

The validity of contracts to dispose of frozen embryos

G Pennings

See end of article for authors' affiliations

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Correspondence to:
Dr G Pennings, Department
of Philosophy, Free
University Brussels,
Pleinlaan 2, lokaal 5 C
442, B-1050 Brussels,
Belgium;
gpenning@vub.ac.be

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The widespread abandonment of frozen embryos by the gamete providers or intentional parents urgently demands a solution. Most centres react by requiring patients to enter a prior agreement governing the future disposition of their embryos in all foreseeable circumstances. These dispositional directives are inappropriate and self defeating in the event of contingencies in which the patients remain competent to execute an updated directive. Internal and external changes may invalidate the prior directive by altering the situation as represented by the couple at the initiation of treatment to such an extent that it no longer corresponds with the actual situation at the time of the execution of the disposition. The prior agreement should only be considered binding if the agreement among the partners on a specific option was a material condition for one of the partners to start treatment.

Reproduction is an important and central part of a person's life plan. Control over one's reproductive capacities is therefore a crucial element of a person's autonomy. This control includes both a right to reproduce and a right not to reproduce. These rights are expressed in the general acceptance of the gamete providers or intentional parents as the primary decision makers about embryos resulting from infertility treatment. In most centres around the world, it became standard practice to ask patients to sign a consent form in which they indicate what should be done with the frozen supernumerary embryos when these are no longer needed for their own reproduction. This practice partly developed because of the remarkable fact that a considerable number of the embryos are abandoned by the gamete providers or intentional parents. As a consequence of conflicts between the intentional parents and the fertility centre and between the partners themselves, questions were raised about the validity of these contracts.

CONTRACTS CONTAINING ADVANCE DIRECTIVES FOR THE DISPOSITION OF EMBRYOS

The persons for whose reproduction the embryos were created give a current informed consent to freeze their supernumerary embryos and simultaneously issue orders as to what should be done with the embryos some time in the future. They have the right to order the disposition of their embryos if the chosen option is among the list of options accepted by the clinic. Normally, this list includes disposal, donation to research, donation to others, and continued storage. Such "instructions for the future", projections into the future of the current informed consent, are known as advance directives. Advance directives originated in the context of end-of-life treatment; people indicate what kind of treatment may be performed when they can no longer decide for themselves. Advance directives are recognised as an extension of the decision making authority of competent patients.¹ The term is used here in the general meaning of an authoritative instruction given by a competent couple regarding the type of treatment (in this case the disposition of their embryos) they want to receive in case they become incompetent in the future.

Originally, the request for advance directives for the disposition of embryos was motivated by the wish to avoid messy situations when some accident happened. For instance, article

5.9 of the Human Fertilisation and Embryology Authority's code of practice rules that: "Anyone consenting to storage . . . must state what is to be done with the gametes or embryos if he or she dies, or becomes incapable of varying or revoking his or her consent".² The contingencies in which the directives were applicable implied an almost total loss of decision making capacity. Gradually, however, the list of contingencies was extended without taking into account the conditional nature of advance directives. Instructions to dispose of the embryos were requested for almost every imaginable future situation. According to the ethics committee of the American Society for Reproductive Medicine,³ dispositional directives should be asked for the following contingencies: death; divorce; unavailability; disagreement; passage of time, and arrears in paying storage fees. This list points towards the shift in rationale underlying the request for advance directives; their main purpose became to "support the market-driven *in vitro* fertilisation clinics and to make their business easier to run".⁴ The most striking indication of this trend is the demand for advance directives in case of dissolution of the fertility practice or storage facility. More than 30% of the Assisted Reproductive Technology (ART) programmes in the United States address the disposition of embryos in this situation rather than trying to contact the patients in the event of dissolution.⁵ The informed consent forms are used by the clinics to facilitate the management of the "stock" of embryos. It is fully acceptable that clinics obtain prior agreements for the disposition of the embryos. Also, they rightly wish to have a clear legal authority for handling the embryos, in the absence or unavailability of the patients. This motive has, however, advanced to a stage where the procedure actually diminishes the patients' autonomy and their ability to look after their interests. Defenders of this solution still claim that the possibility of stating dispositional directives serves to implement the decisional authority of the intentional parents.⁶ When prior instructions are available and are considered enforceable by law, the parents keep control and need not submit to decisions by the court or the clinic. Although it may be true, however, that prior agreements are able to prevent judicial involvement and litigation at a later time,⁷ the avoidance of the court should not be the primary goal of contracts; the main point is to reach a fair solution. Moreover, the claim that prior agreements minimise disputes has not been corroborated in reality for the simple reason that an embryo disposition agreement,

like any contract, can be disputed by one of the partners. Although the early court cases (*Davis v Davis* and *Kass v Kass*^{8,9}) supported the view that a prior written consent about embryo disposition should be enforced, a later case (*AZ v BZ*¹⁰) upheld the right not to procreate of one partner although there was an agreement signed by both partners to release the embryos to one spouse. Future cases will probably specify how the agreement should be drafted (which will likely result in a restriction of the options available to the parents) and under which circumstances it should be enforced. Finally, this statement not only expresses a considerable lack of trust in the abilities of the court to administer justice but it also suggests that personal decisions, even if essentially uninformed and made in unfavourable conditions, are always superior to judicial decisions.

Advance directives are conditional rules: they take effect only if the patient is unable to participate directly in the decision at the time that action has to be taken. In principle, such dispositions should only be required to cover contingencies in which the patient is decisionally incapacitated, unconscious, comatose, demented or suffering from a debilitating mental illness. Implementing the directives in these circumstances effectively increases the patients' autonomy. As mentioned above, however, the large majority of cases in which the clinic has to rely on the advance directives of the patients do not concern death or mental illness but lack of response and untraceability of the patients. This fact makes it necessary to extend the advance directives to all situations in which no current informed consent can be obtained. People who do not respond to the request by the clinic for an updated informed consent or who cannot be found, should, for all practical purposes, be considered as incapable of informed consent.

The solution preferred by clinics to solve the problem of abandonment of embryos is to coerce patients to indicate a disposition for all foreseeable situations when they can be forced to do so, namely just before treatment. This procedure offers a formal legal solution but it is far from ideal from a moral point of view. Two alternative ways may be considered: increasing the efforts to maintain contact with the patients and developing means to help patients to reach a decision. The continuation of the relationship is the shared responsibility of both patients and fertility centre. The patients not only have the right to decide the fate of their embryos, they also have the responsibility to do so. The disposition is the final step after agreeing to the in vitro fertilisation (IVF) treatment and to the cryopreservation. The fertility centre, on the other hand, has a duty of care towards the patients. Taking steps to obtain an updated informed consent at the moment of the execution of the disposition (for instance at the end of the storage period) or when the contingency arises, is part of the clinic's obligation to help patients to reach the decision which best reflects their values and best fits their personal situation. Clinics should make reasonable attempts to contact the couple (comparable for instance to the efforts they would make to get the storage fee) but a fertility centre is no detective agency. It cannot be blamed for the loss of contact when this failure is caused by negligence or refusal to cooperate on the part of the patients.

The position of those practitioners who are opposed to the obligation of the centres to contact the patients is partly based on a background theory about the patient as a decision maker. They argue that couples who change their minds about the destination of their embryos will contact the clinic to convey this change on their own initiative. As long as the fertility centre has not been notified of such alteration, it can reasonably assume that the original disposition still holds. This is a way of recognising the patients as rational and autonomous decision makers. People do not, however, always act purely rationally and consistently. This has been recognised in the context of advance directives to do with end-of-life decisions. "In principle, one may always rescind an existing directive and

issue another that better expresses one's new priorities. But, in practice, people may neglect to do so due to time constraints, procrastination, forgetfulness, or laziness".¹¹ Moreover, the decision context contains several elements that make people prone to these psychological "vices": lack of a clear and established decision structure, high personal and emotional involvement, uncertainty about major points etc. Also, recent research in a Chicago in vitro fertilisation programme confirms the claim that people do not contact the clinic on their own initiative when they change their mind. Only 29% of the couples who could be contacted after the three year storage deadline maintained the disposition they had initially signed.¹² If the embryos had been disposed of without contacting the couples again, most would have undergone a fate contrary to the couples' wishes at that time.

VALIDITY OF CONSENT

The validity of advance directives depends largely on the closeness of fit between the situation as imagined by the decision maker and the real situation at the moment of execution of the decision. The directive is valid to the extent that the couple was able to make an accurate representation of the future situation. Two major sources of distortion can be distinguished: a) external elements composed of the social and legal situation, and b) internal elements related to the values and beliefs of the decision makers. These elements are strong indications that the authority of advance directives should be limited and that an updated informed consent should be obtained. Every important change of circumstances diminishes or endangers the value of the advance directive.

Firstly, all kinds of social and legal changes may occur that are possibly relevant for the choice that was made. The problems caused by the change of regulations in the United Kingdom illustrates this point. In 1991, the law limited the storage period to five years. A few months before the end of that period in 1996, however, an extension for another five years was accepted on the condition that the gamete providers requested the extension. As a consequence, all patients had to be contacted again for a new directive. This is equally true for other legal changes. If the anonymity of donors were abolished, this fact would render all previous dispositions for donation to another couple invalid. Or new options for the disposition of the embryos may be added to the alternatives that were originally offered at the clinic. A clinic that was previously opposed to embryo donation may alter its institutional policy, which in turn generates a duty to contact all people who still have embryos frozen. Finally, major changes in the therapeutic options after signing the consent form may trigger another preference for the cryostored embryos. Suppose a couple has embryos that were conceived with donor sperm because the man's sperm was inadequate. After the introduction of intracytoplasmic sperm injection (ICSI), they may decide to try to obtain embryos with both their genetic material and to donate the existing embryos to others.

Beside these external changes, several internal elements should be mentioned which urge us to carefully consider advance directives. Firstly, the temporal distance may introduce a bias in the decision. It has been argued that future events tend to be less adequately represented than facts of the immediate present and that this influences the motivation to act on them. This provides a partial explanation why people "discount" future events, especially aversive ones.¹³ Psychological research has shown that temporal distance influences both the perception of the seriousness of the event and the perception of the probability of the event.¹⁴ Five years, which is the average storage period for embryos in most European countries, is sufficiently long to generate this effect. Since the contingencies which the advance directives are asked to cover are by definition hypothetical, patients may be inclined not to think too seriously about the matter. The hypothetical nature

of the events may reinforce the perception that the consent form is part of the ritual rather than a potentially important decision. In addition, the contingencies are very difficult to grasp as they run counter to the couple's present state of mind. It is not easy to make arrangements for one's death when one is about to start a treatment to create new life. It is rather difficult to bring your divorce to the fore front of your mind at a time when you need all the emotional and psychological support of your partner to cope with the treatment.

Moreover, it could even be argued that the consent is essentially uninformed. In most clinics, the consent form in which the patients dispose of the embryos is signed by them before they start the IVF treatment. This is an extremely difficult task as they do not even know whether there will be a sufficient number of embryos, whether the embryo quality justifies freezing, and whether they will have children as a result. Although complete information can never be provided, it is advisable to postpone giving consent at least until just before freezing when some of these questions are answered.

Another factor is the occurrence of major changes in the value structure of the person between the decision and the time when it applies. This is an instance of a time-inconsistency: "the best policy currently planned for some future period is no longer the best when that period arrives".¹⁵ Suppose a couple decides at the moment of freezing to donate their supernumerary embryos anonymously to another couple. The couple holds the view that the genetic link between parents and children is of little importance and that the emotional and psychological relationship deserves priority. After having children of their own, they come to attach much greater importance to the genetic link. As a consequence, they want to revoke their decision and have their embryos destroyed. If a significant proportion of the couples do not notify the clinic of this change without an incitement (letter or phone call), most embryo donations will actually take place against or at least not in accordance with the gamete providers' moral wishes. In the study by Klock and colleagues, nine of 11 couples who had initially opted for donation no longer chose that option when asked.¹⁶ Other studies also reported that patients' views about donating changed once couples had children.^{17,18} The most obvious way to prevent this from happening is by contacting the patients shortly before the execution to ask them to confirm or reassess their decision. This recommendation is based on the fundamental rule for advance directives that "whenever a real-time wish exists, prior wishes have no authority".¹⁹ In other words, the clinic should not look for a five year old contract when they can ask the couple what they want now. The conclusion following from this argument is that no contracts or advance directives should be required for situations in which the couple remains competent. Those who have embryos in storage know that they will, regularly, or at least at the end of the storage period, be approached by the clinic to state their wishes as to their disposition.

SPECIAL CIRCUMSTANCES

Patients may alter the directives any time they want before the final execution. Donations for the reproduction of others can be revoked until the effective use of the material. Couples who decide to give their embryos for research may retract their consent as long as research has not started. Still, agreements may be irrevocable in reality not because the contractor relinquished the right to change his or her mind but because of the type of agreement—that is, joint agreements. Whenever the parental project is the project of a couple, the decision concerning the disposition of the embryos is a joint decision. Both partners have an equal stake in the embryos and consequently have equal decisional authority. A joint decision, like most contracts, generally cannot be changed unilaterally. Mutual consent is required to rescind a joint commitment.²⁰

The partner who sticks to the original agreement regarding the destination of the embryos makes the first decision of the other partner irrevocable. This fact probably provides the strongest reason not to ask people to determine in advance what should be done with the embryos in case of divorce, separation or disagreement.

There are, however, two special situations in which prior agreements could be considered binding and irrevocable for future situations in which the persons are still competent, namely Ulysses contracts and reliance by the partner.

ULYSSES CONTRACTS AND PROTECTION AGAINST BIASING INFLUENCES

A possible exception to the general principle that people can modify the contract at any time is when the couple at the moment of signing the consent form explicitly intend to protect themselves from a later change of mind. Precommitment is a strategy to avoid the bias brought about by emotions and passion.¹⁵ The situation resembles Parfit's Russian landlord who knows that his socialist values and ideals will disappear when he gets older and after he inherits the family land.²¹ In order to prevent himself no longer supporting, after the inheritance, what he now thinks he ought to do (distribute the land among the peasants), he makes an irrevocable contract. This arrangement is a Ulysses contract: the contractor intends to guard against the temptations of private property and greed by giving up the right to change his mind. The contracts issued by the intentional parents regarding their frozen embryos can be compared with the solution of Ulysses when he returned from the Trojan war.⁴

Suppose that research shows that people change their mind about the importance of the genetic link to establish parenthood when they have children of their own. If this becomes common knowledge, fertility counsellors will mention this fact to the patients as part of the information they normally impart. Consequently, the couple scrutinise their feelings, values, and principles thoroughly and they conclude that this change is irrational, indefensible, and clouded by emotions. They decide to protect themselves against such a change by introducing an irrevocable clause in the consent form. How do they know, however, that having a child is a biasing factor instead of a revealing factor? They can only decide this on the basis of the value structure they have now and it is precisely this structure which would change. If they still think that parenthood distorts their views after becoming parents themselves, they will be able to make the right decision. There is no need to bind themselves irrevocably, especially given the difficulty of fully imagining the changes that might be brought about by a major life event such as parenthood.

In a similar fashion, patients may anticipate the altered judgment a divorce may bring. In their current opinion, their judgment during the divorce will be biased by emotions and distorted by an atmosphere of hatred and antagonism. The counterargument that the agreement should not be enforced when intervening events have changed the circumstances seems no longer valid. It is rather difficult to claim that a change invalidates the contract when the changed condition is the very circumstance that the directive addressed (namely divorce).^{22,23} Still, this does not show that the best solution to the problem is an advance directive for those situations. If we want to avoid the emotions and simultaneously incorporate the new event into the decision, it is preferable to postpone the final decision about the disposition of the embryos until after the distorting emotions have died down. A decision at that moment is much more valid than the one they could have made before the treatment and before the circumstances changed. Ulysses contracts are not the appropriate way to deal with this type of change.

PROMISES VERSUS RESOLVES: RELIANCE BY THE PARTNER ON THE ORIGINAL AGREEMENT

The second situation in which prior joint agreements could be allowed and enforced is when one partner wants the guarantee that a certain option will be executed. In that case, he or she relies on the original consent to make his or her own decisions: when partner A accepts participation in the IVF treatment on the condition that partner B agrees to a specific disposition of the supernumerary embryos. The agreement on a certain option can be seen as a material condition on which the other partner relied in creating and storing embryos.²⁴ Obviously, it is important that both members of a couple attribute approximately the same meaning to their embryos since this agreement expresses a common view on their parental project. But beside their procreational plans, the disposition choice of the embryos also illustrates the partner's view on the importance of the genetic link and on the intrinsic value of an embryo. As such, the specific disposition can be a necessary condition for starting treatment, especially for religious people who attribute a high moral status to the embryos. Perhaps, for instance, the partner would never have started the IVF procedure unless he or she had been able to rely on the certainty that all resulting embryos would be given a chance to implant.²⁵

The expectations of the partner do not make the prior agreement more or less valid but they change the binding force of the agreement. If the revocation affects others adversely because of their trust in your "faithful adherence to the earlier agreement",²⁶ the original disposition should be enforced. The consent of each partner concerning the disposition of their embryos is not only an expression of autonomy in the disposition of one's body material and in the control of one's reproduction but can also be viewed as a promise to his or her partner. Once the embryo is conceived, there is no turning back without damage to the beliefs of the partner who attributes a high moral status. Moreover, since the trusting partner cannot go back on his or her decision (the embryos are there), the other partner should not be able to do so either.

CONCLUSION

The main purpose of requesting advance directives for the disposition of cryopreserved embryos is to extend the autonomy and control of the intentional parents. At present, the practice has been derailed into a system in which they are asked to give up their right to change their minds and to revise their decisions in light of new beliefs and situational changes. Partners are asked to bind themselves in the future even for situations in which it remains possible to obtain an updated informed consent. The request for advance directives is not based on the future incapability of patients to make rational decisions about the fate of their embryos but on the practical wish of fertility centres to have a potential final destination for

all stored embryos. To avoid this abuse, advance directives to dispose of embryos should only cover contingencies in which one or both parents are decisionally incapacitated. The only exception to the rule should be when a certain disposition of the embryos was a material condition for one of the partners to agree to the infertility treatment.

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