

**PRENATAL TORTS AND PRE-IMPLANTATION GENETIC
DIAGNOSIS**

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I. INTRODUCTION

Over the last several decades, the use of prenatal screening techniques to identify women at risk of giving birth to children with genetic and congenital disabilities has become a routine part of prenatal care.¹ Nearly all pregnant women are screened for risk factors and, among women of advanced maternal age, diagnostic testing of fetuses

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1. See, e.g., Sonia M. Suter, *The Routinization of Prenatal Testing*, 28 AM. J.L. & MED. 233, 234-41 (2002).

to detect abnormalities is now commonplace. The results of such testing can be used to decide whether to continue the pregnancy or abort.² Modern prenatal care also encompasses the decision to become pregnant, with many prospective parents seeking medical advice regarding the risk of their children inheriting a genetic disability.

The legal profession has not lagged far behind these medical advances, at least in holding medical professionals accountable. Concurrently with the increasing scope of modern prenatal care, courts have recognized a series of prenatal torts that allow parents, and sometimes children, to pursue claims against their medical providers for damages flowing from an unwanted birth. These prenatal torts include wrongful birth, wrongful life, and wrongful pregnancy. Many have argued that the development of prenatal torts has, in turn, accelerated the use of prenatal screening techniques by raising the threat of liability and creating a legal standard of care that requires prenatal screening.³ Judicial recognition of prenatal torts continues to be controversial for many reasons, including the potential psychological impact on the child, the message such recognition sends to people living with disabilities, and the difficulties inherent in placing a monetary value on the quality of a human life.⁴

Over roughly the same time period, reproductive medicine has undergone another transformation through the advent of assisted reproductive technology (“ART”). The cornerstone of ART is in vitro fertilization (“IVF”), whereby embryos are conceived outside the body and implanted in the uterus. In what Professor Jaime King has described as a “revolution,”⁵ ART and prenatal screening have been brought together in a recent biotechnological development: preimplantation genetic diagnosis (“PGD”). PGD is the process by which IVF embryos are screened for genetic traits before implantation. Typically, one cell is removed from the embryo for testing when the embryo reaches the eight-cell stage.⁶ The results of the genetic testing are

2. *See id.*

3. *See, e.g.*, Gregory Katz & Stuart O. Schweitzer, *Implications of Genetic Testing for Health Policy*, 10 YALE J. HEALTH POL’Y L. & ETHICS 90, 116 (2010); Suter, *supra* note 1, at 251; Matthew Diehr, Comment, *The State of Affairs Regarding Counseling for Expectant Parents of a Child with a Disability: Do ACOG’s New Practice Guidelines Signify the Arrival of a Brave New World?*, 53 ST. LOUIS U. L.J. 1287, 1289 (2009).

4. *See* Jennifer R. Granchi, *The Wrongful Birth Tort: A Policy Analysis and the Right To Sue for an Inconvenient Child*, 43 S. TEX. L. REV. 1261, 1268 (2002); Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141 (2005).

5. Jaime King, *Predicting Probability: Regulating the Future of Preimplantation Genetic Screening*, 8 YALE J. HEALTH POL’Y L. & ETHICS 283, 285 (2008).

6. For a description of the science of PGD see, for example, GENETICS AND PUB. POLICY CTR., PREIMPLANTATION GENETIC DIAGNOSIS: A DISCUSSION OF CHALLENGES, CONCERNS, AND PRELIMINARY POLICY OPTIONS RELATED TO THE GENETIC TESTING OF HUMAN EMBRYOS 4 (2004) [hereinafter GPPC]; PRESIDENT’S COUNCIL ON BIOETHICS,

used to select embryos for implantation into the gestational mother's womb. In isolation, prenatal screening and ART each raise difficult policy and legal issues. Their combination in PGD has sparked an enormous amount of controversy over the medical, social, and ethical implications of the technology.

Despite vigorous debate over the use of PGD and ongoing controversy over the recognition of prenatal torts in the case of established prenatal screening techniques, there has been very little consideration of how existing prenatal torts might apply to PGD.⁷ This Note explores the application of prenatal torts to cases involving PGD and considers the role that courts might play in the wider debate over PGD.

Part II provides an overview of the medical and legal landscape in which PGD tort suits may arise. Part III argues that existing prenatal tort jurisprudence cannot be applied wholesale to cases involving PGD. Part IV discusses the role of the courts in the continuing debate over PGD, and Part V concludes.

II. MEDICAL AND LEGAL BACKGROUND

A. Various Forms of Prenatal Screening

Of the established forms of prenatal screening, the ultrasound is perhaps the most familiar. Ultrasounds are noninvasive and can be used to identify sex and certain disabilities that have physical manifestations *in utero*.⁸ Less familiar are amniocentesis and chorionic villus sampling, both of which are invasive procedures that allow for genetic testing of the developing fetus, and maternal serum alpha-fetoprotein testing, which identifies pregnancies with a higher risk of neural tube defects.⁹

Depending on one's point of view, PGD either merely shifts prenatal screening to an earlier stage or represents a fundamental change in reproductive medicine. PGD can be used to screen for chromoso-

REPRODUCTION & RESPONSIBILITY: THE REGULATION OF NEW BIOTECHNOLOGIES, 90–92 (2004) [hereinafter PRESIDENT'S REPORT].

7. The potential for liability in cases of intentional diminishment (using PGD to create a child with a disability) has been explored. See I. Glenn Cohen, *Intentional Diminishment, the Non-Identity Problem, and Legal Liability*, 60 HASTINGS L.J. 347 (2008). However, the application of tort rules to other PGD situations does not appear to have been the subject of detailed academic consideration.

8. Jeffrey R. Botkin, *Prenatal Diagnosis and the Selection of Children*, 30 FLA. ST. U. L. REV. 265, 278–79 (2003).

9. For a description of various prenatal screening techniques, see Botkin, *supra* note 8, at 278–80; Cynthia M. Powell, *The Current State of Prenatal Genetic Testing in the United States*, in PRENATAL TESTING AND DISABILITY RIGHTS 44, 44–48 (Erik Parens & Adrienne Asch eds., 2000); Suter, *supra* note 1, at 234–41.

mal abnormalities, sex, and specific genetic markers. Sex selection is typically used to avoid X-linked disorders¹⁰ but is increasingly being used for non-medical reasons.¹¹ As of 2004, it was possible to screen embryos for genetic markers relating to over 100 diseases.¹² More recently, PGD has been used to select embryos that will be compatible tissue donors for an existing sick child.¹³ As our understanding of the human genome grows, the range of characteristics that could potentially be selected for or against will also increase. In the future, it might be possible to select embryos based on features like eye color, height, sexual orientation, or certain behavioral characteristics.¹⁴ Currently, most PGD users are infertile and would be using IVF anyway. According to the President's Council on Bioethics, however, at least "one-third of individuals who use PGD are otherwise fertile."¹⁵ These individuals elect to go through IVF and PGD in order to exert some control over the genetic characteristics of their children, typically to avoid passing on a debilitating genetic condition, and the President's Council suggests the number of fertile people using PGD "may increase as the potential uses of PGD expand."¹⁶

B. The Controversy

The use of post-pregnancy screening for the purpose of selective abortion has long been controversial. One common objection is that selective abortion sends a message to people living with disabilities that they are "unworthy of being born."¹⁷ Another criticism is that it "indicates a problematic conception of and attitude toward parent-

10. X-linked disorders are disorders caused by a mutation on the X chromosome and are more likely to affect boys because they have only one X chromosome, whereas girls, who have two X chromosomes, are more likely to receive at least one chromosome without the mutation. Sex selection can be used to select against male embryos and thus avoid having a child who will suffer from the disorder. Examples of sex-linked disorders include Lesch-Nyhan syndrome and hemophilia. PRESIDENT'S REPORT, *supra* note 6, at 90; see King, *supra* note 5, at 294–95.

11. King, *supra* note 5, at 295.

12. PRESIDENT'S REPORT, *supra* note 6, at 90.

13. Susan M. Wolf et al., *Using Preimplantation Genetic Diagnosis To Create a Stem Cell Donor: Issues, Guidelines & Limits*, 31 J.L. MED. & ETHICS 327, 327 (2003).

14. See King, *supra* note 5, at 300; Louis Paonessa, *Straightening Your Heir: On the Constitutionality of Regulating the Use of Preimplantation Technologies To Select Preembryos or Modify the Genetic Profile Thereof Based on Expected Sexual Orientation*, 33 RUTGERS COMPUTER & TECH. L.J. 331 (2007).

15. PRESIDENT'S REPORT, *supra* note 6, at 90.

16. *Id.*

17. Marsha Saxton, *Disability Rights and Selective Abortion*, in ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950–2000, at 374, 391 (Rickie Solinger ed., 1998).

hood”¹⁸ and that parents should be willing to accept their children regardless of genetic characteristics.¹⁹

The advent of PGD has similarly raised a number of difficult issues. On the one hand, PGD can alleviate suffering by allowing parents to avoid having children who will inherit severe disorders. On the other hand, its use gives rise to medical concerns, including the potential health risks for children born as a result of PGD²⁰ and the accuracy and efficacy of testing.²¹ As with post-pregnancy screening, PGD also raises social and ethical concerns. Some are concerned that PGD sends a hurtful message to people with disabilities and could increase discrimination against the disabled.²² Others object that parents should not be able to control the genetic make-up of their children,²³ and that the use of PGD — especially for non-therapeutic reasons — treats children as a commodity.²⁴ Some see PGD as having the potential to “alter childhood and family dynamics, particularly when it comes to parental expectations and sibling relationships.”²⁵ Particular concerns arise in the case of children designed to be tissue donors for elder siblings.²⁶ Despite these concerns and numerous calls from commentators for regulation of PGD,²⁷ it is largely unregulated in the United States.²⁸

There are obvious similarities between traditional forms of prenatal screening and PGD. Both give parents genetic information about potential children and allow parents to make decisions about whom, genetically speaking, they will bring into the world. But the options

18. Erik Parens & Adrienne Asch, *The Disability Rights Critique of Prenatal Genetic Testing: Reflections and Recommendations*, in *PRENATAL TESTING*, *supra* note 9, at 3, 17.

19. R. McDougall, *Acting Parentally: An Argument Against Sex Selection*, 31 *J. MED. ETHICS* 601, 601 (2005).

20. King, *supra* note 5, at 303–08.

21. GPPC, *supra* note 6, at 5–6; King, *supra* note 5, at 309–11.

22. GPPC, *supra* note 6, at 6; King, *supra* note 5, at 317.

23. *See, e.g.*, McDougall, *supra* note 19.

24. *See, e.g.*, JOHN A. ROBERTSON, *CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES* 150 (1994) (“The very concept of selection of offspring characteristics or ‘quality control’ reveals a major discomfort — the idea that children are objects or products chosen on the basis of their qualities, like products in a shop window, valued not for themselves but for the pleasure or satisfaction they will give parents. The danger is that selection methods will commodify children in a way ultimately harmful to their welfare.”); Dena S. Davis, *Genetic Dilemmas and the Child’s Right to an Open Future*, 28 *RUTGERS L.J.* 549, 561–62, 586 (1997).

25. GPPC, *supra* note 6, at 7.

26. Donna M. Gitter, *Am I My Brother’s Keeper? The Use of Preimplantation Genetic Diagnosis To Create a Donor of Transplantable Stem Cells for an Older Sibling Suffering from a Genetic Disorder*, 13 *GEO. MASON L. REV.* 975, 1017–26 (2006); *see, e.g.*, Wolf, *supra* note 13, at 330.

27. *See, e.g.*, King, *supra* note 5, at 288 n.20.

28. For a description of existing regulation, see Gitter, *supra* note 26, at 984–85; Note, *Regulating Preimplantation Genetic Diagnosis: The Pathologization Problem*, 118 *HARV. L. REV.* 2770, 2773 (2005) [hereinafter *Regulating Preimplantation Genetic Diagnosis*].

available to a pregnant woman following prenatal screening are very limited: she must choose to continue with the pregnancy or to abort. In contrast, parents using PGD can choose which of multiple embryos to implant, and may have a range of information about each embryo. Because the only options open to a pregnant woman would be abortion or taking her chances with another pregnancy, it seems unlikely that traditional prenatal screening techniques would ever be used to identify anything other than a relatively severe disability.²⁹ A couple that has to choose between multiple IVF embryos seems more likely to select against less severe disabilities — for example, color blindness or asthma — or even relatively trivial markers — sex, sexual orientation, or eye color — simply because a choice between embryos must be made.

C. The Current State of Prenatal Torts

Prenatal torts are a species of medical malpractice and generally fall into three categories. The labels have not been applied consistently by courts and commentators, but in this Note, “wrongful pregnancy” refers to a parental claim alleging the physician’s negligence caused the birth of an unplanned but healthy child; “wrongful birth” refers to a parental claim alleging the physician’s negligence caused the birth of a child with one or more disabilities; and “wrongful life” refers to a claim by a disabled infant alleging that, but for the physician’s negligence, “he would not have been born to suffer with an impaired body.”³⁰ All three require the plaintiff to establish the *prima facie* elements of negligence: duty, breach, proximate cause, and injury.³¹

1. Wrongful Pregnancy

A claim for wrongful pregnancy, or wrongful conception, arises from the birth of an unplanned but healthy child following the “negligent performance of a contraceptive device, sterilization proce-

29. Although prenatal screening to selectively abort based on sex has been a problem in some countries, it does not appear to be an issue in the United States. Botkin, *supra* note 8, at 281.

30. Gleitman v. Cosgrove, 227 A.2d 689, 692 (N.J. 1967). In fact, some courts have rejected the labels “wrongful life” and “wrongful birth” as unnecessarily confusing, and have instead analyzed such claims as part of general medical malpractice. *See, e.g.*, Garrison v. Med. Ctr. of Del. Inc., 581 A.2d 288, 290 (Del. 1990); Bader v. Johnson, 732 N.E.2d 1212, 1216 (Ind. 2000). The labels are, however, useful shorthand for identifying the nature of the claim, are used in most jurisdictions, and accordingly will be used in this paper.

31. *See, e.g.*, Coleman v. Dogra, 812 N.E.2d 332, 336 (Ohio 2004).

ture, or abortion.”³² Most jurisdictions permit a cause of action for wrongful pregnancy,³³ although there is continuing disagreement over the appropriate measure of damages.³⁴ In one early case, *Custodio v. Bauer*, the court allowed the plaintiffs to claim the cost of the unsuccessful operation and the cost of raising the child.³⁵ Today, however, the rule in most jurisdictions is that rearing costs are not recoverable.³⁶ Generally, parents can recover the cost of the unsuccessful procedure and costs flowing directly from pregnancy and birth.³⁷ Professor Wendy Hensel argues that this is because courts have been reluctant to characterize the life of a healthy child as an injury.³⁸

2. Wrongful Birth

Most jurisdictions allow parents to bring wrongful birth claims and seek damages from medical providers flowing from the birth of an impaired child.³⁹ Courts characterize the injury to parents not as the birth of an impaired child, but as the lost opportunity to make an “informed and meaningful decision either to abort the already existing and defective fetus . . . or to give birth to a potentially genetically defective child.”⁴⁰ Professor Hensel argues this is disingenuous because it is clear the “true injury” is the “impaired child,” but courts have

32. Fred Norton, Note, *Assisted Reproduction and the Frustration of Genetic Affinity: Interest, Injury, and Damages*, 74 N.Y.U. L. REV. 793, 821 (1999); see, e.g., Wilczynski v. Goodman, 391 N.E.2d 479 (Ill. App. Ct. 1979) (abortion); *Burke v. Rivo*, 551 N.E.2d 1 (Mass. 1990) (sterilization procedure).

33. Hensel, *supra* note 4, at 153 (“[T]hirty-one states and the District of Columbia recognize a cause of action against a medical professional for the unwanted birth of a healthy child.”); Michael T. Murtaugh, *Wrongful Birth: The Courts’ Dilemma in Determining a Remedy for a “Blessed Event,”* 27 PACE L. REV. 241, 277 (2007) (“Today, thirty-two jurisdictions in the United States provide a cause of action for the wrongful birth of a healthy child.”). The cause of action is seen as consistent with traditional medical malpractice actions because it is easy for the plaintiffs to show that, but for the physician’s negligence, the child would not have been conceived. See, e.g., Hensel, *supra* note 4, at 151.

34. See, e.g., *Burke*, 551 N.E.2d at 3 (“The great weight of authority permits the parents of a normal child born as a result of a physician’s negligence to recover damages directly associated with the birth . . . but courts are divided on whether the parents may recover the economic expense of rearing the child.”); Norton, *supra* note 32, at 824.

35. 59 Cal. Rptr. 463 (Cal. Ct. App. 1967).

36. Murtaugh, *supra* note 33, at 278 (stating that rearing costs are not recoverable in twenty-nine jurisdictions).

37. Murtaugh, *supra* note 33, at 280.

38. See Hensel, *supra* note 4, at 153–54.

39. *Id.* at 160 (noting that more than half of all jurisdictions have endorsed a wrongful birth cause of action).

40. *Siemieniec v. Lutheran Gen. Hosp.*, 512 N.E.2d 691, 703 (Ill. 1987); see also *Haymon v. Wilkerson*, 535 A.2d 880, 882 (D.C. 1987); *Coleman v. Dogra*, 812 N.E.2d 332, 337–38 (Ohio Ct. App. 2004) (describing the plaintiff’s alleged injury as “the denial of her right to make an informed choice about terminating her pregnancy”); Hensel, *supra* note 4, at 164–67.

simply found it more palatable to identify lost parental choice as the injury.⁴¹

Unlike a wrongful life claim, discussed in Part II.C.3 *infra*, a wrongful birth claim does not raise metaphysical questions in the damages assessment. The court in *Becker v. Schwartz* held that a wrongful birth claim identifies ascertainable damages: “the pecuniary expense which [the parents] have borne, and . . . must continue to bear, for the care and treatment of their infants.”⁴² Nevertheless, there continues to be substantial divergence on the measure of damages.⁴³ Most jurisdictions allow the parents to recover “only the increase in the costs of raising a child that are attributable to the child’s defects,” and not the general costs of raising a healthy child.⁴⁴

The jurisdictions in which wrongful birth suits are not recognized can be divided into two categories. Some states have enacted legislation to preclude claims for wrongful birth.⁴⁵ In other states, courts have refused to recognize wrongful birth as an available cause of action. Some courts have cited public policy objections, raising concerns that selective abortion is reminiscent of eugenics,⁴⁶ that the claim “involves placing a value on human life,”⁴⁷ or that courts would have to decide the difficult question of which genetic “defects” should warrant recovery.⁴⁸ Others have held that conventional tort concepts “clearly do not fit”⁴⁹ the wrongful birth context, and therefore it is for the legislature, rather than the judiciary, to make the decision to recognize claims for relief for wrongful birth.⁵⁰

41. Hensel, *supra* note 4, at 165; *see also* Diehr, *supra* note 3, at 1297–98.

42. 386 N.E.2d 807, 813 (N.Y. 1978).

43. *See* *Grubbs v. Barbourville Family Health Ctr.*, 120 S.W.3d 682, 690 (Ky. 2003); 62A AM. JUR. 2D *Prenatal Injuries* § 117 (2010).

44. 62A AM. JUR. 2D *Prenatal Injuries* § 117 (2010); *see also* Granchi, *supra* note 4, at 1279–80 (“The majority of courts . . . usually allow for recovery of damages measured by the ‘extraordinary cost’ of supporting the child with severe birth defects as compared to supporting a child that is not so afflicted. This means that no general damages are allowed . . .” (footnotes omitted)). Courts also diverge on whether damages for emotional distress are recoverable. *See* Caroline Crosby Owings, Note, *The Right to Recovery for Emotional Distress Arising from a Claim for Wrongful Birth*, 32 AM. J. TRIAL ADVOC. 143, 165–66 (2008) (explaining that courts in eighteen states, the District of Columbia, and two federal district courts applying state law have addressed the issue, and while ten of those states and the two federal courts have allowed recovery for emotional distress, the others have refused to allow it).

45. These statutes typically provide that no cause of action shall arise based on the claim that, “but for the act or omission of another, a person . . . would have been aborted.” Stephanie S. Gold, Note, *An Equality Approach to Wrongful Birth Statutes*, 65 FORDHAM L. REV. 1005, 1016 (1996) (quoting IDAHO CODE ANN. § 5-334 (1990)); *see also* Hensel, *supra* note 4, at 162 n.123 (listing the various state statutory provisions).

46. *Grubbs*, 120 S.W.3d at 690.

47. *Etkind v. Suarez*, 519 S.E.2d 210, 213–14 (Ga. 1999).

48. *Grubbs*, 120 S.W.3d at 690.

49. *Azzolino v. Dingfelder*, 337 S.E.2d 528, 537 (N.C. 1985).

50. *See Grubbs*, 120 S.W.3d at 689–90; *Azzolino*, 337 S.E.2d at 537.

3. Wrongful Life

A “wrongful life” cause of action arises out of the birth of a child with a genetic disability. The claim is that the negligence of the health care provider resulted in the birth of the impaired child but, unlike a wrongful birth or wrongful pregnancy claim, the plaintiff is the infant rather than his or her parents. The infant alleges that the physician was negligent in the provision of treatment or advice to his or her parents and seeks damages for burdens suffered as a result of his or her creation.⁵¹

In contrast to wrongful birth, the “overwhelming majority” of jurisdictions do not recognize wrongful life claims.⁵² This is for two reasons. First, courts have been reluctant to characterize the child as having suffered a legally cognizable injury, because the only alternative for that particular child was not being born at all.⁵³ This is essentially Derek Parfit’s “Non-Identity Problem”: because that child could never have existed without the disability, the child cannot have been harmed by being born unless the disability is so severe as to result in a life not worth living.⁵⁴ Wrongful life claims involve “the implicit claim that a child would prefer non-existence to existence in an impaired condition.”⁵⁵ In *Becker v. Schwartz*, one of the most frequently cited decisions in this area, the court held that the law can assert “no competence” to resolve the issue whether “it is better never to have been born at all than to have been born with even gross deficiencies.”⁵⁶ The second reason is that the purpose of tort compensation is to put the plaintiff in the position he would have been in if the defendant had not been negligent. Because the absence of negligence by the defendant would have resulted in the child not being born, the measure of damages would depend on a comparison “between the Hobson’s choice of life in an impaired state and nonexistence,” a comparison that “the law is not equipped to make.”⁵⁷

51. Seana Shiffrin, *Wrongful Life, Procreative Responsibility, and the Significance of Harm*, 5 LEGAL THEORY 117, 117 (1999).

52. *Siemieniec v. Lutheran Gen. Hosp.*, 512 N.E.2d 691, 696 (Ill. 1987); see also Botkin, *supra* note 8, at 270 (“To date, five state courts have recognized the wrongful life claim, while nineteen have rejected this tort.”); Hensel, *supra* note 4, at 161 (“With only three exceptions . . . courts have consistently rejected wrongful life actions.”).

53. *Siemieniec*, 512 N.E.2d at 697.

54. See Cohen, *supra* note 7, at 347–48 n.1 (citing DEREK PARFIT, REASONS AND PERSONS 359 (rev. ed. 1987)).

55. Botkin, *supra* note 8, at 270.

56. 386 N.E.2d 807, 812 (N.Y. 1978).

57. *Id.*; see also *Siemieniec*, 512 N.E.2d at 697; *Dumer v. St. Michael’s Hosp.*, 233 N.W.2d 372, 376 (Wis. 1975) (“This Court cannot weigh the value of life with impairments against the nonexistence of life itself. By asserting that he should not have been born, the infant plaintiff makes it logically impossible for a court to measure his alleged damages because of the impossibility of making the comparison required by compensatory reme-

A few jurisdictions, however, allow wrongful life claims.⁵⁸ According to Professor Jeffrey Botkin, these courts have been “willing largely to overlook the philosophical problems inherent in the claim” and have prioritized the medical needs of the child and the “public policy advantages of deterring negligent medical care.”⁵⁹ The jurisdictions that have recognized wrongful life claims have generally allowed the child to recover only the extraordinary medical and educational expenses associated with the impairment.⁶⁰ Unlike parents in wrongful birth claims, a child can claim expenses incurred over his or her lifetime rather than being limited to expenses incurred during his or her minority.⁶¹

III. APPLICATION OF PRENATAL TORTS TO PGD

For decades, courts have been hearing tort claims arising out of the use (or non-use) of established forms of prenatal screening. Some parents who make use of this newer form of prenatal screening will no doubt be disappointed with the results. It seems likely that, given high parental expectations and the expense of IVF and PGD,⁶² some of these disappointed parents will rely on existing prenatal torts and attempt to sue their health providers. A small handful of cases involving PGD have already been litigated, although none have resulted in a detailed consideration of how this body of case law applies to the particular facts of PGD.⁶³ The resulting decisions have not suggested that courts will analyze PGD claims any differently than claims involving more orthodox forms of prenatal screening and testing. This appears

dies.”). For a critique of this view of damages, see Michael B. Kelly, *The Rightful Position in “Wrongful Life” Actions*, 42 HASTINGS L.J. 505, 526–28 (1991).

58. See Cohen, *supra* note 7, at 347–48 n.1.

59. Botkin, *supra* note 8, at 270–71. California first recognized a wrongful life claim in *Curlender v. Bio-Science Laboratories*, 165 Cal. Rptr. 477 (Cal. Ct. App. 1980). The court was not concerned that, but for the defendant’s negligence, the child would not exist, finding that the reality of “wrongful life” claims is that the plaintiff “both exists and suffers, due to the negligence of others.” *Id.* at 488.

60. See, e.g., *Turpin v. Sortini*, 643 P.2d 954, 965 (Cal. 1982); *Procanik v. Cillo*, 478 A.2d 755, 756 (N.J. 1984); *Harbeson v. Parke-Davis*, 656 P.2d 483, 492 (Wash. 1983).

61. 62A AM. JUR. 2D *Prenatal Injuries* § 119 (2010). Supporters of a wrongful life cause of action point to this distinction as a reason to permit wrongful life claims. See Shiffrin, *supra* note 51, at 117 n.3.

62. One cycle of PGD, including IVF, can cost between \$12,500 and \$16,000. King, *supra* note 5, at 313.

63. See, e.g., *Bergero v. Univ. of S. Cal. Keck Sch. of Med.*, No. B200595, 2009 WL 946874 (Cal. Ct. App. Apr. 9, 2009); *Doe v. Ill. Masonic Med. Ctr.*, 696 N.E.2d 707 (Ill. App. Ct. 1998); *Doolan v. IVF America (MA), Inc.*, No. 993476, 2000 WL 33170944 (Mass. Super. Ct. Nov. 20, 2000); *Paretta v. Med. Offices for Human Reprod.*, 760 N.Y.S.2d 639 (N.Y. Sup. Ct. 2003); *Coggeshall v. Reprod. Endocrine Assoc. of Charlotte*, 655 S.E.2d 476 (S.C. 2007). The courts resolved several of these on procedural issues; only a few contain relevant analysis.

reasonable on first impression. Claims of PGD, pre-conception, and post-pregnancy negligence all share the same essential allegation that the negligence of the medical provider caused the parents to give birth to a child with severe disabilities. However, PGD differs from other forms of prenatal screening in some important respects. This section discusses a few of the ways in which courts might analyze PGD claims differently.

As discussed above, PGD can already be used to identify some non-health related characteristics such as sex, and the range of testable non-health characteristics will only increase over time. However, this Note focuses on therapeutic uses for several reasons. First, it seems likely that PGD will primarily be used — at least in the foreseeable future — to screen for severe heritable disabilities, because, for most people, only severe conditions will make the expense and effort involved in IVF and PGD worthwhile. Second, therapeutic uses of PGD are more likely to result in legal action. This is because parents of a severely disabled child face heavy financial burdens and have a greater incentive to seek damages than parents of a healthy child with particular genetic characteristics they sought to avoid.

A. Focusing on the Relevant Distinctions

This section outlines a few of the key distinctions between PGD and other forms of prenatal screening that are most likely to affect the legal analysis. First, PGD is newer, its use is less common than more established forms of screening, and there is greater uncertainty surrounding the procedure.

Second, whereas prenatal tort cases to date have involved either pre-conception or post-pregnancy negligence, cases arguing negligent use of PGD will turn on conduct that is post-conception, but pre-pregnancy. Most wrongful life and wrongful birth suits allege post-pregnancy negligence, such as negligent ultrasound or amniocentesis.⁶⁴ However, suits can also be based on pre-conception negligence, such as a physician's failure to warn the parents they were at risk of conceiving a child with genetic defects.⁶⁵ In a PGD case, the foundation of the suit will be the testing, selection, and implantation of the IVF embryo(s). Parents might also allege a negligent failure to advise

64. For examples of post-pregnancy negligence, see *Siemieniec v. Lutheran Gen. Hosp.*, 512 N.E.2d 691 (Ill. 1987) (post-pregnancy counseling sought for risk of hemophilia); *McKenney v. Jersey City Med. Ctr.*, 771 A.2d 1153 (N.J. 2001) (negligent failure to detect spina bifida during pregnancy screening).

65. For examples of pre-conception negligence, see *Turpin v. Sortini*, 643 P.2d 954 (Cal. 1982) (concerning an allegation that negligent genetic testing of older sibling influenced decision to conceive another child); *Molloy v. Meier*, 679 N.W.2d 711 (Minn. 2004).

that PGD is available, in which case the conduct in question will have occurred before conception.

Third, for the purposes of identifying injury and assessing damages, the counterfactual in a PGD case is slightly different than in cases concerning other forms of prenatal screening. From the infant's perspective, the counterfactual in a case of post-pregnancy negligence would be abortion — were it not for the doctor's negligence, that particular genetic identity would no longer exist. In a PGD context, however, the counterfactual for the child is less clear. Unwanted embryos are normally discarded, but might also be donated to science for research.⁶⁶ On the basis of current technology, it is unlikely that any undesired embryo could be donated to an infertile couple because the embryo must be tested and implanted within a 48-hour window.⁶⁷ From the parents' perspective, the counterfactual in a case of post-pregnancy negligence is abortion. The counterfactual in a case of pre-conception negligence is not conceiving. In a PGD context, however, the most likely counterfactual is that the parents would have given birth at the same time to a different child with the same genetic parents.⁶⁸

B. Duty and Breach

As a general rule, plaintiffs in prenatal cases have no difficulty establishing duty and breach, two essential elements of a tort action. It is well recognized that physicians and other health professionals owe duties of care to their patients.⁶⁹ Even in jurisdictions that do not recognize wrongful birth, courts accept that duty and breach are not difficult to establish.⁷⁰ Similarly, providers of PGD services owe duties of care to their patients.⁷¹ Whether or not that duty has been breached is a question of fact that will turn on evidence of the clinic's treatment of the plaintiff.

Establishing duty and breach may not be as straightforward for plaintiffs who claim that a defendant health care provider was negli-

66. King, *supra* note 5, at 291 n.27.

67. *Id.* at 290 n.25. If it became possible in the future for embryos to be refrozen after testing, unwanted embryos could also be donated to infertile couples (and brought to term). However, presumably this would not occur where an embryo with a severe genetic defect had been selected against.

68. It would be impossible to know with certainty whether, absent the negligence, another embryo would have successfully been implanted and been brought to term. If it were relevant to the analysis, significant expert evidence could be required.

69. *See, e.g.*, 61 AM. JUR. 2D *Physicians* § 185.

70. *See* Atlanta Obstetrics & Gynecology Grp. v. Abelson, 398 S.E.2d 557, 560 (Ga. 1990).

71. *See, e.g.*, Doolan v. IVF America (MA), Inc., No. 993476, 2000 WL 33170944 (Mass. Super. Ct. Nov. 20, 2000).

gent in failing to advise that PGD was an option. Perhaps unsurprisingly, given that PGD is a relatively new technique, it appears no court has yet recognized a duty on the part of physicians to inform patients about PGD. At least one plaintiff has argued that such a duty should exist.⁷² It is not impossible, however, that such a duty could be recognized in the future. Most traditional wrongful birth actions involve the misinterpretation of prenatal tests, but parents have also successfully pursued physicians for failing to advise that a particular post-pregnancy prenatal test was available.⁷³ By analogy, a court might one day find that the prevailing standard of care requires physicians or IVF providers to disclose, at least to at-risk patients, that PGD is an option.

C. Injury

1. Injury in Wrongful Birth Cases

If existing reasoning is extended, plaintiffs bringing a wrongful birth action in a PGD context might struggle to establish injury. As discussed above, courts in wrongful birth cases refrain from labeling the birth of a disabled child an “injury,” and instead characterize the injury as the lost opportunity to make an informed abortion decision.⁷⁴ But PGD does not implicate the abortion right — the claim would not be that, but for the provider’s negligence, the parents would have sought an abortion.⁷⁵ Rather, the claim would be that, but for the provider’s negligence, a different embryo would have been implanted and a different child born. What injury, then, would the parents have suffered? Analogies with wrongful pregnancy are unlikely to be helpful because a plaintiff in a PGD case clearly wanted to become pregnant.

While the nature of the injury suffered may seem elusive, it seems unlikely that courts would refuse to allow wrongful birth claims based on PGD while continuing to allow them in the case of post-pregnancy

72. See *Coggeshall v. Reprod. Endocrine Assoc. of Charlotte*, 655 S.E.2d 476, 478 (S.C. 2007). After going through IVF and giving birth to a baby with Down’s Syndrome, the plaintiffs sued their IVF provider “for failure to inform them of pre-implantation genetic testing.” *Id.* The court did not have to decide whether they had pled a viable cause of action because the defendants brought a successful jurisdictional challenge. *Id.* at 478–81. Similar lawsuits in the future seem inevitable.

73. See, e.g., *Reed v. Campagnolo*, 630 A.2d 1145 (Md. 1993) (finding cause of action where doctor allegedly failed to inform plaintiffs about existence of a diagnostic test that would detect neural tube defects); *Berman v. Allan*, 404 A.2d 8 (N.J. 1979) (finding cause of action where doctor allegedly failed to inform mother of availability of amniocentesis).

74. See *supra* notes 40–41 and accompanying text.

75. Of course, in any case involving PGD there may also be a claim that the defendant negligently failed to provide appropriate post-pregnancy screening. Standard wrongful birth principles would apply to the latter claim.

screening. The distinction between negligent genetic testing of an early *in utero* fetus and negligent genetic testing of an IVF embryo seems a tenuous basis on which to deny recovery. Furthermore, such a distinction theoretically encourages parents to abandon PGD and use the “trial and error” of abortion, which most people would see as a worse policy outcome.⁷⁶ It is also unclear why, as a matter of policy, there should be liability rules that encourage due care in post-pregnancy screening but not in IVF embryo screening.

However, if courts allow PGD claims, they will have to identify a legally cognizable injury. Courts will be loath to recognize the birth of an impaired child as an injury to the parents. That recognition would not only send a hurtful message to people living with disabilities, but would also be an embarrassing retreat from previous insistence that the injury relates to the abortion right and not the impaired child.⁷⁷ Without the abortion right to fall back on, courts will need to look elsewhere to find an injured interest.

The only other option seems to be for courts to say that the parents have lost the opportunity to determine some aspect of their progeny’s genetic make-up, and that this opportunity is part of a protected interest in reproductive autonomy. In the context of the debate over PGD regulation, several commentators have argued that the right to use PGD for at least some purposes falls within constitutionally protected reproductive rights.⁷⁸ This proposition has yet to be tested because PGD is virtually unregulated, so there has been no opportunity for a constitutional challenge. But if these commentators are correct, and there is a constitutional interest in determining the genetic make-up of children, the negligent thwarting of that interest will amount to a legally cognizable injury in the same way that a lost opportunity to abort is an injury in standard wrongful birth cases.⁷⁹

76. See, e.g., Robertson, *supra* note 24, at 156.

77. See, e.g., Hensel, *supra* note 4; Diehr, *supra* note 3.

78. See, e.g., King, *supra* note 5, at 341–53 (arguing that constitutional protection for reproductive autonomy encompasses at least some uses of PGD); Paonessa, *supra* note 14, at 355–56 (arguing that a ban on selecting embryos based on sexual orientation would be unconstitutional, because parents have “[a]n interest in access to genetic information material to the decision whether to procreate” and that “selection technology basically functions as a selective post-fertilization contraceptive”); John A. Robertson, *Assisting Reproduction, Choosing Genes, and the Scope of Reproductive Freedom*, 76 GEO. WASH. L. REV. 1490, 1508 (2008) (“[O]ur conceptions of reproductive liberty (liberty to engage in or avoid reproduction) extend logically to a wide swath of genetic control in reproductive decisions.”); John A. Robertson, *Procreative Liberty in the Era of Genomics*, 29 AM. J.L. & MED. 439, 460–68 (2003). But see, e.g., Ann MacLean Massie, *Regulating Choice: A Constitutional Law Response to Professor John A. Robertson’s Children of Choice*, 52 WASH. & LEE L. REV. 135 (1995).

79. See *supra* note 40 and accompanying text. Even if the interest is not constitutionally protected, parents might be seen as having a sufficiently compelling interest to warrant a finding of injury for tort purposes. In the tort context, Fred Norton has argued that parents should have a cause of action for the birth of a healthy child when donor gametes do not in

If there is any constitutional protection for PGD, further issues will arise over the extent of that protection. Will all uses of PGD be constitutionally protected? Or will such protection, and thus the availability of tort damages, be limited to the right to select against severe disabilities?⁸⁰ Courts would no doubt be reluctant to allow parents to sue because they had given birth to a girl rather than a boy. As Professor Michael Kelly has argued, such a claim intuitively “does not seem . . . valid,” and the “absence of a preferred trait does not cry out for judicial redress in the same way severe genetic defects do.”⁸¹ But if courts allow PGD claims to lie only in the case of severe disability, perhaps Professor Hensel is right that the real injury courts perceive is the birth of an impaired child. The injury is not lost parental choice because negligently-performed PGD causes a loss of parental choice even if PGD was sought for non-therapeutic purposes.⁸²

It is unlikely that any reproductive interest in screening IVF embryos will ever be as important as the right to seek an abortion. However, the argument that the negligent use of PGD interferes with parents’ reproductive autonomy is not implausible. Whatever the eventual result, PGD-based claims are likely to test wrongful birth reasoning.

2. Injury in Wrongful Life Cases

Wrongful life claims suffer from the non-identity problem: the difficulty of comparing life with non-existence.⁸³ But in the case of PGD, the comparison is not necessarily between impaired life and non-existence, but between impaired life and “existence” as a frozen embryo, assuming the embryo would not have been discarded. There might be some alternative state of existence that could, in theory, be the point of comparison for injury and damages. While this slightly different counterfactual might raise an interesting metaphysical question about existence, it is unlikely to make any difference to the legal analysis. The problem in both cases for the infant plaintiff is that his or her existence as a live human being was only possible with this

fact come from the advertised donor. See Norton, *supra* note 32. He argues that the birth of a healthy child can be an injury “because the decision to have a child implicates a complex hierarchy of subjective preferences.” *Id.* at 815. He further argues that the injury to the parents is “the invasion of the individual or familial interest in reproductive autonomy.” *Id.* at 826.

80. See *infra* Part III.E.

81. Kelly, *supra* note 57, at 564–65.

82. Hensel, *supra* note 4, at 143. “To label the injury in wrongful birth as lost choice in the abstract, however, is misleading and inaccurate. A close look at this tort makes clear that the impaired child, not the reproductive choice of the mother, is the true injury at stake.” *Id.* at 165.

83. See *supra* Part II.C.3.

genetic condition. Live human existence, rather than mere genetic existence, is required for legal personhood and the capacity to suffer injury.⁸⁴ One court has already rejected an attempt to distinguish PGD from other wrongful life cases on this basis. In *Doolan v. IVF America (MA), Inc.*, an infant plaintiff suffering from cystic fibrosis brought a claim against his parents' PGD provider.⁸⁵ The court rejected an attempt to distinguish PGD from the general wrongful life jurisprudence, noting that the same "fundamental problem of logic" existed: there was no way the infant "could ever have been born without cystic fibrosis."⁸⁶

D. Proximate Cause

The element of causation has proved to be particularly difficult. One of the reasons occasionally given for refusing to recognize wrongful birth claims is that "the physician cannot be said to have caused the defect" because "[t]he disorder is genetic and not the result of any injury negligently inflicted by the doctor."⁸⁷ In *Wilson v. Kuenzi*, the Supreme Court of Missouri commented that courts in jurisdictions that recognize wrongful birth "have either closed their eyes to traditional tort causation, or have leaped over causation."⁸⁸ But wrongful birth suits do not require the plaintiff to prove causation "in the sense that a physician's negligence caused the birth defect" but rather that "the defendant's negligence was a proximate cause of the parents being deprived of the option to have an elective abortion."⁸⁹ In jurisdictions that recognize wrongful birth, proximate cause requires a plaintiff to show she would have had an abortion had she known of the defect.⁹⁰

84. Although a cause of action may lie for injuries sustained *in utero*, the child must be born alive. See, e.g., *Kassama v. Magat*, 792 A.2d 1102, 1114–15 (Md. 2002); *Grp. Health Ass'n Inc. v. Blumenthal*, 453 A.2d 1198, 1206–07 (Md. 1983).

85. No. 993476, 2000 WL 33170944 (Mass. Super. Ct. Nov. 20, 2000).

86. *Id.* at *4 (internal quotation omitted).

87. *Becker v. Schwartz*, 386 N.E.2d 807, 816 (N.Y. 1978) (Wachtler, J., dissenting); see also *Grubbs v. Barbourville Family Health Ctr.*, 120 S.W.3d 682, 689–90 (Ky. 2003); *Diehr*, *supra* note 3, at 1298 (arguing that "'wrongful birth and wrongful life [suits] broaden the traditional element of proximate cause' almost beyond recognition" because "[t]he physician did not cause the child to have any genetic impairment").

88. 751 S.W.2d 741, 744 (Mo. 1988); see also *Atlanta Obstetrics & Gynecology Grp. v. Abelson*, 398 S.E.2d 557, 560 (Ga. 1990) (holding that traditional tort concepts do not authorize finding a doctor liable "for an impairment which the child [i.e. fetus] unquestionably inherited from her parents and an impairment which was already in existence when the parents first came into contact with the physician.").

89. *McKenney v. Jersey City Med. Ctr.*, 771 A.2d 1153, 1161 (N.J. 2001); see also *Greco v. United States*, 893 P.2d 345, 349 (Nev. 1995); *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 483, 483 (Wash. 1983).

90. See, e.g., *Canesi v. Wilson*, 730 A.2d 805, 818 (N.J. 1999).

The chain of causation is slightly different in a case involving PGD. A provider of PGD services is causally connected to the birth of a particular child in the sense that the provider selects and implants that child's genetic identity. In jurisdictions that recognize wrongful birth, issues may arise over whether the chain of causation is broken if parents learn during pregnancy that the fetus carries the defective gene but choose not to have an abortion. In jurisdictions where wrongful birth is not currently available, litigants may seek to distinguish PGD situations, and claim that there is a causal connection between the actions of a PGD provider and the genetic make-up of the resulting child.⁹¹ While a physician who negligently performs an amniocentesis is not responsible for that genetic identity becoming a fetus and thereby starting on the path to personhood, a provider of PGD chooses the genetic identity that will be gestated to term. Intuitively, the causal connection seems stronger because, without the provider's initial intervention, no fetus would exist. But this does not answer the essential objection noted above, because a PGD provider still does not cause any particular embryo to have a defective gene.

A stronger case for "causing" a genetic defect might exist where donated gametes are used. If a provider is responsible for selecting or screening donor gametes, it is difficult to say that the provider had no causal connection to the genetic make-up of the resulting child. This argument was, however, rejected in *Johnson v. Superior Court of Los Angeles County*, a California case involving a sperm donor with polycystic kidney disease.⁹² The infant argued that, in contrast with *Turpin v. Sortini*,⁹³ she should be entitled to claim general damages because the defendants had "caused the inherited abnormalities at issue" because of their approval of the sperm donor.⁹⁴ The court rejected this argument and held that the gene in the sperm, and not the defendants, had caused her condition, but acknowledged the "harshness" of the rule in *Turpin*.⁹⁵ The point should not be regarded as settled, however, because this reasoning is in tension with causation in other contexts. If a doctor negligently prescribes the wrong drug, he or she is still causally responsible for the consequences even though the technical cause of the injury is the chemical in the drug and not the doctor.

At least one court has already struggled with causation in the PGD context. In *Paretta v. Medical Offices for Human Reproduction*, the court considered claims brought in relation to a child born with

91. Note that if gene therapy were employed on IVF embryos, it would be very difficult to say that the PGD provider had not caused the genetic defect.

92. 124 Cal. Rptr. 2d 650 (Cal. Ct. App. 2002).

93. 643 P.2d 954 (Cal. 1982).

94. *Johnson*, 124 Cal. Rptr. 2d at 665.

95. *Id.* at 666.

cystic fibrosis who had been conceived using donated ova.⁹⁶ The plaintiffs alleged that the defendants should have conducted PGD to ascertain whether the embryo had genetic diseases. The court commented that the case was “unquestionably” distinguishable from other wrongful life claims. In earlier cases there was no suggestion that the physicians had caused the abnormalities in the child whereas here the plaintiffs argued that the defendants “were actually responsible for Theresa’s conception.”⁹⁷ However, the court dismissed the wrongful life claim without responding to the causation argument for the rather perplexing reason that the law should not recognize a distinction between children born “with the help of modern medical technology” and children conceived the old-fashioned way.⁹⁸ For the purposes of a negligence suit, there is a difference between naturally-conceived children and children born with the help of medical technology. In the latter case, potential parents have engaged medical professional services to avoid giving birth to a child with genetic defects. Medical professionals owe duties of care to their patients. The natural conception of a child with a genetic defect inherited from the parents does not involve negligence on anyone’s part.⁹⁹ The *Paretta* court could have reached the same result with different reasoning: the wrongful life claim could have been rejected for the standard reason that the alternative for the child was non-existence.¹⁰⁰ The fact that it did not might suggest a level of confusion or unfamiliarity with the issues.

E. Damages

In jurisdictions that presently allow wrongful birth claims, PGD might result in a different damages assessment. In standard wrongful birth claims, making the parents whole would require courts to determine the difference in expenses associated with having a disabled child as compared to having no child. However, this is not typically the measure of damages awarded. Most jurisdictions do not allow parents to recover “the expenses associated with the raising of a normal,

96. 760 N.Y.S.2d 639 (N.Y. Sup. Ct. 2003).

97. *Id.* at 645–46.

98. *See id.* at 646. Similarly, the parents’ claim for emotional distress damages was dismissed because the distress from watching a genetically diseased child suffer was considered to be the same regardless of the method of conception. *Id.* Although the court held that the emotional distress claim was not compensable, the court did permit the parents’ claim for pecuniary expenses relating to the child’s illness to proceed. *Id.* at 646–47.

99. This assumes that parents are not negligent if they conceive naturally despite knowing they are at risk for conceiving a genetically defective child.

100. Similarly, several jurisdictions deny emotional damages for wrongful birth. *See, e.g.,* Siemieniec v. Lutheran Gen. Hosp., 512 N.E.2d 691, 707–08 (Ill. 1987); *see also* Owings, *supra* note 44, at 175–80 (collecting cases). The *Paretta* court could have adopted the reasoning from one of these cases.

healthy child,” but allow only extraordinary expenses associated with the child’s genetic condition.¹⁰¹ There are a small number of jurisdictions that have held that a negligent defendant is responsible for all the “natural and probable consequences of his misconduct,” and accordingly can be held responsible for the entire cost of raising an impaired child.¹⁰² This approach would be difficult to sustain in a PGD-based claim, however, because absent the negligence of the provider, the probability is that the parents would have given birth to a healthy child and incurred all the normal costs of raising a child.¹⁰³ Damages in a PGD case would therefore have to be limited to the extraordinary expenses associated with impairment.

It would obviously be difficult for a plaintiff who had used PGD for entirely non-health related reasons, such as sex or eye color, to identify recoverable damages.¹⁰⁴ But for the negligence, the parents would likely have given birth to a different, but presumably still healthy, child.¹⁰⁵ In other words, but for the negligence, their financial position would be exactly the same. It might be possible to recover the cost of another round of IVF and PGD by analogizing to wrongful conception cases, which allow plaintiffs to recover the cost of a second attempt at sterilization.¹⁰⁶

101. See, e.g., *Siemieniec*, 512 N.E.2d at 706; *Azzolino v. Dingfelder*, 337 S.E.2d 528, 534 (N.C. 1985). This approach has been criticized for being inconsistent both by opponents of prenatal torts and by those who argue courts have not gone far enough. See, e.g., *Grubbs v. Barbourville Family Health Ctr.*, 120 S.W.3d 682, 690 (Ky. 2003); *Granchi*, *supra* note 4, at 1277–81; *Murtaugh*, *supra* note 33.

102. See *Murtaugh*, *supra* note 33, at 269–74 (quoting *Speck v. Finegold*, 439 A.2d 110, 117 (Pa. 1981)); see also *Robak v. United States*, 658 F.2d 471, 479 (7th Cir. 1981) (holding that damages “must include the costs of raising a normal child”); *Bader v. Johnson*, 732 N.E.2d 1212, 1220 (Ind. 2000) (refusing to “evaluate the type of damages that may be allowed in a claimed ‘wrongful birth’ action” because under Indiana law “all damages directly attributable to the wrong done are recoverable”).

103. See *supra* note 68 and accompanying text. However, there may be some cases in which the parents would not have implanted any embryos because they were all affected.

104. It is not, however, impossible to imagine a situation in which negligent non-therapeutic PGD could give rise to financial harm. Imagine, for example, a family trust which provided that the firstborn son in the next generation would stand to inherit a sum of money (this hypothetical was suggested to me by Harvard Law School Professor I. Glenn Cohen). If the provider knew this was why the parents were using sex selection, acted negligently, and the resulting child was the “wrong” gender, it is not impossible that parents could establish injury and foreseeable damages. There is also the possibility that if PGD was sought to produce a savior sibling, and it was negligently performed resulting in an infant with the “wrong” HLA type, the older sibling might have a cause of action. That is beyond the scope of this Note, but for a discussion of the potential for parents bringing savior sibling suits in the United Kingdom, see Victoria Chico, *Saviour Siblings: Trauma and Tort Law*, 14 MED. L. REV. 180 (2006); see also Roger Brownsword, *An Interest in Human Dignity as the Basis for Genomic Torts*, 42 WASHBURN L.J. 413, 432–40 (2003).

105. As noted above, there could be significant uncertainty here. See *Doolan v. IVF Am., Inc.*, No. 993476, 2000 WL 33170944, at *2 (Mass. Super. Ct. Nov. 20, 2000). In many cases, however, giving birth to a healthy child will be the most likely counterfactual, and in all cases would have been the parents’ intention.

106. See 62A AM. JUR. 2D *Prenatal Injuries* § 96, n.6 (2010).

F. Existence of Cause of Action

The fact that the counterfactual in a PGD case does not involve an abortion could, in some jurisdictions, influence whether a cause of action is even available. In states with legislative bans on wrongful birth claims, PGD cases are likely to be treated differently from other prenatal screening cases. The statutes typically provide that no cause of action shall arise based on the claim that, “but for the act or omission of another, a person . . . would have been aborted.”¹⁰⁷ In a PGD case, there is no claim that a fetus would have been aborted, and thus the bar will not apply.¹⁰⁸ By analogy, wrongful birth cases alleging *pre-conception* negligence have been allowed to proceed because there is no argument that the mother would have had an abortion.¹⁰⁹ State legislatures may, of course, amend these statutes to prohibit PGD-based claims as well.

In jurisdictions in which courts have refused to recognize wrongful birth actions, the different counterfactual might influence some judges to recognize a cause of action where PGD is involved. There is reason to suspect that some judges’ personal views on the moral legitimacy of abortion as an alternative have influenced them to reject wrongful birth claims. A plaintiff in a PGD case does not claim that, but for the defendant’s negligence, she would have had an abortion. Accordingly, to the extent that anti-abortion sentiment is influential in jurisdictions that do not recognize wrongful birth, we may see a different attitude towards PGD cases.¹¹⁰

The suspicion that some judges may be influenced by personal anti-abortion views is suggested by the use of emotive language in

107. Gold, *supra* note 45, at 1016 (quoting IDAHO CODE ANN. § 5-334 (1990)); *see also* Hensel, *supra* note 4, at 162 n.123.

108. The bar could only apply if a court interpreted the word “abortion” to include the destruction of an IVF embryo, which would be fairly tenuous as a matter of construction.

109. *See, e.g.,* Molloy v. Meier, 679 N.W.2d 711 (Minn. 2004). In *Molloy*, the parents alleged that negligent advice regarding the heritability of a condition suffered by the elder child caused them to conceive another child who suffered from the same genetic disorder. The statute was held not to apply because the mother was not claiming she would have had an abortion; rather, she was claiming she would not have conceived another child. Although the plaintiffs were pleading “wrongful conception,” because this case involved the birth of a child with a disability, rather than a healthy child following failed sterilization, this Note categorizes this as a wrongful birth claim.

110. Professor Hensel, a disability advocate, also sees the presence of abortion as the counterfactual as significant, but for a different reason. She draws an important distinction between pre-conception cases and other wrongful birth or wrongful life litigation, noting that “the anti-therapeutic message is actually amplified in the context of wrongful birth and wrongful life litigation.” She notes that the “causal inquiry is . . . not the prevention of a theoretical child with disabilities, but instead the active termination of a specific, identified fetus with impairments.” Hensel, *supra* note 4, at 176–77.

judicial decisions.¹¹¹ For example, in *Atlanta Obstetrics & Gynecology Group v. Abelson*, the dissenters challenged the majority to “look at pregnancy without the emotionalism that arises when termination of a pregnancy is discussed.”¹¹² In *Grubbs v. Barbourville Family Health Center*, the dissenter accused the majority of “inappropriately volunteer[ing] personal opinions regarding the morality of the choices that [the plaintiffs] say they would have made if their physicians had fully informed them.”¹¹³

A series of decisions by the North Carolina Supreme Court also suggests that anti-abortion sentiment affects the legal analysis in these cases. In *Azzolino v. Dingfelder*, the court refused to recognize a wrongful birth claim in a case of post-pregnancy negligence.¹¹⁴ But in *McAllister v. Ha*, the court allowed a claim of *pre-conception* negligence resulting in the birth of a genetically defective child to go to trial.¹¹⁵ The plaintiffs, who had an older child with sickle cell disease, alleged the physician’s negligent advice regarding the heritability of sickle cell disease caused them to conceive another child, who also suffered from the disease. The court distinguished *Azzolino* on the basis that the complaint did not allege that the son’s “very existence” was an injury for which they should be compensated.¹¹⁶ Rather, the injury was that the plaintiffs were “unable to make an informed choice regarding whether to conceive another child.”¹¹⁷

The only plausible explanation for the different results is a judicial reluctance to accept abortion as a legitimate alternative. It is otherwise unclear why the child’s “very existence” could have been the injury in *Azzolino* but not in *McAllister*, when both claims asserted that the physician’s negligence had a causal connection to the birth and “very existence” of the child. The right to make an informed choice whether to conceive and the right to make an informed choice whether to have an abortion are both constitutionally protected rights. Therefore, it is difficult to see why the former can be the basis of a suit when the latter cannot. Although *McAllister* analogized the claim to a wrongful pregnancy claim,¹¹⁸ the case is distinguishable because wrongful pregnancy cases involve plaintiffs who seek to avoid pregnancy altogether. As with wrongful birth cases involving post-

111. See, e.g., *Grubbs v. Barbourville Family Health Ctr.*, 120 S.W.3d 682, 692 (Ky. 2003) (comparing the decision to abort a deformed fetus with Nazi eugenics); *Azzolino v. Dingfelder*, 337 S.E.2d 528, 535 (N.C. 1985) (citing an anecdote suggesting that prenatal screening and abortion would have led to the abortion of Beethoven).

112. 398 S.E.2d 557, 564 (Ga. 1990).

113. 120 S.W.3d at 699.

114. 337 S.E.2d 528 (N.C. 1985).

115. 496 S.E.2d 577 (N.C. 1998).

116. *Id.* at 582.

117. *Id.*

118. *Id.*

pregnancy negligence, these plaintiffs wanted a child; they just wanted to avoid having a disabled child. This is why other jurisdictions characterize pre-conception negligence that causes conception and birth of a disabled child as a wrongful birth claim.¹¹⁹ Further, the court's stated (non-abortion related) reasons for rejecting the claim in *Azzolino* applied equally in *McAllister* but appeared to receive no consideration.¹²⁰

As in *McAllister*, the abortion influence will not normally be present in the PGD context. However, the alternative in a PGD case will generally be that that child would have been destroyed as an embryo, which should be equally problematic for those who believe that life begins at conception. It seems, however, that many people who object to abortion feel quite differently about IVF embryos. In particular, the numerous efforts of state legislatures to place hurdles in the way of getting an abortion¹²¹ stand in stark contrast to comparative legislative silence surrounding IVF.¹²² If it is the case that some courts resist wrongful birth claims because the counterfactual is abortion, wrongful birth claims involving PGD might have some chance of success.

IV. ROLE OF COURTS

Calls for regulation of PGD raise, in addition to medical and ethical controversies, an institutional controversy: who should decide these difficult questions? Typically, three decision-makers are discussed: the government, the medical profession, and individuals.¹²³ Courts as decision-makers attract less attention, and what attention they do attract tends to relate to hypothetical constitutional challenges. In the event of state or federal government regulation of PGD, courts would have an obvious role to play, and could potentially have a significant impact on PGD policy. Judicial involvement could arise as a result of litigation involving interpretation of, or constitutional challenges to, such regulation. But even without regulation, courts will be

119. See, e.g., *Turpin v. Sortini*, 643 P.2d 954 (Cal. 1982).

120. The *Azzolino* court's stated reasons included the difficulty of applying traditional tort concepts, the fact that other jurisdictions had struggled over the issue of damages, and the difficulty of delineating which defects are so severe that parents should be able to recover. *Azzolino v. Dingfelder*, 337 S.E.2d 528, 536 (N.C. 1985).

121. For a description of existing restrictions, which include restricted funding, parental notification requirements, mandatory waiting periods, mandatory counseling, and conscience clauses for doctors, see Julia Lichtman, Note, *Restrictive State Abortion Laws: Today's Most Powerful Conscience Clause*, 10 GEO. J. ON POVERTY L. & POL'Y 345 (2003).

122. But see King, *supra* note 5, at 330 n.238 ("Louisiana prohibits any person from destroying a fertilized human ovum, unless that ovum fails to develop after thirty six hours." (quoting LA. REV. STAT. ANN. § 9:129 (2000))). No other state appears to have similar legislation.

123. See, e.g., *Regulating Preimplantation Genetic Diagnosis*, *supra* note 28, at 2772-77.

forced to engage with issues arising out of the use of PGD because of tort litigation.

Through developing liability rules, courts have the ability to influence the behavior of physicians and IVF clinics, and thus affect the use and uptake of PGD. As discussed above, it is possible that the standard of care may one day be held to require physicians to inform at least some patients about PGD.¹²⁴ Such a duty could have a huge impact on the use of PGD.¹²⁵ If more people are advised about PGD and how it might benefit them, it is logical to assume that more people will use it. Furthermore, if parents are directed to PGD providers to screen for particular health risks, one might expect to see greater use of PGD for non-health purposes as well. If diagnostic testing becomes more sophisticated, and multiple characteristics can easily be screened, parents who are motivated to use PGD for a particular health issue might be inclined to screen for preferred non-health traits at the same time, even though that alone would not have motivated them to use PGD.¹²⁶

Courts have the ability to affect PGD policy through tort litigation, not only because malpractice rules affect behavior, but because judicial opinions can influence policy development. As this Note argues above, PGD tort cases may require courts to consider whether there is any constitutional protection for PGD.¹²⁷ A judicial opinion on whether or not there is a constitutionally protected interest in controlling the genetic characteristics of children could, in turn, influence political appetite for PGD regulation.¹²⁸

124. See *supra* Part III.B.

125. The “ability of the tort system to effectively regulate the fertility industry is much debated.” JUDITH F. DAAR, REPRODUCTIVE TECHNOLOGIES AND THE LAW 692–93 (2006); see also, e.g., Hensel, *supra* note 4, at 191 (arguing that “it is impossible to draw meaningful conclusions on the deterrent effects of” prenatal torts); Urska Velikonja, Note, *The Costs of Multiple Gestation Pregnancies in Assisted Reproduction*, 32 HARV. J.L. & GENDER 463, 493 (2009) (arguing that malpractice liability is particularly unlikely to affect practices in ART because infertility patients are “even less likely to sue, and to prevail, than malpractice claimants in general”). However, many commentators agree that malpractice rules affect physician behavior by encouraging defensive medicine. See, e.g., Katz & Schweitzer, *supra* note 3, at 116 (arguing that wrongful birth suits have set “new standards for obstetricians and their insurance companies, paving the way for widespread adoption of genetic testing for embryo selection”).

126. See King, *supra* note 5, at 298–301 (describing the future capabilities of PGD).

127. See *supra* Part III.C.

128. States have failed to regulate PGD, and so there is little prospect of a constitutional challenge. This may mean that the first time courts meaningfully consider the nature of a parent’s interest in PGD will be in the context of a tort suit.

V. CONCLUSION

Claims alleging negligent use or non-use of PGD will no doubt continue to be brought, but it is dangerous to assume that existing prenatal tort reasoning applies equally to PGD cases. Some of the features of PGD differ from other forms of prenatal screening in ways that are relevant to the analysis. Indeed, the difficulties that are likely to arise in establishing injury in a PGD case may force courts to re-examine their reasoning in traditional prenatal tort cases.

While the political branches of government have, to date, largely avoided confronting many of the issues surrounding the use of PGD, courts will not have that luxury. Courts have no option but to decide claims for wrongful birth and wrongful life, and are therefore an inevitable part of the regulatory landscape surrounding PGD. Reproductive technologies have raised difficult legal questions in a number of fields, and PGD tort suits will add to that list.¹²⁹ Once again, judges will be required to negotiate a technically complex and ethically controversial area with little legislative guidance.

129. *See, e.g.*, *Woodward v. Comm'r of Soc. Sec.*, 760 N.E.2d 257, 272 (Mass. 2002) (dispute over intestacy rights of posthumously conceived children); *J.B. v. M.B.*, 783 A.2d 707, 715 (N.J. 2001) (custody dispute over frozen pre-embryos); *Kass v. Kass*, 696 N.E.2d 174, 178 (N.Y. 1998) (same).