Creating Families through Science and Law

by Serena H. Chen and Bill Singer

Within a generation, there has been exponential growth in the use of what is generally known as assisted reproductive technology (ART) to help people create families. ART medical advances have created opportunities for people who cannot conceive a child on their own, whether for medical or social reasons, to become parents of a newborn.

The ART arsenal offers a variety of techniques. The most common is in vitro fertilization (IVF). IVF is the creation of an embryo in a laboratory and the transferring of that embryo to a uterus. Other ART procedures include: 1) egg, sperm and embryo donation; 2) donor sperm insemination; 3) IVF using donor oocytes; 4) gestational surrogacy (where a woman genetically unrelated to the embryo gestates the child); and 5) cryopreservation of genetic material, whether sperm, eggs or embryos.

Relevant Statutes

Since 2001, New Jersey state law mandates that insurers provide benefits for assisted reproduction. In 2016, the law was updated to expand coverage for single women and same-sex female couples.[1]

Last year, New Jersey enacted the New Jersey Gestational Carrier Agreement Act, which branded the state as one of the more desirable locations for gestational surrogacy.[2] Surrogacy remains illegal or severely limited in some states and foreign countries, including most European nations. As a result of New Jersey's more advanced law in this area, potential parents from throughout the United States, and equally from abroad, may pursue creation of their families using New Jersey gestational carriers, medical facilities, and hospitals.

If the agreement between the intended parents and the gestational carrier follows the requirements of the act, the intended parents are able to obtain a pre-birth order confirming their parentage. This pre-birth judicial process is available to intended parents, regardless of whether they are New Jersey residents and regardless of whether they have a genetic connection to the child.

Also in 2018, the New Jersey Legislature amended the artificial insemination statute (N.J.S.A. 9:17-44) to make it more favorable to same-sex couples. The prior statute was restricted to couples where a husband consented to the artificial insemination of his wife. Although a court had given the statute a gender-neutral reading, the law's scope remained unclear.[3] The newly amended statute replaces the terms 'husband' and 'wife' with 'spouse or civil union partner.' The amended statute also expands access by allowing physician assistants and advanced nurse practitioners, in addition to doctors, to supervise insemination.

Technological advances, increased access to health insurance, shifting cultural perspectives, and new legislation, therefore, have led to increased use of ART to help build families in New Jersey. As more people in the state utilize ART services, it is important for lawyers to be familiar with the unique legal issues of families conceived through ART.

Consent Forms

Obtaining informed consent from all involved parties is a key issue in an ART practice. Medical clinics present ART patients with consent forms concerning whatever part of the ART process they will be using. ART-related consents are valid only if the patients signing them understand their rights and responsibilities when executing them.

Doctors are not lawyers and, thus, they cannot be expected to explain to patients potential legal consequences. At the same time, these consent documents can have lifelong impacts, so patients should not simply sign away certain rights without obtaining adequate, or any, legal advice. As a result, clinics often encourage consultation with an attorney. A knowledgeable attorney can help clients understand the legal implications of various requests and potential outcomes.

Depending on the ART techniques to be employed, patients could be asked to consider, understand and sign a plethora of consent forms. In each consent form, there is a detailed explanation of the contemplated medical procedure.

Here are some examples:

1. **Consent to health screenings.** ART participants must consent to rigorous health screenings and will be asked to sign Health Insurance Portability and Accountability Act (HIPAA) releases to give doctors access to all of their medical records. Those screenings and records may be shared with other potential parties.

   In the early 1990s, when ART techniques were first being used to create families, ART professionals, both medical and legal, were sued when a pregnancy resulted in consequences that could have been prevented through screenings. The Sixth Circuit heard a negligence action against medical and legal professionals for failing to test the sperm for cytomegalovirus (CMV). Both the surrogate and the child were infected.[4] In another matter, an appellate court in Pennsylvania heard a case against a surrogacy agency for failing to conduct psychological screenings of the ART participants, where the sperm donor father murdered the child he conceived through ART.[5]

   Since then, the Food and Drug Administration (FDA) has developed regulations requiring medical screenings of all ART participants.[6] In addition, the American Society for Reproductive Medicine (ASRM) promulgates guidelines for ART practitioners, including recommended screenings for sexually transmitted diseases, exposure to Zika virus, the psychological health of the participants, and similar issues.[7]
2. **Consent for receipt of donated egg.**
3. **Consent acknowledging risk of using donor agency.**
4. **Consent for use of donated egg and fertilization with male partner's sperm.**
5. **Consent to transfer a fertilized egg to the uterus of the female partner or gestational carrier.**
6. **Consent to use of assisted hatching and fragment removal using micromanipulation techniques that can promote attachment to uterus.**
7. **Consent to preimplantation genetic testing (PGT).** PGT is used to test an embryo for specific genetic conditions, including chromosomal abnormalities. It is favored for ART participants who: 1) are 35 years old or older; 2) have had repeated failures using IVF; 3) wish to screen for an inherited genetic disease; or 4) have had repeated miscarriages. As this technology becomes more accurate and less expensive, it may become routine to test all embryos to confirm normal chromosome numbers.
8. **Consent for in vitro fertilization/assisted reproduction using a gestational carrier.** When using a gestational carrier, consents can include:
   - a generalized consent form signed by the gestational carrier and spouse/partner;
   - a consent form by intended parents to transfer cryopreserved, thawed embryos;
   - FDA consent for genetic intended parents using a gestational carrier; and
   - a consent by intended parents to IVF using gestational carrier.

   In addition, in order to take advantage of the new law in this state, the intended parents and gestational carrier (and spouse) need to execute an agreement meeting the act's requirements, with the parties represented by independent counsel.
9. **Consent to cryopreserve embryos or gametes.** This consent is really a contract between clinics storing materials and patients. Patients who decide to cryopreserve gametes or embryos are required to provide specific instructions as to use and disposition. It will set forth storage costs and normal contractual provisions. The contract may state that if the owners of the material fail to pay the storage costs, the clinic may destroy the genetic material.

The owners of the material should direct who will pay for costs of storage and how the material will be handled over time, including divorce or death. Options may include donating material for scientific research or destroying it.

Of all the ART-related forms, contracts about the custody and use of frozen embryos have received the most judicial scrutiny. Cases are usually decided using either of two theories: the contract approach or the balance-of-interests approach.

Under the contract approach, courts are guided by the terms of the contract.[8] Under the balance-of-interests approach, a judge will weigh the interest of the party seeking to use the material to achieve parenthood in contrast to the party seeking to avoid procreation.[9]

Where the language of the contract is clear, judges often enforce the plain meaning of the agreement. However, there are exceptions. For example, divorcing couples have quarreled over cryopreserved embryos created by using the gametes of both spouses.[10] After demonstrating that due to medical circumstances, one party can no longer procreate using their own gametes,

courts have allowed one spouse to use the embryos.[11] When this occurs, judges have held the other spouse free from any liability for the child who may be born.[12]

To better understand the balance-of-interest approach, consider *In re Marriage of Rooks*.[13] The Colorado Supreme Court faced a dispute over embryos where there was no written agreement. In reaching its decision, the Court outlined factors to be considered in resolving a dispute while respecting each party's "procreational autonomy":

- the intended use of the party seeking to preserve the embryos;
- the party's demonstrated ability or inability to become a genetic parent through means other than the disputed material;
- the parties' reasons to undertake IVF in the first place;
- emotional, financial, logistic and hardship for the person seeking to avoid becoming a genetic parent; and
- any demonstrated bad faith or attempt to use embryos as unfair leverage in divorce proceedings.

The court also outlined facts that should not be considered:

- whether the person who wants to use embryos can afford to raise a child;
- the number of the parent's existing children; and
- whether the genetic parent could adopt a child or otherwise parent a non-biological child.

Lawyers who counsel clients on estate planning issues also need to inquire about any stored embryos or gametes. If clients do have embryos or gametes in storage, then their wills should direct disposition upon their death.

Conclusion

Science, society, and legislation are all making New Jersey a more popular place for parents to conceive children with ART. As such, New Jersey family lawyers should have a working knowledge and understanding of the science and law of ART so as to better guide their clients, while at the same time being able to articulate the applicable legal argument supporting the client's position. In particular, family lawyers assisting in the ART process should be familiar with the kinds of consent forms ART participants will be asked to sign, and with the consequences of those decisions, so they can best guide their clients through the legal aspects of the process. ■

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Endnotes

1. N.J.S.A. 17:48-6x.
2. N.J.S.A. 9:17-60 *et seq.*
3. *In re Parentage of Robinson*, 383 N.J. Super. 165 (Ch. Div. 2005).
4. *Stiver v. Parker*, 975 F. 2d 261 (6th Cir. 1992).
5. *Huddleston v. ICA*, 700 A.2d 453 (Pa. Sup. Ct. 1997).
6. 21 C.F.R. 1271 *et. seq.*
7. *See* ASRM, Recommendations for practices utilizing gestational carriers: an ASRM Practice Committee guideline, 97 *ASRM Pages* 1301 (June 2012), available at https://www.fertstert.org/article/ S0015-0282(12)00325-1/pdf; G. David Ball PhD et al., Guidance for Providers Caring for Women and Men Of Reproductive Age with Possible Zika Virus Exposure, Aug. 2018, available at https://www.asrm.org/globalassets/asrm/asrm-content /news-and-publications/practice-guidelines/for-non-members/guidance_for_providers_zika_virus_exposure.pdf.
8. *See, e.g., Kass v. Kass*, 696 N.E.2d 174 (N.Y. 1998).
9. *See, e.g., J.B. v. M.B.*, 783 A.2d 707 (N.J. 2001).
10. *See, e.g., A.Z. v. B.Z.*, 725 N.E.2d 1051 (Mass. 2000).
11. *See, e.g., Reber v. Reiss*, 42 A.3d 1131 (Pa. Sup. Ct. 2012).
12. *Szafranski v. Dunston*, 34 N.E. 1132 (Ill. App. 1st 2015); *Davis v. Davis*, 842 S.W.2d 588 (Tenn. 1992).
13. 2018 CO 85 (Colo. 2018).