

November 19, 1996

COUPLES AND CLINICS - STRANGE BEDFELLOWS:

ASSISTED REPRODUCTIVE TECHNOLOGY AND PRIVACY

RIGHTS

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I. INTRODUCTION TO THE ISSUE

Massachusetts courts had not directly addressed the problems raised by the specter of frozen pre-embryos during the divorce process until, in March 1996, Judge Anthony Nesi of the Suffolk County Probate & Family Court, after a two day hearing, decided the landmark case, A.Z. v B.Z.. This article will present the unique facts and attempt to analyze the multitude of explosive issues - legal, moral, ethical, emotional - that were raised by this unrivaled and important situation. As Assisted reproductive technology swiftly advances and is able to provide hope and help to otherwise infertile couples, the legal, medical and patient communities should be put on alert that this uncharted territory is full of constitutional issues that must be considered before, during and even after the couple ever does separate and/or divorce.

Finally, the authors will address the facilities involved in this newly and rapidly developing medical field and will offer their advice and warnings; these clinics, by virtue of their intervention in the process of conception, must participate by intervening and

even guaranteeing the protection of the privacy rights of individuals, couples and families before and through the conception process. After all, the privacy rights guaranteed by Roe v. Wade and its progeny are constantly evolving and expanding; by protecting the parties before and during conception the safeguards of and by the clinics ensure protection if or after the divorce process.

II. INTRODUCTION TO THE PARTIES

During the summer of 1995, the marital relationship between A.Z. (hereinafter “husband”) and B.Z. (hereinafter “wife”) deteriorated to the extent that the wife obtained a restraining order against the husband and he filed a Complaint for Divorce. A.Z. and B.Z. had, at that time, been married for approximately 17 years and had twin daughters who at that time were 3 years old. The couple had a history of infertility treatments, and their daughters had been conceived in 1991 by means of In Vitro Fertilization (hereinafter “IVF”). The wife had always been intensely concerned with the possibility of conception and continues to be so to the present day. In 1991, the clinic, per the “Ultimate Disposition of the Embryos” form discussed below, froze 2 vials of pre-embryos belonging to the couple for possible future use by the couple. In July 1995, after the break-down of the marriage and just before the filing of a divorce complaint by the husband, the wife, without informing or seeking consent from the husband, put the clinic on notice that she wanted to thaw a vial of frozen pre-embryos in order to attempt conception once again. She testified at trial that she thought this was her “last shot” at further motherhood; that she was now 40 years old and wanted one more chance at

conception. The husband learned of his wife's intent only after he received a statement from his health insurance company that stated she had undergone such an IVF procedure that did not result (fortunately for him) in conception. He was vehemently opposed to the prospect of any further children at this stage of his life. The wife continues to desire an additional procedure using the remaining vial of pre-embryos in an attempt to achieve pregnancy.

III. INTRODUCTION TO THE CLINIC PROCEDURES

The couple had treated at a clinic in the Boston area specializing in Assisted Reproductive Technology (hereinafter "ART") since 1988. It is most important to note that when the couple met with the clinic physician to discuss the medical interventions that were available to them, they never met with a mental health professional for consultation or counseling regarding their options or decisions.

According to the clinic, the protocol in effect then mandates such counseling by their on-site and highly qualified staff mental health professional only when in vitro couples fall into the "self-referral" category by requesting such counseling themselves. Other counseling appears to be mandatory for other infertile couples seeking different procedures (surrogacy, etc.), but in vitro couples have not been seen as needing any counseling absent their own request. The couple involved in the AZ v BZ case did not request counseling and, therefore, never received any clinic guidance about the choices they were asked to make in the "Ultimate Disposition of the Embryos" form which was at issue in the litigation here. The form which was in use in 1991 (and which has been updated since then) asked the couple to choose the disposition of the frozen pre-embryos in

the event of death of one or the other of the partners or in the “should we become separated” scenario. This couple, having been through the harvesting of eggs procedure many times, had seen and signed this type of consent form 6 times prior to the June 1991 procedure which controlled the action in this case. The husband here testified that often his wife would bring home “another one” of the forms for his signature because she had an appointment at the clinic “tomorrow”; she would request his signature and he would comply - at home, in the car, en route to the clinic - often signing the form in blank so that she could and would fill in the blanks later. He further testified that she and he never discussed the options and that he never saw the form signed in 1991 after she had filled it in. Thus, he was ignorant of the fact that she had written in that the embryos should be returned to her “should we become separated.”

The clinic’s very language here is ambiguous, since “separated” is not defined or explained anywhere on the form. This couple had a history of living apart from each other because of their jobs in the military, so the definition of the word “separated” can be seen as ambiguous at best and confusing at least.

Although the clinic form has room for signature by the attending physician and for signature by a witness, examination of the forms of this couple revealed that the signing procedures were very sloppy and that often the physician and/or the witness signatures were illegible and/or were dated at times much later than the date of the procedure or the signing by the parties. Since the couple here was a repeat signer, by virtue of the previous procedures they had undergone, perhaps the clinic rushed the paperwork when, indeed, the inherent risks do increase in such repeaters; with each disappointment a couple such as this must feel when a procedure does not result in conception and viable

pregnancy, their vulnerability must also heighten. The clinic's responsibility for walking such a couple through the paperwork should, therefore, increase rather than decrease with such repeating couples. In addition, the clinic's duty to this and other repeating couples should be heightened by virtue of their increased fragility and vulnerability at this stage of desperation; not only would the patients benefit from a more proactive role from the clinic but the clinic itself would be protected from later complications when and if misunderstandings or other controversies (legal or not) between the patients does occur.

III. IMPLICATIONS AND SAFEGUARDS FOR THE FUTURE

Physicians and clinics who choose to practice in the field of Assisted Reproductive Technology must be aware that they are casting themselves squarely in the midst of the sacred privacy rights which are guaranteed by the U. S. Constitution through Roe v Wade and its progeny. These privacy rights, in their simplest form, protect intimacy from governmental intrusion or regulation; case law has adamantly stated that the government, absent extenuating circumstances, has no place in the bedroom. The clinical intervention in the intimacy of an infertile couple is such an important extenuating circumstance that it demands a high level of intervention by the clinic through counseling, education, communication and monitoring in order to protect the ultimate privacy of the couple. On its face, the advocating for such a high level of clinic intervention could be seen as merely advocating for more governmental intrusion at each step of the Artificial Reproductive Process which could be seen as diminishing the privacy rights of the very individuals, couples and families guaranteed such protection by Roe v Wade; however, by protecting such individuals, couples and families at the early stage of medical

intervention, we are really ensuring that their rights to privacy will remain intact after conception, birth or divorce by empowering the couple in their right to choose. The clinic involved in the AZ v BZ case limits its active role in the conception process to the period of time from before conception until the determination of a viable pregnancy, at which time the couple is referred to an obstetrician for the duration of the pregnancy and birth. The clinic has, therefore, actively chosen to participate in the infertile couple's most vulnerable, fragile and desperate stage; in their compromised emotional state of desperate longing for a child, the couple needs more, rather than less, protection and guidance from the clinic. The choice to procreate or not is such a protected privacy right (Davis v Davis) and this choice, which is normally left to the individual couple alone, must involve the clinic as a third party when Assisted reproductive technology is needed and sought. Although the choice is still ultimately between the couple, the clinic has now been empowered and invited into the choice process and, therefore, into the "bedroom" of the couple; this invitation carries with it a full set of responsibilities to safeguard the privacy which begin before conception and carry through until the medical discharge of the couple. Davis, supra has emphasized the parity of the individuals in the infertility process by recognizing that, absent a pregnancy, the privacy rights of the man and the woman are equally weighted during the entire infertility process. Clinics, therefore, must not lose sight of the fact that both the man and the woman are their patients, that the couple is the entity being treated. Both the man and the woman must be afforded equal and comprehensive guidance during their emotional journey toward conception. Thus, any and all communications, correspondence and, especially,

consultation and counseling opportunities, must be offered to the couple as a unit and not, as is often the case, to the woman only.

A mandatory consultation session, at the very least, by a qualified mental health clinician is essential for couples about to enter the ART arena. Normally a physician has an initial informational session with the prospective patient-couple to outline available medical procedures, but assessment of and/or discussion about their emotional condition is, absent a request or glaring necessity, usually overlooked. A request for counseling may be viewed, by couples desperate to be accepted into an ART program, as compromising their chances of such acceptance because of the couple's own background and/or their own misconceptions or prejudices about counseling in general. However, the clinic, acting in the role of *parens patriae*, should insist on mandatory assessment during the intake process.

The clinic in the AZ v BZ case failed to provide counseling to the couple before the couple signed vital consent forms. When the Family & Probate Court judge was faced with the challenge of adjudicating the validity of these forms during the process of divorce, he noted the lack of counseling as well as the fact that the wife had "filled in the blanks" after the husband signed the forms. The judge also emphasized the fact that over 7 years had lapsed since the husband saw a completed dispositional form (in 1988) and that the clinic's literature itself asserts the consent form at issue is "good for one year". In other words, the clinic could have and should have avoided this messy litigation if, indeed, a procedure had been in place and implemented which would have mandated an in-person review with the patient-couple prior to any procedure that included a consultation session to assess their current emotional and marital status as well as a joint

in-person signing of any needed consent forms. Many questions remain about this recommendation: Who at the clinic should have the ultimate responsibility for coordinating such on-going consultation and counseling services? Is the physician ultimately responsible? Should the clinic have a professional mental health administrator assigned to oversee these services? The issue remains: without counseling around and about the forms to be contemplated and signed, informed consent is grossly absent.

IV. Conclusion

In conclusion, public policy concerns which center around the rights of the individuals to choose further parenthood, to force further parenthood, to protect the rights of the children (born or unborn) mandate enhanced scrutiny and, therefore, protection for the individuals, the couples and the families who need and choose ART. Patients should look out for their own protection in this as in any situation, but, recognizing the compromised state of these patients is the clinic's ultimate responsibility. Providing information, education and consultation to the patient-couple is the only prudent choice available to the clinic to avoid future judicial intervention when and if the underlying relationship of the couple deteriorates. The high rate of divorce in the United States ensures that some of these ART couples will be caught in the divorce net at some point during the conception process. We need, therefore, to be zealous in our protection of our most sacred privacy rights.