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Living ART

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Living ART

Jaime Staples King, Ph.D. *

No matter how much you study, you never fully understand something until you live it. My husband, James, and I, after a year and a half of monthly failures punctuated by specialist visits, invasive tests, daily drinks of disgusting herbs, and acupuncture needles in my ears, toes and hands, decided to venture into the world of *in vitro* fertilization (IVF). Sure I'd heard the horror stories about assisted reproduction—endless injections, hormonal mood swings, depression, pain, and isolation followed by more disappointment. But, I had something others did not—a working knowledge of the advances in assisted reproductive technology (ART), informed consent law, and bioethics. Having just recently graduated from a Ph.D. program at Harvard that focused on health policy and ethics, I had spent the last five years researching both the flaws in our current informed consent system and the risks associated with IVF as part of my dissertation.[1] I had interviewed Ob/Gyns, shadowed clinicians at leading fertility centers, and read all the latest studies. It seemed like some form of ironic justice that I would walk in the shoes of the women I'd studied.

It began simply enough. We scheduled a consultation at a local fertility clinic that had both high success rates for women aged thirty-two to thirty-five and a strong reputation among local providers. I'd done my homework. The Centers for Disease Control and Prevention (CDC) requires all fertility clinics to report their success rates annually, and posts them on their website grouped by age and whether the cycle was with a fresh or frozen embryo.[2] The Bay Area had many ART clinics with high

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* This article is dedicated to my husband, James, who lived the whole ART experience with me and has always been the most supportive husband and friend I could ever ask for, and to Otis Henry Hazard King, the light of both our lives. This article is drafted from James' and my memories of these events and from my medical record. Any errors are my own.

[1] Jaime S. King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J. L. & MED. 429 (2006); Jaime King, *Predicting Probability: Regulating the Future of Preimplantation Genetic Screening*, 8 YALE J. HEALTH POL'Y L. & ETHICS 283 (2008).

[2] *Annual ART Success Rates Reports*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/art/artreports.htm (last updated Aug. 29, 2011); *Fertility Clinic Reports*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://apps.nccd.cdc.gov/art/Apps/Fertility Clinic Report.aspx (last updated Jan. 26, 2011).

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success rates, so I called the contacts I'd made in my doctoral research for recommendations. The results were unanimous—San Francisco Bay Fertility Center (SFBFC)[3] was the place to go. I was warned that it was a bit of a "baby factory," but if I wanted results, it was my best bet.

My research demonstrated that the success rates for various procedures fluctuated significantly from clinic to clinic, so I knew I wanted the most experienced clinicians with proven success. I also felt that James and I could overcome any of the coldness associated with a "baby factory." We had already thought a lot about many of the risks and benefits of different aspects of IVF, which I thought would enable us to engage in a more meaningful dialogue with our provider about the choices we faced. So much so, that I daydreamed about our provider taking interest in my research and being a possible collaborator for future projects. I thought we were on equal footing. We were different IVF patients, and thoroughly expected to be treated as such.

On the day of our initial consultation, James and I walked hand in hand through the cold winter air brimming with both expectation and resignation. As the elevator doors opened to SFBFC's offices, a white wall with molded plaster waves illuminated the silver lettering of the clinic's name above an enormous vase of fresh white calla lilies. The waiting area oozed success with its sterile high-end modern design and floor-to-ceiling views of the bay. A similarly cold but attractive receptionist checked us in and asked us to fill out the pages and pages of medical history forms that we had become so accustomed to during prior eighteen months. I smiled at James, "They are doing well for themselves aren't they?" He gave me a bittersweet smile that betrayed both hope that their success would become our own and disdain at the thought that the money we had scrimped and saved would go towards such lavish décor.

After several minutes, we were called back to Dr. Parker's office. He gave us a warm welcome and sat down behind his desk with an air of confidence and a quick smile. I immediately wanted him to like us. "I've reviewed your file, and I think this is going to be easy. We will make quick work of you two." Elation spread across my face. He explained that we each had small challenges that in combination created a larger problem. Through use of hormones for me and a technique known as intracytoplasmic spermatozoa injection (ICSI), in which a tiny needle is used to inject one sperm into each harvested egg, we could ensure fertilization. I nodded knowingly and enthusiastically. We then discussed the general process: daily injections of Lupron, Ganirelix, and Follistim for twelve days to stimulate my ovaries to develop multiple egg follicles at once, then on day fourteen, James would give me a shot of human

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[3] Both the name of the clinic and the provider have been changed.

chorionic gonadotropin (hCG) to prepare the follicles for egg harvest. The egg harvest itself would consist of my being put under general anesthesia and a minor surgical procedure to remove the eggs. Finally, my eggs would be fertilized through ICSI. After growing in culture for five days, the best looking embryo would be transferred into my uterus in hopes of producing a pregnancy. I knew all of this. James knew all of this, as he'd been forced to read draft after draft of my dissertation and listen to countless practice job talks. God bless him. Nonetheless, we were happy to have it explained again to us in the context of our own medical situation.

Dr. Parker then asked us if we had questions. We did. We wanted to know about side effects of the drugs that I would be taking, both short and long term, and we wanted to know Dr. Parker's thoughts on how many embryos to transfer. He gave a very standard answer regarding the side effects of the drugs—most women have some negative effects that go away after the treatments, and while there were not extensive studies on the long-term risks of these treatments, generally women fared well. He also explained the small risk of ovarian hyperstimulation syndrome. I had hoped he would offer additional information on the long-term risks, but accepted his answer, as it generally reflected my prior research findings. Nobody knew what the long-term risks were. I put that out of my mind.

While we were mildly concerned about the risks to me (rightly or wrongly), we were much more concerned about the implications of a multiple gestation and a multiple birth.[4] My concerns stemmed from the extensive evidence in the literature regarding the risks to the child associated with multiple gestation. Multiples risk prematurity, which is associated with respiratory distress syndrome, intracranial hemorrhage, cerebral palsy, and blindness, as well as higher risks of physical, mental, and developmental disabilities and death.[5] Further, one study found that the risk of perinatal death nearly quadrupled for IVF multiples in comparison to naturally conceived infants, and that IVF multiples were significantly more likely to require hospitalization beyond seven days and spend time in the NICU.[6] James shared these concerns. But given that we were paying out of pocket for IVF with our entire life savings, he also had

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[4] I strongly believe that each couple must evaluate their own medical, financial, and personal situation in determining how many embryos to transfer. Our preferences were simply that, our preferences. Other couples can and do weigh the risks and benefits in significantly different ways, and this narrative is in no way meant to be a criticism of others' choices.

[5] Tarun Jain et al., *Insurance Coverage and Outcomes of In Vitro Fertilization*, 347 N. ENG. J. MED. 661, 665 (2002).

[6] Reija Klemetti et al., *Health of Children Born as a Result of In Vitro Fertilization*, 118 PEDIATRICS 1819, 1822 (2006). Klemetti et al. found that, when compared with naturally concieved infants, nearly half of IVF infants born from multiple births required hospitalization beyond seven days (47.4% vs. 6.4%) and treatment in the NICU (42.1% vs. 8.2%).

significant misgivings about the financial implications of twins or triplets on our comfortable, but not too-comfortable lifestyle. Childcare alone for twins would be the equivalent of doing two to three rounds of IVF every year. Further, James knew that I loved my job and that twins might stretch to the breaking point my ability to be the mother and the professor I wanted to be. We both also knew that pregnancy reduction was not an option that we were willing to consider, despite the increasing number of women who were electing to reduce their ART pregnancies down to one fetus when faced with the full implications of a twin or higher gestation.[7] We did not share these concerns with Dr. Parker and he did not ask. He simply said, "You two are perfect candidates for a single embryo transfer. You are young, healthy, and have not had any prior miscarriages. I don't think there will be a need to transfer more than one." And that was it.

We were thrilled. Here was a clinician who understood that many couples would prefer to transfer one embryo multiple times, rather than up the odds of success on the first try and increase the physical, emotional and financial risks associated with a multiple birth. He got us, without even asking.

The next few weeks went pretty smoothly, all things considered. I went to classes at SFBFC to learn how to self-administer an injection and explain all of the drugs I would be taking. We were given both a procedural advisor[8] and a financial advisor with whom we had phone consultations and could call at any time with questions. I received an enormous binder of materials to serve as a reference in case I could not immediately get in touch with my procedural advisor. I was overwhelmed with information, but happily so. I read everything they gave me and double-checked it against my research. I noted that there was a surprising lack of information on the risks of multiple births and how to decide how many embryos to transfer, but felt relieved that I was a lucky "single embryo transfer" patient.

At what was supposedly my last visit to SFBFC prior to starting my treatments, Dr. Parker had given me an ultrasound and some blood tests. He remarked that unless something went wrong, I should plan to start my injections in a couple of days, as detailed on my SFBFC schedule. Later that day, a nurse called to tell me that I would not start my injections on Monday, but rather, I would need to do another two weeks of birth control pills to regulate my cycle. I was devastated and confused. "What had gone

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[7] For a detailed description of twin reduction, *see* Ruth Pawader, *The Two-Minus-One Pregnancy*, N.Y. TIMES, Aug. 14, 2011, (Magazine) at MM2, *available at* http://www.nytimes.com/2011/08/14/magazine/the-two-minus-one-pregnancy.html.

[8] The procedural advisor was there to answer questions and instruct me on all aspects of the IVF process, including how to order and store medications, perform the injections, and keep a calendar of times and dates when each step of the process needed to be performed.

wrong?" I asked. The nurse replied, "Dr. Parker felt that two more weeks would be best." I hung up the phone upset and unsure what had occurred. I then called back and left a message for Dr. Parker inquiring as to why he had changed my protocol. Two days went by without a response. I called again. My procedural advisor called me back and explained to me again that I would need to take birth control pills for two more weeks. When I pressed her as to why, she transferred me to a nurse. Confronted with my questions, the nurse replied with answers that revealed a lack of knowledge regarding both my current situation and my basic patient history. I felt that she just wanted to tell me something that would encourage me to comply and stop pestering them with questions. I was outraged and scared. What was wrong with me? Was I not an "easy" case? Would we lose all of our savings and still not have a child? I became flooded with anxiety about why a nurse would give me such unhelpful, generic answers.

I called again and left Dr. Parker another message. When my call was returned the next day by another nurse, I could no longer contain my frustration. "I am not looking to talk to you or anyone else other than Dr. Parker about why he changed my protocol. We are paying tens of thousands of dollars; the least he could do is return my phone call to explain to me what went so wrong that he changed my protocol." I had become the cliché IVF patient—emotional, needy, and desperate for answers—and I hated myself for it. I waffled between anger at the clinic and anger at myself for lashing out.

When Dr. Parker finally called, he too was clearly frustrated. "How can I help you Mrs. King?" he half-sighed, half-complained, as if he were so tired of dealing with people like me. I apologized for bothering him, and then tried to clearly and logically lay out my questions regarding the change to my protocol. He then nonchalantly gave me a quick answer for why he'd changed the protocol, informed me that nothing was wrong, and in the future if I had questions, I should just "grab him and shake him," because sometimes he was just hard to pin down. He then said he'd see me at my next appointment and hung up.

So nothing was wrong. We were moving forward as planned, just on a new schedule. I was simultaneously unimpressed and amazed at Dr. Parker's lack of communication skills and the lengths I had to go to in order to speak to him on the phone. But I also felt a strong need to rectify our relationship and be a "good patient" the next time he saw me. And by "good," I mean compliant. I really wanted all of the staff at SFBFC to be pulling for us. I could keep my mouth shut and get on board with the program. I'd read about patients who did not want to upset their doctors by questioning their decisions or not taking their advice. I just never thought I would dedicate myself so wholly to being one of them, especially not in IVF, something I knew a lot about. But, I did.

When it finally came time to start my injections, my anxiety turned to how the drugs would make me feel, as I had always been extremely sensitive to hormone fluctuations. At the same time, a large part of me was excited that we were finally moving forward. Steeling myself against the effects of the drugs, I spent most of my time trying to make sure everything appeared normal on the outside. Was I overreacting to things? Too emotional? Too distracted?

Thankfully, this part of the IVF process went quickly and easily. I had very few reactions to the drugs. I learned how to give myself the shots in a way that minimized the discomfort and was able to keep to my obligations as if nothing was really happening. My interactions with Dr. Parker were fairly limited and I made a point to do what was asked of me with little to no questions or objections. Luckily, I was able to schedule the egg retrieval surgery after my morning class. The procedure went quickly and easily, with minimal pain in recovery. I produced thirteen eggs, nine of which were successfully fertilized through ICSI. Hooray! All reports were positive. While I'd been a fertility failure before, I was beginning to feel like an IVF natural.

Five days after the egg retrieval, feeling hopeful if not confident, James and I went back to SFBFC for the big day—our embryo transfer. In comparison to the shots and the surgery, the embryo transfer seemed like a piece of cake. We checked in at the front desk and Dr. Parker met us there. He was looking at our chart. I said, "How do they look, Doc?" trying to keep the mood light and jovial. He gave me a more serious look and said, "Well, your embryos haven't developed as well as I would have liked. They are underdeveloped. You have no blastocysts. You have one grade I early blastocyst and one grade II early blastocyst. The rest are still in the morula stage and are not fit for transfer. We will give them one more day to see if they will progress to a blastocyst and can be frozen."

"What does that mean?" I asked, as all of the blood drained out of my face and my brain screamed, "And why are we just finding this out now?"

"It means we should transfer two embryos to give you the best odds of getting pregnant. That okay?"

I was frozen. This was minutes before my transfer. Where was informed consent? Where was the discussion of the risks and benefits and alternatives I'd beaten in to my students' heads time and again? I knew of the risks, but would another couple in our situation? I turned to James who looked as taken aback as I was. Dr. Parker tapped his pen.

"How underdeveloped is underdeveloped?" I blurted out. "What are their chances?"

Dr. Parker replied, "I've definitely seen embryos of this quality survive, but it's not what I'd hoped. I think it is best to transfer two."

My mind raced. I really did not want to expose my children to the risks of a multiple gestation, if I could help it, especially not for the sake of my convenience. But I had already been "difficult" over a simple issue and Dr. Parker clearly thought this was the right thing to do. Hadn't I learned my lesson? I felt that I had to make an instant decision. He was the expert. I was just a law professor who liked to read medical journals. I said, "If that's what you think is best, then I guess that's ok with me."

I turned to James and said "What do you think?" He replied, "It's your call, but I'm ok with transferring two, if that's what Dr. Parker thinks we should do." His hesitation was palpable.

Dr. Parker said, "Great. Janine, please take them in to room five for their transfer."

After the transfer, we went home, grinning, nervous and conflicted. We just kept saying "Crazy." "Crazy." "Crazy."

Over the next week, I fully embraced the idea of twins — how could I possibly not want both embryos to survive? I put any thought of the potential problems that could arise for them and for myself out of my head and just hoped for the best. James just hoped that we would be pregnant, but said little else.

Ten days after the transfer, I went back into SFBFC for the first of two blood tests that would determine our fate. My hCG[9] levels strongly confirmed that at least one embryo had implanted. I then had to wait forty-eight hours to see if the hCG levels would continue to increase. They did. And they did at such a rate that the clinicians surmised that we either had one very strong embryo or twins. Only time would tell.

During the next two weeks, James and I thought a lot about twins, and how we'd gotten into this situation. I continued to pray for both embryos to survive, but I wondered about myself. Why had I made a decision that I knew was against my personal preferences and values? Was I prepared to be their mother, if I could not even assert myself for their wellbeing the first time I was given a chance? Why hadn't I been stronger in that moment? Surely another potential mother would have been, but what if she had not known the risks, as I had? Dr. Parker certainly did not discuss them with us while we were standing at the intake counter, nor did he have any reason to suspect we knew them. Even if the risks associated with multiple gestations had been disclosed at the beginning of our IVF process, it would not have changed the helplessness we felt in that moment. We were informed, but our experience certainly did not constitute an ideal form of medical decision-making.

My mind began to think about how law and ethics could improve this process. Four oft-cited principles guide biomedical ethics: respect for patient autonomy, beneficence, non-maleficence, and justice.[10] In general

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[9] hCG is a hormone made by the developing embryo following implantation into the uterus. hCG levels can be measured in blood and urine to test for pregnancy.

[10] TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 12

medical practice, these principles often conflict with one another, requiring a physician to balance the competing goals. With respect to informed consent, physicians must balance their obligation to act with beneficence[11] with their obligation to respect the patient's autonomy.[12] In the last thirty years, medical ethics, which used to encourage physicians to focus on beneficence and improving patient health, has shifted to prioritizing a more subjective and "patient-centered" practice, which advocates more strongly for patient's autonomy in medical decision-making.[13] While this shift toward autonomy is well-documented in the literature and ethical guidelines, most physicians have yet to strike the ideal balance between autonomy and beneficence.[14]

In the case of IVF, the situation becomes even more muddled, because the patient's goal of becoming pregnant also competes with her own health and well-being. Jody Madiera has argued that depictions of infertile women as "desperate and obsessed" cause providers and other entities, including legal scholars and judges, to underestimate their ability to make autonomous choices.[15] At SFBFC, there seemed to be an expectation that the only goal was a viable pregnancy, regardless of the emotional, physical, and financial costs. Ironically in our case, it seemed that it was the providers who had lost sight of the possibility that a patient could have multiple priorities in the course of an IVF cycle.

For providers, all the incentives align. They have a strong motivation to value a viable pregnancy over other health concerns, as they must report their success rates to the CDC for publication to an Internet-savvy and information-hungry patient population. Further, many patients, like us, opt for a payment plan that offers two or three rounds of IVF and all subsequent transfers of frozen embryos for a fixed price. The clinic's obligation concludes when a pregnancy successfully survives beyond the first trimester, placing a high financial incentive on a successful pregnancy in the first round. Therefore, a twin or triplet pregnancy is a medical, and often a financial success for providers. They rarely encounter the patient or

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(6th ed. 2009).

[11] BEAUCHAMP & CHILDRESS, *supra* note 10, at 207. The principle of beneficence obligates physicians to act for the benefit of their patients' health.

[12] *Id.*; Onora O'Neill, AUTONOMY AND TRUST IN BIOETHICS 39 (2002). Respect for autonomy ensures an individual's ability to make and carry out informed medical decisions that arise from unbiased and thoughtful deliberation. King & Moulton, *supra* note 1, at 435; Rebecca Kukla, *Conscientious Autonomy: Displacing Decisions in Health Care*, HASTINGS CENTER REP., Mar.–Apr. 2005, at 34, 35.

[13] Mark Sullivan, *The New Subjective Medicine: Taking the Patient's Point of View on Health Care and Health*, 56 SOC. SCI. & MED. 1595, 1595 (2003).

[14] Benjamin Moulton & Jaime S. King, *Aligning Ethics with Medical Decision-Making: The Quest for Informed Patient Choice*, 38 J. L. MED. & ETHICS 85, 85 (2010).

[15] Jody Madiera, *Woman Scorned? Resurrecting Infertile Women's Decision-Making Autonomy*, 71 MD. L. REV. (forthcoming Feb. 2012) (manuscript at 7) (on file with author).

the children after the first trimester. They don't witness the months spent on bed rest, gestational diabetes, C-sections, or developmental delays. Those experiences are for someone else.

In defense of Dr. Parker, no financial or reputational incentive caused our embryos to be underdeveloped, and he did not force us to transfer two. He simply gave us his medical opinion. We made an irrational choice, given our personal values and preferences, to engage in unnecessarily risky behavior not because we were desperate to have a child, but because we were not given the opportunity to discuss our options and make a reasoned decision. In that moment, we did not understand the clinical implications of our embryos' under-development and we were not given the chance to discuss those implications in light of our preferences. So we did what so many others do in the face of medical uncertainty and time pressure—we defaulted to Dr. Parker's advice.

California law requires medical providers to disclose to the patient "all material information—that is, 'information which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject a recommended medical procedure'—needed to make an informed decision regarding proposed treatment."[16] But just simply informing patients of the risks of a treatment option is not enough to ensure, or even encourage, informed medical decision-making. Whenever they possibly can, ART providers need to give patients both information on the risks, benefits, and alternatives to their recommended treatment options, as well as the opportunity to consider and discuss the treatment choice in a nonjudgmental way. IVF patients, like all patients, need time and space to consider their values and their overarching goals and how each treatment option would fit those goals.

The law can and should do more to ensure that patients not only have the information they need to make medical decisions, but that they also have the opportunity to discuss their preferences and values with providers in the course of determining the best treatment outcome. To do so, states should move from an information-disclosure model of informed consent to requiring physicians to engage their patients in a process known as shared decision-making (SDM). SDM has three key steps that have been proven to dramatically improve a patient's medical decision-making process.[17] First, the patient receives information on the risks, benefits, and alternatives to a specific treatment option. Second, the patient explores his or her

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[16] Arato v. Avedon, 5 Cal.4th 1172, 1186 (1993) (quoting Cobbs v. Grant, 8 Cal.3d. 229, 243-245 (1972)).

[17] Stacey et al., *Decision Aids for People Facing Health Treatment or Screening Decisions,* COCHRANE LIBR. no. 10, 2011, *available at* http://decisionaid.ohri.ca/cochsytem.html (reviewing decision aids).

personal values and preferences regarding the range of treatment outcomes. Steps one and two can be completed under the guidance of a physician, a decision coach,[18] or increasingly commonly through the use of a decision aid. Decision aids, frequently in video format, provide patients risk and benefit information on the array of treatment options available for a specific condition in a clear manner and offer thought exercises to help them ascertain their own personal values.[19] Finally, once the patient has been informed and had time to consider their preferences, the physician and the patient discuss the benefits and detriments of the various treatment options and agree on a selected treatment. In our own decision-making process, step three was missing, or impressively deficient. We were informed and even knew our values, we just needed the space to air them.

Looking back, Dr. Parker could have done a number of things differently to align our decision-making process more closely with the core principles of informed consent and shared decision-making. Ideally, he would have begun our initial consultation appointment by gauging our understanding of the IVF process and asking about our goals, values, and preferences. He should have also been prepared to explain how different patient values might lead to different treatment decisions, risks, and outcomes. Taking our case as an example, imagine how different the scenario would have been if Dr. Parker had asked us to describe our goals for the process before he told us what treatment we would receive. He would have learned pretty quickly that getting pregnant in the first cycle was significantly less important to us than avoiding the risk of a multiple birth. At which point, we could have had a more in depth discussion several weeks in advance of my transfer about the implications of different stages of embryo development and the treatment options available for each. He could have told us what the odds of getting pregnant with transferring one versus two underdeveloped embryos, as well as the risk that a viable fresh embryo would not remain so after being frozen and thawed. James and I could have thought in advance about what we would do in the instance that our embryos were underdeveloped. Further, Dr. Parker could have checked our chart earlier on the day of transfer and asked us to come in a few minutes early to discuss our transfer strategy. We could have talked in his office, rather than standing at the nurses' station, which would have provided us a more appropriate space to adapt to our new circumstances and make a reasoned decision. Just a couple of questions

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[18] A decision coach is a trained facilitator, who assists patients in making complex medical decisions. Decision coaches are frequently nurses, but they may also be other health care professionals or trained patients. O'Connor et al., *Coaching to Support Patients in Making Medical Decisions*, 336 BMJ 228, 228 (2008).

[19] Moulton & King, *supra* note 14 at 91.

could have gone a long way toward opening the doors of communication and a better treatment decision.

For a couple with substantially less background knowledge of the process and risks of IVF, Dr. Parker's ethical and legal obligations with respect to informed consent demand significantly more discussion. He should begin any consultation by gaining a sense of the couple's values. In the case that they are not sure of their values, he should be prepared to ask them questions or provide them with a decision aid to help them do so. With respect to embryo transfer, he should explain that while transferring multiple embryos improves the likelihood of pregnancy in a given cycle, it also significantly increases the odds of a multiple gestation.[20] He should then fully disclose the risks of a twin or triplet pregnancy and birth for both the mother and her children. These decisions are too important to the future lives of all involved to not even discuss.

Each step in the shared decision-making process is essential. And too few patients experience even one or two of these steps in the course of making important and potentially life-altering medical decisions. When patients are given the opportunity to engage in SDM, studies demonstrate significantly higher engagement and satisfaction, and significantly less decisional conflict.[21] What's more, for some conditions, SDM has also been shown to reduce the uptake of a number of invasive procedures without compromising the patient's overall health, because once patients knew the risks and benefits, they opted for a treatment path that better suited their personal values.[22] In thinking about what SDM can do in other medical contexts, I could not help but wonder about whether engaging IVF patients in SDM would reduce both the number of women transferring multiple embryos as well as the overall health care costs associated with caring for prematurely born IVF multiples. It would have in our case.

Post-script

After two weeks of hoping, fretting, and praying, James and I went back to the clinic for our first ultrasound. After the shock of cold jelly on my stomach and some scratchy noises, a soft sound came through the cacophony—the joyous rhythm of a single, tiny heartbeat.

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[20] CTRS. FOR DISEASE CONTROL & PREVENTION, 2004 ASSISTED REPRODUCTIVE TECHNOLOGY SUCCESS RATES: NATIONAL SUMMARY AND FERTILITY CLINIC REPORTS 22 (2006), available at http://ftp.cdc.gov/pub/Publications/art/2004ART508.pdf (stating that approximately 33% of all live births from IVF produced more than one infant (30% twins, 3% triplets or more) compared with 3% incidence in the normal population).

[21] O'Connor et al., *supra* note 18.

[22] Wennberg et al., Extending the P4P Agenda, Part 1: *How Medicare Can Improve Patient Decision-Making and Reduce Unnecessary Costs*, 26 HEALTH AFFAIRS 1564, 1570 (2007).

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