. Sess. (Ariz. 2013).

82. *See* Daar, *supra* note 13, at 658–60; Lyerly, *supra* note 76, at 702.

83. *See* Daar, *supra* note 13, at 658–59; Jimenez, *supra* note 77, at 384–86.

ASRM continuously refines its guidelines for IVF embryo transfers in an effort to reduce the number of high-order multiple pregnancies.[84] Second, such regulation risks running afoul of fundamental procreative liberties.[85] While some regulation of ART is appropriate, regulations like that proposed in Arizona could possibly undermine those liberties by burdening providers with redundant requirements and passing the added costs on to patients.[86]

D. ETHICAL AND LEGAL FRAMEWORKS OF SELECTIVE REDUCTION

Since the first successful birth of an infant conceived through IVF in 1978, this technique has grown worldwide to become one of the most popular methods of assisted reproduction.[87] Along with this success, however, arise a number of complications. The process of IVF, in short, involves treating the mother with fertility drugs to increase the production of eggs, retrieving and fertilizing the eggs outside of the mother's uterus, and later transferring the healthy embryos back into the

84. Am. Soc'y for Reprod. Med., *Criteria for Number of Embryos to Transfer: A Committee Opinion*, 99 FERTILITY & STERILITY 44, 44 (2013), http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/Guidelines_on_number_of_embryos(1).pdf (issuing a new set of guidelines, further refining the guidelines last issued in 2009, reducing the recommended number of embryos to transfer to a single embryo for women under 35, no more than two embryos for women between 35 and 37, no more than three embryos for women 38 to 40, and no more than five embryos for women 41 to 42).

85. *See* Daar, *supra* note 13, at 641–42 (considering Supreme Court decisions protecting procreative liberties by affirming the constitutional right not to procreate and opining that "[a]ny regulation of ART that has the effect of interfering with procreational choices could be invalidated as interfering with fundamental rights"); Jimenez, *supra* note 77, at 391. *But see* Radhika Rao, *Reconceiving Privacy: Relationships and Reproductive Technology*, 45 UCLA L. REV. 1077, 1113–21 (1998) (opining that procreational rights are based in the constitutional right to privacy and as such, are limited).

86. *See, e.g.*, *Arizona Legislators Put Fertility Clinics Under Microscope* (Arizona Nightly News television broadcast) (noting that the CDC already publishes much of the information sought by the Arizona bill), http://archive.azcentral.com/video/#/Arizona+legislators+put+fertility+clinics+under+microscope/2189339366001; Letter from RESOLVE: The National Infertility Association to Arizona Senator Andy Biggs (Feb. 22, 2013), http://www.resolve.org/get-involved/the-center-for-infertility-justice/state-legislation/resolves-letter-to-arizona-senators.pdf (noting that because Arizona law does not require insurers to cover infertility treatment, any added costs would fall to patients).

87. *See* Daar, *Lifeboat Ethics*, *supra* note 5, at 789–90 (noting that as of 1992, over 10,000 IVF infants had been delivered worldwide, and more than 180 IVF programs were operating in the United States).

mother's uterus.[88] Physicians originally took an aggressive approach to transferring embryos to increase the mother's chance of pregnancy.[89] Because IVF patients make substantial financial and emotional investments in the process, IVF physicians naturally experience pressure to get results faster by transferring higher numbers of embryos.[90] Furthermore, IVF is a competitive industry where fertility clinics have a "vested stake in the outcome of fertility treatments"[91] and thus an incentive to continue higher-order transfers. Although they are not legally binding, ASRM guidelines may temper some of this pressure by limiting the number of recommended transfers.[92] High-order transfer rates have dropped since the late 1998, when the ASRM first published these guidelines.[93] Despite the industry's great strides in reducing the number of high-order multiples produced through IVF, it has not yet succeeded in reducing the number of twins.[94] The CDC reports that while the birth rate for triplets and higher-order multiples dropped four percent between 2012 and 2013, the twin birth rate increased by two percent, reaching a new high of 33.7 per 1,000 births.[95]

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88. *Id.* at 790.

89. *Id.* at 791.

90. *See* Stacey Pinchuk, *A Difficult Choice in a Different Voice: Multiple Births, Selective Reduction and Abortion*, 7 DUKE J. GENDER L. & POL'Y 29, 50–51 (2000).

91. *Id.* at 50.

92. *See supra* note 84 and accompanying text.

93. *See* Tarun Jain et al., *Trends in Embryo-Transfer Practice and in Outcomes of the Use of Assisted Reproductive Technology in the United States*, 350 NEW ENG. J. MED. 1639, 1641 (2004). Patterns of embryo-transfer practice are likely also influenced by other factors, such as improvements in technology. *Id.* at 1643–44. Patient preference is also likely to influence embryo-transfer practices, as many fertility patients desire multifetal pregnancies and may prefer to transfer higher numbers of embryos. *See* Ginny L. Ryan et al., *The Desire of Infertile Patients for Multiple Births*, 81 FERTILITY & STERILITY 500, 503 (2004) (noting that one in five women in one study listed multiple births as their most desired outcome of infertility treatment).

94. The Society for Assisted Reproductive Technology's 2013 national data summary showed that twin births constituted 28.2% of live births for women under 35, which was a decrease from 29.5% in 2012, 30.8% in 2011, 32.4% in 2010, 33.3% in 2008, and 32.7% in 2004. *Clinic Summary Report*, SOC'Y FOR ASSISTED REPROD. TECH., https://www.sartcorsonline.com/rptCSR_PublicMultYear.aspx?ClinicPKID=0 (last visited Nov. 29, 2015); *see also* Laurie Tarkan, *Lowering Odds of Multiple Births*, N.Y. TIMES, Feb. 19, 2008, at F1, http://www.nytimes.com/2008/02/19/health/19mult.html (stating that while efforts to reduce multiples by transferring fewer embryos per IVF cycle have "substantially lowered the rates of triplets . . . they have not made a dent in the twin rate").

95. Joyce A. Martin et al., *Births: Final Data for 2013*, 64 NAT'L VITAL STATS. REPS. 1, 2 (2015), http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_

While transferring higher numbers of embryos increases the chances of pregnancy, it also increases the odds of multifetal pregnancy.[96] Because of the high risks associated with multifetal pregnancies, physicians will often urge their patients to consider selective reduction.[97] The procedure has become more common since it was first performed, with one center reporting more than 2,000 procedures by 2008.[98] The technical process of selective reduction, performed in the first trimester, involves inserting a needle into the chest or heart of the fetus and injecting potassium chloride, after which "[t]he terminated fetuses remain in the woman's uterus where they are resorbed, allowing the remaining fetuses to grow normally."[99] Although most physicians determine which fetus to terminate by proximity to the maternal abdominal wall,[100] some have said that they will consider other factors including genetic abnormalities or the parents' preference to have a child of a particular sex.[101] Over time, physicians have performed more selective reductions with increasing success,[102] but the procedures are still not without risk.[103]

Because of the nature of the procedure, scholars frequently

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96. *See* Am. Soc'y for Reprod. Med., *supra* note 84 ("High-order multiple pregnancy (three or more implanted embryos) is an undesirable consequence . . . of assisted reproductive technologies."); *supra* note 2 and accompanying text.

97. *See supra* notes 3–4 and accompanying text.

98. Joanne Stone et al., *Contemporary Outcomes with the Latest 1000 Cases of Multifetal Pregnancy Reduction (MPR)*, AM. J. OBSTETRICS & GYNECOLOGY, Oct. 2008, at 406.e1, http://www.ajog.org/article/S0002-9378(08)00627-3/pdf (referring to Mount Sinai Medical Center).

99. Daar, *Lifeboat Ethics*, *supra* note 5, at 780–81.

100. *Id.* at 781.

101. *See* Evans, *supra* note 6; *see also* Ruth Padawer, *The Two-Minus-One Pregnancy*, N.Y. TIMES (Aug. 10, 2011), http://www.nytimes.com/2011/08/14/magazine/the-two-minus-one-pregnancy.html (noting that although most doctors once refused to offer sex selection, "that ethical demarcation has eroded" in the last decade).

102. Daar, *Lifeboat Ethics*, *supra* note 5, at 788 (noting that United States physicians reported over 200 procedures by 1992, as well as a decrease in the fetal loss rate from 33.3% to 9.5%, compared to the general fetal mortality rate of 16% to 41% among multifetal pregnancies).

103. *See* Am. Soc'y for Reprod. Med., *supra* note 84 (stating that selective reduction "may result in the loss of all fetuses, does not completely eliminate the risks associated with multiple pregnancy, and may have adverse psychological consequences"); *see also* Kathleen Lee, *In Support of a Gender-Neutral Framework for Resolving Selective Reduction Disputes*, 44 FAM. L.Q. 135, 140–41 (2010) (noting that "selective reduction carries with it heavy psychological burdens" and also produces moral and ethical dilemmas for parents considering the procedure).

compare and distinguish selective reduction and abortion.[104] While both involve the termination of one or more fetuses, the two procedures differ in technical respects, context, and objectives.[105] Abortions are performed in an "increasingly hostile" political and regulatory climate, but "selective reduction occurs in the context of the vast, widely-used and largely unregulated fertility industry."[106] Whereas a pregnant woman typically seeks an abortion because her pregnancy is unwanted, selective reduction takes place after the mother has gone to significant lengths seeking to become pregnant.[107] Most state abortion laws, however, do not explicitly consider these distinctions in motivation; rather, they define abortion as "the termination of a human pregnancy."[108] The aim of selective reduction is not to terminate a pregnancy, but to preserve it along with the health of the mother and remaining fetus.[109] In spite of these differences, some scholars consider the two procedures legally identical.[110] The extent of a pregnant woman's power to choose which fetus to terminate by selective reduction in a state with laws prohibiting motivation-based abortions requires an analysis of how selective reduction might fit within the legal definition of abortion.

II. HOW MOTIVATION-BASED ABORTION LAWS COULD CREATE BARRIERS TO WOMEN SEEKING SELECTIVE REDUCTIONS

While selective reduction is not without its ethical questions, physicians consider the procedure ethical and even necessary in many situations.[111] Nonetheless, the growing prevalence of motivation-based abortion prohibitions across the country[112] may create significant barriers to women seeking this

104. *See, e.g.*, Pinchuk, *supra* note 90, at 34–51. S*ee generally* Rao, *supra* note 16 (discussing the legal and ethical distinctions between the procedures).

105. *See* Pinchuk, *supra* note 90, at 34–51.

106. *Id.* at 50.

107. *See id.* at 34.

108. Lee, *supra* note 103, at 145.

109. *See id.* at 144.

110. *See, e.g.*, John Robertson, *Is Selective Reduction Covered by State Abortion Law?*, HARV. L. SCH.: BILL OF HEALTH BLOG (Apr. 10, 2013), http://blogs.law.harvard.edu/billofhealth/2013/04/10/john-robertson-on-is-selective-reduction-covered-by-state-abortion-law-online-abortion-and-reproductive-technology-symposium.

111. *See supra* notes 3–4 and accompanying text.

112. As of the time of writing this Note, there are at least six states that have enacted motivation-based abortion prohibitions and at least ten states that have proposed such legislation, although it has yet to be enacted. *See su-*

vital procedure. Although there are many other factors that could have a chilling effect on physicians providing selective reduction,[113] this Note focuses on motivation-based abortion prohibitions as the most pressing barrier.

Section A first probes the constitutional validity of laws prohibiting abortions on the basis of motivation, then, assuming such laws are not unconstitutional per se, identifies which laws are most likely to pass constitutional muster. Second, assuming such laws are generally valid, Section B considers their application to selective reduction, concluding that while there is a strong argument that selective reduction should not legally qualify as abortion, states may still seek to apply motivation-based abortion prohibitions in cases of selective reduction. Finally, to the extent that these laws validly limit the availability of selective reduction, Section C considers the implications of such laws in the types of cases where a particular fetal characteristic is more likely to be an ethically relevant consideration as part of a selective reduction decision.

A. THE CONSTITUTIONAL VIABILITY OF MOTIVATION-BASED ABORTION PROHIBITIONS

Some have challenged these laws as discriminatory,[114] but the Supreme Court has not yet determined their constitutionality.[115] Despite the likelihood that many of these laws are invalid, some have a significant chance of survival.[116] This Section applies recent Supreme Court jurisprudence on state abortion laws, discussed in Part I.B, to determine which states' laws would be the most likely to survive a constitutional challenge.[117] This Section concludes that while there is a strong argument

pra notes 43–46 and accompanying text.

113. *See* Christine E. Dehlendorf & Kevin Grumbach, *Medical Liability Insurance As a Barrier to the Provision of Abortion Services in Family Medicine*, 98 AM. J. PUB. HEALTH 1770, 1770–71 (2008) (finding that "[t]he cost and availability of liability insurance have emerged as a prominent barrier" for family physicians providing abortions).

114. *See supra* notes 68–73 and accompanying text.

115. Gillette, *supra* note 17, at 671; King, *supra* note 19, at 30; Molony, *supra* note 53, at 1092.

116. Even if they are found to be unconstitutional, this Note acknowledges that many state legislatures are likely to reenact modified versions of these statutes. *See supra* note 75 and accompanying text.

117. While a full analysis of the constitutionality of these additional prohibitions is outside the scope of this Note, a full analysis is not necessary to the analysis below, which explores how these prohibitions would apply in several hypothetical scenarios assuming that the prohibitions are upheld or remain unchallenged.

that constitutional protection should extend to any reason a woman may have for seeking pre-viability abortion,[118] states may permissibly impose limitations on pre-viability abortions in narrow, limited circumstances.

The Supreme Court's decisions in *Roe*[119] and *Casey*[120] create the judicial standard that the Court will use to determine how far states can go in limiting a woman's right to have an abortion based on her motivation. If a court interprets *Casey* to bar only blanket or comprehensive pre-viability abortion bans but allow some narrower bans, then the narrowest motivation-based abortion prohibitions are those most likely to be upheld. None of the state laws discussed in Part I.A.2 of this Note contain provisions limiting their application to post-viability abortions. Thus, they would all be subject to *Casey*'s undue burden test for pre-viability abortion bans, should the Court choose this route. The laws most likely to survive this test are those that apply only to abortions sought "solely" on the basis of the sex of the fetus. This limitation would allow a woman to consider the sex of the fetus where her decision to terminate her pregnancy is ultimately influenced by other, permissible reasons.

Those laws that purport to apply the most broadly—North Carolina's and Arizona's—are the least likely to survive a constitutional challenge. North Carolina's law applies even where sex selection is merely one among other reasons for terminating a pregnancy, and it contains no exceptions relating to the preservation of the life or health of the mother.[121] The Arizona law is also problematic because it may apply in any scenario in which a pregnant woman considers the sex of the fetus in her decision to opt for an abortion.[122] Because they are limited in scope, most other states' laws are more likely to survive the *Casey* undue burden test, should *Casey* be interpreted to allow narrow pre-viability abortion prohibitions. Even if the Court determines that such laws are unconstitutional because they limit a woman's choice to have an abortion prior to viability, state legislatures can easily modify their laws to apply only post-viability (in states in which a post-viability abortion is otherwise permitted).

In contrast to laws only prohibiting abortions for the pur-

118. *See* Gillette, *supra* note 17, at 671–81; King, *supra* note 19, at 30–43.
119. Roe v. Wade, 410 U.S. 113 (1973).
120. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).
121. *See* Molony, *supra* note 53, at 1130.
122. *See* ARIZ. REV. STAT. ANN. § 13-3603.02 (2011).

pose of sex selection, those that also prohibit abortions based on other qualities, such as genetic abnormality or race, raise more complex questions. If the state has a compelling interest in eliminating discrimination based on sex, it follows that the state might also have a compelling interest in eliminating other forms of discrimination.[123] However, these laws may face additional hurdles in passing the undue burden test, even if *Casey* is interpreted to allow some narrow pre-viability abortion bans. Arizona's prohibition on race-selective abortions is similar to prohibitions on sex-selective abortions, because like the sex of the fetus, the race of the fetus does little to affect the woman's health or the burdens of raising a child.[124] Thus, laws that prohibit abortions based solely on genetic abnormality may be less likely to survive a constitutional challenge because, unlike sex or race, a genetic abnormality may impose significant financial, medical, and emotional burdens on the mother.[125]

B. SELECTIVE REDUCTION ON THE SPECTRUM OF ABORTION

As discussed above, scholars have identified a number of ways to distinguish selective reduction from abortion.[126] While the two procedures are conceptually and ethically separable, their legal separability is less clear. Ultimately, the legal status of selective reduction depends on statutory interpretation, as selective reduction is not mentioned explicitly in most state abortion statutes. Using a statutory purpose approach,[127] "a

123. *See* Moloney, *supra* note 53, at 1118–19 (noting several cases in which the Supreme Court considered whether public accommodation statutes prohibiting discrimination based on race, religion, sex, and sexual orientation infringed on a group's associational rights using a balancing test, rather than applying strict scrutiny).

124. *Cf.* Clifford Ward, *Suit Filed over Mix-Up at Downers Grove Sperm Bank Is Dismissed*, CHI. TRIB. (Sept. 3, 2015), http://www.chicagotribune.com/suburbs/downers-grove/news/ct-dupage-sperm-bank-suit-met-0904-20150903-story.html (reporting that in dismissing this case, the judge agreed that an action for "'wrongful birth' could not be legally sustained in a case where a healthy child was born").

125. *See* Daar, *Lifeboat Ethics*, *supra* note 5, at 842 n.306 (noting that courts have allowed damages in wrongful birth actions including the expenses of ordinary and extraordinary medical care and education of a disabled child, the expenses of pain and suffering of the mother during pregnancy, and the emotional distress of the parents); Padawer, *supra* note 101 ("What drives [the decision to abort a fetus with an identified genetic condition] is not just concern over the quality of life for the future child but also the emotional, financial or social difficulty for parents of having a child with extra needs.").

126. *See supra* notes 104–09 and accompanying text.

127. At times, the Supreme Court has used this method of statutory interpretation where the words of the statute themselves do not provide adequate clarity. *See, e.g.*, Jonathan T. Molot, *The Rise and Fall of Textualism*, 106

natural reading" of most abortion statutes would determine that they include selective reduction, "[s]ince protection of fetuses is a main purpose of such statutes."[128] A more technical, strictly language-based interpretation,[129] however, can substantiate a plausible argument that selective reduction should not be covered.

Most of the state laws discussed in Part I.A.2 of this Note define abortion in nearly identical terms. Arizona law, for example, defines abortion as "the use of any means to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will cause, with reasonable likelihood, the death of the unborn child."[130] It excludes "the use of any means to save the life or preserve the health of the unborn child, to preserve the life or health of the child after a live birth, to terminate an ectopic pregnancy or to remove a dead fetus."[131] The language in the Oklahoma, Illinois, and Pennsylvania statutes is very similar.[132]

North Dakota's law is unique because it explicitly includes selective reduction in the definition of abortion. The law defines

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COLUM. L. REV. 1, 41 (2006) (citing FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120 (2000)) ("[T]he Court employed a purposivist approach to manufacture statutory clarity and to overrule an agency interpretation that otherwise seemed well within the bounds of the statutory text.").

128. Robertson, *supra* note 110.

129. The Supreme Court has long used the "plain language rule" as the starting point of statutory construction. Immigration & Naturalization Serv. v. Phinpathya, 464 U.S. 183, 189 (1984) ("[I]n all cases involving statutory construction, 'our starting point must be the language employed by Congress,' . . . and we assume 'that the legislative purpose is expressed by the ordinary meaning of the words used.'" (quoting Am. Tobacco Co. v. Patterson, 456 U.S. 63, 68 (1982))); United States v. Mo. Pac. R.R. Co., 278 U.S. 269, 278 (1929) ("[W]here the language of an enactment is clear, and construction according to its terms does not lead to absurd or impracticable consequences, the words employed are to be taken as the final expression of the meaning intended.").

130. ARIZ. REV. STAT. ANN. § 36-2151 (2015).

131. *Id.*

132. 720 ILL. COMP. STAT. 510/2 (2010) (defining abortion as "the use of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus"); OKLA. STAT. tit. 63, § 1-730 (2011) (defining abortion as "the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a female known to be pregnant with an intention other than to increase the probability of a live birth, [or] to preserve the life or health of the child after live birth"); 18 PA. CONS. STAT. ANN. § 3203 (West 2011) (defining abortion as "[t]he use of any means to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child").

abortion as "the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable intrauterine pregnancy of a woman, including the elimination of one or more unborn children in a multifetal pregnancy, with knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child."[133] Other states' abortion laws do not refer to multifetal pregnancies or selective reduction.

Selective reduction does not precisely fit within most states' statutory definitions of abortion. State laws generally define abortion in terms of terminating a pregnancy.[134] The purpose of a selective reduction is not to terminate pregnancy, but to preserve the pregnancy along with the health of both the pregnant woman and the remaining fetuses.[135] North Dakota's is the only law that anticipates multifetal pregnancies and explicitly includes selective reduction in its definition of abortion, suggesting that North Dakota is the only state where a selective reduction would clearly fall under the purview of its abortion statutes.

While selective reduction is not explicitly covered by most state law definitions of abortion, if state legislatures intend to impose limits on selective reduction as part of their interest in protecting fetal life, it is possible that they would amend their laws to mirror North Dakota's. However, many state laws contain exceptions that would encompass selective reduction. First, a selective reduction is arguably most often used as a means for increasing the probability of a live birth, which is a statutory exception under Oklahoma law.[136] This conclusion is subject to debate, however, because some women elect to have selective reductions for reasons other than increasing the probability of a live birth.[137] In these cases, selective reduction may not meet the exception of increasing the probability of a live birth.

Second, many selective reductions may fall under the ex-

133. N.D. CENT. CODE § 14-02.1-02 (2013).

134. *See supra* notes 130–32 and accompanying text.

135. *See supra* note 109 and accompanying text.

136. *See* Daar, *Lifeboat Ethics*, *supra* note 5, at 800 ("Plainly, the principal purpose of selective reduction is to produce one or more live births. Because the law seems to define abortion by one's motivation to avoid producing a live birth, the legal definition of abortion cannot also include selective reduction.").

137. *See, e.g.*, Padawer, *supra* note 101 (relating one woman's decision to reduce twins to a singleton based on her concern that because of her age and financial position, she would not be able to care for two children).

ception of necessity. In Pennsylvania, for example, an abortion is permissible if the physician "determines that, in his best clinical judgment, the abortion is necessary."[138] The statute does not define the term "necessary" outright, although it provides limitations.[139] The law requires that, in determining necessity, the physician exercise his or her "best clinical judgment . . . in light of all factors (physical, emotional, psychological, familial and the woman's age) relevant to the well-being of the woman."[140] A literal interpretation of the law suggests that, should selective reduction be classified as a form of abortion, it would permit a physician to perform the procedure based on considerations other than the preservation of the pregnancy or the health of the mother and the remaining fetuses.

Based on a textual, "plain meaning" interpretation, it is unlikely that a court would interpret any of the examined state laws, except for North Dakota's,[141] to apply to selective reduction. The Supreme Court is likely to use this method of interpretation when examining a state statute limiting the right to seek an abortion.[142] If state legislatures intend these laws to encompass selective reduction, however, they can amend their laws to mirror North Dakota's. The next Part of this Note assumes that most motivation-based abortion prohibitions could either be interpreted to apply to selective reduction, or modified to explicitly include it.

C. POTENTIAL APPLICATIONS OF SELECTIVE ABORTION PROHIBITIONS TO SELECTIVE REDUCTION

With few examples of actual prosecutions of physicians under these laws, it is difficult to determine how a motivation-based abortion prohibition would apply in a typical abortion case,[143] much less in a case of selective reduction. Assuming

138. 18 PA. CONS. STAT. ANN. § 3204 (West 2011).

139. *Id.* (providing that except in cases of emergency, prior to performing the procedure, the physician must have a private consultation with the woman to enable the physician to determine whether, based on his best clinical judgment, the abortion is necessary).

140. *Id.*

141. The phrase, "including the elimination of one or more unborn children in a multifetal pregnancy" suggests that North Dakota has banned selective reduction all together. *See* N.D. CENT. CODE § 14-02.1-02 (2013). While this provision raises questions of the law's constitutionality, a full analysis is outside the scope of this Note.

142. *See* Stenberg v. Carhart, 530 U.S. 914, 939–40 (2000) (determining that the "plain language" of Nebraska's partial-birth abortion ban covered two distinct but similar procedures).

143. Boyd, *supra* note 19, at 438–42 (concluding that prosecutors would

that selective reduction could fit within state law definitions of abortion, and these laws remain unchallenged, access to selective reduction may be limited in the same ways that access to abortion is limited in these states. If that is the case, physicians must determine the extent to which they can offer choices in selective reduction. In other words, could state law command that the choice of which fetuses to reduce and which to keep must be determined by their fortuitous location in the mother's womb? This Section seeks to answer these questions by exploring hypothetical, but probable, situations in which women opt for selective reduction. First, Part II.C.1 analyzes various situations where a woman carrying multiples discovers that one of them carries a genetic abnormality. Then, Part II.C.2 explores similar situations where a woman carrying multiples is offered the choice of which fetuses to save or reduce based on sex.[144] Ultimately, this discussion aims to determine whether states can mandate that the selective reduction of a fetus be based solely on the fetus's random location in the womb.

1. Selection as the Sole Motivation for an Abortion or Selective Reduction

If selective reduction is otherwise permissible, the legitimacy of selecting which fetus to keep and which to terminate based on sex or genetic abnormality depends on state law. If the state has enacted a motivation-based abortion prohibition, the first thing to consider is whether the law is limited to cases in which sex selection is the sole motivation for the decision. Therefore, the use of the term "solely" is critical in determining how different states' motivation-based abortion prohibitions

face significant hurdles in prosecuting abortion providers in most scenarios that would arise under Arizona's motivation-based abortion statute).

144. Arizona's motivation-based abortion law anticipates a third scenario, race selection, which is not analyzed in this Note, but warrants a full discussion on its own terms. *See* ARIZ. REV. STAT. ANN. § 13-3603.02 (2011). It is possible that such a prohibition would affect selective reduction and abortion in ways not anticipated by the statute. For example, there are cases in which women have given birth to children of different races due to mix-ups in IVF clinics, raising the question of whether a woman could selectively reduce the child of a different race, or abort the entire pregnancy rather than carry another's child. *See, e.g.*, Clare Dyer, *Judge Backs Adoption of IVF Mix-Up Twins*, GUARDIAN (Feb. 26, 2003, 9:25 PM), http://www.theguardian.com/uk/2003/feb/27/claredyer; *see also* Meredith Rodriguez, *Lawsuit: Wrong Sperm Delivered to Lesbian Couple*, CHIC. TRIB. (Oct. 1, 2014, 7:22 AM), http://www.chicagotribune.com/news/local/breaking/ct-sperm-donor-lawsuit-met-20140930-story.html (discussing a lawsuit brought by an Ohio woman against a sperm bank for mistakenly implanting her with genetic material from an African-American donor, resulting in a mixed-race child).

might apply to selective reduction.

Presumptively, if a woman has already chosen to undergo a selective reduction, she has chosen to do so not because she only wants children with or without a particular characteristic, but because preserving her health and the well-being of the remaining fetuses warrants it,[145] or because she feels that she cannot or does not want to accommodate more than one child.[146] Thus, the types of motivations generally anticipated by the motivation-based abortion prohibitions discussed in Part I.A.2 would rarely be the *sole* motivation for a selective reduction. This is not necessarily the case, however, with respect to twin pregnancies. Until recently, many physicians did not consider selective reduction of twins a necessity, and many refused to perform them at all.[147] Although the number of twin-to-singleton reductions has increased,[148] it is less likely to be considered a medical necessity than the reduction of high-order multiples.[149] Given the fact that physicians may be less likely to recommend a selective reduction of twins out of medical neces-

145. *See Committee Opinion No. 553*, *supra* note 2, at 408 (directing that in cases of high-order multifetal pregnancies, patient counseling should "convey that multifetal pregnancy reduction increases the chance of achieving at least one live birth and decreases the risk of a spontaneous loss of the entire pregnancy").

146. *See, e.g.*, Padawer, *supra* note 101 ("The idea of managing two infants at this point in her life terrified her. [Jenny] and her husband already had grade-school-age children, and she took pride in being a good mother. She felt that twins would soak up everything she had to give, leaving nothing for her older children. Even the twins would be robbed, because, at best, she could give each one only half of her attention and, she feared, only half of her love. Jenny desperately wanted another child, but not at the risk of becoming a second-rate parent.").

147. *Compare id.* (noting that many if not most physicians who perform selective reductions will not perform a reduction of twins to a singleton if not medically necessary), *with* Mark I. Evans et al., *Fetal Reduction from Twins to a Singleton: A Reasonable Consideration?*, 104 OBSTETRICS & GYNECOLOGY 102, 102 (2004) (concluding that, given the risk of spontaneous twin pregnancy loss, the experience of physicians in safely reducing multifetal pregnancies, and data suggesting that the likelihood of a successful birth is higher after a reduction of twins, "twin-to-singleton reductions might be considered with appropriate constraints and safeguards").

148. *See, e.g.*, Padawer, *supra* note 101 (noting that between 1997 and 2010 at Mount Sinai Medical Center, one of the largest selective reduction providers, the number of overall reductions to a singleton increased from 15% to 60%, and in 2010, 62% of reductions to a singleton were twin-to-singleton reductions).

149. *See* Mark I. Evans & David W. Britt, *Multifetal Pregnancy Reduction: Evolution of the Ethical Arguments*, 28 SEMINARS REPROD. MED. 295, 301 (2010) (recommending "that the obstetrics community not adopt elective twin reduction as a general practice but refer patients who make this request to centers with experience in MFPR that also offer counseling about this choice").

sity, it is easier to imagine a woman being motivated to reduce solely by the sex or genetic abnormality of a fetus in a twin pregnancy.

2. Selection to Avoid Genetic Abnormality

As technologies have advanced to allow earlier detection of fetal abnormalities, abortions and selective reductions of the fetuses carrying them have become more common, regardless of whether those abnormalities are life-threatening.[150] The decision to terminate a fetus to avoid having a child with a genetic disorder is often driven by concern not only for the quality of life of the child but also the impact on family life and the emotional, financial, or social concerns of the parents.[151] Consider a woman who has become pregnant with twins after IVF and is healthy enough to give birth to the twins safely. She intends to carry both to term until genetic testing reveals that one fetus carries a genetic abnormality. She then opts for a selective reduction. If her physician is aware of the woman's intentions and motivations and willing to perform a reduction from twins to a singleton, could the physician be prohibited from performing the selective reduction?

To date, Indiana,[152] North Dakota,[153] Missouri,[154] and Ohio[155] are the only states to attempt motivation-based abortion prohibitions focused on genetic abnormality.[156] North Dakota's law both prohibits abortions based solely on genetic abnormality or the risk of a genetic abnormality[157] and explicitly includes selective reduction within the definition of abortion.[158] If the woman's sole reason for opting for selective reduction is based on the genetic abnormality of the fetus, then she could face significant obstacles in any state that has enacted a law like North Dakota's. If the genetic abnormality could affect the health of the remaining fetus, then it is possible that she would still be able to seek a selective reduction under the statutory exception for saving the life or preserving the health of the unborn

150. *See* Padawer, *supra* note 101 ("Many studies show the vast majority of patients abort fetuses after prenatal tests reveal genetic conditions like Down syndrome that are not life-threatening.").

151. *Id.*

152. S.B. 334, 119th Gen. Assemb., 1st Sess. (Ind. 2015).

153. N.D. CENT. CODE § 14-02.1-04.1 (2013).

154. H.B. 439, 98th Gen. Assemb., 1st Reg. Sess. (Mo. 2015).

155. H.B. 135, 131st Gen. Assemb., Reg. Sess. (Ohio 2015–2016).

156. *See supra* notes 38–49 and accompanying text.

157. N.D. CENT. CODE § 14-02.1-04.1.

158. *See supra* note 133 and accompanying text.

child.[159] To avoid risking the harsh consequences of liability, a physician in North Dakota would likely refrain from performing the procedure and refer the woman to a provider in another state.[160]

Even though North Dakota's abortion laws explicitly include selective reductions, a more nuanced, text-based interpretation of the statute may also leave some room for the selective reduction of a fetus with a genetic abnormality if the primary reason for the reduction is something other than the existence of the abnormality. The statute prohibits physicians from "intentionally perform[ing] or attempt[ing] to perform an abortion with knowledge that the pregnant woman is *seeking the abortion solely* . . . [b]ecause the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality."[161] The most recent bills in Indiana, Ohio, and Missouri contain similar language.[162] This language leaves a gap that may allow a pregnant woman to choose which fetus to keep in a selective reduction procedure, provided that she does not initially seek the reduction because of the genetic abnormality.

The North Dakota statute is only written to prevent selection in the decision of *whether* to terminate, rather than *which fetus* to terminate.[163] In the above scenario, because the woman did not decide to have a selective reduction until she found out about the abnormality of one of the fetuses, her physician could be prohibited from performing the reduction under North Dakota law. Conversely, had she been pregnant with higher-order multiples and wanted to reduce the number to twins for the sake of her health and the health of the remaining fetuses, the language of the statute may allow her doctor to perform the se-

159. *See* N.D. CENT. CODE § 14-02.1-04.1.

160. *Cf.* Mark Leach, *Does the North Dakota Law Banning Down Syndrome-Selective Abortions Impose an Undue Burden?*, DOWN SYNDROME PRENATAL TESTING (Apr. 3, 2013), http://www.downsyndromeprenataltesting.com/does-the-north-dakota-law-banning-down-syndrome-selective-abortions-impose-an-undue-burden (noting that North Dakotans already face a significant barrier in seeking an abortion to begin with, as there is only one abortion clinic in the state, and it is in Fargo, on the Minnesota state border). If just living in North Dakota is enough to prevent a woman from seeking an abortion due to lack of providers, it is likely that she would have to travel to seek a selective reduction anyway.

161. N.D. CENT. CODE § 14-02.1-04.1 (emphasis added).

162. *See* S.B. 334, 119th Gen. Assemb., 1st Sess. (Ind. 2015); H.B. 439, 98th Gen. Assemb., 1st Reg. Sess. (Mo. 2015); H.B. 135, 131st Gen. Assemb., Reg. Sess. (Ohio 2015–2016).

163. N.D. CENT. CODE § 14–02.1–04.1.

lective reduction. In this scenario, she would not be seeking the reduction because of the genetic abnormality of the fetus, but she may consider the abnormality as a factor in deciding which fetuses to reduce and which to keep. Ultimately, however, the effect of the law is still likely to produce a chilling effect that discourages North Dakota physicians from performing selective reductions.[164]

The same analysis appears to apply to Missouri's proposed law.[165] The Missouri bill differs from North Dakota's law in that it does not explicitly include selective reduction in its definition of abortion, although it may be read to implicitly include selective reduction.[166] In either state, the practical effect may be that a prudent physician would be unwilling to abort or selectively reduce a fetus with a genetic abnormality, given the uncertainty of the laws' application to selective reductions and the harsh penalties for violations.[167] The outcome may be different, however, in the case of high-order multiples.

Consider a similar scenario in which a woman who has gone through IVF becomes pregnant with triplets or quadruplets. Her doctor recommends a selective reduction for the sake of her health and the success of the pregnancy and finds that one of the fetuses carries a genetic abnormality. In this case, a selective reduction of the fetus carrying the abnormality should be permissible assuming that the ultimate purpose of the reduction is to preserve the health of the mother and the remaining fetuses, and not solely for the purpose of selection. The inclusion of the word "solely" in the text of the North Dakota law and the proposed Missouri law would limit the laws' application in this scenario, because the physician would not be performing the reduction in the first place were it not for the health of the woman and her pregnancy. Thus, even though North Dakota law explicitly bans selective reduction based on genetic abnormality, such a selective reduction would be permissible in cases of high-order multiples.

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164. *See supra* note 160 and accompanying text.

165. Mo. H.B. 439.

166. *See* MO. REV. STAT. § 188.015 (2015) (defining "[a]bortion" as "[t]he act of using or prescribing any . . . means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb," *or* "[t]he intentional termination of the pregnancy of a mother by using or prescribing any . . . means or substance with an intention other than to increase the probability of a live birth or to remove a dead or dying unborn child"). Although selective reduction would fit within the exception that increases the probability of a live birth, it would be prohibited by the first provision.

167. *See supra* notes 43–45 and accompanying text.

3. Selection for Sex

There are a number of scenarios in which a pregnant woman undergoing selective reduction may desire sex selection. For example, consider a woman who has undergone IVF and become pregnant with quadruplets. Three of the fetuses are male, one is female, and all four are healthy. The woman already has two sons and has a strong desire for a daughter. Her physician strongly recommends a selective reduction from quadruplets to twins or a singleton, and the female fetus is the closest to the abdominal wall. Is the physician legally permitted to ask the woman of her preferences? If the physician knows the woman's preference for a daughter, could the physician be prohibited from reducing one of the male fetuses that is more distant from the abdominal wall instead of the female?

Under the Illinois, Oklahoma, Pennsylvania, and North Dakota motivation-based abortion prohibitions, this scenario would be permissible provided that the ultimate purpose of the reduction was to preserve the health of the mother and the remaining fetuses and not solely to select for sex. The inclusion of the word "solely" in the text of these statutes would limit the laws' application in this scenario, because the physician would not be performing the reduction in the first place were it not for the health of the woman and her pregnancy. Under Arizona's motivation-based abortion law, however, this procedure may not be permitted, because the law prohibits such a procedure if the sex of the fetus plays *any* role in the decision.[168] Assuming that selective reduction would be classified as an abortion under Arizona law, a prosecutor would merely have to show that the physician knew that the sex of the fetuses played a role in the woman's decision of which ones to terminate. To avoid liability, the physician in such a scenario would have to decide which fetus to terminate based solely on a random characteristic—the most logical characteristic being proximity to the abdominal wall.[169]

A more nuanced interpretation of Arizona law makes the outcome less clear in this context in several ways. First, Arizona's definition of abortion does not anticipate multifetal pregnancies or the need for selective reduction.[170] Second, even if the law applies equally in all cases, a literal reading of the statute should not allow the law to govern the choice of which fetus to

168. *See supra* note 47 and accompanying text.
169. *See supra* note 5 and accompanying text.
170. *See supra* notes 130–31 and accompanying text.

terminate in most selective reductions. In construing a statute, courts first consider "whether the language at issue has a plain and unambiguous meaning with regard to the particular dispute in the case."[171] The Arizona statute covers anyone who "[p]erforms an abortion knowing that *the abortion is sought based on* the sex . . . of the child . . . ."[172] Because the law does not anticipate a multifetal pregnancy, it appears the law is written only to prevent sex selection in the decision of *whether* to terminate, rather than *which fetus* to terminate.

While the term "abortion," as discussed above, is subject to multiple interpretations, the remaining language of the statute is unambiguous. The requirement that an abortion be "sought based on" the sex of the fetus has a plain and unambiguous meaning: if a woman learns the sex of the fetus and subsequently decides to have an abortion based on that knowledge, then her decision falls within the meaning of the statute. For example, if a woman pregnant with twins, one male and one female, opts for a selective reduction because she wants only daughters and the twin pregnancy otherwise poses no major health risks, her physician would probably not be permitted to perform the procedure. In such a case, the woman opts for a selective reduction *because of* the sex of the male fetus, whereas if both fetuses had been female, she would have carried the full pregnancy with both twins to term. Conversely, a woman's decision to seek an abortion prior to identifying the sex of the fetus does not fall within the meaning of the statute. In a scenario involving high-order multiples, for example, it is more likely that the woman has already decided to terminate one or more fetuses. Thus, she has sought a selective reduction for the sake of her health and the safety of the remaining fetuses, and even if she chooses which fetus to terminate based on its sex, she has not *sought* the reduction *based on* that characteristic.

Third, the application of Arizona's law to selective reduction can be challenged by a purpose-based approach to statutory interpretation. Such an interpretation suggests that Arizona's law should not apply in the above scenario. The purpose of Arizona's motivation-based abortion prohibition is "to protect unborn children from prenatal discrimination in the form of being subjected to abortion based on the child's sex or race."[173] This purpose is based on the perception that such abortions do in fact occur and that they "are elective procedures that do not

171. Robinson v. Shell Oil Co., 519 U.S. 337, 340 (1997).

172. ARIZ. REV. STAT. ANN. § 13-3603.02 (2011) (emphasis added).

173. 2011 Ariz. Legis. Serv. Ch. 9 (H.B. 2443) (West).

in any way implicate a woman's health."[174] The choice of which fetus to reduce in a selective reduction procedure does not reflect this purpose. First, selective reductions are performed with the object of reducing or eliminating significant risks to both the remaining fetuses and the mother,[175] and thus they are not merely "elective procedures" that have no effect on the woman's health. Second, denying a pregnant woman the option to choose which fetus to terminate in a selective reduction does not necessarily resolve prenatal discrimination. Not all physicians offer their patients the option to select for sex in a selective reduction, and not all patients have the desire to exercise that choice.[176] Given the little evidence of disproportionate discrimination against a particular gender in selective reduction,[177] it follows that selective reduction is less of a vehicle for prenatal discrimination than an unfortunate necessity for women who must avoid the high risks of carrying multiples.

The above analysis suggests that the current regulatory framework for abortion cannot be usefully applied in the context of selective reduction. First, it is not entirely clear whether most motivation-based abortion prohibitions would apply to selective reduction procedures, and there are valid arguments that they should not. Second, this ambiguity could have a chilling effect on providers who would otherwise recommend selective reduction. Third, allowing motivation-based abortion prohibitions to regulate selective reduction would not have any meaningful effect on the social problems that such laws purportedly aim to solve. Considering the growing number of motivation-based abortion prohibitions, the high numbers of multiple pregnancies, and the increasing recognition of risks associated even with twins, a different legal framework for regulating selective reduction is warranted.

III. LOOKING FORWARD: A VIABLE LEGAL FRAMEWORK

174. *Id.*

175. *See, e.g.*, *Committee Opinion No. 553*, *supra* note 2.

176. *E.g.*, Padawer, *supra* note 101 (noting that some patients "want no part in the decision"). The decision to have a selective reduction can be emotionally painful and psychologically scarring in its own right without the added burden of choosing one fetus over the other. *See* Lee, *supra* note 103.

177. First, considering the procedure's recent development, selective reduction is less common than abortion to begin with. *See* Evans, *supra* note 6 (noting that as of 2009, Evans was only "one of a small cadre of experienced, high-risk obstetricians who now offer selective reduction"). Furthermore, there is evidence that among women who do choose selective reduction, some may elect to choose the sex of the remaining fetus, while many others do not wish to have any part in the decision. *See supra* note 176.

FOR SELECTIVE REDUCTION

Selective reduction requires a legal framework that separates the procedure from abortion, allows the ART industry to continue refining its practices, and serves legitimate state interests without unnecessary state intervention in medical decisions. There is no bright-line rule indicating when the risk of carrying a multifetal pregnancy to term becomes so high that selective reduction is "necessary" to save the life of the mother or preserve the pregnancy, and such bright-line rules would make little sense from a health or policy perspective.[178] Allowing states to impose broad limits on selective reduction—for example, making selective reduction permissible where necessary to preserve the life or health of the mother and/or the remaining fetuses—would require physicians to draw these arbitrary lines. Therefore, this Note proposes a solution that attempts to balance the interests of ART patients and the ART industry with state interests.

Section A proposes that states should enact or amend their laws to ensure the legal separation of selective reduction from abortion. Then, Section B proposes that regulatory measures intended to reduce the need for selective reduction and prevent abuse of the procedure should for the most part be left to the medical community. If selective reduction were determined to be within the ambit of state abortion laws, the above analysis regarding motivation-based abortion prohibitions suggests that it may be permissible for states to mandate that selection be based on random placement. Section C, however, proposes that because mandating random selection would do little to resolve state legislatures' concerns regarding discrimination, states should be able to impose such a mandate in very limited circumstances.

A. STATES SHOULD LEGALLY DISTINGUISH SELECTIVE REDUCTION FROM ABORTION

In most states, statutory language leaves it unclear whether state abortion laws would encompass selective reductions.[179] Because of the inherent differences between selective reduction and abortion,[180] current abortion laws should not be interpreted

178. *See* Evans et al., *supra* note 147, at 105–08 (discussing the benefits as well as the ethical dilemmas of reducing twin pregnancies that make such line-drawing impractical).

179. *See supra* Part II.B.

180. *See supra* notes 104–07 and accompanying text.

to encompass selective reduction.[181] Whereas motivation-based abortion prohibitions anticipate the termination of a pregnancy because of an inherent characteristic of the fetus (such as sex or genetic abnormality), selection in the context of selective reduction is a necessity—the physician must either choose which fetus to reduce based on a random characteristic (i.e., proximity to the abdominal wall) or offer the choice to the patient, who must choose which fetus to keep based on whatever characteristics can be identified. In selective reduction, the choice generally arises out of medical necessity, whereas in the types of abortions anticipated by motivation-based abortion prohibitions, the choice typically arises out of preference alone.[182]

From a policy perspective, allowing these laws to limit a pregnant woman's choices when undergoing a selective reduction would do little to resolve the issues of discrimination identified by proponents of such prohibitions. The purpose of selective reduction is to diminish the risks posed by high-order multiple pregnancies,[183] rather than to offer parents a "menu" from which they can choose the fetus with the most desirable genetic qualities—and there is little evidence that pregnant women and physicians are abusing IVF and selective reduction in this way.[184] Furthermore, the medical community already generally condemns the practice of sex selection.[185] It is also unclear that prohibiting abortions based on genetic abnormality would actually resolve discrimination against those who carry those abnormalities, since a woman living in a state with such a prohibition can travel to another state to terminate her preg-

181. *See* Daar, *Lifeboat Ethics*, *supra* note 5, at 783 ("A woman undergoing a 'traditional' abortion intends that her entire pregnancy will be terminated: that following successful completion of the procedure she will no longer be pregnant. In contrast, a woman undergoing selective reduction intends that her pregnancy will not be terminated, but rather will be enhanced by creating a better environment for her fetus(es) to develop. The difference in intent so separates [selective reduction and abortion] as to render them wholly distinguishable. This distinction should be maintained in the policy-making and political arenas that swirl around the abortion issue.").

182. *See supra* note 104–107 and accompanying text.

183. *See supra* note 3 and accompanying text.

184. *See supra* note 176 and accompanying text.

185. *See Committee Opinion No. 360*, *supra* note 23, at 478 (explaining that while the ACOG accepts sex selection to prevent sex-linked genetic disorders, it opposes sex selection for other reasons, including discriminatory beliefs and "family balancing"). The ACOG also acknowledges, however, that patients are entitled to information including the sex of the fetus, and therefore "it will sometimes be impossible for health care professionals to avoid unwitting participation in sex selection." *Id.*

nancy.[186] Given the purposes of selective reduction, however, even if prohibiting abortions based on genetic abnormality would have an anti-discriminatory effect, it is not likely that such a prohibition would have the same effect in the context of selective reduction, because the decision to reduce in the first instance is most often made based on the risks posed by the pregnancy rather than the characteristics of the fetus. Because motivation-based abortion prohibitions would do little to resolve discrimination if applied to selective reduction, there is little value in allowing such laws to apply to selective reduction.

For the sake of providing clarity, particularly for physicians, states should amend their abortion laws to explicitly exclude selective reduction from the definition of abortion. Such a provision might read, "Nothing in this Chapter shall be construed to limit the selective reduction of a multifetal pregnancy where a physician has determined that selective reduction is in the best interest of the health of the mother and the remaining fetus or fetuses." Such a provision would provide needed clarity, especially in states that have enacted motivation-based abortion prohibitions. As physicians continue to refine selective reduction procedures and demonstrate higher success rates, particularly for women who want to reduce twins to singletons, this practice will become more prevalent and accessible. Allowing selective reductions to fall within the ambit of motivation-based abortion prohibitions could produce a chilling effect on those providers in states with the most restrictive laws, given the high costs of violating such laws. Such a chilling effect could result in fewer providers offering selective reduction services, adding extensive travel costs to the already immensely expensive IVF process for women who may have to seek out providers in other states. Although the total number of physicians that provide selective reductions still remains relatively low, meaning that many women already have to travel to find a

186. *See* Alison Piepmeier, *Outlawing Abortion Won't Help Children with Down Syndrome*, N.Y. TIMES: MOTHERLODE (Apr. 1, 2013, 12:05 PM), http://parenting.blogs.nytimes.com/2013/04/01/outlawing-abortion-wont-help-children-with-down-syndrome (arguing that North Dakota's new abortion law would not stop women from terminating their pregnancies but instead would make "an incredibly difficult process even more difficult for them"). *But see* Mark Leach, *Outlawing Abortion Won't Help Children with Down Syndrome? History Might Suggest Otherwise*, DOWN SYNDROME PRENATAL TESTING (Apr. 2, 2013), http://www.downsyndromeprenataltesting.com/outlawing-abortion-wont-help-children-with-down-syndrome-history-might-suggests-otherwise (noting that "the termination rate [where abortion is outlawed] is still lower than in countries permitting selective abortion").

provider, the need for travel is likely to diminish as the procedure becomes more prevalent and accessible.[187]

It is unclear whether states would opt for this route. The existence of the provision in North Dakota's law stating that abortion includes "the elimination of one or more unborn children in a multifetal pregnancy"[188] suggests that some state legislatures may actually lean in the opposite direction. However, given the continued prevalence of multiples resulting from IVF and the risks associated with multiple pregnancies, it is urgent that these state legislatures reconsider the effects that laws limiting selective reduction might have on women's health and the ability of the ART industry to provide healthy pregnancies.

B. STATES SHOULD CONSIDER REGULATORY MEASURES AIMED AT ENCOURAGING CERTAIN PRACTICES IN THE ASSISTED REPRODUCTION INDUSTRY

While the ideal solution to the ethical problems contemplated by this Note may be to reduce the need for selective reduction to begin with, it is not clear that most plausible regulations in the ART industry would actually have this effect. The assisted reproduction industry has made strides toward reducing the occurrence of high-order multiples in the context of IVF,[189] but SART reports show that industry self-regulation limiting embryo transfers has not yet led to a significant reduction in the occurrence of twins.[190] This discrepancy is most likely the result of hesitance within the industry to implement a policy of single embryo transfer. Many doctors will recommend transferring no more than one embryo at a time to avoid the risk of multiples, but they are also responsive to the needs and desires of patients who exert pressure to transfer multiple em-

187. This Note acknowledges that it is not a certainty that the practice of selective reduction will become significantly more prevalent, especially if industry regulation succeeds in curtailing the number of high-order multiples in IVF pregnancies. However, considering the present lack of success in reducing the occurrences of twins, as well as physicians' increased recognition of the risks inherent in twin pregnancies, it is likely that selective reduction will continue to progress. *See supra* note 95 and accompanying text; *infra* note 199.

188. N.D. CENT. CODE § 14-02.1-02 (2013).

189. *See supra* note 84 and accompanying text.

190. *See Clinic Summary Report*, *supra* note 94 (showing that for IVF pregnancies in women under 35, twin births decreased from 33.5% in 2003 to 28.3% in 2013, while the occurrence of triplets or more decreased from 6.4% in 2003 to 0.9% in 2013, a much more significant change); *see also supra* note 95 and accompanying text.

bryos at once to increase the chances of obtaining a pregnancy and bypass the need to go through multiple costly IVF cycles.[191]

The most significant obstacle to effectively regulating selective reduction by limiting embryo transfers is the cost of IVF. Were the government to adopt, for example, legislation mandating a policy of no more than single embryo transfers, it would risk putting desperate patients in the position of having to spend two to three times more to obtain a pregnancy.[192] As physician and scholar Mark Evans argues:

> [A]dopting a program of single embryo transfer in the U.S. won't work because the cost of [IVF] is too expensive. At about $15,000, most couples are willing to accept the possibility of complications and have a pregnancy versus none at all. In Australia, where the out-of-pocket cost for I.V.F. is about $400 per cycle, there is relatively little pressure to transfer more than one embryo. Until we get a handle on health care costs, we will continue to see multiple births.[193]

Thus, while the government may feasibly impose a single embryo transfer limit, such a regulation would most likely only be effective if the government also subsidized IVF.[194] Others have advocated a policy of promoting single embryo transfers from within the industry.[195] Such a policy might include reminding legislators and insurance companies of the benefits of reducing multiple pregnancies; encouraging insurance companies to pay the relatively small costs for IVF (as opposed to the much higher costs of high-risk pregnancy); and modifying the national reporting system to disincentivize multiple pregnancy as a measurement IVF success, which could be accomplished by ceasing to count triplets or higher order multiples as a "success-

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191. *See* Robert Stillman, Response to *The Trouble with Twin Births*, N.Y. TIMES: ROOM FOR DEBATE (Oct. 11, 2009, 3:00 PM), http://roomfordebate.blogs.nytimes.com/2009/10/11/the-trouble-with-twin-births ("In our non-single payer health care system and in our national cultural context (with its paramount legacy of individual rights over those of the state), patient autonomy will almost always prevail.").

192. *See* Mark I. Evans, Response to *The Trouble with Twin Births*, N.Y. TIMES ROOM FOR DEBATE (Oct. 11, 2009, 3:00 PM), http://roomfordebate.blogs.nytimes.com/2009/10/11/the-trouble-with-twin-births.

193. *Id.*

194. *See* Judith Daar, *Federalizing Embryo Transfers: Taming the Wild West of Reproductive Medicine?*, 23 COLUM. J. GENDER & L. 257, 321 (2012) ("While a standalone federal law can impose embryo transfer limits, the success of any such regime hinges on the compliance patients and physicians are willing to provide. Changing patient and physician behavior in the surgical suite will start by neutralizing or reducing the cost each must bear in order to attain their desired results. A federal mandate to cover or subsidize the cost of infertility care, as a companion to embryo transfer restrictions, should provide the necessary incentive for adherence.").

195. *See* Stillman, *supra* note 191.

ful cycle" and increasing the evaluative weight assigned to births resulting from single embryo transfers.[196] Given the impracticability of a legally mandated single embryo transfer policy, implementing such policies might be the most effective measure for reducing the need for selective reduction. However, such policies need not be implemented at the industry level alone. Federal and state laws imposing reporting requirements already exist,[197] and such laws may be modified with provisions such as those suggested above to better promote a single embryo transfer policy within the ART industry.

Thus, while state legislatures should refrain from enacting laws to regulate the embryo transfer stage of IVF as long as the costs of IVF remain high, those with an interest in reducing multiple pregnancies and thus the need for selective reduction should enact, or review and modify, laws that impose reporting requirements and amend them to better promote a single embryo transfer policy without legally mandating it. States may not be able to eliminate the need for selective reduction, but those with an interest in eliminating perceived discrimination through selective reduction may still be able to permissibly enact separate laws dealing specifically with selective reduction.

C. STATES SHOULD ONLY MANDATE RANDOM SELECTION IN TWIN-TO-SINGLETON REDUCTIONS, EXCEPT IN CASES WHERE GENETIC ABNORMALITIES ARE IDENTIFIED

While this Note contends that selective reduction should be legally separate from abortion, it also acknowledges that some regulation of selective reduction may be permissible under the same principles that permit the regulation of abortion. It is possible that these principles would permit the regulation of the selection process in selective reduction. As a general policy matter, states should not intervene in the doctor-patient decision of whether to opt for a selective reduction. However, there are some cases in which regulation might be permissible. This Note contends that while it may be permissible for states to mandate random selection in some cases where sex is the only distinguishing factor, states should not be able to mandate random selection where a genetic abnormality exists.

If narrow limitations on motivation-based abortions are otherwise constitutionally permissible, then states might also be able to impose similar narrow limits in the selective reduc-

196. *Id.*

197. *See supra* notes 78–80 and accompanying text.

tion context. Given the questionable constitutionality of motivation-based abortion prohibitions to begin with,[198] the most prudent approach might be to impose the narrowest ban possible. For example, it is possible that states could prohibit selection at the point where selective reduction toes the line between being a necessary procedure and being an elective one—the selective reduction of twins to a singleton.[199] To the extent that selective reduction resembles abortion, state legislatures should consider guidelines similar to those articulated by the Supreme Court in *Roe* and *Casey* in drafting laws regulating selective reduction.[200] While this Note argues that states should take steps to completely eliminate selective reduction from the scope of abortion laws,[201] states could enact other laws under a different rubric to deal specifically with the issue of impermissible bases for selection in the context of selective reduction.[202]

Such laws might limit patients' choices by mandating that, in a twin-to-singleton reduction, the selection of which fetus to reduce be random. This limitation would ensure that, at least in twin reduction cases, the decision to seek a reduction is not motivated solely by the desire to have a child of one sex over the other. A woman motivated by such a desire would not opt for a selective reduction in the first place, knowing that she would not be able to select for the sex of her choice. Such a provision would serve the purpose of state legislatures in enacting motivation-based abortion prohibitions, if the true goal of such prohibitions is to eliminate gender discrimination. The practi-

198. *See supra* Part II.A.

199. The idea that selective reduction of twins resulting from IVF is elective rather than necessary may be controversial, as doctors are increasingly recognizing the risks of twin pregnancies. *See, e.g.*, Evans, *supra* note 192 ("Identical twins are more prone to miscarriage; premature birth; structural abnormalities of the brain, spine and heart; and have a 10 percent to 15 percent risk of the twin-to-twin transfusion syndrome where the fetuses fight over the shared blood supply, and fundamentally they both lose. The mother has higher risks of toxemia and a plethora of other complications including mortality. Although difficult for many to accept, if one defines success as a healthy mother and healthy family, there is no question that it is safer for a woman with twins to opt for reduction and give birth to only one child.").

200. *See supra* notes 50–56 and accompanying text.

201. *See supra* Part III.A.

202. The interests of the states in regulating medical procedures are well-established, so such regulation would not be entirely unique. *See* Gonzales v. Carhart, 550 U.S. 124, 157 (2007) ("There can be no doubt the government 'has an interest in protecting the integrity and ethics of the medical profession.' Under our precedents it is clear the State has a significant role to play in regulating the medical profession." (citation omitted) (quoting Washington v. Glucksberg, 521 U.S. 702, 731 (1997))).

cal effect would be that in the consultation phase, physicians would inform their patients that should they opt for a selective reduction, the physician will select the fetus closest to the abdominal wall and that no other characteristics may be considered.[203]

The validity of such a law would present many more complex issues in the context of a selective reduction based on a genetic abnormality of the fetus. With respect to the issue of genetic abnormality, while states may have a strong interest in eliminating disability discrimination, explicitly prohibiting the selective reduction of fetuses with genetic abnormalities may lead to unjust results. Consider a woman who goes through IVF and becomes pregnant with twins. Her physician performs a screen and informs her that one of the fetuses carries a genetic abnormality that is likely Down syndrome. If her state could prohibit the selective reduction of a fetus on the basis of genetic abnormality, her physician would not be able to perform the procedure without running afoul of state law, even though the physician would ordinarily advise it.

The practical effects of the state's law could produce a number of complex moral issues. For example, if the woman in this scenario were unable to travel outside the state to obtain a selective reduction, the law would effectively force her to bear and raise a child with a genetic abnormality. Furthermore, many women choose to terminate pregnancies in which the fetus carries a known abnormality not because of the added financial or emotional costs of raising the child, but as a "protective measure" based on their own sense of morality and justice.[204] While a full analysis of the constitutionality of this result is outside its scope, this Note concludes that states should not enact laws that could potentially lead to the constitutionally questionable results of infringing on procreative liberty and imposing significant financial, medical, and emotional burdens on the mother.

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203. Generally, this would be with the exception of genetic abnormalities, which the doctor would ordinarily screen for beforehand. *See, e.g.*, Evans, *supra* note 6.

204. *See* Piepmeier, *supra* note 186 (noting that in interviewing several women who chose to terminate their pregnancies when they learned that the fetus had Down syndrome, it was not because they wanted a "perfect child," but because they feared the problems that their children would face as adults, including a heightened risk of sexual abuse).

CONCLUSION

Assisted reproductive technology has brought tremendous joy into the lives of many hopeful parents, yet this advanced technology can also lead to devastatingly difficult choices. For many fertility patients, the joy of finally becoming pregnant will be tempered by the difficult choice of which fetus or fetuses to keep in order to ensure a healthy pregnancy. Many patients, to relieve the ethical and emotional burden of such a difficult decision, would have their physicians choose which fetus to reduce at random. Others, however, may wish to have the option to choose the sex of their child. More commonly, those carrying one or more fetuses with a genetic abnormality may wish to make their decision based on that knowledge.

Recently enacted state legislation may impose limits on these choices. The number of states adopting or proposing motivation-based abortion prohibitions is growing rapidly. Interpreted literally, it is not certain that such statutes would encompass selective reduction, but there is a strong argument that they could. While there is also a strong argument that these laws may be unconstitutional, unless and until their constitutionality is decided, they will continue to apply to motivation-based abortions and may even apply to selective reductions. Furthermore, even if these laws are found to be unconstitutional, it is likely that state legislatures will modify them to comply with constitutional requirements. In the meantime, an increasing number of state legislatures are proposing or enacting motivation-based abortion prohibitions. The mere presence of these laws could easily produce a chilling effect on providers, particularly where state law explicitly includes selective reduction within the definition of abortion.

Given the important technical and ethical distinctions between abortion and selective reduction and the low likelihood that allowing choices in selective reduction will lead to discriminatory results, motivation-based abortion prohibitions should not be applied in the context of selective reduction. Rather, states that wish to limit patients' choices in the selective reduction context should consider revising reporting requirements in the assisted reproduction industry in order to encourage policies that lead to a decline in the number of multifetal pregnancies and the need for selective reduction. If states wish to eliminate the possibility of discrimination in selective reduction, they should refrain from adopting anything more than a very narrow limitation on selection for sex in the reduction of twins to a singleton. Anything more would unnecessarily burden both

providers and patients in the process of ensuring healthy pregnancies for patients in need.