Precommitment Issues in Bioethics

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Precommitments are strategies used by individuals to rearrange the payoff structure for later decisions in order to influence the choices that are made at a future time. When that time arrives, the precommited person may regret his or her prior choice and seek to avert its effects. If a different Time 2 choice is possible, third parties charged with enforcing precommitments may face difficult questions of which temporal self to heed.

Resolving the issues generated by precommitment behavior ensnares one in complex issues about exercising freedom over time. Precommitments and their dilemmas have a special urgency in the field of bioethics—the application of ethical and legal norms to biomedical practices and decisions that extend or create life. Bioethical situations typically involve questions affecting the body, medical treatment, reproduction, and even life or death. Whether people live, die, or have offspring, or, less significantly, whether they will be the objects of research or be subjected to discomforting or intrusive medical procedures, may be at stake.

Because of the intimate and intrusive nature of biomedical decisions, a central focus of bioethics has been to respect and protect an individual's autonomy in making those decisions.[1] Accordingly, much debate and analysis in bioethics has been over whether present autonomy is morally sufficient to justify an action, and if it is, whether the conditions for the informed consent essential to autonomy are satisfied. Indeed, much of the bioethical literature addresses whether the conditions for informed consent in medical practice and human subjects research exist and, if not, whether their absence can be justified.[2]

Given this normative stance, the use in bioethical situations of precommitments at Time 1 to substitute for actual consent at Time 2 is apt to engender conflict and controversy. Precommitment devices may be the best approximation that one could have for the person's consent when actual

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1. *See generally* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 56–94 (1979) (discussing the significance of autonomy, informed consent, competence, information disclosure, and voluntariness with respect to biomedical decisions).

2. *See generally* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986) (answering the question "What is informed consent?" from a historical and conceptual perspective); JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (2d ed. 2001) (providing a comprehensive discussion of informed consent for the purposes of practicing clinicians in clinical and research settings).

consent is not possible due to unavailability or incompetence, a frequent occurrence in some medical settings. If we do not rely on an advance directive at Time 2, we lose the Time 1 opportunity to control such future states. Harder questions arise if the maker of the precommitment is competent and available at Time 2 and now wishes to revoke his Time 1 consent to the action at hand. Yet there will be strong arguments for enforcing at Time 2 the contractual precommitments needed to carry out assisted reproduction and other biomedical projects and, possibly, for enforcing other precommitments. Many cases, however, may lack clear factors for determining whether the Time 1 or Time 2 self should take precedence.[3]

In this Article, I endeavor to deepen understanding of precommitment behavior by examining how the dilemma of choosing between Time 1 and Time 2 interests is handled in biomedical situations involving medical care, the body, and life or death. I discuss precommitment in three bioethical settings—consent to medical treatment, human subjects research, and assisted reproduction. As in other precommitment settings, no algorithm instructs us how the Time 1 vs. Time 2 dilemma should be resolved. The answer is context and fact dependent, as the following examples will show.

I. Consent to Medical Treatment or Nontreatment

Much of the work of bioethicists involves the rules, norms, practices, and policies for allocation of control over medical decisionmaking. Protecting personal autonomy has come to be a preeminent value in these decisions, with the right of competent patients to decide to have available treatments withheld or provided strongly protected.[4] Indeed, current policy debate is now focused on whether personal autonomy should also extend to physician-assisted suicide or even active euthanasia, including questions about the right to exercise that right in advance of incompetency.[5] I focus

3. As Dan Brock has shown, respect for autonomy does not give any special priority to Time 1 choices simply because they came earlier in time. Dan W. Brock, *Precommitment in Bioethics: Some Theoretical Issues*, 81 TEXAS L. REV. 1805, 1818–20 (2003).

4. BEAUCHAMP & CHILDRESS, *supra* note 1, at 83 (noting that recent court rulings have given a patient's informed choices broad protections).

5. *See, e.g.*, Washington v. Glucksburg, 521 U.S. 702, 716, 735 (1997) (holding that the due process right to receive lifesaving medical treatment does not imply a right to assisted suicide); Vacco v. Quill, 521 U.S. 793, 797 (1997) (holding that New York's ban on assisted suicide did not violate the Fourteenth Amendment). An advance directive for active euthanasia when one is incompetent raises issues of whether the incompetent person still has interests at Time 2 that should or should not take priority over the Time 1 directive, a topic discussed in the next subpart. An advance directive for active euthanasia when one is competent at Time 2 would raise weakness of the will issues. The person authorizes X to give the lethal injection at Time 2 because he is afraid that at that time he won't be able to request the injection. If the person at Time 2 objects to the injection, there would appear to be no good reason for privileging his Time 1 choice over his Time 2 objection to death.

here first on decisions competent individuals make to govern a future time when the person may still be competent and seek a different decision, and then on situations in which the person is incompetent at Time 2 to counter the Time 1 commitment.

A. Competency at Time 2: Cauterizing Captain Ahab

A paradigmatic case of precommitment for bioethics comes from Thomas Schelling's example of Captain Ahab facing cauterization of a leg bitten by a whale.[6] Ahab requests that the blacksmith cauterizing the leg steadfastly continue his work even if Ahab screams "no" once the burning begins. Ulysses' precommitment to be bound to the mast was a preemptive (or causal) precommitment. With the crew's ears stopped with wax, they could not hear his pleas to unbind him at Time 2 so that he could swim to the Sirens (and his death). In Ahab's case, the precommitment is executory, requiring a further decision to follow Ahab's Time 1 directive to ignore the preference that he expresses at Time 2. Transposed to a medical setting, is a physician's moral and legal duty to the patient to honor his Time 1 wishes and to continue a procedure over his protests, or is it to his Time 2 directions to stop?

In this case, the decision to honor the Time 1 preference might seem easy, but quickly leads to complications. In an age without anesthesia, Ahab's Time 2 countermand appears to be of questionable competence because of searing pain (the Time 2 choice is too hotly made to overcome his cooler Time 1 choice).[7] Even if he is deemed competent at Time 2, then the preference expressed reflects Ahab's immediate experiential needs over his long-term or critical interests preferred at Time 1. Indeed, the classic instance of a precommitment is Ulysses' intent to overcome the rationality-distorting passion inspired by the Sirens' song at Time 2. Similarly, urging a doctor to ignore a patient's Time 2 plea to stop serves the patient's long-term interest of avoiding an infection that could take his life.

Framed in legal terms, reliance on Ahab's Time 1 directive in order to promote Ahab's long-term interests should be a good defense against a charge of battery for continuing to cauterize even after Ahab withdraws consent. Similarly, a physician should not be found liable or morally condemned for continuing to operate despite withdrawal of consent. The

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6. THOMAS C. SCHELLING, CHOICE AND CONSEQUENCES 83–84 (1984); Thomas C. Schelling, *Self-Command in Practice, in Policy, and in a Theory of Rational Choice*, 74 AM. ECON. REV. 1, 9–10 (1984).

7. For distinctions between hot and cool choices, see Jon Elster, *Don't Burn Your Bridge Before You Come To It: Some Ambiguities and Complexities of Precommitment*, 81 TEXAS L. REV. 1751, 1765–74 (2003).

doctor's choice to promote the patient's longer-term best interests by adhering to the Time 1 preference seems sound.

Suppose, however, that a physician decided to follow the patient's Time 2 request and stopped the procedure. Is there a duty in some cases to follow Time 1 preferences despite the Time 2 countermand? Given a standard tort duty of care based on the practice of other respected practitioners in similar circumstances, such a physician might be liable for negligently honoring Time 2 preferences over those at Time 1. The outcome should arguably be different, however, if the physician had notified the patient in advance that he would always honor his right to stop, thus making the Time 1 precommitment even less binding at Time 2. Or if the medical procedure were experimental, then the mainstay of research ethics that a patient may always withdraw from research might support following the Time 2 preference.[8]

Lest this analysis of Ahab's cauterization be deemed too theoretical, it is easy to find contemporary cases that play changes on these same chords. On rare occasions, the colonoscopies to screen for colon cancer that persons over 50 are urged to have every five years become quite discomforting, and the patient requests that the doctor stop the previously agreed to procedure. Should the physician do so? Perhaps a precommitment, agreed to in advance would best resolve the problem, thus preventing the physician from having to choose between the patient's Time 1 and Time 2 preferences during the procedure. Of course, executory precommitments still leave some room for decision, but the recognition that following them would bar liability would strongly favor their enforcement at Time 2.[9]

Consider also the pregnant woman firmly committed to natural childbirth who requests that her physician administer no drugs, no matter how much she screams in pain for them. Is the obstetrician liable if she (1) follows the Time 2 preference and gives drugs, or (2) ignores the Time 2 request and sticks with the Time 1 commitment to drug-free parturition? An advance agreement for resolving this dilemma might help, but only if we are already committed to honoring precommitments. In this case, however, following the Time 1 commitment is not essential to save her life, as it is in the case of Ahab.

Finally, there is the famous case of Dax Cowart, the severely burned patient who was forced to endure painful treatments over his repeated refusals.[10] Although not a case of precommitment against treatment, it does

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8. *See* discussion *infra* Part II(A).

9. Whether the physician would be liable if he failed to enforce the directive would also affect his decision whether or not to follow it.

10. *See* Keith Burton, *A Chronicle: Dax's Case As It Happened*, *in* DAX'S CASE: ESSAYS IN MEDICAL ETHICS AND HUMAN MEANING 1, 7 (Lonnie D. Kliever ed., 1989) (describing how Dax "bitterly protested" treatment for his burns and stopped taking food and water); ROBERT BURT,

show how some people might rationally prefer that short-term present interests in not receiving medical treatment take priority over longer-term needs for survival. The case has many features of the quadriplegic case that Dan Brock discusses.[11] Ordinarily, present autonomy to refuse medical treatment would allow Dax or the quadriplegic to refuse treatment, thus causing an otherwise avoidable death. Yet if their present wishes were overridden for the sake of preserving a future, they might be glad that their physicians were permitted to prefer a future autonomy over current wishes, even if they do not ratify the decision as morally correct.[12]

B. Competency at Time 2 and Implantable Defibrillators

Precommitment concepts may also be useful in thinking through the ethical, legal, and policy issues posed by the development of small implantable defibrillators to correct abnormal heart arrhythmias. Some persons with advanced heart disease are subject to heart arrhythmias that could kill them if not immediately corrected. Implantable defibrillators are a great benefit for patients with severe or frequent arrhythmias, for they automatically restore proper heart function when an arrhythmia occurs by shocking the person, thus preventing death from cardiac arrest. More than 80,000 patients have received implantable defibrillators since 1996, and many of the four million patients who might benefit from them are likely to receive them in the future.[13]

Yet precommitting to having one's heart function restored once an arrhythmia occurs has also been a major problem for some patients. "Defibrillator storms," in which the devices go off six or more times a day, "with a jolt . . . like a boxer's punch to the chest," have proved so stressful for some patients that they eventually request that the device be turned off.[14] Turning the device off would not cause death as rapidly as turning off a respirator would, but it very likely means that the patient will die the next time a serious arrhythmia develops. Thus, accepting implantation of these devices means that the patient may face a situation where he may later have

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TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS 2 (1979) (discussing how Dax "expressed doubts about whether he wanted to live").

11. Brock, *supra* note 3, at 1806.

12. Dax's case is interesting because Brock thinks that it would be wrong to treat at Time 1 over his wishes, even if he would ratify the result at Time 2. *Id*. For cases involving contractual arrangements for Time 2 outcomes which are then rejected by a then-competent person, see Robert H. Frank, *Commitment Problems in the Theory of Rational Choice*, 81 TEXAS L. REV. 1789, 1801–03 (2003).

13. Each device costs $20,000, plus $10,000 for the operation to insert it. Vice President Dick Cheney has one. Gina Kolata, *Extending Life, Defibrillators Can Prolong Misery*, N.Y. TIMES, Mar. 25, 2002, at A1.

14. *Id*.

to request termination of the device, which some persons will view as a request for termination of care or even suicide. The ethical issue posed is how much patients receiving these devices should be told in advance about facing a future decision to have the defibrillator turned off.

Other approaches may adequately address the question of whether and when to tell heart patients of these risks, but it strikes me as helpful to view the use of implantable defibrillators as a type of precommitment. True, their use is not that of a classic Ulysses contract, for they are not used to restrain a choice that the Time 1 self fears will arise at Time 2. But in accepting such a device, a properly informed patient may be "precommitting" himself to face the Time 2 defibrillator storms, thereby entailing a difficult decision about whether to cause his own death by requesting that the device be turned off if future defibrillations become unbearable. If one accepts implantation, there is no way to avoid the decision to turn off the device once defibrillator storms occur. Viewing their implantation as a type of precommitment to accept that contingency might then increase attention to the need for fully informed consent for the implementation. This could result in much greater attention to the informed consent process than would have otherwise occurred. As with many preemptive precommitment situations, the ethical, legal, and policy problems are to ensure that the person is aware of the Time 2 implications of his Time 1 choice, and that he has knowingly and intelligently made that preemptive choice.[15]

The concept of precommitment, of course, is not essential to resolve these issues. As most analysts would agree, the question is how fully informed a patient should be about defibrillator storms before receiving the implant. Viewing it as a precommitment to possibly having to request removal at a later time, however, helps to focus attention on the nature of the choice and the need to think carefully about the future implications of actions before taking them. But there is no precommitment dilemma here, other than the more general problem that a present choice may restrain or affect our future options in ways that then pose their own problems.[16]

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15. Elster might argue that the example confuses function and purpose and, that in any case, there is no weakness of the will or other self-binding problem at issue here. *See* Elster, *supra* note 7. I prefer to think of this as a preemptive precommitment; it provides in advance the opportunity to be resuscitated, which would not have otherwise existed, yet that opportunity carries the possible burden of having to request future termination.

16. The person who refuses implantation of such a device has effectively burned his bridges (or ships) for escaping future arrhythmias in order to have to avoid facing the decision to turn off the defibrillator at that future time. A refusal throws away the key needed for resuscitation in order to avoid a future decision not to be resuscitated.

C. Incompetency at Time 2: Advance Directives for Withholding Treatment

The precommitment dilemma that arises most frequently in bioethics is the problem of whether competently made directives or precommitments should continue to control what happens to the maker in future states of incompetency (e.g., living wills and durable powers of attorney). Such directives differ from classic precommitment situations in which a more rational or cooler Time 1 self attempts to control or preempt a less rational or hotter decisionmaker at Time 2—the typical insurance against weakness of will or Ulysses contract. In contrast, prior directives are often used in bioethics to precommit or to determine what happens to people at Time 2 who are no longer able or competent to consent, though they may still have interests at stake.[17] Here the precommitment enforcement question posed is not whether a Time 1 choice should override different preferences expressed at Time 2, but whether the Time 2 situation of the person should matter at all if she is no longer competent to express preferences. That is, should the person at Time 2 still be regarded as having interests which now conflict with the Time 1 preference, even if the person is not competent to reject that premise, as occurs in the usual precommitment situation?[18]

Living wills and advance directives have come to play a major role in the ethics and jurisprudence of terminal care, suggesting a strong preference for the power of Time 1 preferences. Since California gave legal recognition to such arrangements in its Natural Death Act of 1976,[19] they have been widely recognized as an ethically and legally acceptable way to handle end-of-life decisions. The federal Patient Self-Determination Act requires all hospitals receiving federal funds to ask patients being admitted to a hospital to inform them of their rights under state law to make such directives.[20] Treatment can be withheld or withdrawn on the basis of that directive, thus avoiding the need to determine whether the patient has independent interests in being treated or whether family wishes should ultimately control. Indeed, several state courts have gone so far as to hold that conscious but demented

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17. Richard Markovits presents an argument for determining whether a person is still a rights-bearing entity at Time 2 and remains the same person. Richard S. Markovits, *Precommitment Analysis and Societal Moral Identity*, 81 TEXAS L. REV. 1877, 1896–1905 (2003). He does recognize, of course, that many cases would remain of incompetent persons at Time 2 who retain the capacities that make them bearers of rights. *Id.* at 1903.

18. Contrast the case in which a person, perhaps a Jehovah's Witness or one opposed to medical treatment, has expressed a strong objection to a blood transfusion and then falls into a coma, while the need for treatment remains. Should doctors nevertheless treat at Time 2? This is closer to Dax's case, if we assume he was overcome with pain at the time that he objected to treatment, but would object to what was done once he had recovered.

19. CAL. HEALTH & SAFETY CODE § 7186.5 (Deering 1999) (repealed 2000).

20. 42 U.S.C. § 1395cc(f) (2000).

individuals must be treated unless they had clearly and convincingly made such a prior directive.[21]

Rebecca Dresser's paper for this Symposium has quite thoroughly and convincingly made the case against relying on advance directives as a mainstay of policy for end-of-life decisions and, indeed, has questioned whether they should ever be enforced if, without them, a person has Time 2 interests in receiving medical treatment and staying alive.[22] Her bill of particulars against living wills includes the reluctance of people to make such directives and the ill-informed state of those who do. Among the cognitive deficiencies in their making is the failure of makers to focus on how their interests at Time 2, when incompetent, might be quite different from how those interests would be viewed from the vantage point of a competent individual at Time 2. Dresser has also quite effectively shown how a policy focus on living wills has detracted from efforts to focus on the needs of sick, vulnerable persons, which should be the main concern of policy.[23]

I agree with much of Dresser's analysis and think that legislatures, courts, and practitioners have relied unjustifiably on advance-directive precommitments as a way to handle treatment decisions for conscious but demented, or otherwise incompetent, patients. This is a problem, of course, only if at Time 2 the incompetent patient has interests that argue for treatment rather than the nontreatment that his prior directive envisaged. If not, the nontreatment decision will be noncontroversial, regardless of whether there is an advance directive.[24] If there is a conflict, adherence to the precommitment will mean that Time 1 preferences about how a person would like to be treated at Time 2 will take priority over a judgment based on current Time 2 interests, judged as they now are from the patient's situation of incompetency.

Dresser argues that the patient's experiential interests at Time 2 should be the key determining factor, regardless of what the patient might have requested at Time 1.[25] As a general matter of policy, she may be right, but I find myself in disagreement if she is arguing that position on the basis of principle as well—that Time 1 directives should never control Time 2 actions.[26] The problem with denying the use of advance directives on the basis of a more general principle against precommitment is that it leads to an

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21. *See, e.g.*, *infra* note 30 and accompanying text.

22. Rebecca Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81 TEXAS L. REV. 1823 (2003).

23. *Id.* at 1837–46.

24. John A. Robertson, *Second Thoughts on Living Wills*, HASTINGS CENTER REP., Nov.–Dec. 1991, at 6, 7.

25. Dresser, *supra* note 22, at 1840, 1845.

26. I do not mean to imply that Professor Dresser has or would take a stance on this matter on principle.

extreme presentism where current interests always trump past wishes. Such a view would appear to deny differences between critical and experiential selves. It also would deny that the need to have temporally-extended goals requires that certain things occur in the future, even if the future self objects. While Dan Brock has argued that there is no inherent reason to prefer the Time 1 self over that at Time 2, even he recognizes that there may be many cases in which a third party decisionmaker could choose to enforce the Time 1 directive.[27] Although there is no moral duty to enforce it, no moral duty is necessarily broken in doing so.[28]

That said, I do recognize that one must proceed carefully here and not exclude Time 2 preferences in all cases. Perhaps I would not call a priest for Brock's dying atheist,[29] but I would allow the older Russian nobleman, if an option still exists, to override his more idealistic younger self. In certain cases, Time 1 advance directives should control, and in others Time 2 preferences may prevail. The very nature of the precommitment problem is the lack of an all-purpose algorithm that neatly decides all cases.

The possible disjunction between Time 1 and Time 2 interests becomes important in states that take a more restrictive view of when treatment may be withheld from a conscious, incompetent patient. Several state supreme courts, confronted with spouses or family requesting that treatment be stopped on such patients, have held that some form of advance directive from the incompetent patient is necessary for treatment to be withheld.[30] Absent clear and convincing evidence of such a directive, these courts require treatment to continue, despite the objections of family and the permanently impaired situation of the patient.

In such cases, the courts seem to be saying that incompetent, conscious patients still have interests in being treated and kept alive that their families alone cannot override. If that is so, then their willingness to allow treatment to be withheld on the basis of a Time 1 directive at times when the family cannot make that judgment needs justification. Is Time 1 autonomy so important that it should always be protected over different preferences or interests at Time 2? Is the state consistent in protecting prior autonomy in

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27. *See* Brock, *supra* note 3, at 1820. .

28. *Id*. at 1820–21.

29. *Id.* at 1806.

30. *See In re* Westchester County Med. Ctr., 531 N.E.2d 607, 608 (N.Y. 1988) (requiring clear and convincing proof that a mentally incompetent hospital patient, who was unable to eat without medical assistance, "had made a settled commitment, while competent, to decline . . . medical assistance"); *In re* Martin, 538 N.W.2d 399, 401 (Mich. 1995) (requiring clear and convincing proof that an impaired medical patient on "nutritive support" had "made a firm and deliberative decision, while competent, to decline medical treatment"); Conservatorship of Wendland v. Wendland, 28 P.3d 151, 154 (Cal. 2001) (holding that "a conservator may not withhold artificial nutrition and hydration from [a mentally disabled] person absent clear and convincing evidence that the conservator's decision is in accordance with either the conservatee's own wishes or best interest").

other circumstances as well, for example, surrogate-mother contracts or agreements for postdivorce disposition of frozen embryos? Finally, if a Time 1 directive is so robust as to outweigh Time 2 interests in life that the family as proxy decisionmakers cannot override, should there not be special procedures for ensuring that the directive was knowingly and deliberately made?

The hard question for those courts is explaining why the Time 1 commitment should take priority over Time 2 interests even though those Time 2 interests are strong enough to trump the contemporaneous wishes of family against further treatment. The courts' failure to address these points suggests that judges are looking for a symbolic cover or fig leaf for what is in fact a decision about the respect owed incompetent, demented patients.[31] Without the cover provided by the patient's previously expressed preference that treatment cease, family members, who might have their own conflicting interests, will not be able to determine the outcome. With that precommitment as a cover, the choice can be rationalized as implementing the patient's own prior wishes.

II. Advance Consent to Research with Human Subjects

Another bioethical setting in which precommitment devices play a role is in human subjects research. Here the question is whether Time 1 consent to use a person's tissue, DNA, or embryos in research at Time 2 should be binding, or whether consent must also be obtained at Time 2 for that research to occur. Rebecca Dresser might argue that such research should not be permitted on the basis of a Time 1 commitment.[32] Others would argue that a Time 1 consent should suffice.[33]

To appreciate this issue, one should consider it in the context of biomedical research generally. A driving force behind the development of bioethics as a discipline has been the recognition of the many abuses that

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31. *See* John A. Robertson, *Respect for Life in Bioethical Dilemmas—The Case of Physician-Assisted Suicide*, 45 CLEV. ST. L. REV. 329, 336–42 (1997) (noting that, in the context of physician-assisted suicide, Supreme Court decisions based on symbolism come at a cost to patients—the acceptance of "a mode of death that is less desirable for them and . . . more vulnerable to abuse").

32. *See* Rebecca Dresser, *Advance Directives in Dementia Research: Promoting Autonomy and Protecting Subjects*, IRB: A REVIEW OF HUMAN SUBJECTS RESEARCH, Jan.–Feb. 2001, at 1, 2 (discussing research advance directives and arguing that, if allowed, more attention needs to be paid to "(1) the information that individuals must understand before making a research advance directive; and (2) safeguards to promote the welfare of the incapable participant during the research process").

33. NAT'L BIOETHICS ADVISORY COMM'N, 1 RESEARCH INVOLVING HUMAN BIOLOGICAL MATERIALS: ETHICAL ISSUES AND POLICY GUIDANCE 63–65 (1999) [hereinafter NAT'L BIOETHICS ADVISORY COMM'N, HUMAN BIOLOGICAL MATERIALS] (encouraging use of multilayered consent forms for future use of biological samples and proposing several recommendations to provide the subject with choices about consenting to the different, future uses of his or her biological sample).

have occurred in medical experimentation with human subjects.[34] To prevent abuses, substantive norms of informed consent to research, procedural requirements of prior review, and approval by an institutional review board (IRB) have been adopted and are now used throughout the United States and much of the developed world.[35]

The resulting system contains both a set of substantive rules or norms for conducting such research and a set of procedural rules for determining whether those norms will be satisfied. Although this system of human subjects research has operated reasonably well, a number of criticisms have recently been made.[36] Efforts are now ongoing to improve the system.[37] While many of those efforts are structural and administrative, much attention has also focused on reinforcing the strong position that informed consent to research plays in this system. I begin with a discussion of the research ethics norm that a subject may always withdraw from research, which amounts to a prohibition on enforceable precommitments to participate in future research. I then discuss two situations in which advance consent to future research, though generally frowned upon, should nevertheless occur.

A. The Right to Withdraw from Research

A mainstay of research ethics has been the right of subjects to withdraw from research at any time, regardless of the reason or the cost to researchers.[38] This ban holds even if the subject had specifically agreed not

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34. Nazi Germany was the most egregious offender, but the United States was not without sin in this regard. *See* JAY KATZ, EXPERIMENTATION WITH HUMAN BEINGS 293–94, 1007–10 (1972) (detailing German war crimes and American hepatitis research carried out on unwitting retarded children at the Willowbrook State School); *Human Guinea Pigs; Another Example of Scientific Abuse*, PITTSBURGH POST-GAZETTE, June 10, 2002, at A8 (describing research secretly conducted on black syphilis victims at Tuskegee over a period of years and similarly unethical radiation experiments on soldiers conducted in the United States).

35. *See, e.g.*, Protection of Human Subjects, 45 C.F.R. §§ 46.101–46.409 (1999) (stating the United States Department of Health and Human Services policy on human experimentation); World Medical Association, *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects*, 284 JAMA 3043, 3043–45 (2000) [hereinafter *Helsinki Declaration*] (reprinting the Association's policy on medical research involving human subjects).

36. *See, e.g.*, Beverly Woodward, *Challenges to Human Subject Protections in U.S. Medical Research*, 282 JAMA 1947, 1947 (1999) (arguing that current trends in research and research regulations "continue to erode the requirements of consent, while the notion of minimal risk has become . . . upwardly mobile").

37. Donna Shalala, *Protecting Research Subjects: What Must Be Done*, 343 NEW ENG. J. MED. 808, 808–10 (2000) (arguing that a number of steps can be taken to improve the safety of subjects in clinical trials, including the promulgation of more specific rules on consent and clearer regulations on conflicts of interest).

38. Protection of Human Subjects, 45 C.F.R. § 46.116(a)(6) (1999) (setting forth the Department of Health and Human Services' determination that "the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled"); *Helsinki Declaration*, *supra* note 35, at 3044 ("The subject should be informed of the right . . . to withdraw consent to participate at any time without reprisal.").

to withdraw and the researcher has relied to his detriment on that promise. Indeed, IRBs are unlikely to approve of consent forms in which the subject is penalized in some way for withdrawal, for example, by researchers' withholding compensation for early withdrawal. This rule prevents research subjects from precommitting themselves—except by preemptive action—to stay in a research protocol for any period of time.[39]

A rule permitting withdrawal from research is meant to privilege the interests and autonomy of the subject at Time 2 over the interests of the researcher and the Time 1 subject. Given the past history of research abuse and the knowledge and power differential between subject and researcher, the rule is a desirable prophylactic. It protects the Time 1 subject from having insufficient appreciation of the Time 2 experience to which he would be precommitting himself.[40] Rather than frontload the Time 1 decision process with rules and procedures for ensuring that the choice is sufficiently informed, the policy preference has been to ban all such agreements.

Adoption of such a rule is not, strictly speaking, ethically required. With robust frontloaded consent procedures, patient autonomy and consent could still be respected in such arrangements. Indeed, one could argue that a Time 1 option about Time 2 participation in research enhances the freedom of subjects. Nevertheless, a decision to ban such agreements does have a prudential justification. There are good reasons to think that some precommitting subjects would not be making a sound choice. It is difficult to know how one will react in the future, especially if a first-time participant, and some subjects might be unduly influenced by the researcher's request to enroll.[41] As long as the costs to researchers and the research enterprise of a free withdrawal policy are small, the policy is sound and justified.

A policy of free withdrawal from research appears to have been a workable norm. A more precise assessment of its wisdom would require

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39. Only if the research involved a preemptive step of some sort—and all choices do to some extent—would it be possible for the subject to make a precommitment. A subject might, for example, agree to winter over at the South Pole as part of a research team studying the effects of lower ozone in that environment. *See* JERRI NIELSON, ICEBOUND: A DOCTOR'S INCREDIBLE BATTLE FOR SURVIVAL AT THE SOUTH POLE (2001) (recounting the story of a doctor who agreed to winter in Antarctica and was trapped there for months despite an urgent need for medical attention for her breast cancer). In that case it was physically impossible to withdraw one month into the process, just as it is physically impossible to withdraw from a drug study once the agent is administered. In such cases, fully informed consent before the preemptive step is taken is obviously necessary.

40. I view the consent to research without a right to withdraw as a precommitment because the person is not able to withdraw without significant penalty. At Time 1, he limits his option to withdraw at Time 2.

41. Researcher influence is a special risk if the researcher is also serving as the patient's physician. *See Helsinki Declaration*, *supra* note 35, at 3044 ("The physician may combine medical research with medical care, only to the extent that such research is justified by its potential prophylactic, diagnostic or therapeutic value.").

determining the costs to researchers and subjects of not being able to precommit to nonwithdrawal and the harm that the subject at Time 2 would experience from that commitment. If the costs to the research enterprise become too great (e.g., important studies requiring full participation over time are hurt by dropouts), one could reconsider the policy. In those cases, adequate upfront consent procedures might sufficiently protect patient autonomy.

B. Advance Consent to Research on Stored Tissue/DNA Samples

The use of precommitment in human subjects research also arises in the debate over whether advance consent has any role to play in research with stored tissue or DNA samples. The rule protecting the right to withdraw from research at any time creates a general presumption against the use of advance consent with tissue samples. However, there is a growing recognition that some cases of advance consent are both ethically and prudentially acceptable.[42]

Accepting some form of advance consent in those cases flows from a recognition that obtaining actual informed consent in every case of human subjects research might be too burdensome in cases that pose little risk to subject interests. One way to minimize those costs while respecting the principle of consent is to use presumed or advance consent instead of actual consent of the person at the time that the research occurs.

The use of advance consent to research has received much attention recently in policy debates about using stored tissue or DNA samples in later genetic or medical research.[43] To identify genes and determine their phenotypic effects it is often necessary to correlate an individual's DNA with her medical records or other characteristics. Yet identifiable genetic and medical information is quintessentially private and is generally not available for research or other examination without the person's informed consent. For studies involving samples and information that have already been collected, as well as for studies involving information that will be collected in the future, it may be very difficult or costly to locate a person and obtain his or her consent to a future study involving identifiable data.[44] A current policy debate rages over whether something less than actual informed

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42. *See* NAT'L BIOETHICS ADVISORY COMM'N, HUMAN BIOLOGICAL MATERIALS, *supra* note 33, at 62–68 (recommending that where there is only minimal risk to the patient and meeting a consent requirement is impracticable, research on previously identified human materials should be acceptable).

43. *See id*. at i–viii (describing growing concern about the use of human biological material in research and the debate about how to regulate it).

44. If the material is not identifiable, then it may be used without consent, for research does not then involve a "human subject" because the research will not obtain "[i]dentifiable private information." Protection of Human Subjects, 45 C.F.R. § 46.102(f)(2) (1999).

consent may suffice for respecting a person's privacy and dignity in conducting genetic and medical research with identifiable tissue and information.

Two views of the requirements of consent clash in this debate. The actual-consent perspective would argue that consent to future research cannot be informed if the research is unknown at the time consent is obtained. The opposing advance-consent view would argue that informed consent validly encompasses waiver of future rights to consent, if the general categories of what is being waived are specified. The National Bioethics Advisory Commission recommended that advance consent to later, unspecified research be accepted in some circumstances, but at least two members, including Professor Alexander Capron, dissented on the ground that such consent was not meaningful if the nature of the research was unknown at the time of the consent.[45]

In assessing the two positions, it is important to remember that alternatives to actual consent, such as advance consent, can take a variety of forms. One version of the advance-consent view would have the patient consent in advance to all future research that an IRB found not to be so problematic as to require actual consent.[46] Another version uses advance consent to accept an opt-out or presumed-consent system for future research studies of already collected or to be collected biomaterial. Under such an approach, researchers would presume consent from the prior choice to donate to projects of which the donor has been notified—unless he affirmatively opts out of them. Researchers, for example, could inform subjects every few months via confidential internet sites of planned projects, though semiannual or even annual notifications by letter, as well as e-mail, might suffice.

Advance consent to research is a type of precommitment strategy. Although not adopted for the purpose of preventing Time 2 weakness of the will, advance consent eliminates the opportunity for a person to decide to withdraw at Time 2. Although some would argue for allowing advance consent to many kinds of future research, apparently, few persons would argue for total Time 1 control over Time 2 research.[47] A person's circumstances or views might have changed, and the Time 1 estimate of

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45. NAT'L BIOETHICS ADVISORY COMM'N, HUMAN BIOLOGICAL MATERIALS, *supra* note 33, at 65.

46. Diana S. Chase et al., *The North Cumbria Community Genetics Project*, 35 J. MED. GENETICS 413, 413–16 (1998) (noting that participants in the North Cumbria community study collecting genetic materials from newborns gave their advance consent to the future study of those materials so long as the research was approved by an ethics committee).

47. *See* NAT'L BIOETHICS ADVISORY COMM'N, HUMAN BIOLOGICAL MATERIALS, *supra* note 33, at 64–66 (arguing that advance consent can be useful in some contexts, but that even if a patient consents to future use of his or her specimen, "he or she should enjoy the additional protection afforded by the requirement of specific consent to uses of the sample that he or she might consider sensitive or objectionable").

Time 2 preferences, in light of the now specified research, may at Time 2 turn out to be mistaken. As a result, intermediate positions such as presumed consent or IRB approval for research that was never specifically agreed to may be a better balance of subject rights and efficient research than a Time 1 waiver of rights in all future research.

Questions of advance consent to genetic, medical, or embryo research present a novel variation on precommitment behavior. Advance consent does restrict the feasible set of options at Time 2 over biologic material from the subject. The purpose or reason for the advance consent, however, is different from the paradigmatic use of precommitment as a way to control the self's future behavior. It is more akin to the strategic use of precommitment to control or influence the actions of others. That use occurs in the research context not to attain a selfish end, but rather to facilitate the researcher's use of genetic or other material so that science might progress.[48] Advance consent to future research thus functions as a gift to researchers to facilitate the research enterprise. Once delivery of the gift occurs, the donor no longer has control over the substance of the gift.[49] There is nothing especially challenging here, but it is a nice example of how easily policy can accommodate the trade-offs entailed in precommitment.

As with other types of precommitment, review of the precommitment to see if it should be permitted can occur either at the front or backend of the process. If the Time 1 consent is given effect, then there should be closer controls over how informed and knowing it is.[50] Requiring actual consent at the time the research occurs avoids a precommitment at all. A system encompassing advance consent to presumed consent on notification of the precise research project is a happy medium between a frontloading and backloading review of research. Similarly balanced is a policy that allows advance consent to Time 2 research only if an IRB finds that the precommited research poses minimal risk. If the research is more risky, then one can override the advance consent and require actual consent at Time 2.

C. Advance Consent to Donation of Frozen Embryos for Stem Cell Research

An interesting example of advance consent to research arises in the context of donation of embryos for embryonic stem cell research. A public debate over federal funding of embryonic stem (ES) cell research arose in 1998 after scientists reported being able to maintain human ES cells

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48. *See* Elster, *supra* note 7, at 1761–65.

49. In personal situations one could, with great embarrassment, request a return of the gift, which would be very difficult for many people to do.

50. This is true whether the precommittment is preemptive or executory. Because preemptive precommitments provide no leeway at Time 2, greater scrutiny of them at Time 1 is justified than may be needed for executory precommitments. However, executory precommitments also need review, for the precommitment itself will be a strong reason to follow it at Time 2.

indefinitely in culture.[51] This discovery opened the door to development of cell replacement therapies derived from the ability to direct ES cells to differentiate into the tissue of concern to a particular patient. The general counsel of the Department of Health and Human Services concluded that since ES cells were not embryos within the meaning of a congressional ban on federal funding of embryo research, the National Institutes of Health (NIH) could legally fund research with them.[52] The NIH then developed procedures for awarding such grants to ensure that embryos were not created for research purposes and that donor couples were fully informed of the choice they were making.[53]

One condition set by the NIH for research funding was that a couple's consent to donate excess embryos to ES cell research must be contemporaneous with the donation, rather than based on a directive or consent form signed at the time that the embryos were first frozen, which could be several years before the research was conducted. The rejection of advance consent to research was justified as a way to protect naïve patients from undue pressure from physicians at the time that embryos were created. It was also based on a belief that research use of embryos is so important for individuals that they should know what the research is that they are consenting to. This can occur only if consent is requested for a specific research project at the time that they dispose of their stored embryos.

As a policy matter, setting careful constraints on embryo donations is a reasonable approach on several grounds. If the control of the couple creating the embryo is valued, then contemporaneous consent is clearly preferable. Indeed, in most situations, there is no need to dispense with contemporaneous consent, therefore, little is gained by relying on an advance directive for donation. Couples can easily make their wishes known about research when they decide to end storage of their embryos. Given the few occasions when advance consent is actually needed, a policy strongly committed to actual consent will prevent errors and reassure the public that embryonic stem cell research is being conducted responsibly.

Yet there are some cases in which reliance on a prior commitment or directive for research use of embryos is essential. In some cases, the couple may not be available to give actual, contemporaneous consent—for example, when they have lost contact with the clinic, have died, or have abandoned

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51. For an in-depth account of the ethical and policy issues in ES cell research, see, for example, John A. Robertson, *Ethics and Policy in Embryonic Stem Cell Research*, 9 KENNEDY INST. OF ETHICS J. 109 (1999). For a general discussion, see NAT'L BIOETHICS ADVISORY COMM'N, ETHICAL ISSUES IN HUMAN STEM CELL RESEARCH (1999) (analyzing ethical, legal, and policy issues in embryonic stem cell research and recommending governmental funding for both derivation and use of embryonic stem cells in research).

52. *See* Robertson, *supra* note 51, at 112.

53. National Institutes of Health Guidelines for Research Using Human Pluripotent Stem Cells, 65 Fed. Reg. 51,976, 51,979–81 (Aug. 25, 2000).

their embryos. In such cases, a prior directive that embryos may then be discarded should be legally acceptable. Likewise, the precommitment of those who requested that the embryos be donated for ES cell research should be honored without having to procure their consent at that time. Indeed, in some cases, couples may have strong preferences that unwanted embryos contribute to biomedical research and specifically request that if they divorce, die, or cannot be contacted, their embryos may be used in ES cell or other research.[54] The need to rely on advance consent would also arise if the couple no longer wishes to store its embryos and would like to donate them for research, but there is no research project that would use them. It is reasonable in those circumstances to allow them to donate the embryos for research, even if the particular research cannot yet be specified. The NIH guidelines and some bioethics commentators, however, would not accept advance consent to research that is unspecified at the time of donation.[55]

As with restrictions on the right to withdraw generally, this policy is ethically and prudentially acceptable as long as its punctiliousness about actual consent does not impose undue costs on research progress. Because many embryos are or could become available with contemporaneous consent for research, this restriction is not likely to deter or raise the costs of embryonic stem cell research. A few couples may end up not being able to donate their leftover embryos in advance because they are unavailable to consent at the time of donation, but this interest does not appear to be strong enough to outweigh the policy's prudential benefits.

III. Precommitment in Assisted Reproduction

A third bioethical arena in which precommitment issues have been prominent is in assisted reproduction. Although the decision to have or adopt a child usually involves a commitment to take on parental rights and duties, disputes over the role of precommitment in reproduction have usually arisen in cases of assisted or collaborative reproduction in which spouses and third-party donors or surrogates make agreements concerning the transfer of

54. A harder question arises if the precommitted condition is the inability to agree. If so, enforcing the condition would mean donation for research over the Time 2 objection of one of the parties. Unless one could show that the insisting party would not have embarked on in vitro fertilization without the assurance that unwanted embryos would be used in research, the case for allowing precommitments for research use of unwanted embryos in this scenario seems weak. *But see* Kass v. Kass, 696 N.E.2d 174, 182 (N.Y. 1988) (holding that agreements between progenitors that in the case of divorce embryos be donated for research should be presumed valid and binding).

55. The Ethics Committee of the American Society of Reproductive Medicine, the professional organization of fertility doctors and providers, would recognize such an exception. *See* ETHICS COMMITTEE, AMERICAN SOCIETY OF REPRODUCTIVE MEDICINE, *Donating Spare Embryos for Embryonic Stem-Cell Research*, 78 FERTILITY AND STERILITY 957, 959 (2002) ("The consent process should inform donors of the nature of ES cell derivation [and] the specific research project, if known . . . .").

gametes, embryos, gestation, and rearing rights and duties in children.[56] At a later point, disputes about custody or visitation may arise that turn on the validity of an earlier agreement to transfer those interests to another person or couple.

A typical agreement would involve a woman's agreeing to provide gestational services to an infertile couple with a promise to relinquish the resulting child at birth in return for a sum of money, perhaps $20,000. Or a woman and a man faced with infertility are considering going through in vitro fertilization (IVF) treatment for infertility. The woman is unwilling to undergo the hyperstimulation and surgical intervention required to stimulate and retrieve eggs unless her husband promises that she may use all resulting embryos, if she wishes, for implantation and motherhood. He agrees to do so in exchange for the woman agreeing to submit her body to the intrusions of the IVF cycle to provide him with the opportunity to have biologic offspring.

Such agreements, it should be clear, are instances of precommitment. Some might quarrel with this label, arguing that the main purpose of the contract was to influence or control the behavior of others and not to restrain themselves, as occurs in the classic weakness-of-the-will or Ulysses contract-type precommitment. But the motive for limiting one's future action should not be determinative of whether something is labeled a precommitment. What matters is whether someone has changed in advance the payoffs associated with his future actions, not whether he has made the commitment to control himself or control another.

On this score, contracts that do not involve simultaneous, unavoidable performances would appear to involve paradigmatic precommitment behavior. One is doing or promising at Time 1 to do something at Time 2 in order to induce reciprocal behavior by another. It may be that the maker is quite happy anyway to do what she has promised at Time 2, and merely puts her intention in the form of a promise or precommitment solely to induce action at Time 2 by another person. But such promises limit the maker's actions at Time 2 as much as they do that of the other party. If their circumstances or preferences change, they too will be bound at Time 2 by their Time 1 promise. Because promisors bind themselves as well as their promisees, and each could have different preferences at Time 2 from those

56. *See* MARTHA FIELD, SURROGATE MOTHERHOOD 84–96 (1988) (surveying a range of arguments that may justify surrogacy contracts, and then claiming that such contracts should be treated as adoption contracts, which allow the natural mother to opt out of the contract); Johnson v. Calvert, 851 P.2d 776, 779–87 (Cal. 1993) (construing a surrogacy agreement to decide who a resulting child's "natural mother" is when a zygote formed by the gametes of a married couple is implanted in and carried by a surrogate mother, whether a deprivation of the gestating woman's constitutional rights ensues upon a determination in favor of the genetic donor, and whether public policy bars such an agreement).

that they had envisaged, contracts share both strategic and nonstrategic aspects of self-binding and binding others.[57]

The exchange of joint promises at Time 1 concerning Time 2 actions makes contractual precommitments a relatively easy case for enforcing the Time 1 preference—for choosing the Time 1 self over the Time 2 self's voicing of a different preference. True, the Time 2 self was not present at the making of the Time 1 commitment and can argue that she should not be bound by a promise made at an earlier stage of the self when all the facts about Time 2 preferences were not known. But unless Time 1 preferences for Time 2 were enforced, the chance to increase mutual welfare through the institution of contract would not be possible.

The same point can be made by noting the reliance of the other party on the Time 1 commitment. The fact that the other party relied to his detriment on the maker's commitment at Time 1 to do "X" at Time 2 should itself be a strong reason for enforcing the contractual commitment. Of course, as Dan Brock notes, that reliance is reasonable and should be honored only if we have already assumed that contracts generally (including contracts of the kind at issue here) should be enforced.[58] However, given deeply entrenched practices of promising and enforcing promises, and the benefits that these ordinarily provide, it is reasonable for parties exchanging promises to rely on the enforceability of their own and others' promises.

Contracts for body parts and reproductive and parenting roles pose especially difficult enforcement problems. Because of a general reluctance to enforce contracts for parenting and bodily arrangements, there is a tendency to undercut the validity of contractual precommitments in this area,[59] even though the joint actions that contracting makes possible also apply to agreements for gametes and embryos. Courts confronting these issues tend to downplay the importance of contractual certainty in reproductive agreements in favor of considerations of public policy.[60] However, doing so loses the gains of collaborative reproduction that precommitment through contract makes possible.

I submit that contractual precommitments for exchange of body parts and reproductive factors should ordinarily have a strong presumption in their

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57. Elster, *supra* note 7, at 1761–65. *See also* John A. Robertson, "*Paying The Alligator": Precommitment in Law, Bioethics, and Constitutions*, 81 TEXAS L. REV. 1729 (2003) (identifying contracts as strategic precommitments).

58. *See* Brock, *supra* note 3, at 1810.

59. *See, e.g.*, *In re* Baby M, 537 A.2d 1227, 1246 (N.J. 1988) (invalidating a surrogacy contract as against the public policy of New Jersey). The New Jersey Supreme Court spoke directly in terms of precommitment: "The contract's basic premise, that the natural parents can decide in advance of birth which one is to have custody of the child, bears no relationship to the settled law that the child's best interests shall determine custody." *Id*.

60. *See, e.g.*, *id*. at 1234 ("We invalidate the surrogacy contract because it conflicts with the law and public policy of this State.").

favor.[61] After illustrating this point with agreements for transfer of gametes, embryos, and gestation, I will then address a situation—posthumous reproduction—in which precommitment concepts other than contract play an important role.

A. Transfer of Reproductive Resources (Gametes and Gestation)

An obvious set of issues arises around whether one can relinquish parental rearing rights in advance when making sperm, egg, and embryo donations and agreeing to serve as a gestational or full surrogate for other couples. While such agreements are usually given effect when they involve egg and sperm, there is a mixed reaction to them when they involve embryos, as the cases involving postdivorce disposition of frozen embryos show.[62] The surrogacy cases are also split, with advance agreements for rearing recognized in cases involving gestational surrogacy, but not when the surrogate also provides the egg (so-called "full" surrogacy).[63]

These are cases of contractual precommitment, as the surrogacy case shows. The woman agrees to be a surrogate mother for an infertile couple, but because she or the couple is afraid that she might change her mind once the child is born, she executes a written contract that she agrees will be enforced at Time 2. When Time 2 comes along, she challenges it. Because these issues have been extensively debated elsewhere and are by now quite familiar,[64] I will mention briefly just one variation on them that tests how far contractual arrangements for reproduction will be honored.

Many people find the transfer of rearing rights and duties by advance agreement that occurs in gamete donation acceptable, even if the donor later seeks custody or visitation.[65] They may also find that the couple who has entrusted its embryos to a gestational surrogate should win in later disputes with the surrogate over custody of the child, as the California Supreme Court

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61. Enforcement here means paying damages, the usual remedy for breach of contract, and not specific performance, except in those cases that meet general contract law requirements for specific performance.

62. *See infra* Part III(B).

63. *Compare* Baby M, 537 A.2d at 1253 (N.J. 1988) (holding that a surrogate mother retains rearing rights), *with* Johnson v. Calvert, 851 P.2d 776, 782 (Cal. 1993) (stating that a gestational surrogate mother does not retain rearing rights).

64. *See, e.g.*, Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1925–36 (1987) (relating market-inalienability to an ideal of human flourishing and applying this theory to the contested market-inalienability of surrogate motherhood).

65. *See, e.g.*, Marjorie Maguire Shultz, *Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality*, 1990 WIS. L. REV. 297, 323–24 (arguing that intention should be the determining factor for legal parenthood and noting that public policy concerns might require modification of this default rule in some circumstances).

held in *Johnson v. Calvert*,[66] the leading case on this issue. Yet they would draw the line at enforcing the gestational surrogate's commitment to conduct herself in a certain way during pregnancy (e.g., not smoke or drink, undergo prenatal testing, and then abort or not abort on the basis of those tests).[67]

Such a line could be defended on the ground that it protects against advance agreements for bodily intrusions or performances, while other reproductive precommitments involve rearing rights and duties alone. In these cases the Time 1 commitment is to a Time 2 bodily intrusion or physical performance—for example, undergoing genetic testing, accepting medical treatment, or not aborting a fetus with genetic anomalies. Enforcing such contracts would require interference with the surrogate's personal liberty or bodily integrity in ways that other reproductive contracts would not. Rearing agreements, for example, address who has access to a child once that child exists independently of the body; gestational agreements involve continuing or not continuing a pregnancy.

A strong legal tradition of not enforcing such arrangements exists precisely because of the physical aspect of the Time 2 action. The situation is closely akin to the right to withdraw from research. In both cases there are doubts about whether a person can provide truly informed and free consent in advance, and many persons object to legal intrusions on a person's bodily liberty or integrity.

It is not clear, however, that such a result is morally or even prudentially required. One could agree that a woman should not be specifically ordered to abort or undergo prenatal tests. However, she could still be required to pay damages for the loss caused the couple from violating her promise that she would screen (or not screen) the fetus prior to birth and continue (or terminate) the pregnancy as a result. The couple will have suffered the physical and financial costs of producing the embryos as well as uncertainty and mental stress about their prospective child's well-being.[68] Enforcing a contractual precommitment for damages should be acceptable even if specific performance of the contract is not.

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66. 851 P.2d at 778. *See also* Culliton v. Beth Israel Deaconess Med. Ctr., 756 N.E.2d 1133, 1135 (Mass. 2001) (holding that the genetic parents should be declared the legal parents of twins born of a surrogate mother).

67. *See, e.g.*, Lori B. Andrews, *Beyond Doctrinal Boundaries: A Legal Framework for Surrogate Motherhood*, 81 VA. L. REV. 2343, 2372–74 (1995) (praising the refusal of the courts to enforce contractual provisions that allow the contracting party to control the actions of the pregnant surrogate).

68. A similar distinction might apply to a woman who intentionally misleads a man about her fertility status or her use of contraception, and then has a child that the man had not consented to conceive. Perhaps the state may still hold him jointly liable for child support, but there is no reason why he should not then have a cause of action based on fraud against her to recoup his damages. Indeed, a person with a sexually transmitted disease would have a duty to disclose it or pay damages if transmission occurred.

B. Postdivorce Disposition of Frozen Embryos

Precommitment issues have also figured strongly in disputes over enforcing agreements for the disposition of frozen embryos after divorce. The four state supreme courts that have spoken on the issue are evenly split over whether advance agreements for postdivorce disposition of embryos should be enforced.[69] Having addressed this issue in great depth in another article,[70] I summarize here the argument for enforcement in order to emphasize its precommitment aspects.

Couples going through IVF treatment for infertility customarily produce many more eggs and embryos than can be safely implanted in a single cycle, with the remainder usually frozen for later use. Sometimes at the time of freezing the couple will agree with each other (and the clinic) that in case of divorce, death, or other specified contingency, one of the parties may dispose of remaining embryos as he or she chooses, including transfer to the uterus of that party or another so that reproduction with those embryos might occur. Litigation has arisen when one of the parties at Time 2 withdraws consent for the previously indicated disposition and sues to prevent the transfer or implantation agreed to at Time 1.

Consider a married couple, unable to conceive after two years of trying, who are found to be appropriate candidates for IVF treatment. Some women and men may be willing to undergo IVF, but only if they are assured that embryos will not be discarded and that either of them can use all resulting embryos for reproduction. In this hypothetical, the wife is more concerned about this issue than the husband, but he agrees that she may use all embryos in case of divorce or other contingencies. She then undergoes the hormonal injections and surgical retrieval that oocyte stimulation and retrieval entail. Ten eggs are recovered, seven successfully fertilize, and three embryos are transferred to her uterus, with the remaining four frozen for later use. The wife becomes pregnant but miscarries in the eighth week—not an uncommon occurrence. Before she is ready to have the remaining embryos implanted, the husband announces that he is seeking a divorce and objects to any transfer or implantation of the remaining embryos without his consent.

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69. *Compare* Davis v. Davis, 842 S.W.2d 588, 604 (Tenn. 1992) (stating that if there is a prior agreement between the parties, then that agreement should be carried out); Kass v. Kass, 696 N.E.2d 174, 182 (N.Y. 1998) (holding that agreements between progenitors providing for the donation of embryos for research upon divorce should be presumed valid and binding); *with* A.Z. v. B.Z., 725 N.E.2d 1051, 1059 (Mass. 2000) (holding that an agreement that embryos may be implanted after divorce was unenforceable); J.B. v. M.B., 783 A.2d 707, 719 (N.J. 2001) ("We believe that the better rule . . . is to enforce agreements entered into at the time in vitro fertilization is begun, subject to the right of either party to change his or her mind."). *See also* Cahill v. Cahill, 757 So. 2d 465, 467–68 (Ala. Civ. App. 2000) (suggesting that agreements giving physicians dispositional control of stored embryos in case of divorce may be enforceable in further litigation between the contracting parties).

70. *See* John A. Robertson, *Precommitment Strategies for Disposition of Frozen Embryos*, 50 EMORY L.J. 989, 1016–27 (2002).

Contrary to the recent decisions of the Massachusetts and New Jersey Supreme Courts, but in accord with decisions in Tennessee and New York, I think that there is a strong case for enforcing the agreement to allow the wife to implant the embryos at Time 2 (after divorce), even over the husband's objection. Both parties were fully informed of their options, and the husband was aware that the wife was agreeing to undergo the burdens of IVF in reliance on his agreeing to relinquish postdivorce rights over the embryos. Although he does not now want children from the failed marriage, he knew that contingency could arise when he gave his advance agreement or commitment. It was his promise that he would accept such an outcome—the advance waiver of his right to object to embryo transfer—that was material to her decision to undergo the physical intrusions of IVF.

The Massachusetts and New Jersey courts took the position that enforcing the agreement, or recognizing it as a valid advance waiver of his right to object to embryo transfer, would result in "forcing" the husband to reproduce against his will.[71] This misdescribes what is at stake in the decision. Holding the husband to his previous agreement will not "force" him to do anything, since he has already provided the sperm to create the embryos and agreed that they can be so used. Unlike an agreement requiring a person to provide sperm, eggs, or other tissue, or to gestate or abort or not abort another couple's embryo, no bodily intrusions or efforts are required on his part. The only matter at issue is whether the woman and the clinic, or the physicians assisting her, are legally free to transfer the embryos to her uterus. Permitting transfer without his Time 2 consent could lead to the husband becoming a genetic parent over his Time 2 objection, and it is possible that rearing duties might also follow. Procreation is occurring without his consent, but he is not being "forced" at Time 2 to procreate. It results instead from giving effect to his Time 1 agreement to such an outcome. Indeed, his wife relied on that agreement when she underwent the physical burdens that provided him with the chance of having biologic offspring.

The Massachusetts and New Jersey courts appear to have overlooked the fact that the precommitment aspects of contract both extend and limit freedom. An agreement to waive future rights to control embryos is a classic case of a two-party precommitment. At Time 1 each agrees to limit his or her options at Time 2 in order to achieve the chance of having a baby at Time 1. True, the arrangement might seem more aimed at getting others to act in certain ways than at constraining one's own future behavior. But there is no guarantee that the promise that one is willing to accept at Time 1 about Time 2 will reflect actual preferences at Time 2. Also, the person incurring the

71. *See J.B.*, 783 A.2d at 718 (stating that if the implantation is successful, "that party will have been forced to become a biological parent against his or her will").

Time 1 burdens of the IVF procedure wants to be sure that she will get Time 1 and Time 2 benefits—full use of embryos—as a result.

Viewing Time 1 agreements for Time 2 disposition of frozen embryos as a form of precommitment is helpful in several respects. If these agreements are to be enforced, careful attention must be paid to frontloading Time 1 agreements to ensure that agreements are knowingly and freely made, because there should be no backend recourse if a unilateral change of mind occurs. At the same time, dilemmas exist when conflicts between Time 1 and Time 2 preferences arise. The problem is to decide whether the Time 1 or Time 2 preference should be preferred—whether freedom at Time 1 or Time 2 should be privileged over the other.

In cases of executory precommitments that bind only the individual—for example, sticking with one's diet or savings plan—the interests of others may not hang on the outcome. But where the precommitment takes a contractual form, one party's attempt to free himself from his previously chosen Time 2 obligation harms the interests of the enforcing party. In most cases—including those involving frozen embryos and other reproductive factors—the reliance of the other party on that promise should count very heavily toward enforcing the advance waiver of Time 2 options. In other words, contracts, even reproductive contracts, should be enforced, at least if no new bodily burdens are entailed. Detrimental reliance by others is a good reason for enforcing Time 1 expressions of Time 2 preferences despite one party's Time 2 objections.

Enforcing contracts for the disposition of frozen embryos, however, raises the additional problem of whether to enforce advance agreements for rearing rights and duties in offspring born after Time 2 enforcement of those agreements. Although the arguments advanced here would give a strong presumption in favor of such agreements, the need to protect the best interests of children has traditionally limited contractual allocation of support and custody arrangements over offspring. Prenuptial agreements, for example, apply only to division of property and not to child support, custody, or visitation.[72] It is likely that those concerns will continue to limit advance agreements for rearing rights and duties in children born from frozen embryos after divorce. Honoring the agreement for postdivorce implantation of embryos may occur without also requiring that agreements for rearing rights and duties in those offspring also be followed.[73]

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72. *See* UNIF. PREMARITAL AGREEMENT ACT § 3(b), 9C U.L.A. 43 (2001) (prohibiting the parties from adversely affecting a child's right to support through a premarital agreement). The UPAA is in effect in 26 states, including Texas. *Id.* at 35 (listing the jurisdictions in which the UPAA has been adopted).

73. For a discussion of the constitutionality of enforcing or not enforcing prior agreements for allocation of rearing rights and duties in offspring born from thawed embryos after divorce, see Robertson, *supra* note 70, at 1032–38.

C. Advance Directives and Posthumous Reproduction

Another reproductive area in which precommitment ideas play a role is in determining the legal parentage of a child born after posthumous conception or embryo transfer. The typical case arises with men diagnosed with cancer who, prior to radiation or chemotherapy, freeze their sperm to preserve their fertility.[74] If their cancer treatment is successful, they may use the frozen sperm to have offspring. If the cancer treatment is unsuccessful, the surviving spouse might request that the frozen sperm be thawed and used to impregnate her.[75]

Legal questions about the child's paternity have arisen in cases of posthumous insemination when the widow has then sought social security survivor and widow benefits. Social security regulations award those benefits only if the child would qualify as the deceased's child under state intestacy statutes, thus necessitating an inquiry into whether a child born after posthumous conception is the "issue" or "natural child" of the deceased under a particular state's intestacy statute.

The Supreme Judicial Court of Massachusetts recently faced such a case. A husband with leukemia stored sperm prior to undergoing the massive chemotherapy that precedes bone marrow transplantation. The leukemia treatment was not successful. Sixteen months after his death his widow had his sperm thawed and on the second try was successfully impregnated. She eventually gave birth to twin girls born 2.5 years after his death. She was refused social security widow and survivor benefits and sued in federal district court. The district court requested certification of the children's status under the Massachusetts law of intestacy. In response the Massachusetts high court held:

> In certain limited circumstances, a child resulting from posthumous reproduction may enjoy the inheritance rights of "issue" under the Massachusetts intestacy statute . . . . These limited circumstances exist where, as a threshold matter, the surviving parent or the child's other legal representative demonstrates a genetic relationship between the child and the decedent. The survivor or representative must then establish both that *the decedent affirmatively consented to posthumous*

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74. Cases could also arise with frozen embryos or eggs or ovarian tissue. I will limit my discussion to the case of frozen sperm.

75. This assumes that she has lawful custody of the sperm and the right to dispose of it as she wishes, including to use it for reproduction. *See* Hecht v. Superior Court, 20 Cal. Rptr. 2d 275, 283 (Cal. Ct. App. 1993) (holding that sperm of the deceased is "properly part of decedent's estate," that his widow is the "residual beneficiary," and ordering twenty percent of the sperm vials—the widow's share as residual beneficiary—to be released to her for conception purposes); *cf.* Hecht v. Superior Court, 59 Cal. Rptr. 2d 222, 227–28 (Cal. Ct. App. 1996) (ordered not to be officially published) (concluding that although the deceased's sperm was not an "asset" of his estate that could be divided by settlement, it constituted "property" for the sole use of the decedent's widow because the decedent's intent governs, and ordering all remaining sperm to be released to the decedent's widow).

> *conception and to the support of any resulting child*. Even where such circumstances exist, time limitations may preclude commencing a claim for succession rights on behalf of a posthumously conceived child.[76]

The court's criteria for satisfying the intestacy statute provide yet another variation on the use of precommitment ideas. The court is willing to give a Time 1 choice—consent to posthumous reproduction with an intent to support—to determine whether, at Time 2, the child is the "issue" of the deceased and thus qualifies for intestacy or social security benefits. Absent a Time 1 commitment or intention of the deceased to support the child after his death, concerns about preventing fraud and ensuring fairness to heirs will take precedence. The novel twist on the usual precommitment situation is that the maker of the Time 1 precommitment is deceased when Time 2 arises. He has no interests at Time 2, much less a different preference, which is the dilemma posed by most precommitment situations.[77]

Although it might seem odd to have the posthumously conceived child's legal status turn on the deceased's Time 1 commitment to posthumous support, the court's reasons for doing so are defensible. Given that a wife may use the frozen gametes anyway to bear a child, there are strong policy reasons for assuming that the legislature wanted to protect the financial welfare of children (as well as possibly not burdening her choice to use those gametes). Requiring proof of the husband's intent at Time 1 is a defensible way to prevent fraud and enhance certainty, while recognizing his prior and her current interest in using the sperm. He can establish proof of intent at the time of deposit by executing a document stating that it is his intention to allow his wife to thaw the sperm after his death and to support any children born as a result. If time periods for the orderly administration of estates are followed, the interests of husbands, widows, and children are reasonably well served by this solution.

Given the practice of making wills to direct the posthumous distribution of property, there is nothing novel about allowing premortem Time 1 wishes to control postmortem Time 2 distributions. Although wills do not usually grant legal status to children or determine the application of federal social security law, both the federal and state governments might decide to give a Time 1 choice that effect when it serves important state interests at Time 2, as it appears to do here. It is yet another example of when a Time 1 choice might usefully control a Time 2 outcome.

This conclusion is consistent with the demands of some state courts for evidence of a Time 1 directive to settle Time 2 questions about whether

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76. Woodward v. Comm'r of Soc. Sec., 760 N.E.2d 257, 259 (Mass. 2001) (emphasis added) (internal citations omitted).

77. In the living will situation, the incompetent person still has interests that are affected by the Time 1 choice, even if he now lacks the competency to now opt for those interests. *See* discussion *supra* subpart I(C).

treatment may be provided or withheld from conscious incompetent persons at the end of life.[78] In those cases, several states (but not Massachusetts) have required such a directive to permit withdrawal of treatment from conscious incompetent persons to prevent harming patient interests. The Time 1 directive in those cases creates the appearance that the incompetent person has chosen the outcome. In contrast, *Woodward* requires evidence of a Time 1 choice about Time 2 parentage in order to receive Time 2 federal benefits, so as to prevent fraud and provide certainty. But it is not unreasonable for a state to privilege those concerns, even if the absence of a directive will discourage a widow from being impregnated with her deceased husband's sperm or deny children born as a result from the receipt of the same benefits that other children of that father receive. That is a policy choice dependent on the court's view of a reasonable accommodation of the competing concerns.

In the end, cases of posthumous reproduction are only tangentially related to the basic problem of precommitment. What precommitment ideas add to this issue is a means to highlight the need for a Time 1 commitment to a Time 2 outcome, even if at Time 2 there is no temporally different self, or even an incompetent self, with different wishes or interests. Thus, the Time 1 directive can be used to resolve questions of intestacy and the social welfare benefits dependent on them.

IV. Reflections and Conclusions

This survey of precommitment in bioethics illustrates the pervasiveness of precommitment as a form of behavior and the typical issues that it poses. Used in many different areas of life, precommitments pose dilemmas of when and under what circumstances a Time 1 choice should be binding at Time 2 when Time 2 preferences or interests are quite different from those envisaged at Time 1. Viewing those situations as "precommitments" is not essential to come to adequate resolutions of the problems they present, but the concept highlights the conflicting temporal freedoms and trade-offs which such situations present.

Sometimes the precommitment cannot be undone because it operates preemptively by removing the possibility of any different choice or action at Time 2. In those cases, the Time 1 choice takes on a much greater importance. Frontloaded procedures to ensure that it is free and informed may be needed. In other precommitment situations, the Time 1 choice is still executory, requiring a Time 2 decision by the maker or another actor to implement the Time 1 choice. In those cases, the Time 1 choice can be undone, but often only at significant costs to the actor or others.

Determining what circumstances and principles explain or justify adhering to or overriding the prior commitment is the problem of precommitments generally. As this Article has shown, the question of when

78. *See* discussion *supra* subpart I(C).

Time 2 preferences or interests should control in the biomedical setting cannot be answered in the abstract. The priority accorded to Time 1 over Time 2 choices varies with the subject area, the benefits and harms of one temporal choice over another, the type of precommitment, and other factors. Indeed, the force of a Time 1 commitment may be treated differently within the same subject area, as shown by examples in medical decisionmaking, human subjects research, and assisted reproduction.

Focusing on precommitment situations in bioethics reminds us how context dependent precommitment devices and the conflicts they engender are. One can decide what protections are needed for a preemptive precommitment only with detailed knowledge of what is at stake, and that will vary with the context of decision. In bioethics, a preemptive precommitment might involve loss of life, control over one's DNA and the genomic information that it contains, or loss of the opportunity to raise one's biologic offspring. In addition, precommitments in bioethical situations pose unique problems because they frequently involve agreements about the body, gametes, and embryos. Also, they often involve Time 1 directives that take effect when a person is incompetent or unavailable to evaluate the earlier decision.

Precommitments are devices to enhance or extend present freedom by constraining future freedom, but they carry the price tag of reduced freedom in the future. The failure to honor precommitments reduces a person's freedom at Time 1 while enhancing it at Time 2. Which freedom should be curtailed to "pay the alligator" is the question that law, ethics, and policy must repeatedly confront when individuals use precommitment devices to shape their future in medical settings and other areas of life.[79]

79. Flatlanders, *Pay the Alligator*, *on* NOW AGAIN (New West Records 2002) ("It may be sooner, it may be later, but there is no escaping, you have to pay the alligator.").