

Embryo Disposition and Divorce: Why Clinic Consent Forms Are Not the Answer

by
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Introduction

After two years of attempting to conceive a child naturally, Allison and Bruce consult a fertility specialist, Dr. Stevens, with the ABC Fertility Clinic. Dr. Stevens advises Allison and Bruce to undergo in vitro fertilization (IVF). Prior to commencing treatment, Allison and Bruce both sign a number of consent forms, including one entitled “Consent and Agreement for Cryopreservation.” This form provides for cryopreservation (freezing) of any suitable excess embryos remaining after transfer to Allison. In addition, the form requires Allison and Bruce to consider the future disposition of the embryos in a variety of circumstances, including divorce. The form states that “In the event we divorce, the embryos shall be dealt with as follows: (1) The embryos shall be transferred to patient for future use by her to initiate a pregnancy; (2) The embryos shall be transferred to partner for future use; (3) the embryos shall be donated to another individual or couple; (4) the embryos shall be donated to research or

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(4) the embryos shall be thawed and discarded.” Prior to treatment, Allison and Bruce initialed choice #1.

Allison undergoes oocyte retrieval, her eggs are combined with Bruce’s sperm in the laboratory, and six embryos result. Two embryos are transferred to Allison’s uterus, and the remaining four are cryopreserved for future use. Allison fails to become pregnant. Allison and Bruce cannot afford another cycle of IVF at that time, so they agree to wait until they have saved enough money before attempting another cycle. Two years pass. In that time, the marriage deteriorates, and Allison files for divorce. She would like to attempt to initiate a pregnancy by thawing and transferring the remaining embryos as soon as the divorce is final. Bruce wants the embryos destroyed. Whose wishes will control in this situation?

Allison and Bruce are a hypothetical couple, but they are far from unique. Thousands of individuals and couples undertake in vitro fertilization each year, hoping to start a family.¹ In many cases, an IVF cycle will yield more embryos than the couple can use, and they will choose to cryopreserve those excess embryos. Some of those frozen embryos will be used in future IVF cycles, but many will languish in storage, awaiting a final disposition decision by the progenitors. Indeed, researchers now estimate that some 400,000 embryos currently remain in storage at clinics throughout the country.² While few couples want to contemplate divorce, the high divorce rate makes it certain that some of these couples will eventually divorce and find themselves in disagreement about the appropriate disposition of those embryos. A difficult decision under ordinary circumstances now becomes nearly impossible.

It has become increasingly common for clinics to require couples undergoing IVF to sign a cryopreservation consent or

¹ In its latest report on the matter, the Centers for Disease Control (CDC) reported that more than 70 percent of the 148,055 assisted reproductive technology cycles performed in 2008 involved IVF. The statistics were obtained from 436 clinics nationwide that reported their annual data as required. Centers for Disease Control, *Assisted Reproductive Technologies Success Rates: National Summary and Fertility Clinic Reports (2008)*, available at http://www.cdc.gov/art/ART2008/PDF/ART_2008_Full.pdf.

² Anne Drapkin Lyster et al., *Factors That Affect Infertility Patients’ Decisions About Disposition of Frozen Embryos*, 85 *FERTILITY & STERILITY* 1623 (2006).

agreement, such as the one described above, prior to initiating treatment.³ These documents vary in their particulars, but typically ask patients to choose from a number of options for disposition under a variety of contingencies, such as death, divorce or abandonment of the embryos.⁴ A few states now require by statute that physicians provide their fertility patients with a form covering dispositional choices.⁵

While these documents might appear to settle the matter, in fact, the content of the forms and the process and circumstances surrounding their execution raise serious doubts about their value in resolving disputes over embryos in the context of divorce. Case law to date evinces the uncertainty plaguing the validity of these forms and how to resolve disputes over embryo disposition at divorce more generally. Courts in most states have yet to consider the issue. In those that have, the judicial decisions range from those that purport to view such agreements as binding and enforceable to those that explicitly refuse to enforce certain dispositions chosen at the time of treatment, in the absence of contemporaneous consent. Moreover statutory proscriptions related to embryo disposition, which vary widely in some respects, nonetheless share the dubious distinction of bringing confusion rather than clarity to the question of embryo disposition in cases of divorce.

Scholars, too, have struggled to devise a suitable framework for settling these matters. In particular, they have disagreed about the efficacy and appropriateness of using contracts and consent forms to do so.⁶ I assume for purposes of this article,

³ Judith F. Daar, *Frozen Embryo Disputes Revisited: A Trilogy of Procreation-Avoidance Approaches*, 29 J.L. MED. & ETHICS 197, 201 (2001).

⁴ See, e.g., Anne Drapkin Lyster, et al., *Fertility Patients' Views About Frozen Embryo Disposition: Results of a Multi-Institutional U.S. Survey*, 93 FERTILITY & STERILITY 499, 500 (2010) (Table 1 showing options included in informed consent documents of center participating in study).

⁵ CAL. HEALTH & SAFETY CODE § 125315 (West 2010); MASS. GEN. LAWS ANN. ch. 111L, § 4 (West 2010); FLA. STAT. ANN. § 742.17 (West 2010); N.J. STAT. ANN. § 26:2Z-2 (West 2010). Similar legislation is pending in New York. S.B. 394, 234th Legis. Sess. (N.Y. 2011-2012); Assemb. B. 3218, 234th Legis. Sess. (N.Y. 2011-2012).

⁶ On problems of consent forms, see Ellen A. Waldman, *Disputing Over Embryos: Of Contracts and Consents*, 32 ARIZ. ST. L.J. 897, 940 (2000). On the wisdom of using contracts to decide embryo disposition, compare, e.g., I. Glenn

that no categorical policy (for example, that embryos are considered persons and thus not subject to contract) or constitutional barrier prohibits the use of contracts generally to govern embryo disputes.⁷ Rather, I focus here exclusively on the problems inherent in considering clinic consent forms as enforceable contracts between the progenitors in the event of divorce or comparable change in status for unmarried couples. In doing so, the article enriches existing critiques of embryo contracts and consents in three ways: (1) by considering a body of social science literature that has developed over the last decade concerning how fertility patients and partners make embryo disposition choices; (2) by analyzing closely existing and pending legislation bearing on the topic; and (3) by incorporating insights derived from drafting consent forms for and working closely with fertility clinics and physicians.

This article begins in Part I by reviewing the various approaches courts have adopted to resolve these disputes. Part II identifies and explores the weaknesses inherent in viewing standardized consent forms as binding agreements between the progenitors, while Part III critically examines statutory efforts related to embryo disposition that have served more to confound than to clarify. Part IV argues that the many intractable deficiencies of clinic embryo disposition consent forms and the process surrounding them make them unsuitable for contractual enforcement. Instead, clinic consent forms should be redrafted to dispel any notion that they constitute a binding agreement between the

Cohen, *The Right Not To Be a Genetic Parent*, 81 S. CAL. L. REV. 1115 (2008) (arguing in favor of embryo disposition contracts); John A. Robertson, *Precommitment Strategies for Disposition of Frozen Embryos*, 50 EMORY L.J. 989 (2001) (same); Mark P. Strasser, *You Take the Embryos But I Get the House (and the Business): Recent Trends in Awards Involving Embryos Upon Divorce*, 57 BUFF. L. REV. 1159 (2009) (same), with Carl H. Coleman, *Procreative Liberty and Contemporaneous Choice: An Inalienable Rights Approach to Frozen Embryo Disputes*, 84 MINN. L. REV. 55 (1999) (arguing against enforceable embryo disposition contracts); Judith F. Daar, *Assisted Reproductive Technologies and the Pregnancy Process: Developing an Equality Model to Protect Reproductive Liberties*, 25 AM. J.L. & MED. 455, 474-77 (1999) (arguing that embryo contracts infringe women's constitutional rights).

⁷ This assumption is clearly open to debate. See *supra* sources cited in note 6. In a companion piece, I will fully explore this underlying assumption.

progenitors in the event of divorce or change in relationship status, and courts should refuse to enforce them on policy grounds.

I. An Overview of the Cases

A. *The Balancing Approach*

The first case to consider the disposition of disputed embryos in a divorce was *Davis v. Davis*.⁸ Mary Sue and Junior Davis had been through several unsuccessful courses of IVF and, at the time of their divorce, had seven cryopreserved embryos in storage. Mary Sue initially wanted to implant the embryos;⁹ Junior wanted the embryos destroyed. They had not signed any written agreement regarding disposition of the embryos. In the absence of a prior agreement, the Tennessee Supreme Court balanced what it saw as the parties' conflicting constitutional interests in procreation—Mary Sue's right to procreate and Junior's right not to procreate.¹⁰ The court viewed the parties as "entirely equivalent gamete-providers," despite acknowledging Mary Sue's greater physical contribution to creating the embryos.¹¹ After weighing these competing interests, the court ultimately decided in favor of Junior's right not to procreate, in part relying on the possibility that Mary Sue might achieve parenthood through another cycle of IVF or through adoption.¹² The *Davis* decision went on, however, to advise that courts resolve these disputes according to the preferences of the embryos' progenitors, if a prior agreement exists. The *Davis* court's balancing test then would be a last resort, exercised only in the absence of an

⁸ 842 S.W.2d 588 (Tenn. 1992).

⁹ By the time the case reached the Tennessee Supreme Court, Mary Sue had changed her mind about disposition: she now wanted to donate the embryos for use by a childless couple. *Id.* at 590.

¹⁰ *Id.* at 603-04.

¹¹ *Id.* at 601. Women undergoing IVF need to follow a strict drug protocol involving regular injections and submit to an invasive medical procedure for retrieval of their oocytes. Men must merely ejaculate into a cup. *See also* Kerry Lynn Macintosh, *Brave New Eugenics: Regulating Assisted Reproductive Technologies in the Name of Better Babies*, 2010 U. ILL. J.L. TECH. & POL'Y 257, 264-65.

¹² *Davis*, 842 S.W.2d at 604.

agreement between the parties, and in most of those cases, the party wishing to avoid procreation would prevail.¹³

B. *Cases That Have Enforced Prior Agreements: The Contract Approach*

Although no prior agreement existed in *Davis*, rendering its endorsement of using contract to decide embryo disputes mere dicta, a number of courts have subsequently heeded its call. In *Kass v. Kass*,¹⁴ wife Maureen and husband Steven had five cryopreserved embryos created in connection with several failed IVF cycles. The consent form signed at the clinic provided that disposition of the embryos in the event of divorce would be determined in a property settlement. However, it also included a provision that called for donation to research in the event the couple could not agree on disposition. In interpreting the agreement, the New York Court of Appeals held that cryopreservation agreements should be presumed valid and enforceable,¹⁵ and that the provision calling for donation to research should control.¹⁶ However, the court did note that “[s]ignificantly changed circumstances” in some cases might “preclude contract enforcement.”¹⁷

Likewise, in *In re Marriage of Dahl*, an Oregon appellate court gave effect to a cryopreservation contract that provided that the wife would have decision-making authority over the embryos if the parties could not agree.¹⁸ The wife wanted to destroy the embryos; the husband wanted to donate them to another couple. In a 2006 Texas case, *Roman v. Roman*,¹⁹ the parties’ positions were reversed: The husband wanted to discard the embryos; the wife wanted to implant them. Nonetheless, the outcome was essentially the same. The court found a provision contained in the clinic consent form to discard unused embryos in the event of divorce to be valid and enforceable.²⁰

¹³ *Id.*

¹⁴ 696 N.E.2d 174 (N.Y. 1998).

¹⁵ *Id.* at 180.

¹⁶ *Id.* at 182.

¹⁷ *Id.* at 179, n.4.

¹⁸ 194 P.3d 834, 842 (Or. Ct. App. 2008).

¹⁹ 193 S.W.3d 40 (Tex. 2006).

²⁰ *Id.* at 52, 54.

In a case decided by the Washington Supreme Court, *Litowitz v. Litowitz*,²¹ the embryos had been created with the husband's sperm and donor eggs. At the time of divorce, the wife sought to implant the embryos in a surrogate; the husband sought to put them up for adoption. The cryopreservation contract provided that the Litowitzes must petition a court if they could not agree on disposition of the embryos.²² However, it also contained a provision that the clinic would thaw any embryos still in storage five years after the initial date of cryopreservation. More than five years had passed at the time the Washington Supreme Court rendered its decision, so, in a rather mystifying decision, the court ruled that pursuant to the contract, any embryos remaining in storage were to be thawed and discarded.²³ The court completely ignored the fact that the dissolution action was filed merely two years after the Litowitzes signed the cryopreservation contract, well within the five-year period. The Litowitzes might well have assumed that the five-year limitation on storage would apply only if they had not sought instructions from the court. The dissent thus argued that filing the action should have tolled the contractual period of limitation.²⁴ In the end, neither party got the result it desired.

C. *Cases That Have Allowed the Parties to Change Their Mind: The Contemporaneous Consent Approach*

Several other states have acknowledged the importance of agreements between the progenitors, but with a key difference. While these cases, like those previously discussed, declare that cryopreservation contracts should be presumed enforceable, these courts will not enforce such agreements in disputes between the progenitors where one party has had a change of heart. In other words, the agreement would likely be enforceable primarily in a dispute between the couple and the clinic, not between the progenitors themselves, at least in cases where one

²¹ 48 P.3d 261 (Wash. 2002). A subsequent unpublished Washington appellate decision likewise applied the contract approach in a case involving a dispute over embryos created with the husband's sperm and donor eggs. *In re Marriage of Nash*, 2009 WL 1514842 (Wash. Ct. App. 2009).

²² *Litowitz*, 48 P.3d at 268.

²³ *Id.* at 271.

²⁴ *Id.* at 272 (Sanders, J., dissenting).

party wanted to use the embryos to attempt to initiate a pregnancy.

The New Jersey Supreme Court adopted this “contemporaneous consent” approach in the case of *J.B. v. M.B.*²⁵ J. B. and M.B. underwent an IVF procedure. J.B. became pregnant and gave birth to a daughter. Eight embryos were cryopreserved and remained in storage when J.B. sought a divorce. J.B. wanted to have the embryos discarded. M.B. wanted to use the embryos herself or donate them to another couple. J.B. and M.B. had signed a consent form that provided that they would relinquish the embryos to the clinic’s IVF Program in the event of a marital dissolution, unless a court ordered otherwise. The court ruled that the consent form “did not manifest a clear intent by J.B. and M.B. regarding disposition of the preembryos” in the event of divorce and that they “never entered into a separate binding contract providing for the disposition of the cryopreserved preembryos.”²⁶ The court went on to declare that contracts entered into at the time of IVF could be enforced if executed with reasonable safeguards (agreement written in plain language, reviewed with clinic personnel, not signed in blank), subject to either party’s right to change his or her mind about disposition up to the point of use or destruction of any stored embryos.²⁷ In the absence of mutual contemporaneous agreement, “ordinarily the party choosing not to become a biological parent will prevail.”²⁸ Since J.B. did not object to continued storage, M.B. could continue to pay the fees; otherwise the embryos would be destroyed.²⁹

The Supreme Court of Iowa took a similar approach in *In re Marriage of Witten*.³⁰ Tamera and Trip Witten had undergone several failed embryo transfer attempts and had seventeen embryos in storage when they sought to divorce. They had signed a form that required joint consent for release of the embryos and

²⁵ 783 A.2d 707 (N.J. 2001).

²⁶ *Id.* at 713-14.

²⁷ *Id.* at 719.

²⁸ *Id.* The court left open the resolution in a case where a party has become infertile and wishes to use the embryos, “noting only that the possibility of adoption also may be a consideration.” *Id.* at 720.

²⁹ *Id.*

³⁰ 672 N.W.2d 768 (Iowa 2003).

an exception in the event of death of a party, but the agreement did not specifically address disposition in divorce. Tamera wanted to use the embryos to attempt to get pregnant; Tripp wanted the embryos discarded. The court held that where the progenitors of the embryo disagree about disposition, contemporaneous mutual consent is required. In the absence of mutual consent, no transfer, release, use or other disposition can occur. Hence, as a practical matter, the embryos would remain in storage indefinitely, with the party opposing destruction paying the fees.³¹ As with *J.B.*, the court distinguished enforceability by the progenitors against each other from enforceability between the couple and the medical facility. As to the latter, the contract would be binding.³²

The Supreme Judicial Court of Massachusetts resolved the issue in a somewhat different way. In *A.Z. v. B.Z.*,³³ the court refused to enforce a cryopreservation agreement that contained a provision giving the embryos to the wife for implantation in the event the parties separated. The court was skeptical that the agreement actually reflected the intent of the parties, given ambiguities in the language and the circumstances surrounding the signing of the form.³⁴ The wife had written in the disposition after the husband had signed a blank form.³⁵ More importantly, the court went on to assert that even if the agreement had been unambiguous, it would not enforce a clause that would compel one provider of gametes to become a parent against his or her wishes.³⁶ Such a provision went against the public policy of Massachusetts. Hence, to the extent one party wants to use the embryos to initiate a pregnancy over the objection of the other, Massachusetts would require mutual contemporaneous consent.³⁷ However, in a footnote, the court explicitly refrained from deciding whether courts might enforce agreements providing for other dispositions, such as destruction of the embryos or donation to research or to a surrogate, over the present objection

³¹ *Id.* at 783.

³² *Id.*

³³ 725 N.E.2d 1051 (Mass. 2000).

³⁴ *Id.* at 1056.

³⁵ *Id.* at 1054.

³⁶ *Id.* at 1057.

³⁷ *Id.* at 1058.

of one of the parties.³⁸ It also noted the continued vitality of the contract for disputes between the couple and the clinic.

II. Evaluating the Contract Approach: Process and Substance Problems with Forms

The contract approach appears to have assumed the lead among courts considering the issue. Seven of the ten appellate decisions considering embryo disputes at divorce have adopted or endorsed this approach.³⁹ However, the contracts at issue in each of these cases were created via consent forms provided to the couple by the fertility clinic. Even if contracts in theory are a desirable way to resolve these disputes,⁴⁰ viewing these consent forms as contracts between the parties in the divorce context is extremely problematic and, ultimately unsustainable as a matter of policy. Research on embryo disposition decision-making highlights the difficulty patients experience deciding the fate of their

³⁸ This provision is curious, because it seems to suggest that a court might compel genetic parenthood through use of a surrogate, without contemporaneous consent. The reference to implantation in a surrogate as outside the scope of the decision seems at odds with the rest of the opinion, particularly its discussion of the lack of enforceability of surrogacy contracts without a sufficient waiting period allowing the mother to change her mind. *Id.* at 1059.

³⁹ See *supra* notes 14-24 and accompanying text and *Cahill v. Cahill*, 757 So.2d 465, 467 (Ala. Civ. App. 2000) (affirming trial court's ruling that clinic "appeared" to own embryos, where wife refused to produce actual agreement); *Karmasu v. Karmasu*, 2009 WL 3155062 (Ohio Ct. App. 2009) (affirming trial court's holding that "custody" of frozen embryos was controlled by contract between clinic and progenitors). *Cf. Dodson v. Univ. of Ark. for Med. Sci.*, 601 F.3d 750 (8th Cir. 2010) (involving federal challenge to state court ruling enforcing property settlement that approved of disposition of embryos according to clinic Disposition Statement signed as part of IVF treatment). See also *Roman v. Roman*, 193 S.W.3d 40, 48 (Tex. App. 2006) (describing enforcement of embryo agreements as "emerging majority view.") In addition, even the appellate decisions that refused to enforce the contract between the progenitors have approved their use to govern the relationship between the clinic and the couple. See *supra* notes 25-38 and accompanying text. It is worth noting that regardless of the courts' views regarding the enforceability of embryo disposition contracts, the cases thus far have uniformly ruled against the party wishing to implant embryos against a former spouse's objection. See *Strasser*, *supra* note 6, at 1224; *Daar*, *supra* note 3, at 201.

⁴⁰ This assertion has generated considerable controversy among courts, see *supra* notes 14-38 and accompanying text, and among scholars, see *supra* note 6 and sources cited therein.

embryos and the volatile nature of that decision. The circumstances surrounding review and execution of the forms, as well as the substance of the forms themselves, cast further doubt on whether these forms accurately reflect the progenitors' intentions even at the time of signing, let alone whether they can reasonably forecast preferences years into the future in the context of divorce. Moreover, for a host of reasons, these flaws of process and substance will likely prove impossible to ameliorate sufficiently in the context of clinic consent forms to consider them contractually binding on the couple in a dispute with each other. Each of these problems will be discussed below.

A. *Too Much (Information), Too Soon*

Fertility patients often first encounter the issue of embryo disposition when they are handed a thick packet of consent forms to review and sign prior to commencing their IVF cycle. Embryo disposition provisions regarding divorce are typically embedded in a larger document covering many aspects of cryopreservation, including such topics as the medical risks and benefits of the procedure, storage limits and payment terms. In some instances, the cryopreservation agreement may constitute merely one part of a much lengthier document that covers the risks and benefits of IVF, egg retrieval and other aspects of the fertility treatment.

Indeed, despite calls for disaggregation of the medical aspects of the consent form from the legal aspects of embryo disposition dating back more than a decade,⁴¹ clinics continue to use forms that combine a series of subjects in a way that can easily obscure the significance of the embryo disposition divorce provision. Clinic consent forms too often present their information using highly technical language in densely packed, single-spaced documents, that may not even clearly delineate the different topics.⁴² Indeed, in 2008, the Society of Assisted Reproductive Technology (SART), in a joint project with the American Society of Reproductive Medicine, created a standardized consent form

⁴¹ Ellen A. Waldman argued persuasively for this change in an article published in 2000. Waldman, *supra* note 6, at 940. Other scholars have since echoed the call. See e.g., Daar, *supra* note 3, at 201; Cohen, *supra* note 6, at 1194 n.243.

⁴² Waldman, *supra* note 6, at 931.

for use by member clinics throughout the country.⁴³ Given the prestige of the organizations and the cost of the documents (free to members), one would expect that they would be viewed as model documents and widely adopted. Unfortunately, they fail to improve the presentation of information related to embryo disposition. The documents are available in two forms—a sequential form, in which the embryo cryopreservation consent comprises the last seven pages of the 27-page document, and an “embedded” form, in which the embryo cryopreservation consent appears in the middle of the document.⁴⁴ In addition to requiring patients to make choices regarding embryo disposition, both versions of the form cover IVF, ICSI (intracytoplasmic sperm injection), and assisted hatching, and include extremely detailed descriptions and explanations of the medical risks of the various IVF-related procedures. On the plus side, the SART documents’ use of headings and boxes presents a relatively reader-friendly layout.

Even where clinics provide a separate form for cryopreservation, it is merely one of many the patients must wade through prior to treatment. For example, in *Roman*, the court noted that the couple signed nine forms in one day, including the embryo cryopreservation consent.⁴⁵ In *Kass*, the parties signed four documents. The first two consisted of a twelve page, single-

⁴³ Kirtly Parker Jones, *Informed Consent in Advanced Reproductive Technology*, in *REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY: INTEGRATING MODERN CLINICAL AND LABORATORY PRACTICE* 52, 53 (Douglas T. Carrell & C. Matthew Peterson, eds., 2010).

⁴⁴ The documents are essentially identical except for the placement of the cryopreservation section. SART, *Informed Consent for ART*, January 1, 2009 (Embedded); SART, *Informed Consent for ART*, Jan. 1, 2009 (Sequential). Subsequent page number references to the SART documents are to the sequential version. The SART Documents are only available to clinics that are members of SART. The author viewed portions of the documents at a course held at the ASRM annual meeting in 2008. See James P. Toner, *Journey to an Informed Consent for SART Clinics*, Nov. 8-9, 2008, materials accompanying presentation at Course 1: Managing Risk in Assisted Reproductive Technologies, ASRM Annual Conference. Complete copies of the documents were obtained in full from a member clinic. They remain on file with the author [hereinafter SART Documents].

⁴⁵ *Roman*, 193 S.W.3d at 50. It is not entirely clear from the opinion whether the Romans had time to review the documents prior to the day they signed them at the clinic, despite the recitation on the cover page that “Many

spaced document that covered the IVF and embryo transfer procedures and an “Addendum” approving cryopreservation. They also signed a separate cryopreservation consent form—another seven pages of single spaced text, also in two parts.⁴⁶

Information overload can hinder patients’ ability to make a thoughtful, informed decision, particularly in the emotionally charged atmosphere of fertility treatment.⁴⁷ Medical researchers and legal scholars alike have noted the barriers to understanding presented by overdetermined consent forms that aim to do too much and ask patients to contemplate scenarios that in some ways are mutually inconsistent. Strong emotions combined with an excess of information may increase the likelihood of selective perception, by which people screen out information at odds with their preconceived ideas or wants and overemphasize information consistent with them.⁴⁸ Patients are particularly likely to resist anxiety-provoking information, and fertility consent forms are chock full of such information, including distressing medical

forms require careful thought regarding decisions you and your spouse will be asked to make.” *Id.*, at 51.

⁴⁶ *Kass v. Kass*, 696 N.E.2d 174, 176 (N.Y. 1998).

⁴⁷ RUTH R. FADEN, ET AL., *A HISTORY AND THEORY OF INFORMED CONSENT* 324 (Oxford Univ. Press 1986); S. Michael Sharp, *Common Problems with Informed Consent in Clinical Trials*, 5 *Research Practitioner* 133, 135 (identifying common problems of poor readability and excessive length of consent forms as barriers to obtaining informed consent). *See also* Matthew E. Falagas, et al., *Informed Consent: How Much And What Do Patients Understand?* 198 *Amer. J. of Surgery* 420, (2009) (finding lack of adequate understanding of information among surgery patients); Mark Hocchauser, *Memory Overload: The Impossibility of Informed Consent*, *Applied Clinical Trials Online*, Nov. 1, 2005, available at <http://appliedclinicaltrialsonline.findpharma.com/appliedclinicaltrials/article/articleDetail.jsp?id=192756> (accessed March 8, 2011) (arguing limits on working memory make understanding lengthy, complex informed consent documents impossible regardless of how they are written).

⁴⁸ Melissa Boatman, Comments, *Bringing Up Baby: Maryland Must Adopt an Equitable Framework for Resolving Frozen Embryo Disputes After Divorce*, 37 *U. BALT. L. REV.* 285, 303-04 (2008); Waldman, *supra* note 6, at 922-23. Lyerly, et al., describe this phenomenon as “cognitive-affective dissonance.” They observe that “While managing the strain of infertility, some participants were not in a suitable affective state to meet the cognitive demand of carefully considering the eventuality of ‘spare’ embryos. It therefore may be unrealistic to expect people beginning the process of creating embryos to be able to reflect seriously about whether or how they might eventually dispose of them.” Lyerly, *supra* note 2, at 1628.

risks to the participants or the future child and the risk of failure of the procedure. On top of that vital information, embryo disposition forms ask the patients to consider worst-case scenarios such as their own mortality and divorce,⁴⁹ at a time when they are intensely focused on having a child.⁵⁰ Expecting careful deliberation of myriad contingencies and disposition options under these circumstances seems unrealistic, to say the least.⁵¹

B. *Difficult Decisions*

Indeed, the foolhardiness of relying on standardized consent forms to govern embryo disposition in the event of a divorce—perhaps many years into the future—becomes apparent when we consider the literature regarding embryo disposition generally. Studies that have evaluated how patients decide among embryo disposition options outside the context of divorce uniformly demonstrate two critical points: first, the exceedingly difficult nature of the decision for many, and second, the instability of the decision over time.

Numerous studies have documented how daunting participants in the IVF process find the embryo disposition decision. According to the most recent literature and the largest study to date, substantial evidence indicates that embryo disposition decisions are “extremely difficult” for patients.⁵² One study found that almost half the survey sample considered decision-making

⁴⁹ Lyerly, *supra* note 2, at 1628; Waldman, *supra* note 6 at 924-25.

⁵⁰ Lyerly, *supra* note 4, at 506; Lyerly, *supra* note 2, at 1627 (noting that many survey participants “stated they were overwhelmed by the volume of information they were asked to absorb. They reflected that in the early stages of IVF, they were not in a state of mind to consider what they might do in the future should they be fortunate enough to achieve all the pregnancies they desired.”); Robert D. Nachtigall et al., *Parents’ Conceptualization of Their Frozen Embryos Complicates the Disposition Decision*, 84 *FERTILITY & STERILITY* 431, 433 (2005) (“One root cause of the ambivalence about the disposition decision is that couples are initially focused on the immediate goal of achieving a pregnancy while working their way through the complex intermediate steps and decisions required by the IVF technique and do not anticipate that having surplus embryos will present a challenge in the future.”).

⁵¹ See Waldman, *supra* note 6, at 925.

⁵² A. D. Lyerly et al., *Decisional Conflict and the Disposition of Frozen Embryos: Implications for Informed Consent*, 26 *HUM. REPROD.* 646 (2011).

about embryo disposition “distressing,”⁵³ while another study reported patients feeling ‘anguished’ and ‘agonizing’ over the decision.”⁵⁴ Fertility patients commonly perceive that they face “a choice among unappealing disposition options.”⁵⁵ Others describe a decision-making process “often marked by ambivalence, discomfort, and uncertainty.”⁵⁶ Indeed, in one study involving embryos created with donor eggs, a number of the interviewed couples revealed that “contemplating the fate of their embryos was harder than their decision to go forward with the donor oocyte procedure itself.”⁵⁷ This statement is astounding, especially given that one of the partners had no genetic connection to the embryo. The high level of difficulty patients experience with embryo disposition decisions undoubtedly accounts for the vast number of embryos persisting in storage for years. Many patients simply decide not to decide.⁵⁸

In addition to illuminating the great challenge embryo disposition poses to patients, the literature makes clear that patients’ views regarding preferred disposition often change significantly over time.⁵⁹ A study reported in the *New England Journal of Medicine* comparing dispositional choices at time of treatment and after a three-year storage deadline had passed found that 71 percent of the 41 couples had changed their prefer-

⁵³ Karin Hammarberg & Leesa Tinney, *Deciding the Fate of Supernumerary Frozen Embryos: A Survey of Couples’ Decisions and the Factors Influencing Their Choice*, 86 FERTILITY & STERILITY 86, 90 (2006).

⁵⁴ Sheryl de Lacey, *Parent Identity and “Virtual” Children: Why Patients Discard Rather than Donate Unused Embryos*, 20 HUM. REPROD. 1661, 1664 (2005).

⁵⁵ Lyerly, *supra* note 4, at 506.

⁵⁶ Robert D. Nachtigall et al., *How Couples Who Have Undergone In Vitro Fertilization Decide What To Do With Surplus Frozen Embryos*, 92 FERTILITY & STERILITY 2094 (2009).

⁵⁷ Nachtigall, *supra* note 50, at 431.

⁵⁸ Lyerly, *supra* note 52, at 646 (reporting that in their survey, of those who had completed childbearing, 40% still could not identify a preferred disposition for their remaining embryos, and 20% of those expected to put off the decision indefinitely); Catherine A. McMahon et al., *Mothers Conceiving Through in Vitro Fertilization: Siblings, Setbacks and Embryo Dilemmas After Five Years*, 10 REPROD. TECH. 131, 134 (2000) (reporting 70% of parents surveyed with surplus embryos planned to delay decision as long as possible).

⁵⁹ Lyerly, *supra* note 2, at 1629.

ences.⁶⁰ In a study involving Canadian clinics, 59 percent of couples that provided an updated directive upon being contacted changed their decision.⁶¹ An Australian study likewise found widespread shift in preferences over time.⁶²

Described as a “dynamic process,” decision-making about embryo disposition shifts as patients move through various stages before and after treatment.⁶³ Researchers have identified salient factors that contribute to this volatility. First, patients’ views about embryo disposition are strongly influenced by their experience with IVF.⁶⁴ Research has indicated that at the time of initial treatment, many couples see the possibility of extra embryos as a “bonus,” because they do not yet know how many cycles it will take to achieve a pregnancy.⁶⁵ Consequently, they do not anticipate the challenge that surplus embryos will pose in the future. During this phase, patients do not seriously consider options other than using all stored embryos, until they no longer want another child.⁶⁶ Hence couples during this time tend to experience low decisional conflict, i.e. uncertainty about disposition.⁶⁷ Ironically, then, couples may feel unduly confident in their decision even though, or perhaps because, they have not really given it careful thought.

⁶⁰ Susan C. Klock et al., *The Disposition of Unused Frozen Embryos*, 345 *NEW ENG. J. MED.* 69 (2001).

⁶¹ C.R. Newton et al., *Changes in Patient Preferences in the Disposal of Cryopreserved Embryos*, 22 *HUM. REPROD.* 3124 (2007).

⁶² De Lacey, *supra* note 54, at 1663 (all participants in study had changed their mind about disposition from initial preference for donating to another couple to discarding); McMahon, et al., *supra* note 58, at 134 (discussing two previous studies). Anecdotal evidence supports this conclusion as well. Susan E. Crockin, *The “Embryo” Wars: At the Epicenter of Science, Law, Religion, and Politics*, 39 *FAM. L.Q.* 599, 615-16 (2005) (anecdotal evidence of author and others suggests that 50-75 percent of patients who initially seek to donate embryos to others ultimately change their mind).

⁶³ Nachtigall, *supra* note 50, at 433.

⁶⁴ Lyerly, *supra* note 2, at 1629 (“Our data suggest that the process of infertility treatment, whether successful or not, profoundly influences what these preferences turn out to be.”).

⁶⁵ Nachtigall, *supra* note 50, at 433.

⁶⁶ Lyerly, *supra* note 2, at 1627; Nachtigall, *supra* note 56 (finding patients could not “seriously consider other disposition options” until question of using embryos for additional attempts at conception was resolved).

⁶⁷ Lyerly, *supra* note 52, at 5.

This certainty stands in sharp contrast to the experience of patients post-treatment. These couples more frequently experienced high decisional conflict,⁶⁸ as well as conflict between partners.⁶⁹ Moreover, considerable research indicates that successful IVF, in particular, leads to changes in preference, at least among those able to make a decision.⁷⁰ Before or during treatment, patients' preferences often reflect an altruistic aim of assisting others, resulting in a preference for donation to research⁷¹ or donation to another infertile couple.⁷² By contrast, after treatment, couples who succeeded in having a child preferred discarding the embryos, rather than donating to research.⁷³ While we might assume that having a child would ease the decision for couples, in fact, it complicates it in certain ways. Research indicates that decisions about embryo disposition are strongly influenced by the patients' conceptualization of the embryo, and that successful birth of a child alters that conception.⁷⁴ Rather than see the embryos as a "back-up" plan, patients' now see them as "virtual children" and as potential siblings of the children they had through IVF.⁷⁵ Again, while we might have assumed that viewing embryos as akin to children would reduce the interest in dis-

⁶⁸ *Id.*

⁶⁹ McMahon, et al., *supra* note 58, at 133-34.

⁷⁰ After treatment, most couples avoid the issue unless prompted to respond, typically by bills for storage or notice of time limits on storage. Nachtigall, *supra* note 50, at 433. Nachtigall identifies this response as Stage 2 of the embryo disposition decision process—Avoidance. *Id.* See also Newton, *supra* note 61, at 3126 (noting that one-third of couples successfully contacted by clinic still failed to give final directive regarding disposition). See also McMahon, et al., *supra* note 58, at 134 (findings consistent with others who stress importance of existing IVF child in parents' subsequent views regarding embryos). Interestingly, in half of the appellate cases, the couples already had children. *Cahill*, 757 So.2d at 466; *Litowitz*, 48 P.3d at 262; *J.B. v. M.B.*, 783 A.2d 707, 710 (N.J. 2001); *A.Z. v. B.Z.*, 725 N.E.2d 1051, 1053 (Mass. 2000); *In re Marriage of Nash*, 2009 WL 1514842 at *2.

⁷¹ Newton, *supra* note 61, at 3127.

⁷² De Lacey, *supra* note 54, at 1666.

⁷³ *Id.*

⁷⁴ *Id.*; Nachtigall, *supra* note 450, at 433.

⁷⁵ Nachtigall, *supra* note 50, at 433 (in study of decision-making regarding embryos created with donor eggs); Newton, *supra* note 59, at 3127; De Lacey, *supra*, note 54, at 1665 ("Parenthood changed the status of the embryos and the way parents thought about them."); Gillian M. Lockwood, *The Embryo: An Entity Worthy of Respect*, in CONTEMPORARY ETHICAL DILEMMAS IN ASSISTED

carding the embryos, in fact, patients' viewed donating the embryos to others more as relinquishing a child, a choice they were not willing to make.⁷⁶

Each of the studies relied on here has its methodological limitations. Sample size, location, demographic profile, including gender of participants, varied among them, and admittedly they did not test preferences in the event of divorce.⁷⁷ Nonetheless, they consistently demonstrate the challenge of the embryo disposition decision for participants and how significantly life experiences, including the treatment itself, can change attitudes about the embryos and disposition preferences. These insights should give courts pause in considering whether to enforce disposition provisions in clinic consent forms.

Beyond concerns about patients' inability to accurately predict their future preferences regarding disposition, the timing of the consent process renders the resulting "contract" suspect for another reason. Conditioning treatment and cryopreservation on completion of an embryo disposition form may coerce patients into making a decision they were not ready to make or choosing an option they otherwise would have rejected.⁷⁸ Indeed, in *Roman*, the wife testified that "she would have signed anything to move forward because her goal was to have a child."⁷⁹

While changes to the consent process have the potential to address some of the conditions that make the decision so challenging, some consider the disposition question "intrinsically (and in some respects unyieldingly) difficult."⁸⁰ Moreover, more than one study has concluded that disposition choices made prior

REPRODUCTION 8, (Françoise Shenfield & Claude Sureau eds., 2006) (couples with successful birth from IVF view frozen embryos as "potential siblings").

⁷⁶ De Lacey, *supra* note 54, at 1667; Lyerly, *supra* note 2, at 1628; Nachtigall, *supra* note 56, at 2095. This shift in perception might help explain why someone might agree to allow the other party to use the embryos in the event of divorce, but then wish to renege on that promise after experiencing IVF or the birth of a child, though, of course, individuals might change their minds for an infinite number of reasons. See *A.Z.*, 725 N.E.2d 1051 (where husband and wife initially chose option of allowing wife to implant but husband objected when she sought to use them after divorce).

⁷⁷ Cohen, *supra* note 6, at 1179.

⁷⁸ Coleman, *supra* note 6, at 104.

⁷⁹ 193 S.W.3d at 53.

⁸⁰ Lyerly, *supra* note 52, at 652.

to treatment are virtually worthless, and that physicians should focus on providing adequate counseling and support at the time couples actually need to make a disposition decision.⁸¹

C. Questionable Signing Circumstances

In elucidating the problems of information overload and the difficulties couples face grappling with the decision, we are at least assuming that the progenitors will actually read the document. Although no empirical data exist regarding the number of patients who sign without reading, evidence from the cases that have been adjudicated, as well as from the author's experiencing working with fertility clinics, suggests that it is not uncommon for one party (typically the spouse or partner) to (ostensibly) review and sign the documents at home. Undoubtedly some of these progenitors skip the review part and simply sign. In *A.Z.*, the husband was present when the wife completed the first form and both signed it. The form allowed the wife to implant the embryos in the event of divorce. For subsequent cycles, the husband signed a blank form, and the wife filled in the disposition, each time providing that excess embryos would return to her for implantation.⁸² Nor did the husband in *Marriage of Nash* read the document; he merely signed where his wife told him to, after she initialed certain dispositions.⁸³ In *Dahl*, the husband denied initialing the divorce provision or reading the contract at all. He said he signed the last page without a notary and without seeing the full document. The court found that he did sign in the notary's presence, but interestingly, it did not doubt the husband's veracity. Rather, the court believed the husband had "an inaccurate recollection of signing the consent form."⁸⁴ How seriously could the husband have considered the matter if he did not even remember reading or signing the document? In general, one can-

⁸¹ Newton, *supra* note 61, at 3127 ("contracts signed before or even during an IVF treatment cycle may be literally and ethically worthless."). See also Lyerly, *supra* note 2, at 1629 (doubting the feasibility of informed decision-making through the use of standardized forms executed prior to treatment); Lyerly, *supra* note 52, at 652 (recommending discussions when decisional conflict highest); Nachtigall, *supra* note 56, at 2096 (recommending IVF centers provide ongoing information and support).

⁸² 725 N.E.2d at 1054.

⁸³ 2009 WL 1514842, at *1.

⁸⁴ *In re Marriage of Dahl*, 194 P.3d 834, 837 (Or. Ct. App. 2008).

not avoid the obligations of a written contract even if s/he has failed to read what s/he has signed.⁸⁵ Nonetheless, the prevalence of this practice undercuts the assumption that embryo disposition contracts reflect the considered judgment of participants.

In some practices, the patients may have the opportunity to review the documents with the physician or, more likely, a nurse coordinator. However, in light of the many issues to be addressed, it seems more probable that questions and discussion would revolve around the medical aspects of the procedure, since these are imminent and involve the potential for serious harm to the woman or the child the couple hopes to conceive, rather than questions involving future events and circumstances that may never come to pass. The sheer volume of information contained in these forms supports this supposition. The SART documents spend approximately twenty pages covering the medical aspects of the procedure, and require participants to make significant decisions about the types of procedures to undergo and how many embryos to transfer. Moreover, even if the couple was inclined to focus on the embryo disposition provisions, neither a physician nor a nurse coordinator would be capable of advising the couple about the legal ramifications of their choices.

D. *Drafting Difficulties*

The lack of legal advice is particularly troublesome given certain inherent limitations of embryo disposition consent forms. Even the *Kass* court, which enforced a disposition based on a clinic consent form, noted the “extraordinary difficulty” of obtaining an “explicit agreement” in this context.⁸⁶ The court noted that, unlike other contracts, many of which might look to the future, “the uncertainties inherent in the IVF process itself are vastly complicated by cryopreservation, which extends the viability of pre-zygotes indefinitely and allows time for minds, and circumstances, to change.”⁸⁷ Yet surprisingly, the *Kass* court uses these uncertainties to justify enforcing embryo disposition consent form contracts. This approach ignores, as we have seen, the

⁸⁵ See RICHARD A. LORD, 1 WILLISTON ON CONTRACTS § 4:19 (4th ed. West 2010).

⁸⁶ *Kass*, 696 N.E.2d at 180.

⁸⁷ *Id.*

growing body of research demonstrating just how difficult and unstable the disposition decision can be. It also too easily dismisses the formidable, perhaps insurmountable, challenges to drafting clear and meaningful agreements in the guise of a clinic consent form, a subject to which I now turn.

1. *Too Many Variables*

Typical consent forms require patients to check a box or initial next to one of several dispositions. Those dispositions may include: allowing one of the partners to use the embryos or to have “custody” of the embryos, to do with as he or she sees fit: donating the embryos to research, donating the embryos to another individual or couple, or allowing the embryos to be thawed and discarded. Not all forms provide each of these options.⁸⁸ For example, in the multi-clinic survey done by Lyerly, et al., although all of the consent documents allowed for thaw and discard, only three offered the option of donating to another couple.⁸⁹ In some instances, forms may leave a line or two to

⁸⁸ Waldman, *supra* note 6, at 937.

⁸⁹ It is not clear from the study whether those dispositions were offered in the event of divorce or some other contingency. Lyerly, *supra* note 4, at 501 (Table 1). See also Cahill, 757 So.2d at 466 (providing only that embryos cede to the clinic in the event of divorce); *In re Marriage of Witten*, 672 N.W.2d 768, 773 (Iowa 2003) (where the form did not allow the parties to select an option in case of divorce; it merely contained a predetermined provision governing control of embryos if one party died); *A.Z.*, 725 N.E.2d at 1054 (offering options of “donated or destroyed—choose one or both” for contingencies of death of one or both parties or separation); *J.B.*, 783 A.2d at 710 (the form apparently did not offer options to couples but provided that control of embryos ceded to the IVF program in the event of divorce, unless a court dictated otherwise); *Kass*, 696 N.E.2d at 176-77 (where one portion of the couple’s IVF consent form asked the parties to indicate their wishes for embryo disposition in the event of their death or any other unforeseen circumstance that might prevent both participants from determining disposition, another part stated that legal ownership of any stored pre-zygotes would be determined in a property settlement by a court); *Karmasu*, 2009 WL 3155062 at *2 (providing only two options: that the clinic assume rights to “preserve, dispose of or donate” embryos or that the clinic immediately dispose of embryos upon notice of divorce); *In re Marriage of Nash*, 2009 WL 1514842, at *2 (offering choice of destruction of embryos or custody to a patient or partner, but not donation to research or another person); *Litowitz*, 48 P.3d at 263-64 (offering donation to research or another or destruction of embryos but not use by either partner in the event of death and other circumstances).

allow the couple to write in another disposition, if the instructions are sufficiently clear, subject to the approval of the clinic. However, anecdotal evidence suggests couples rarely utilize that option.⁹⁰

Needless to say, these pro forma options cannot hope to capture all the nuances that couples might find relevant in a divorce situation. For example, the forms do not allow the couples to specify different dispositions based on the outcome of the IVF cycle, such as a successful birth versus a failed attempt.⁹¹ This fact plays a critical role for many patients in forming their disposition preferences.⁹² We could imagine myriad other possibilities couples might want to consider that standardized forms do not typically offer, such as dividing the remaining embryos between the parties; allowing for one party to use the embryos, but specifying that the ex-spouse not be considered a legal parent under that situation, or specifying that parental rights would flow from post-dissolution use of any embryos.⁹³ Forms also usually fail to differentiate embryos created with gamete donors, even though it seems doubtful that a court would actually enforce a disposition

⁹⁰ *But see* A.Z., 725 N.E.2d at 1054 (stating that the wife filled in disposition requiring return of embryos to the wife for implantation in the event of divorce and suggesting that she wrote the words herself); *cf. Litowitz*, 48 P.3d at 264 (where the parties indicated approval of option 3—that embryos be thawed—by rewriting that choice in longhand in space provided).

⁹¹ *Cf. Roman*, 193 S.W.3d at 53 (where wife claimed she thought agreement only applied to embryos remaining *after* implantation and that she would not have agreed to destruction without opportunity to get pregnant).

⁹² *See supra* notes 52-81 and accompanying text.

⁹³ Whether a provision to relinquish parental rights in this fashion would be enforceable is open to question. Some states have statutes that expressly address this issue, *see infra* note 146 and accompanying text. Elsewhere, courts might follow the model used with coital reproduction and refuse to enforce a private agreement to relieve a biological parent of his or her parental rights and responsibilities. *See Robertson, supra* note 6, at 1032-33. Alternatively, a court might treat the relinquishing party as a sperm or egg donor and thus enforce the agreement. *Id.* at 1033-34. For an interesting case essentially applying both these rules, see *In re Paternity of M.F.*, 938 N.E.2d 1256 (Ind. App. 2010) (finding agreement between mother and known sperm donor relieving donor of parental rights and responsibilities was enforceable as to child conceived pursuant to agreement but not to child conceived subsequently through artificial insemination).

giving control of such embryos to the non-genetic spouse or partner.⁹⁴

Drafting the disposition choices in a meaningful way is further complicated by the medical and scientific uncertainties inherent in the cryopreservation process. For example, if a clinic did offer a standard choice to divide remaining embryos between the parties (assuming more than one existed), how would that provision take into account the varying quality of the embryos or the risk that one or more might not survive the thawing process?⁹⁵ Certainly lawyers might be able to draft appropriate language, but we cannot expect standardized forms to consider this level of complexity and specificity.

2. Dispositions Impossible to Implement

Standardized consent forms also create difficulties by offering options that clinics likely will not carry out without contemporaneous consent. It seems hard to fathom that a physician would donate embryos to another couple or individual years later based on a box checked next to a one or two-line description at the time of treatment. Embryo donation agreements, at a

⁹⁴ See *Litowitz v. Litowitz*, 10 P.3d 1086, 1092 (Wash. Ct. App. 2000), *rev'd en banc*, 48 P.3d 261 (2002) (holding wife who did not contribute gametes did not have constitutional right to procreate, while husband who provided sperm did and allowing husband to exercise right to procreate by donating embryos to another couple) and *id.* at 1094-95 (Bridgewater, J., concurring) (arguing for decision based “solely on the genetic connection to the husband . . . It would no more make sense to allow Ms. Litowitz to control the use of Mr. Litowitz’s DNA in reproduction than it would to allow her to take a sample of his DNA to create a clone. And, if the situation were reversed, we would not permit a husband to take some of his spouse’s eggs upon dissolution.”); Coleman, *supra* note 6, at 114-17.

If we assume for the moment, as the *Davis* court did, that spouses who each contribute gametes to the embryo are “equivalent” in constitutional terms, the same could not be said for embryos created with donor gametes, raising questions about whether the “contract” can trump a possible constitutional right of one of the parties. *But cf.* *Litowitz*, 48 P.3d 261 (where court based decision on embryos created with donor eggs on cryopreservation contract, not sperm provider/husband’s constitutional right to procreate, and ordered destruction of embryos); *In re Marriage of Nash*, 2009 WL 1514742 (where court based decision on embryos created with donor eggs on cryopreservation contract, not sperm provider/husband’s constitutional right to procreate, but did award embryos to husband).

⁹⁵ Strasser, *supra* note 6, at 1222.

minimum, should contain clear recitations regarding the intent of the donors not to assume parental rights and to protect them from parental responsibilities, and ideally would also address issues of anonymity, future contact, and other significant matters.⁹⁶ Moreover, federal and state regulations concerning tissue testing can complicate embryo donation. While FDA regulations have tried to ease the process by exempting embryos originally created for use by the gamete providers from certain disease testing, they still strongly encourage testing of donors prior to embryo donation,⁹⁷ and state regulations may require testing of embryo donors for certain transmissible diseases under various circumstances.⁹⁸ These requirements might make enforcement of an agreement to donate impossible to effectuate years later if the embryo donors are unavailable or unwilling to undergo testing. Similarly, donation to research in some cases requires contemporaneous consent from the creators of the embryo.⁹⁹ If the embryos were created using donated gametes, state regulations or research protocols may require the express consent of the original gamete provider.¹⁰⁰ If that consent was not provided at the time of donation, a clinic might be unable to donate the resulting embryos to research, regardless of the intended parents' choice of that option in the event of divorce at the time of treatment.

3. *Hopelessly Confusing and Ambiguous Forms*

In addition to the challenges of accounting for a wide range of contingencies and options in a situation rife with medical and personal uncertainty, standardized forms too often fail to provide disposition instructions that clearly and accurately reflect the

⁹⁶ Crockin, *supra* note 62, at 613-15.

⁹⁷ 21 C.F.R. § 1271.90(a)(4) (2011).

⁹⁸ See, e.g., CAL. HEALTH & SAFETY CODE § 1644.5 (West 2010).

⁹⁹ See National Institutes of Health, *National Institutes of Health Guidelines on Human Stem Cell Research*, available at <http://stemcells.nih.gov/policy/2009guidelines.htm> (accessed on February 14, 2011) (requiring consent at time of donation for NIH-funded stem cell research, even if donors provided general consent at time of treatment).

¹⁰⁰ CAL. CODE REGS. tit. 17, §§ 100080, 100090, 100010 (2010); John Kasprak, *Stem Cell Research Guidelines*, OLR RES. REP., Apr. 29, 2005, available at <http://www.cga.ct.gov/2005/rpt/2005-R-0448.htm> (accessed Feb. 23, 2011) (summarizing guidelines for National Academies on stem cell research).

parties' intentions, even at that moment in time. Clinic consent forms as a general rule are very poorly drafted, often with confusing, conflicting and ambiguous provisions. Moreover, a host of reasons make more effective drafting in this setting unlikely.

We need look no further than the reported cases to find examples of the bewildering, unclear, and internally inconsistent nature of the documents fertility patients sign. The consent forms in *Kass*, a case where the court actually enforced the "agreement," exemplify the problem. It took the court several pages of pouring through various parts of the consent for it to "resolve" the document's many apparent ambiguities.¹⁰¹ At one point, the document provided that: "we understand that legal ownership of any stored pre-zygotes must be determined in a property settlement and will be released as directed by order of a court of competent jurisdiction."¹⁰² A patient might reasonably assume from that provision that the ultimate disposition of embryos in the event of divorce will await a marital dissolution resolution. However, the second part of the cryopreservation consent form, titled "INFORMED CONSENT FORM NO. 2-ADDENDUM NO. 2-1: CRYOPRESERVATION-STATEMENT OF DISPOSITION," provided that "In the event that we no longer wish to initiate a pregnancy or are unable to make a decision regarding the disposition of our stored, frozen pre-zygotes, we now indicate our desire for the disposition" The Kassess had initialed the option for donation to research.¹⁰³ The Addendum began with language referencing "The possibility of our death or any other unforeseen circumstances that may result in neither of us being able to determine the disposition of any stored frozen pre-zygotes requires that we now indicate our wishes."¹⁰⁴ Given the earlier statement specific to divorce, which is not even mentioned in the Addendum, even a careful reader might well conclude that the disposition statement contained in the second addendum did not apply to divorce. Thus the court's conclusion that "the informed consents signed by the parties *unequivocally* manifest

¹⁰¹ *Kass*, 696 N.E.2d at 180-82.

¹⁰² *Id.* at 352.

¹⁰³ *Id.* at 352-53.

¹⁰⁴ *Id.* at 352.

their mutual intention” to donate to research in the event of divorce seems flagrantly at odds with the evidence.¹⁰⁵

The consent form in *Litowitz* contained similarly conflicting provisions. Recall that the clinic consent form in *Litowitz* stated that “In the event we are unable to reach a mutual decision regarding the disposition of our pre-embryos, we *must* petition to a Court of competent jurisdiction for instructions concerning the appropriate disposition of our pre-embryos.”¹⁰⁶ However, the form went on to provide that the clinic would thaw any embryos still in storage five years after the initial date of cryopreservation. The five-year limit came after language specifically referencing decisions not to use frozen embryos for various reasons such as “our choice, death of both of us, our achieving our desired family size.”¹⁰⁷ Conspicuously, those “various reasons” did not include divorce. As in *Kass*, the Litowitzes might plausibly have understood a dispute over disposition in the event of divorce to require an independent court resolution, and the five-year provision to apply only in the event of the other circumstances mentioned.¹⁰⁸

The consent form enforced as a contract between the parties in *Roman* presented the divorce question more clearly than the forms in *Kass* and *Litowitz*. It specifically stated that “If we are divorced . . . while any of our frozen embryos are still in the program, we . . . authorize . . . that one of the following actions be taken”¹⁰⁹ The Romans had initialed the choice to discard.

Nonetheless, this form, as well, suffers from deficiencies of clarity based on both poor drafting and the uncertainty surrounding the law’s treatment of embryos. Once again, the form contained a somewhat ambiguous statement that might be

¹⁰⁵ *Id.* at 357 (emphasis added). The court’s reliance on a proposed marital settlement, which would have affirmed the donation to research disposition, is misplaced. The parties never filed that agreement, and three weeks later, Mrs. Kass informed the clinic in writing of her opposition to destruction of the embryos. *Id.* at 353. Other scholars likewise have found the *Kass* court’s conclusion difficult to comprehend and defend. See, e.g., Daar, *supra* note 6, at 470-71 (describing court’s finding of no ambiguity as “startling”).

¹⁰⁶ *Litowitz*, 48 P.3d at 263 (emphasis added).

¹⁰⁷ *Id.*

¹⁰⁸ At the least, they might reasonably have concluded that filing a court action would toll the five-year period. See *supra* note 105 and accompanying text.

¹⁰⁹ *Roman*, 193 S.W.3d at 51.

interpreted to allow revocation of the consent by either party, thereby undermining the reliability of the divorce disposition provision: “We understand that we are free to withdraw our consent as to the disposition of our embryos”¹¹⁰

In addition, the document itself is titled “Informed Consent for Cryopreservation of Embryos.”¹¹¹ While the document uses the words “consent,” “authorize,” and “direct” throughout, none of the excerpts included in the court’s opinion contain the words “agreement” or “contract,”¹¹² two words that might have signaled to the parties that the document could constitute a binding agreement between them, not just between them and the clinic. The only use of the word “agree” appears in a recitation at the end of the document referencing their voluntary participation in the program and their right to withdraw consent to disposition and discontinue participation.¹¹³ Use of the language of consent, rather than contract or agreement, appears commonly in these documents.¹¹⁴ This choice is not surprising given that clinics provide the forms and their primary purpose is to provide written documentation of the patients’ informed consent and thereby protect the physician from liability.¹¹⁵

The *Roman* consent form further evidences a problem inherent in using consent forms to determine embryo disposition in

¹¹⁰ *Id.* at 51-53. See Strasser, *supra* note 6, at 1215. For further discussion of the right to revoke in *Roman*, see *infra* note 148 and accompanying text.

¹¹¹ *Id.*

¹¹² *Id.* at 51-52.

¹¹³ *Id.* at 52.

¹¹⁴ See, e.g., *Kass*, 673 N.Y.S.2d at 352; *A.Z.*, 725 N.E.2d at 1053; *In re Marriage of Nash*, 2009 WL 1514842, at *1. The designation of the cryopreservation document in *Nash* as a “consent” stands in contrast to the egg donor contract at issue there, which references the “Agreement” throughout. *Id.* at *2. Other clinics have used more precise terminology in titling their forms. See, e.g., *Litowitz*, 48 P.3d at 263 n.20 (“Agreement and Consent for Cryogenic Preservation (Short Term)”); *In re Marriage of Witten*, 672 N.W.2d at 772 (“Embryo Storage Agreement”); *In re Marriage of Dahl*, 194 P.3d 834, 836 (Or. Ct. App. 2008) (“Embryology Laboratory Specimen Storage Agreement”); *Karmasu*, 2009 WL 3155062, at *2 (referencing “Cryopreservation Agreement” between parties and clinic). The SART document also uses the word “Consent” in its title, but uses the word “agree” in the section governing embryo disposition. SART Documents, *supra* note 44.

¹¹⁵ See *infra* notes 121-22 and accompanying text. Waldman, *supra* note 6, at 921.

divorce. The purported agreement operates in a legal vacuum. In most jurisdictions, neither legislation nor case law makes clear whether embryo disposition agreements are binding. Consequently, the *Roman* form, like others, contains language disclosing the unsettled nature of the law governing embryo disposition.¹¹⁶ This type of caveat is both appropriate and necessary. Unfortunately, it can undermine patients' reliance on the document, particularly in the absence of language at least indicating that the parties intend the agreement to be binding between them to the extent permitted by law.¹¹⁷ Patients may understandably doubt the significance of the disposition provisions, given the uncertain legal landscape. Embryo disposition agreements certainly are not the only types of contracts that delineate rights and responsibilities of parties in the absence of clear law on the subject, but they represent a rather extreme example, since not only is the outcome in a given case unpredictable, in the vast majority of states, so too is the standard a court would apply to decide the question.¹¹⁸

4. *Better Drafting Unlikely*

One might argue that better drafting can solve the problems of ambiguity, denseness and complexity. But certain structural realities and perceptions make widespread improvements in the quality of these documents dubious. First, the patients obtain these forms from the clinic or physician. The drafters may, or may not, be attorneys. In some cases, physicians draft the documents themselves or borrow forms from other clinics; in others, they hire a friend, former patient or other acquaintance who happens to be a lawyer to undertake the task. That lawyer may, or may not, have any expertise in this area. A review of various consent forms used by clinics across the country reveals greatly

¹¹⁶ "We understand that legal principles and requirements regarding IVF and embryo freezing have not been firmly established. There is presently no state legislation dealing specifically with these issues. . . . We are aware that these regulations may change at any time." *Roman*, 193 S.W.3d at 51.

¹¹⁷ *Cf. A.Z.*, 725 N.E.2d at 1057 (questioning validity of agreement based on consent form for failing to indicate the spouses intended it to act as a binding agreement between them).

¹¹⁸ Even in states that presume to enforce the contract, a party might raise one or more contract defenses or questions of interpretation to successfully challenge it. Daar, *supra* note 6, at 470-71, 477.

disparate quality, with most woefully inadequate. Indeed, even in states where statutes dictate in some respects the content of the forms, physicians use forms that do not comply even minimally with the statute.

Obtaining high quality consent forms requires a lawyer with specialized knowledge of the law of assisted reproduction, and lawyers cost money, which physicians may choose not to invest. For a variety of reasons, doctors generally have little incentive to ensure that provisions regarding embryo disposition in the event of divorce are effectively worded and well-understood. Indeed, physicians' needs and patients' needs may well operate at cross-purposes in the cryopreservation consent arena. As mentioned previously, clinic consent forms serve two primary purposes. First, physicians use them, ideally in conjunction with discussion, to obtain informed consent for the procedure at hand, which may include the fertility treatment itself (egg retrieval, IVF, embryo transfer, etc.) as well as cryopreservation of any excess embryos.¹¹⁹ Second, the forms create a written record that can help protect the doctor from liability—specifically an allegation that the patient did not, in fact, give informed consent because s/he was not informed of a particular risk.¹²⁰ The focus in these instances is thus clearly and understandably on the medical risks and benefits of the procedure, since this is where both the physicians' expertise and potential exposure to liability are greatest.¹²¹

¹¹⁹ Waldman, *supra* note 6, at 920.

¹²⁰ *Id.* at 921.

¹²¹ There have been a handful of cases against fertility treatment physicians or clinics related to harm or misappropriation of embryos, *See* York v. Jones, 717 F. Supp. 421 (E.D. Va. 1989); Jeter v. Mayo Clinic Arizona, 121 P.3d 1256 (Ariz. Ct. App. 2005); Unruh-Haxton v. Regents, 76 Cal. Rptr. 3d 146 (Cal. App. 2008); Perry-Rogers v. Obasaju, 723 N.Y.S.2d 28 (App. Div. 2001). However, there has been no reported case of physician liability stemming from a known dispute over the embryos in the course of a couple's divorce. The closest case arose in Massachusetts. A husband and wife sought infertility treatment from a Boston IVF clinic. In connection with the treatment, they both signed a consent form authorizing cryopreservation of excess embryos. Two years later, the wife returned on her own to the clinic for another round of IVF after her husband had filed for divorce. The clinic proceeded with the treatment relying on the original cryopreservation consent form, which provided that: "We agree to have the embryos returned to the body (womb) of the female spouse so named on this form within three years from the date of embryo freezing. Our wishes regarding the ultimate disposition will be signed now." The

Moreover, even if physicians retain an attorney well-versed in the legal issues related to embryo disposition and assisted reproduction, the attorney's legal and ethical duty runs to the physician, not to the patients. Hence, the lawyer will draft a form designed first and foremost to protect the physicians' interests, not those of the patients.

The embryo disposition clauses do serve an additional worthwhile purpose—governing the relationship between the clinic and the couple jointly.¹²² They can provide useful guidance for clinics in dealing with embryos when one or both progenitors die or abandon the embryos, although their efficacy even in these situations may be limited.¹²³ Physicians and clinics do have a significant interest in devising a clear and effective protocol for dealing with stored embryos. Otherwise, they risk developing into long-term storage facilities with a stockpile of abandoned embryos without room to store them. Nonetheless, even when they have a direct interest in the issue, physicians often rely on poorly drafted, incomplete consent forms that may well prove unworkable.

The model SART documents provide further evidence of the challenges inherent in drafting effective consent forms. Since

husband learned of the procedure when the wife announced she was pregnant, and he brought suit against the clinic for breach of contract for creating a child without his knowledge or consent. The jury found for the plaintiff against the clinic (but not the physicians) and awarded him the cost of rearing the child and emotional distress damages. Jeffrey B. Catalano, *IVF: New Horizons in Informed Consent*, Massachusetts Bar Association Section Review, Vol. 7, No. 3 (2005), available at <http://www.massbar.org/publications/section-review/2005/v7-n3/ivf-new-horizons-in-informed> (accessed Feb. 15, 2011). Neither the husband nor the wife had apparently notified the clinic of the impending divorce prior to the transfer. Kirsty Horsey, *Man Awarded Compensation by Boston IVF Clinic*, BIONEWS, Feb. 3, 2004, available at <http://www.ivf.net/ivf/man-awarded-compensation-by-boston-ivf-clinic-o263.html> (accessed Feb. 15, 2011).

¹²² *In re Marriage of Witten*, 672 N.W.2d at 782 (affirming validity of disposition agreements between donors and fertility clinics and noting “it is this relationship, between the couple on the one side and the medical facility on the other, that dispositional contracts are intended to address.”); *A.Z.*, 725 N.E.2d at 1058 n.22 (recognizing agreements among donors and clinic “essential to clinic operations” and enforceable).

¹²³ The problems of executing certain dispositions without contemporaneous consent, e.g. donation to another couple or to research, noted *supra* note 38 and accompanying text, would apply in this situation as well.

they were created by a committee comprised of both lawyers and physicians after lengthy study and deliberation, we might expect these documents to have avoided the problems and ambiguity identified here.¹²⁴ However, the SART documents ultimately fail to provide an adequate basis for viewing and enforcing the disposition choice in the event of divorce as a contract. As with other consent forms, nowhere does the SART form indicate that the parties are entering into a binding legal document. Rather, the document merely points out that the law “is, or may be, unsettled in the state in which either the patient, spouse, partner, or any donor currently or in the future lives, or the state in which the ART Program is located,” that the clinic has not provided any legal advice, but that the patients might wish to obtain such advice if they have any questions.¹²⁵ In terms of the actual divorce disposition provision, the SART document provides couples with only three choices in the event of divorce: (1) “A court decree and/or settlement agreement will be presented to the Clinic directing use to achieve a pregnancy in one of us or donation to another couple for that purpose;” (2) the embryos will be donated to research or (3) the embryos will be destroyed.¹²⁶

The first choice is problematic. On the plus side, leaving the disposition to future resolution by court order or settlement makes sense in light of the problems we have elucidated. However, the wording of that option clearly exhibits bias in favor of the party who opposes procreation.¹²⁷ Couples wishing to allow use of the embryos in the event of divorce must seek a court order; couples desiring to donate to research or destroy the embryos can simply check a box on the form.¹²⁸ Perhaps even more problematically, this provision would actually significantly curtail the couple’s options. For example, it allows only for implantation

¹²⁴ The physicians vastly outnumbered the lawyers on the committee, which was comprised of ten physicians, three attorneys, and four researchers. Toner, *supra* note 44, at 15.

¹²⁵ SART Documents, *supra* note 44, at 26.

¹²⁶ *Id.* at 23.

¹²⁷ For critiques of rules and rulings favoring procreation avoidance, see Daar, *supra* note 6; Ellen A. Waldman, *The Parent Trap: Uncovering the Myth of “Coerced Parenthood” In Frozen Embryo Disputes*, 53 AM. U.L. REV. 1021 (2004).

¹²⁸ SART Documents, *supra* note 44, at 23.

of the embryos in one member of the couple—not in a surrogate. This limitation would essentially prohibit the male progenitor from using the embryos after divorce, as his only option in that situation would be through a surrogate carrier. This restriction seems particularly inappropriate given that the disposition provisions apply regardless of whether the embryos were created with donor gametes. Hence an ex-husband (or gay partner) who provided sperm for creation of embryos with donor eggs would be forever prohibited from using the embryos with a surrogate without his ex-wife's or partner's consent; even a court could not order otherwise.¹²⁹

Moreover, this provision conflicts on its face with an earlier provision contained in a bullet point at the beginning of the embryo disposition section. The bullet point states that: "Embryos cannot be used to produce pregnancy against the wishes of the partner. For example, in the event of a separation or divorce, embryos cannot be used to create a pregnancy without the express, written consent of both parties, even if donor gametes were used to create the embryos."¹³⁰ Yet, as set forth above, the actual disposition choice offered in the event of divorce says that use of the embryos *can* be compelled by court order or settlement agreement.¹³¹ In addition, the bullet point does not state whether the "express, written consent" means contemporaneous consent, although another statement appearing a few paragraphs above the bullet point lists among the permissible disposition alternatives "[u]se by one partner with the contemporaneous permission of the other for that use."¹³² It strains credulity to imagine that a couple embarking on an IVF cycle could understand or reconcile these conflicting statements, especially since they are surrounded or preceded by pages of material covering the medical aspects of the procedure.

¹²⁹ Of course, a court might find in any of these situations that foreclosing use of the embryos by the gamete provider violates the genetic progenitor's constitutional rights. *See supra* note 94. A lesbian couple who created embryos using one partner's eggs and donor sperm would at least have the option of seeking a court order to allow one partner to use the embryos, though the gamete-providing partner would still have the burden of seeking a court order to use the embryos.

¹³⁰ SART Documents, *supra* note 44, at 20.

¹³¹ *See supra* note 127 and accompanying text.

¹³² SART Documents, *supra* note 44, at 20.

The SART documents suffer from another flaw that puts physicians at risk of liability and could mislead patients. The documents fail to take account of specific rules that have developed in some states, whether through case law, as discussed above, or statutes, governing embryo disposition. While a “one-size fits all” approach makes perfect sense when drafting disclosures related to medical information, which presumably do not vary from state to state, it makes little sense when dealing with legal matters that vary substantially based on jurisdiction.

III. Existing Statutes and Proposed Legislation Hinder Rather than Help

While most states have no law explicitly governing embryo disposition, a few have enacted statutes that address the issue in some fashion. Others currently have proposed statutes under consideration by the legislature. Unfortunately, these statutes create more problems than they solve. The statutes fall into roughly two groups: those specifically dealing with embryo disposition and those that address parental status related to embryos used after divorce.¹³³

¹³³ A third group of statutes and pending legislation declares the embryo to be a person and severely curtails the embryo’s creators of their rights to control disposition. *See, e.g.*, H.J.R. 3 84th Gen. Assem. (Iowa 2011) (joint resolution proposing constitutional amendment declaring embryos persons with fundamental right to life); LA. REV. STAT. ANN. § 9:122 (West 2011) (declaring an embryo a “juridical person;” providing that physicians or clinics have responsibility for embryos and prohibiting destruction of embryos); H.B. 1571, 2011 Reg. Sess. (Okla. 2011) (declaring embryos persons with “free and inalienable rights”). These proposed statutes all raise serious constitutional questions and are not generally supported by the fertility medical community. Kimberly Berg, *Special Respect: For Embryos and Progenitors*, 74 GEO. WASH. L. REV. 506 (2006); Anthony John Cuva, *The Legal Dimensions of In Vitro Fertilization: Cryopreserved Embryos Frozen in Legal Limbo*, 8 N.Y.L. SCH. J. HUM. RTS. 383(1991); *ASRM Opposes Iowa Personhood Bill*, 13 ASRM BULL., No. 4, Feb. 15, 2011. *But cf.* Naomi Cahn & June Carbone, *Embryo Fundamentalism*, 18 WM. & MARY BILL RTS. J. 1015 (2010), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1585988 (accessed Mar. 1, 2011) (observing Louisiana fertility specialists in 1980s supported Louisiana statute).

A. Embryo Disposition Statutes

California Health & Safety Code § 125315 typifies the first category. It provides that physicians offering fertility treatment must obtain written, informed consent regarding embryo disposition.¹³⁴ It then instructs that the informed consent form shall include “advanced written directives” offering statutorily delineated options to the patients in the event of a variety of contingencies, including death of one or both of the partners, separation or divorce of the partners, or abandonment of the embryos. The statute appears to require that the form offer the patient the same set of options, modified slightly, for each contingency: (1) make available to the partner (male or female in case of divorce or separation; not applicable where both parties have died or the embryos have been abandoned); (2) donate to research; (3) thaw; (4) donate to another individual or couple; or (5) make another disposition, clearly stated. Yet the statute says nothing about whether these dispositions will constitute a binding legal agreement between the progenitors in the event the relationship ends. Indeed, the use of the term “advanced directives” may undercut the notion that these forms constitute contracts. Advance directives provide instructions for embryo disposition at a future time, if the maker is unavailable to decide. As such, they are “purely self-binding” and subject to revocation by the maker “at any time prior to the occurrence of the operative contingency at Time B. Contracts, on the other hand, involve the exchange of promises and reliance by clinic or partner about actions or performance at Time B.”¹³⁵

The California statute also does not distinguish or even acknowledge embryos created in whole or in part with donor gametes. Nor does it provide for any procedural protections for patients considering their options, beyond requiring the consent to be in writing. It does not require a separate form for the consent. In addition, the statute actually creates expectations of dispositions that physicians might be unable or unwilling to carry out without contemporaneous consent, such as donating to another individual or couple when the embryos have been aban-

¹³⁴ CAL. HEALTH & SAFETY CODE § 125315 (West 2007).

¹³⁵ Robertson, *supra* note 6, at 1004.

done.¹³⁶ These flaws are not surprising when we consider the impetus for the statute. It did not arise from concern over disputes involving divorcing fertility patients. Rather, it arose from concerns related to stem cell research, especially the need to obtain embryos in an ethical way.¹³⁷

Massachusetts has a statute that tracks an earlier version of California's advance directive statute, also located in its chapter on biotechnology.¹³⁸ It provides that the physician present the patient with the options of storing, donating to another person or to research or destroying any unused embryos "as appropriate."¹³⁹ It does not address any specific contingencies, such as divorce, and Massachusetts will not compel procreation in the absence of contemporaneous consent.¹⁴⁰ New Jersey and Connecticut also have statutes dealing with stem cell research that require physicians treating fertility patients to present patients with the options of storing or donating excess embryos to another or to research, but they do not address contingencies such as divorce.¹⁴¹ New Jersey, too, has adopted the rule of contemporaneous consent by case law.¹⁴²

Likewise, pending legislation in New York requiring embryo disposition advance directives has arisen from the desire to engage in stem cell research. New York is currently considering several bills. One tracks closely California's legislation.¹⁴³ The others, while worded somewhat differently, all require written directives regarding disposition in the event of death, separation or divorce and abandonment that offer the same options identified

¹³⁶ CAL. HEALTH & SAFETY CODE § 125315(b)(4)(C) (West 2007). *See also supra* notes 96-100 and accompanying text. From the physicians' standpoint, it also fails to account for physicians who might object to certain dispositions and thus prefer to offer the patients the option of transferring their embryos to another facility.

¹³⁷ CAL. HEALTH & SAFETY CODE § 125300 (West 2007).

¹³⁸ MASS. GEN. LAWS ANN. ch. 111L § 4 (West 2005).

¹³⁹ *Id.* at § 4(a).

¹⁴⁰ A.Z., 725 N.E.2d 1051.

¹⁴¹ CONN. GEN. STAT. ANN. § 19a-32d(c)(2) (West 2011); N.J. STAT. ANN. § 26:2-2(b)(2) (West 2011).

¹⁴² J.B., 783 A.2d 707.

¹⁴³ S.B. 394, 234th Legis. Sess. (N.Y. 2011-2012). The bill goes beyond the California statute, though, with more extensive provisions related to stem cell research and by providing for a similar disposition form for oocyte donation.

above.¹⁴⁴ None provides any procedural protections for the parties or asserts that the divorce disposition provisions would bind them in a dispute with each other. Unlike California's statute, these bills do note that parties choosing to donate embryos for use by another person must meet donor qualifications.¹⁴⁵

B. *Parentage Statutes*

The second category of statutes relating to embryo disposition resides in code sections related to family law and parentage. These statutes seek to clarify that if a marriage dissolves or, in some cases, a dissolution action is filed, prior to placement of gametes or embryos, the former spouse will not be considered the legal parent of any subsequently resulting child, unless the former spouse consented in writing to be a parent of a child if the assisted reproduction occurred after marital dissolution.¹⁴⁶ This provision addresses one of the significant uncertainties surrounding the use of embryos after divorce: whether a progenitor should shoulder legal responsibilities as a parent if the other progenitor is allowed to use the embryos. These statutes also allow a former spouse to revoke consent to the assisted reproduction "anytime before placement of eggs, sperm, or embryos,"¹⁴⁷ which seems to undercut the reliability of the contract considerably, as either party can apparently withdraw consent, at least prior to filing for divorce.¹⁴⁸ These laws do not address the enforceability

¹⁴⁴ S.B. 388, 234th Legis. Sess. (N.Y. 2011-2012); Assemb. B. 3218, 234th Legis. Sess. (N.Y. 2011-2012).

¹⁴⁵ S.B. 388, 234th Legis. Sess. (N.Y. 2011-2012), at § 131(3)(c); Assemb. B. 3218, 234th Legis. Sess. (N.Y. 2011-2012), at § 131(3)(d).

¹⁴⁶ COLO. REV. STAT. ANN. § 19-106 (&)(a) (West 2011); N.D. CENT. CODE ANN. § 14-20-64 (2011); TEX. FAM. CODE ANN. § 160.706 (Vernon 2011); VA. CODE ANN. § 20-158 (2011); WASH. REV. CODE ANN. 26.26.725 (West 2011). Hawaii and New Mexico have similar legislation pending. S.B. 1463, Reg. Sess. (Haw. 2011); S.B. 146, Reg. Sess. (N.M. 2011).

¹⁴⁷ COLO. REV. STAT. ANN. § 19-106 (&)(a) (West 2011); TEX. FAM. CODE ANN. § 160.706 (Vernon 2011). *See also* statutes cited *supra* in note 148.

¹⁴⁸ *Roman* appears to be the only case to interpret this kind of statute so far. Recall that the *Roman* court validated the embryo disposition agreement calling for discard of embryos in the event of divorce. Interestingly, the parties had conceded that neither had withdrawn consent to the disposition of the embryos prior to filing for divorce. Hence the court concluded that the contract, not the statute, would control. *Roman*, 193 S.W.3d at 52, 54. Why Augusta did not submit a written withdrawal of consent to the fertility clinic remains a mys-

of embryo disposition consent forms, except as they relate to this particular question.¹⁴⁹

Moreover, like the stem cell research disposition statutes, these parentage statutes suffer from ambiguity and inconsistency. All but one of the statutes provide that the divorce, its filing or the withdrawal of consent must precede “placement of the eggs, sperm, or embryos,” yet the statutes fail to define placement.¹⁵⁰ Does it mean when the embryo is created, i.e. the eggs and sperm are “placed” in the petri dish? Or does it mean when the sperm (in intrauterine insemination) or embryo (in IVF) is implanted in the woman’s uterus? There is no circumstance where an egg would be “placed” in the woman’s body unless fertilized, yet eggs are included. Most probably, the reference to “placement” regarding embryos means transfer. However, the “Definitions” sections applicable to these statutes do not define “placement,” though they do define “embryo transfer.”¹⁵¹ Clearly the legislature could have used the latter term had it so chosen.

North Dakota’s statute further complicates matters by containing an additional provision that injects significant confusion into the question of whether one party can use embryos without the other’s consent upon divorce.¹⁵² The provision reads as follows: “The consent of a woman or a man to assisted reproduc-

tery. However, certainly by the time the divorce case came to trial, Augusta had at least implicitly indicated her desire to withdraw consent, and the statute allows withdrawal any time prior to placement of the embryos. Strasser, *supra* note 6, at 1215.

¹⁴⁹ See *Roman*, 193 S.W.3d at 49 (noting the absence of any legislative directive regarding embryo disposition on divorce from these statutes and nothing inconsistent with finding the disposition agreement controlling).

¹⁵⁰ Virginia’s statute identifies filing “before in utero implantation” as the significant event.

¹⁵¹ N.D. CENT. CODE ANN. §14-20-02 (2011); TEX. FAM. CODE ANN. §160.102 (Vernon 2011) (referencing “transfer of embryos” under the definition of “assisted reproduction”); VA. CODE ANN. § 20-156 (2011); *C.f.* TEX. FAM. CODE ANN. §160.754 (e) (Vernon 2011) (providing that parties to a gestational agreement must contract prior to “transfer of eggs, sperm, or embryos to the gestational mother”).

¹⁵² N.D. CENT. CODE ANN. §14-20-64(2) (2011). Hawaii and New Mexico are considering similar legislation. S.B. 146, Reg. Sess. (N.M. 2011). Hawaii’s version is somewhat different. It allows a participant to withdraw consent to assisted reproduction prior to placement or if placement has not occurred within one year of the consent. S.B. 1463, Reg. Sess. (Haw. 2011).

tion may be withdrawn by that individual in a record at any time before placement of eggs, sperm, or embryos. An individual who withdraws consent under this section is not a parent of the resulting child.”¹⁵³ The infirmities of the first sentence have already been identified; the second makes the situation worse, because it seems to suggest that even though a former spouse can withdraw consent to assisted reproduction, the other spouse could nonetheless proceed to use the gametes or embryos. Otherwise, why would the statute need to state that an individual who withdraws consent is not a parent of the resulting child? The second sentence thus seems to render the right to revoke consent completely illusory, unless it aims only to cover mistakes by fertility clinics. Alternatively, perhaps the second paragraph merely intends to allow a spouse who initially agrees to post-divorce implantation and legal parenthood to withdraw consent to be a legal parent prior to the point of “placement.” However, the statute speaks of consent to “assisted reproduction,” not to parenthood. Needless to say, these provisions are far from clear on that point, and, if the latter reading is correct, it raises troubling questions about the underlying assumption—that once someone provides gametes or participates in creation of embryos, the party wishing to conceive will always be able to do so; the ex-spouse would retain only the power to decide whether to assume legal responsibility for any resulting children.¹⁵⁴ These statutes thus serve to confuse, rather than clarify, the role of clinic consent forms in deciding embryo disposition on divorce.

Florida Domestic Relations statute § 742.17 takes a different approach. It requires that a couple and physician “enter into a written agreement” that addresses disposition of gametes and embryos in the event of death, divorce or any other unforeseen circumstance.¹⁵⁵ The Florida statute also sets forth default rules governing disposition of gametes in the absence of a written agreement, with decision-making authority for embryos resting

¹⁵³ N.D. CENT. CODE ANN. §14-20-64(2) (2011).

¹⁵⁴ Of course the statutes that leave off the second sentence may be adopting the opposite rule, also troubling, that the party wishing to avoid procreation will always prevail, as s/he can “revoke” consent any time prior to placement. For critiques of rules and rulings favoring procreation avoidance, see Daar, *supra* note 6, and Waldman, *supra* note 127.

¹⁵⁵ FLA. STAT. ANN. § 742.17 (West 1993).

jointly with the couple.¹⁵⁶ The use of the word “agreement,” the explication of default rules, and the placement of the provision in the Domestic Relations chapter dealing with parentage suggest that a court might be inclined to enforce a divorce disposition, though again, the statute provides no assurance of the quality or clarity of the drafting or the process by which the parties review and execute the agreement.

C. *The Latest Proposal: California’s “Model Act”*

A bill introduced in the California legislature in February 2011 attempts to address both the embryo disposition decision and the family law implications by establishing the “Model Act Governing Assisted Reproductive Technology.”¹⁵⁷ The Model Act would repeal Health and Safety Code § 125315, discussed above, and replace it with several new sections governing embryo disposition. Once again, though, the proposed bill is poised to create more problems than it solves.

The Act first addresses embryo disposition in “Part 2. Informed Consent.” As under existing law, the Act requires a signed and dated written informed consent, but it specifies that the consent must be written in plain language—a step in the right direction.¹⁵⁸ The next section provides that the form should disclose various dispositions, including storage, transfer, destruction, or donation to a known or unknown person or to research.¹⁵⁹ The form must also contain a statement identifying

¹⁵⁶ *Id.* at (2).

¹⁵⁷ A.B. 1217, 2011-12 Reg. Sess. (Cal. 2011) (containing amendments to both the Family Code and the Health and Safety Code). Prior to going to press, the bill’s authors substituted an amended version that; *inter alia*, deleted the sections governing embryo disposition. *Id.* (amended in Assembly Apr. 14, 2011). Nonetheless, the original version of the bill, at least in the provisions discussed here related to embryo disposition, tracks closely the ABA Model Act Governing Assisted Reproduction (2008) (Article 2 and Article 5), available at <http://apps.americanbar.org/family/committees/artmodelact.pdf> (accessed Feb. 24, 2011). As such, other states may consider it a model to emulate.

¹⁵⁸ A.B. 1217, 2011-12 Reg. Sess. (Cal. 2011), at § 126003(a)(1).

¹⁵⁹ *Id.* Apparently, the parties can waive their right to disclosure of these options—another puzzling provision that seems potentially at odds with the common law obligation of physicians to obtain informed consent. *Id.* at § 126004(a). Perhaps this provision is intended to apply to third parties involved in collaborative reproduction, such as a gestational surrogate, who would ordinarily have no interest in the disposition of the embryos.

which of the dispositions are permissible under applicable law.¹⁶⁰ Unfortunately, the Act does not explain which, if any, are prohibited. It leaves providers the burden of discerning that crucial piece of information.

A separate section, “Part 5. Embryo Transfer or Disposition,” deals with embryo agreements.¹⁶¹ This section mandates that intended parents “execute a binding agreement” prior to embryo creation that covers, *inter alia*, the use and disposition of the embryos in case of divorce, illness, incapacity or death of one or both parents or “other change of circumstances, including, but not limited to, separation or estrangement.”¹⁶² The agreement must state “whether an intended parent may use the embryos in the event of divorce” or other circumstances.¹⁶³ However, a few subsections later, the proposed statute *directly contradicts* this provision. Section 126012(d) allows a party to an embryo disposition agreement to withdraw consent to its terms and expressly prohibits use of the embryos to initiate a pregnancy if the intended parents later disagree. Once the objecting party provides notice of his or her “intent to void conception. No prior agreement to the contrary shall be enforceable.”¹⁶⁴ It makes no sense to ask the parties to dictate whether an intended parent can use the embryos, but then to declare any such use impermissible without contemporaneous consent. Which provision controls?¹⁶⁵

Moreover, this same subsection begins by stating that “[a] party to an embryo storage or disposition agreement may withdraw his or her consent to the terms of the agreement in a re-

¹⁶⁰ *Id.* at §126004(a).

¹⁶¹ *Id.* at §126012-126017.

¹⁶² *Id.* at §126012(a)(2).

¹⁶³ *Id.* at § 126012(a)(3).

¹⁶⁴ *Id.* at § 126012(d). The use of the word “conception” here seems to be in error, since conception would already have occurred at the time the embryos were created. Providing notice of intent to avoid “transfer” makes considerably more sense.

¹⁶⁵ The ABA Model Act is clearer on this point. It provides that the agreement is “subject to” the withdrawal of consent provided for in subsections (c) and (d). ABA Model Act, *supra* note 159, at § 501(3)(a). However, unless “use” of the embryos refers to something other than initiating a pregnancy (unlikely), the requirement that the parties address the issue seems a pointless exercise and potentially misleading unless the agreement is very carefully drafted.

cord.”¹⁶⁶ Allowing revocation by either party in this fashion renders the “agreement” meaningless as a legal matter. This section overall requires intended parents to make a “binding” agreement and thereby inevitably induces their reliance on choices made in the agreement. But it then completely undercuts that reliance for those who may have chosen the option of using the embryos in the event of divorce.¹⁶⁷

To make matters even worse, the Act specifies that in the absence of an agreement, “the following” shall control embryo disposition.¹⁶⁸ “The following” imports the language of the current statute (section 125315), stating that, in the event of specified contingencies, including separation or divorce, the embryos “shall be disposed of by one of the following actions,” which include donation to another or to research, destruction or making them available to the female or male partner (in direct contravention of the previously noted section prohibiting use if the other party objects).¹⁶⁹ The Act gives no guidance on which of the options would apply, leaving parties who attempt to fulfill the mandate to enter into an agreement for disposition in the previously described “legal vacuum,” with no way to divine the default rule a court would use to decide the dispute. It also perpetuates the inconsistency of offering the option of making the embryos available to one of the parties for use upon divorce,

¹⁶⁶ *Id.*

¹⁶⁷ This section also contains language similar to some of the parentage statutes discussed above, which declares an intended parent not to be the parent of a child born if transfer occurs after the objecting party has provided notice of his or her intent to avoid gestation. A.B. 1217, 2011-12 Reg. Sess. (Cal. 2011), at § 126012(e). This provision might be interpreted to allow transfer despite revocation—another significant inconsistency. More likely it seeks to provide protection in the event transfer occurs by mistake. *Compare supra* notes 148-158 and accompanying text. However, it would also seem to prevent the intended parent from asserting parental rights in the event transfer occurred after notice. If this provision is aimed at mistakes, presumably the intended parent should have the opportunity to assume parental rights, if s/he so chooses. Otherwise, the Act arguably provides an incentive for a party wishing to use the embryos over the objection of the other intended parent to induce such a mistake, since the person using the embryos would then have sole parental status.

¹⁶⁸ *Id.* at § 126016(c). This section does not appear in the ABA Model Act, *supra* note 159.

¹⁶⁹ *Id.*

while stating earlier that no embryos will be implanted over the objection of the other party.

The Model Act also raises concerns in cases where intended parents use donor gametes. The ban on using the embryos against the wishes of the other party would apparently apply to embryos created with donor gametes as well.¹⁷⁰ Thus, as we saw with the SART documents,¹⁷¹ the Act would bar the intended parent who provided the sperm or egg from using the embryos, despite the lack of genetic connection by the other intended parent, and regardless of any agreement at the time of treatment to the contrary. The Act further increases the possibility of controversy related to the forms by specifying that donors can control the disposition of embryos created from those gametes.¹⁷² While some egg donors currently do impose disposition restrictions in separate contracts with intended parents, sperm donors typically relinquish all rights upon donation. Even assuming that good reasons exist to treat egg and sperm donors equally and to codify their right to place conditions on disposition of embryos—questions deserving of further scrutiny—this requirement places a burden on physicians to coordinate all the various “records” to ascertain that the instructions provided by the various parties are compatible.

Moreover, the Act may exacerbate the problem of inviting couples to make disposition choices for the future that clinics may not be able to carry out. In particular, it may make a decision to donate to research upon death, divorce or other contingency even more problematic than it already is under the current California statute. Although very poorly worded, the Act appears to require that all parties—intended parents and gamete providers (sperm or egg) provide consent for specific approved research.¹⁷³ Hence, a general consent to research at the time of

¹⁷⁰ *Id.* at 126012(d).

¹⁷¹ *See supra* note 44 and accompanying text.

¹⁷² *Id.* at § 126006(c).

¹⁷³ *Id.* at §126013(b). The section states that:

Intended parents may choose to donate their unused embryos for either of the following purposes . . . (b) Donation for approved research, the nature of which may be specifically set forth in the informed consent record and which will require the approval of an institutional review board. No research shall be permitted that is not within the scope of the informed consent of the recorded agreement.

gamete donation and embryo creation may not satisfy the statute and could effectively foreclose donation to research at a later date without contemporaneous consent of all gamete donors and intended parents. As most donors are anonymous, such a requirement would be impossible to satisfy in the vast majority of cases.

Finally, the proposed Model Act, like all the other statutes and pending legislation discussed so far, ignores the many process concerns we have identified, beyond requiring the use of plain language in the informed consent form. Moreover, it invites confusion by requiring both an informed consent “record” offered by the medical provider and an “agreement” between the intended parents, without specifying their relationship to each other. Under these circumstances, the “agreement” will likely continue to be subsumed in the “informed consent” and thus be drafted for the physicians, rather than the parties, with all the problems that entails.¹⁷⁴ Thus the Model Act ultimately would create the worst of all possible worlds regarding embryo disposition in divorce. It would require parties to make a supposedly “binding” agreement, which would, in fact, not actually be binding, without doing anything to ensure more effective deliberation, greater clarity of terms or better understanding by the parties.

This agreement shall be modified only with the consent of both gamete providers and of the intended parents. . . .

Id. at §126013 and 126013(b).

¹⁷⁴ See *supra* notes 121-123, and accompanying text. A bill introduced in Maryland in 2003 offered a possible solution to the problem of poorly drafted forms designed to protect physicians. H.B. 481, 428th Sess., Gen. Assem. (Md. 2003). It would have required providers to offer a standard “advance directive” form covering various disposition options and contingencies, but it would also have required the provider to submit the form to the Department of Health and Mental Hygiene for review, in consultation with assistant attorneys general, to ensure that it set forth the “rights, responsibilities, and duties of the parties . . . clearly and legibly,” complied with applicable laws and did not include provisions in violation of public policy. *Id.* at §20-802. The bill passed the Maryland House but not the Senate. 2003 Reg. Sess B Information Current as of Dec. 15, 2003, available at <http://mlis.state.md.us/2003rs/billfile/hb0481.htm> (accessed Feb. 24, 2011).

IV. Time for a Change in Drafting and Policy

Embryo disposition decisions are inordinately difficult—both for the parties involved and for the courts asked to resolve disputes when parties divorce. Asking couples to sign a standardized form selecting a disposition in the event of divorce and enforcing that choice might seem, at first glance, an efficient and appropriate solution. However, courts and legislatures should resist the temptation to view these forms as binding contracts in future disputes, and clinic forms should be drafted to dispel any notion of enforceability.

Standardized clinic consent forms signed prior to treatment present a particularly poor vehicle for ascertaining and expressing the parties' intentions either at that point in time or projecting into the future. Nor is the process surrounding use of the forms or their content likely to improve sufficiently to justify reliance on them. Physicians have neither the incentive nor the expertise to ensure embryo dispositions related to divorce have resulted from careful thought and accurately reflect the parties' preferences. Legal uncertainties and myriad variations in life circumstances would make drafting even a customized contract between the parties challenging. A standardized form simply cannot hope to accomplish the task, nor should it pretend to.

Consequently, to avoid the illusion of certainty and the potential for misplaced reliance, clinic consent forms should be drafted to make clear that disputes between the progenitors in the event of divorce or comparable change in relationship status will be decided by a court or other binding alternative dispute resolution process if the parties cannot reach agreement at that time. The forms can, and should, inform the parties that disputes have arisen in the context of divorce and invite them to seek legal counsel to answer any questions they may have.¹⁷⁵ Statutes like California's that currently require health care providers to

¹⁷⁵ Cf. Lyerly, *supra* note 2, at 1629 (suggesting that the goal of discussion before treatment should be not to obtain commitment regarding disposition, but to "communicate that embryo cryopreservation may have untoward consequences" including the burden of difficult disposition decision in future). In jurisdictions that have developed rules governing disposition, the forms should be drafted accordingly. For example, in Massachusetts, the forms might disclose that contemporaneous consent would be required for transfer of the embryos to the other party to initiate a pregnancy. *A.Z.*, 725 N.E.2d at 1057-59.

provide disposition forms should likewise be modified, if necessary, to eliminate any apparent requirement that the parties select a disposition choice in the event of relationship break down or divorce.

Couples who create embryos using one party's gametes and donor sperm or egg arguably stand on a different footing than those where both parties contribute gametes, or where the embryo is created entirely with donor gametes. Where only one member of the couple contributes gametes, only that party will have a genetic connection to the embryo and any resulting child. We might expect courts to view the gamete provider as the person with the greater claim to the embryo in the event of a dispute, although no statute or court precedent has yet made that clear.¹⁷⁶ Given the lack of clear legal guidance on this issue, leaving the matter to future judicial resolution may remain the best approach. However, under these circumstances, it may be worth considering an alternative possibility. The clinic consent form might provide that the intended parent who provides sperm or egg shall control disposition on divorce unless a court order or agreement of the parties at that time provides otherwise. This approach would preserve the opportunity for the non-gamete providing party to persuade a court that s/he should obtain control of the embryos, while recognizing that, in most cases, the gamete provider will prevail. This approach might reduce the incidence of litigation over these matters and give the parties a more realistic expectation regarding future disputes.

Indeed, we should acknowledge that eliminating the option of divorce disposition choice in the consent form and leaving the question to future resolution by agreement or judicial action may have the unintended negative effect of encouraging litigation on this issue. Despite all the problems with consent forms identified herein, it may be that some couples perceive themselves as bound by the consent form (whether they really are or not), and thus choose not to litigate the matter, even if they no longer agree with the chosen disposition. At this point, there is no way to know whether such an increase will occur. We can be encouraged by the history: In the roughly twenty years clinics have

¹⁷⁶ Recall the appellate court in *Litowitz* took this position, but the Washington Supreme Court overturned that decision. *See supra* note 94.

offered cryopreservation of embryos, the use and content of consent forms have varied considerably, yet only a small number of cases have actually been adjudicated. There may also be other ways of mitigating or forestalling any increase, such as providing better counseling and support,¹⁷⁷ clarifying the default rules governing disposition or honoring contracts entered into outside the clinic setting.¹⁷⁸ Moreover, although reducing litigation is generally a worthy goal, especially in family law matters, it is not sufficient reason to enforce divorce disposition provisions in consent forms so deficient in substance and process.

The suggestion here would apply only to dispositions based on divorce or change in relationship status. Certainly, embryo disposition forms still play an important role in defining the relationship between the couple and the clinic. For the clinic to function, the parties must provide instructions for how to deal with the embryos if one or both partners are unavailable to decide about disposition due to death, cessation of treatment or abandonment of the embryos. Most clinics are not long-term storage facilities, nor should they be conscripted as such. Clinics should require patients and partners to complete an advance directive that offers an array of disposition choices in the event of these contingencies at the time of treatment, and physicians should be entitled to rely on them if they act in accordance with the instructions. The clinic should also seek reaffirmation of disposition choices as part of its annual storage agreement.¹⁷⁹ However, no compelling need exists for physicians to know at the time of treatment how the parties would dispose of the embryos in the event of divorce, separation or a future dispute between the progenitors. As long as the physician can continue to recoup fees for the embryos' storage or transfer them to another facility, requiring the couple's agreement or a court order should not negatively impact the practice.

In addition, courts should refuse to enforce divorce disposition choices made in clinic consent forms as a matter of policy. Generally, courts require several elements to recognize a contract as valid and enforceable. These include offer, acceptance, a

¹⁷⁷ See *supra* note 81.

¹⁷⁸ I leave full discussion of those for the companion article.

¹⁷⁹ See Lyerly, *supra* note 4, at 506 (suggesting clinics include updated disposition information with annual billing for storage).

“meeting of the minds,” each party’s consent to the contract’s terms and “execution and delivery of the contract with the intent that it be mutual and binding.”¹⁸⁰ Moreover, contracts may fail from a variety of defenses, including duress and unconscionability.¹⁸¹ In any given case, a court might find a necessary element of a particular contract missing or a valid defense established. Indeed, the ambiguity and internal inconsistencies characteristic of many standardized consent forms may well suffice to preclude a finding of “meeting of the minds” in some cases. Likewise, the coercive timing and emotional state of a particular patient may coalesce to give rise to the credible claim of duress in certain instances.

However, the flaws identified above may not invariably add up to an unenforceable contract in every case. As we have seen, despite exhibiting many procedural and substantive weaknesses, courts have repeatedly enforced embryo disposition provisions found in consent forms.¹⁸² Likewise, while the forms may “smack” of unconscionability,¹⁸³ they do not fall neatly within the commonly understood forms of procedural and substantive unconscionability. Although the density and complexity of the forms may make it difficult for participants to understand and process all the information, these characteristics would not necessarily rise to the level of “surprise” necessary to find procedural unconscionability.¹⁸⁴ Nor would the forms necessarily qualify as a typical adhesion contract. Adhesion contracts are contracts drafted by the party with greater bargaining position and offered on a “take it or leave it” basis.¹⁸⁵ Although drafted by the stronger party (the physician or clinic) and presented in stan-

¹⁸⁰ Roman, 193 S.W.3d at 50. As the court pointed out, contracts also typically require consideration, which in this type of case may be provided by the gamete donation process undergone by both husband and wife. Of course there may be a consideration issue for a non-gamete provider partner in cases where donor sperm or egg is used.

¹⁸¹ LORD, *supra* note 85, at § 1:20; RICHARD A. LORD, 8 WILLISTON ON CONTRACTS § 18:10 (4th ed. West 2008).

¹⁸² See *supra* notes 14-38 and accompanying text.

¹⁸³ Waldman, *supra* note 6, at 926.

¹⁸⁴ RICHARD A. LORD, 8 WILLISTON ON CONTRACTS § 18:10 (4th ed. West 2008).

¹⁸⁵ HOWARD O. HUNTER, MODERN LAW OF CONTRACTS § 6.2 (West 2010).

standardized form, clinic consent forms commonly allow the parties to select among several disposition options and some may offer them the opportunity to write in another choice. Moreover, enforcement is sought not against the stronger, drafting party (the clinic), but against the other co-signatory, the patient or partner. In terms of substantive unconscionability, a particular disposition choice is likely not so one-sided as between the progenitors as to be deemed unreasonably harsh.¹⁸⁶

Certainly parties can make arguments in a particular case that the form was unconscionable. But they should not have to rely on a case-by-case establishment of a contract defense. The flaws illuminated in this article, taken as a whole, should suffice to conclude that embryo disposition provisions related to divorce embedded in clinic consent forms should not qualify as enforceable contracts as a matter of policy. These are not contracts for widgets. They bear directly on matters of constitutional import—the fundamental rights surrounding procreation and parenthood.¹⁸⁷ Like the embryos themselves, which many argue deserve “special respect,”¹⁸⁸ agreements regarding embryo disposition deserve special treatment—certainly more than a box checked in a standardized form covering a multitude of complex issues.¹⁸⁹ Indeed, even those scholars who advocate in favor of contracts governing embryo disposition call for some procedural safeguards as a condition of enforceability.¹⁹⁰

¹⁸⁶ LORD, *supra* note 184, at § 18:10. *But see* Waldman, *supra* note 6, at 926-929 (arguing that disposition agreements disadvantage women, at least in agreements that prohibit use of embryos after divorce).

¹⁸⁷ See I. Glenn Cohen, *The Constitution and the Rights Not to Procreate*, 60 STAN. L. REV. 135 (2008); Robertson, *supra* note 6, at 1030-38.

¹⁸⁸ See *Davis*, 842 S.W.2d at 597; Coleman, *supra* note 6, at 67 (observing that “[m]ost commentators” and ASRM agree embryos have heightened moral status and deserve “special respect”). *Cf.* Angela P. Upchurch, *A Postmodern Deconstruction of Frozen Embryo Disputes*, 39 CONN. L. REV. 2107 (2007) (discussing and critiquing “special respect” categorization of embryos).

¹⁸⁹ Embryo disposition contracts operate in an area of the law—rights related to marriage, children and procreation—that has shown heightened concern for clarity as a condition of enforceability. *See, e.g.*, *Woodward v. Commissioner Soc. Sec.*, 760 N.E.2d 257, 268 (2002) (requiring donor of gametes to “clearly and unequivocally consent” to posthumous reproduction and support of any resulting children).

¹⁹⁰ Cohen, *supra* note 6, at 1180-81; Theresa M. Erickson & Megan T. Erickson, *What Happens to Embryos When a Marriage Dissolves? Embryo Dis-*

Conclusion

We have seen the inherent flaws in the process surrounding review and execution of these forms, the exceptional difficulty of the disposition decision and the intractable barriers to drafting clear agreements that can adequately express the true preferences of the parties. Rather than ameliorate these problems, legislation has more often exacerbated them. Clinic consent forms can accomplish a variety of tasks reasonably well, but fairly and effectively binding the parties to a disposition for their embryos in the event of divorce or change in relationship status is not among them. In light of these realities, clinic forms should not attempt to secure a commitment to a particular disposition on divorce, nor lead the parties to believe one would be binding. Courts and legislatures should likewise resist the trend and refuse to enforce embryo disposition divorce provisions found in clinic consent forms.

position and Divorce, 35 WM. MITCHELL L. REV. 469, 480 (2009); Ann Marie Noonan, Note, *The Uncertainty of Embryo Disposition Law: How Alterations to Roe Could Change Everything*, 40 SUFFOLK U.L. REV. 485, 517-18 (2007); Robertson, *supra* note 6, at 1016-17. I will consider whether embryo disposition contracts drafted separately from the clinic consent process should be enforceable, and, if so, under what circumstances, in a companion article.

