

Note

A Chilling Experience: An Analysis of the Legal and Ethical Issues Surrounding Egg Freezing, and a Contractual Solution

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It is 2015 and your daughter is graduating from college. You search the Web for gift ideas and come across this promotion:

Your neighborhood fertility clinic can help you give your daughter the perfect college graduation gift—egg freezing! Help your daughter freeze her eggs now, because before you know it, she will be breaking her “heart and the bank . . . in an attempt to snatch a child from the jaws of menopause.”¹ Over seventy-five healthy babies have been born from frozen eggs at our clinic.² Plus, if your daughter signs up for future in vitro fertilization treatments with us, she will receive 30% off of her first three rounds of egg freezing!³

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1. SARAH ELIZABETH RICHARDS, *MOTHERHOOD, RESCHEDULED: THE NEW FRONTIER OF EGG FREEZING AND THE WOMEN WHO TRIED IT* 4 (2013) (internal quotation marks omitted).

2. See generally Frozen Egg Bank, Inc., *Egg Freezing for Friends – Spring Promotion*, EGGFREEZING.COM (Mar. 2013), <http://www.eggfreezing.com/wp-content/uploads/2013/03/Spring2-Special-2013-Egg-Freezing-West-Coast-Fertility-Centers.pdf> [hereinafter *Spring Promotion*] (illustrating a similar promotion that paired a buy-one-get-one-half-off discount on egg freezing with the slogan: “Reproductive Freedom at Last! Over 75 healthy babies born from Frozen Eggs”).

3. For examples of egg freezing discounts offered by fertility clinics, see *id.*; Nataly Atalla, *‘Freeze and Share’: An Evolution of Egg-Sharing*, BIONEWS (Sept. 22, 2008), http://www.bionews.org.uk/page_38016.asp (detailing a “Freeze and Share” program in the UK that offers qualified donors free egg freezing, plus five years of free egg storage, when they agree to divide their

Although the above-mentioned gift promotion is hypothetical, fertility clinics *are* offering discounts for egg freezing,⁴ an assisted reproductive technology (ART) that has increasingly gained attention since the American Society for Reproductive Medicine (ASRM) lifted the procedure's "experimental" designation in October 2012.⁵ Because egg freezing is expensive,⁶ some women seek financial assistance from their parents.⁷ This trend has ignited a debate about the college graduation gift scenario⁸ and has prompted strategic promotional advertising by clinics to strengthen the appeal of egg freezing.⁹ One ad, for example, touts: "Pay for one egg freezing procedure and get the second for half off the regular price. Share the cost savings together with your friend or sister."¹⁰ Companies such as Apple, Facebook, and Citigroup now include egg freezing in benefit packages.¹¹ In New York, an egg freezing broker has even

eggs equally between themselves and a recipient).

4. See *Spring Promotion*, *supra* note 2; see also Julie Steinberg, *The Big Chill: Financial Planning for Egg Freezing*, WALL ST. J., (Aug. 9, 2013), <http://www.online.wsj.com/article/sb10001424127887323997004578639861242029962.html> (reporting that some clinics offer discounts for multiple rounds of egg freezing).

5. Steinberg, *supra* note 4.

6. See *id.* ("For each treatment cycle, medications can range between \$2,000 and \$5,000; the surgery between \$3,000 and \$7,000; thawing and fertilization between \$1,000 and \$2,000; the implantation process between \$3,000 and \$5,000; and annual storage costs from \$100 to \$1,000 . . .").

7. See *id.* (suggesting that women are setting up separate savings accounts to finance egg freezing, as well as asking their parents to help foot the bill); Rachel Pomerance Berl, *Egg Freezing: A New Frontier in Fertility*, U.S. NEWS (July 11, 2013), <http://health.usnews.com/health-news/health-wellness/articles/2013/07/11/egg-freezing-a-new-frontier-in-fertility> (describing a woman who spent fifty thousand dollars on eight rounds of egg freezing, depleting her own savings and the wedding fund that her parents had saved for her).

8. Compare Anna Hodgekiss, *Egg Freezing Should Be Every Father's Graduation Present To His Daughter, Claims Leading Fertility Expert*, DAILYMAIL.COM (Nov. 26, 2012, 8:09 AM), <http://www.dailymail.co.uk/health/article-2238592/Egg-freezing-fathers-graduation-present-daughter-claims-leading-fertility-expert.html>, with Lindsay Cross, *Egg Freezing as a College Graduation Gift? Not the Way to Celebrate Women's Achievements*, GRINDSTONE (Aug. 15, 2012), <http://www.the grindstone.com/2012/08/15/work-life-balance/egg-freezing-college-graduation-gift-601>.

9. See *Spring Promotion*, *supra* note 2.

10. *Id.*

11. Pamela Mahoney Tsigdinos, *The Sobering Facts About Egg Freezing That Nobody's Talking About*, WIRED (Oct. 24, 2014), <http://www.wired.com/2014/10/egg-freezing-risks> ("The very latest whizzy reproductive 'product' being marketed and wrapped into lucrative employee benefit packages . . . is egg freezing."); see also *Corporate Egg Freezing Offers May Send the Wrong Message*, NPR (Oct. 16, 2014), <http://www.npr.org/2014/10/16/356728014/>

started hosting “egg freezing parties” to promote egg freezing to “career-focused” women.¹² As women are increasingly encouraged to deplete their savings to “preserve [their] fertility while their eggs are still healthy and robust,”¹³ the legal and ethical implications of egg freezing must be thoroughly investigated. While egg freezing benefits patients by avoiding the legal and ethical controversies specific to embryo freezing,¹⁴ egg freezing nevertheless creates a new sphere of legal issues and uncertainty.

This Note suggests that while egg freezing should remain an available fertility option, it raises complex issues about reproductive rights that are unlikely to be resolved by free market solutions. Consequently, this Note recommends a flexible, yet uniform solution—state-mandated standard form contracts—which will provide consistency, predictability, and security for both patients and fertility clinics. Although contracts fail to prevent or solve all frozen embryo disputes, particularly where two progenitors¹⁵ are involved,¹⁶ contracts may better address the interests of women freezing their eggs and of fertil-

corporate-egg-freezing-offers-may-send-the-wrong-message (hypothesizing that additional companies, including Fortune 500 companies, will follow suit); Jessica Bennett, *Company-Paid Egg Freezing Will Be the Great Equalizer*, TIME (Oct. 15, 2014), <http://time.com/3509930/company-paid-egg-freezing-will-be-the-great-equalizer> (“From Facebook to Citigroup, more companies are covering the cost of elective egg freezing for women who want to delay child-bearing. Is this the key to real gender equality?”).

12. Jillian Berman, *Why You Should Be Wary of Egg Freezing As a Ticket to “Having It All,”* HUFFINGTON POST (Oct. 17, 2014), http://www.huffingtonpost.com/2014/10/17/egg-freezing-for-profit_n_5996516.html.

13. *Spring Promotion*, *supra* note 2.

14. See Carl H. Coleman, *Procreative Liberty and Contemporaneous Choice: An Inalienable Rights Approach to Frozen Embryo Disputes*, 84 MINN. L. REV. 55, 56 (1999) (“The long-term storage of frozen embryos can give rise to complex legal dilemmas . . .”). For more in-depth discussions of ethical controversies arising out of embryo disputes, see also *Kass v. Kass*, 91 N.Y.2d 554 (1998), holding that the law will honor the parties’ clear, contractually-manifested intent to donate their frozen embryo for approved research, in the event of future disagreement over disposition, and *Davis v. Davis*, 842 S.W.2d 588 (Tenn. 1992), in which the court found that a party wishing to avoid procreation shall ordinarily prevail when divorced progenitors disagree on embryo disposition.

15. See *Progenitor*, DICTIONARY.COM, <http://www.dictionary.reference.com/browse/progenitor> (last visited Mar. 9, 2015) (defining “progenitor” as “a biologically related ancestor: a *progenitor of the species*”).

16. See, e.g., Coleman, *supra* note 14, at 57 (“[C]ontracts for the disposition of frozen embryos undermine important societal values about families, reproduction, and the strength of genetic ties.”).

ity clinics since there is only one progenitor whose intent and consent is important in egg freezing.

Part I of this Note introduces egg freezing and the lack of current regulation over egg freezing.¹⁷ Part II analyzes the problems associated with clinic self-regulation and addresses the need for implementing clear default rules and a uniform egg freezing contract. Part III proposes that egg freezing contracts must be drafted specifically to avoid unforeseen and unethical outcomes, especially when clinics offer discounts contingent on egg “sharing” or future in vitro fertilization (IVF). This Note argues that statutes should mandate the use of a form contract for egg freezing that clearly addresses informed consent, each patient’s wishes regarding extra, abandoned,¹⁸ or pre-deceased frozen eggs,¹⁹ and appropriate damages in the event that either party breaches the contract. If these matters are explicitly addressed in writing, at the outset of each transaction, contract law can serve to provide much-needed structure within the largely unregulated sphere of ART. Greater structure will help prevent legal and ethical controversies from arising as egg freezing continues to grow in demand.

I. EGG FREEZING: A NEW TECHNOLOGY, FOR BETTER OR FOR WORSE

This Part explores what is known, and what remains unknown, about fertility, infertility, and egg freezing. Section A reviews the statistics and science behind infertility, fertility treatments, and egg freezing. Section B considers some women’s motives for egg freezing, and other women’s arguments against relying on egg freezing as an “insurance policy.” Lastly, Section C describes current ART-related regulation.

17. See Michele Goodwin, *Assisted Reproductive Technology and the Double Bind: The Illusory Choice of Motherhood*, 9 J. GENDER RACE & JUST. 1, 2, 5 (2005) (scrutinizing the presumption that ART is “equitable accommodation for women . . . who wish to delay pregnancy”).

18. In this context, “abandoned” refers to eggs that remain in storage after the patient has failed to make storage payments, or eggs that were frozen and stored by someone who has become unreachable.

19. “Pre-deceased” refers to frozen eggs that the progenitor has not used, donated, or disposed of before her death.

A. INFERTILITY, FERTILITY, AND ASSISTED REPRODUCTIVE TECHNOLOGY

As with any new procedure, it is important to understand the context in which egg freezing exists. Consequently, Section A.1 addresses infertility and egg freezing statistics, while Section A.2 explains the steps involved in egg freezing.

1. Infertility and Fertility: The Numbers

Egg freezing poses legal and ethical controversies that can only be understood, avoided, and resolved within the context of medical, social, cultural, and personal histories surrounding fertility and infertility.²⁰ Fact, fiction, and fear guide collective and individual responses to infertility, as ART makes the impossible possible.²¹ ART now includes a wide range of procedures that allow fertilization, pregnancy, and birth to occur without a woman and a man engaging in sexual intercourse.²² These procedures have gained widespread popularity, arguably because “infertility statistics are real and scary.”²³ Experts suggest that fertility declines as women near thirty, declines “more dramatically” after thirty-five, and “plummets” when they reach forty.²⁴ An estimated thirty-three percent of couples are infertile by age forty.²⁵

Despite the availability of figures on *infertility*, little is known about *fertility*. Data cannot yet explain when fertility peaks. While some women may undergo fertility treatment in their thirties, other women can get pregnant naturally in their forties.²⁶ Perhaps a 22-year-old and a 36-year-old are both “fer-

20. See NAOMI R. CAHN, TEST TUBE FAMILIES: WHY THE FERTILITY MARKET NEEDS LEGAL REGULATION 2 (2009) (“How do we navigate this world of thoroughly modern family-making? What guides—legal, emotional, and sociological—are there for us as individuals and as a society?”).

21. See *id.* at 1–5.

22. See KAREY HARWOOD, THE INFERTILITY TREADMILL: FEMINIST ETHICS, PERSONAL CHOICE, AND THE USE OF REPRODUCTIVE TECHNOLOGIES 11 (2007) (“In all types of ART, fertilization takes place without sexual intercourse.”).

23. CAHN, *supra* note 20, at 1.

24. See *id.* For comprehensive statistics on maternal age at first birth, see T.J. MATHEWS & BRADY E. HAMILTON, NAT’L CTR. FOR HEALTH STATISTICS, NCHS DATA BRIEF NO. 21, DELAYED CHILDBEARING: MORE WOMEN ARE HAVING THEIR FIRST CHILD LATER IN LIFE (2009), available at <http://www.cdc.gov/NCHS/data/databriefs/db21.pdf>.

25. CAHN, *supra* note 20, at 1.

26. Sarah Elizabeth Richards, *We Need To Talk About Our Eggs*, N.Y. TIMES (Oct. 23, 2012), <http://www.nytimes.com/2012/10/23/opinion/we-need-to>

tile,” yet the 22-year-old may conceive within six months of trying to get pregnant, while it may take the 36-year-old two years to become pregnant. In addition, although both women may be able to produce *some* viable eggs for retrieval and freezing, the 22-year-old may produce fifteen to thirty viable eggs, while the 36-year-old may produce fewer eggs. Harvesting fewer eggs, and at a later age, would likely make the entire process of egg retrieval, egg freezing, and future IVF more expensive and less certain to lead to pregnancy for the 36-year-old. Ultimately, “women of all ages produce many eggs that are unusable.”²⁷

Regardless of the unknown, women as young as twenty-two²⁸ and as old as thirty-eight²⁹ are now turning to one of the most recently developed assisted reproductive technologies—egg freezing—to preserve or increase their chances of becoming pregnant in the future.³⁰ As of September 2013, roughly two thousand babies had been born from frozen eggs.³¹ In October 2012, the ASRM issued a report hailing egg freezing, technically known as oocyte cryopreservation, as “an exciting and improving technology . . . [that] should no longer be considered experimental.”³² Although the ASRM was careful not to overshadow the potential risks of elective egg freezing for delaying pregnancy, the report was largely positive.³³ The data are en-

-talk-about-our-eggs.html.

27. Nancy Hass, *Time To Chill? Egg-freezing Technology Offers Women a Chance To Extend Their Fertility*, VOGUE MAG. (Apr. 28, 2011, 12:00 PM), <http://www.vogue.com/865443/time-to-chill-egg-freezing-technology-offers-a-chance-to-extend-fertility>.

28. Steinberg, *supra* note 4.

29. Richards, *supra* note 26 (“I stashed away several batches of eggs between the ages of 36 and 38 – just before the cutoff at which many doctors no longer consider eggs worthwhile to save.”).

30. *Fertility Experts Issue New Report on Egg Freezing; ASRM Lifts Experimental Label from Technique*, AM. SOC’Y FOR REPROD. MED. (Oct. 22, 2012), https://web.archive.org/web/20121226061747/http://www.asrm.org/Fertility_Experts_Issue_New_Report_on_Egg_Freezing_ASRM_Lifts_Experimental_Label_from_Technique [hereinafter ASRM Lifts Experimental Label] (summarizing a report from October 2012 that describes the American Society for Reproductive Medicine’s decision to remove the experimental label from egg freezing techniques).

31. See *Egg Freezing FAQ’s*, USC FERTILITY, <http://uscfertility.org/fertility-preservation/egg-freezing-faqs> (last visited Mar. 9, 2015) (declaring that of these approximately two thousand babies, nine hundred were part of a study that found no increased rate of birth defects).

32. ASRM Lifts Experimental Label, *supra* note 30.

33. See *id.* (warning that patients should “be carefully counseled” due to “a lack of data on safety, efficacy, cost-effectiveness, and potential emotional risks”).

couraging: in young patients, egg freezing “produce[d] pregnancy rates, leading to the birth of healthy babies, comparable to IVF cycles using fresh eggs.”³⁴ While egg freezing used to be much less successful, due to the difficulty of freezing and thawing cells made up largely of water,³⁵ the ASRM’s new data show that ninety to ninety-seven percent of eggs studied were viable after being frozen and thawed.³⁶

2. Egg Freezing Is Only One Step in Attempting To Have a Baby

Egg freezing is a multi-step process.³⁷ It requires the administration of hormones to stimulate the ovaries (to produce more eggs), egg retrieval, cryopreservation of the eggs (either through a “slow-freeze” or vitrification³⁸ process), and storage of the eggs.³⁹ Furthermore, egg freezing can only lead to pregnancy if combined with additional steps: thawing the eggs, combining viable thawed eggs with sperm through IVF (to form embryos), and transferring one or more embryos into a womb for implantation.⁴⁰ If each step is successful, egg freezing and IVF

34. *Id.*; see also Deborah Kotz, *Egg Freezing Works To Preserve Fertility, New Guidelines Say*, BOSTON.COM (Oct. 19, 2012), <http://www.boston.com/dailydose/2012/10/19/egg-freezing-works-preserve-fertility-new-guidelines-say/5XCEX40MIM1DRkyKYe2sVL/story.html> (“About 40 percent to 60 percent of women in the studies who underwent in vitro fertilization using previously frozen eggs were able to achieve pregnancy on their first IVF attempt, which is similar to the success rate using IVF from eggs that were freshly harvested . . .”).

35. See JUDITH DAAR, *REPRODUCTIVE TECHNOLOGIES AND THE LAW* 540 (2d ed. 2013) (“[E]ggs proved more difficult to freeze [than sperm and embryos] because they contain a significant amount of water . . .”); see also Matthew Balan, *NPR Wholeheartedly Endorses Women Freezing Eggs; Fails To Disclose Risks*, NEWSBUSTERS (June 1, 2011), <http://newsbusters.org/blogs/matthew-balan/2011/06/01/npr-wholeheartedly-endorses-women-freezing-eggs-fails-disclose-risks> (“Of late though, the technology has exploded, thanks to scientific leaps, including a flash-freeze method called vitrification. In [the] lab, you can hear the sizzle as a tiny tube is plunged into liquid nitrogen . . .”).

36. Kotz, *supra* note 34.

37. See *Oocyte Storage—Services*, REPROTECH LIMITED, <http://www.reprotech.com/oocyte-storage.html> (last visited Mar. 9, 2015) (describing the egg freezing and storage process).

38. See DAAR, *supra* note 35, at 540 (“New techniques focus on a process known as vitrification, in which eggs are cooled and dehydrated at a rapid rate to minimize damage to the cell structures.”).

39. See *Oocyte Storage—Services*, *supra* note 37.

40. Lyria Bennett Moses, *Understanding Legal Responses to Technological Change: The Example of In Vitro Fertilization*, 6 MINN. J. L. SCI. & TECH. 505, 510 (2005) (listing the steps of IVF).

allow women to become mothers later in life, at times when their eggs are no longer viable (and even post-menopause).⁴¹

B. WOMEN ARE FREEZING (AND NOT FREEZING) THEIR EGGS FOR A VARIETY OF REASONS

Women are freezing and refraining from freezing their eggs for numerous reasons. Section B.1 identifies who has already turned to egg freezing and discusses accessibility, age-specific considerations, and health-related motives. Section B.2 then explores reasons to embrace or be cautious of egg freezing, focusing heavily on potential risks. These motives and risks highlight the potential vulnerability of this specific patient population. These motives and risks thus influence the need for legislation providing uniformity, predictability, and security for patients and fertility clinics as egg freezing becomes more routine.

1. Identifying Women Who Are Freezing Their Eggs

Because egg freezing is a relatively new procedure, it is unclear how many women have frozen their eggs and how many women have thawed cryopreserved eggs for IVF. As with many new procedures, egg freezing arose out of medical necessity; cancer patients froze their eggs to preserve their fertility before undergoing cancer treatment, since many treatments would preclude them from later producing viable eggs.⁴² Now, however, many other women are turning to “elective” egg freezing, and there are numerous reasons why it may become common for young women to freeze their eggs. The following subsections in Section B.1 explore why women are increasingly opting to freeze their eggs and address legal issues that may arise if egg freezing becomes a more routine procedure.

41. See Judith Daar, *Death of Aging Mother Raises More Questions About IVF Rules*, L.A. DAILY J., July 29, 2009, in DAAR, *supra* note 35, at 243 (telling the story of Maria del Carmen Bousada, who used IVF and much younger eggs to give birth to twins at the age of sixty-six; Ms. Bousada died three years later).

42. See generally Briana Rudick et al., *The Status of Oocyte Cryopreservation in the United States*, 94 FERTILITY & STERILITY 2642, 2642 (2010) (recognizing the use of egg freezing to preserve fertility for cancer patients).

a. *The Gap Between Availability and Accessibility*

Women freeze their eggs for a variety of reasons.⁴³ Some women face imminent cancer treatment,⁴⁴ family histories of premature menopause, or other challenges to achieving future pregnancies.⁴⁵ Other women fear the ticking of their biological clocks as they decide to pursue educational or career-related opportunities, continue to search for a supportive partner, or go through separation or divorce.⁴⁶

Although these reasons vary considerably, all women who freeze their eggs arguably have disposable income. Egg freezing is an expensive endeavor. Although egg freezing is becoming less expensive as women cut costs by using generic drugs and other cost-saving measures, they are still paying over ten thousand dollars for doctor's visits, egg extraction, and egg freezing alone.⁴⁷

b. *Age-Specific Motives and Success Rates*

Egg freezing is growing in popularity as it becomes more common for women to have children later in life.⁴⁸ Since wom-

43. RICHARDS, *supra* note 1, at 9 (citing a meta-analysis of twelve studies from 2010 that addressed the reasons why women are freezing their eggs).

44. *Fertility Preservation in Cancer Patients*, U. MINN. PHYSICIANS, <http://www.umphysicians.org/Clinics/ReproductiveMedicineCenter/fertility-preservation/index.htm> (last visited Mar. 9, 2015) (offering egg freezing only to cancer patients seeking to preserve their fertility).

45. See RICHARDS, *supra* note 1, at 9.

46. See *id.*; *supra* text accompanying note 43; see also *Probability of Live Birth After Egg Freezing Related to Patient Age and Freezing Method*, AM. SOC'Y FOR REPROD. MED. (May 14, 2013), https://web.archive.org/web/20130624215317/http://www.asrm.org/Probability_of_Live_Birth_After_Egg_Freezing [hereinafter ASRM Probability of Live Birth] (summarizing a study analyzing data from infertility patients in different age brackets who froze, thawed, fertilized, and implanted their eggs, using either the slow freeze or vitrification method).

47. See Sarah Elizabeth Richards, *Do You Have To Be Rich To Freeze Your Eggs?*, SLATE (Aug. 22, 2013), http://www.slate.com/articles/double_x/doublex/2013/08/the_cost_of_egg_freezing_after_years_of_prohibitive_pricing_clinics_are.html; Steinberg, *supra* note 4 (noting that egg freezing produces a "hefty bill" that demands "up to tens of thousands of dollars"). This expense is arguably the greatest factor in determining who has access to egg freezing and generally furthers the debate about ART: "[F]or those who have access to it, reproductive technology exploits women because it reinforces a pronatalist ideology; for those who do not have access to it, reproductive technology provides evidence of privilege, allowing wealthy white women to reproduce themselves; and the mere concept of reproductive technology encourages women to live men's lives." CAHN, *supra* note 20, at 5.

48. See generally MATHEWS & HAMILTON, *supra* note 24.

en's fertility generally declines with age, egg freezing is closely related to many patients' age consciousness and perceived ticking "biological clocks."⁴⁹ Because frozen eggs result in live births most often when the eggs were frozen before the woman turned thirty, women as young as twenty are now proactively freezing their eggs.⁵⁰ It is foreseeable that egg freezing will even become a routine proactive procedure for young women.⁵¹ This is potentially problematic, considering the extreme void of legal guidelines for fertility clinics and patients.

On the other end of the spectrum, many women in their late thirties and early forties are freezing their eggs, especially women who are single but hope to reproduce with a partner in the near future.⁵² Both the median age of American women at first marriage and the median age of American women at first birth have increased significantly from 1970 to 2011.⁵³ About one in twelve births in 2006 were to women over the age of thirty-five, compared with one in one hundred in 1970.⁵⁴

49. See Steinberg, *supra* note 4 (depicting a woman who "doesn't want her biological clock to dictate when she has to bear children"); Tomáš Sobotka, *Oocyte Cryopreservation As an Insurance Strategy: A Socio-Demographic Viewpoint*, in SYMPOSIUM PROCEEDINGS, FIRST INT'L SYMPOSIUM ON SOC. EGG FREEZING (Feb. 1, 2013), http://www.socialfreezing.org/wp-content/uploads/2013/02/symposium_2013.pdf (citing a *Vogue* article that controversially claimed: "stopping the biological clock through egg freezing has long been the ultimate feminist fantasy").

50. See ASRM Probability of Live Birth, *supra* note 46 (describing studies that focused on women who froze their eggs between the ages of twenty and fifty-one).

51. See, e.g., Aylin Pelin Cil et al., *Age-Specific Probability of Live Birth with Oocyte Cryopreservation: An Individual Patient Data Meta-Analysis*, 100 FERTILITY & STERILITY 492, 492 (2013) ("[W]e suggest that policy makers should consider oocyte freezing as an integral part of prevention and treatment of infertility.").

52. See Richards, *supra* note 26 (identifying the author's experience freezing eggs between age thirty-six and thirty-eight).

53. See MATHEWS & HAMILTON, *supra* note 24, at 1 (reporting that in 1970, the average mother's age at first birth was 21.4, while by 2006, the average was 25.0); Kay Hymowitz et al., *Summary*, KNOT YET: THE BENEFITS & COSTS OF DELAYED MARRIAGE, <http://twentysomethingmarriage.org/summary> (last visited Mar. 9, 2015) (noting that the median age at first marriage now "lags about a year behind that of first birth," and both medians have surpassed the age of twenty-five).

54. MATHEWS & HAMILTON, *supra* note 24, at 2; see also NAOMI CAHN & JUNE CARBONE, RED FAMILIES V. BLUE FAMILIES: LEGAL POLARIZATION AND THE CREATION OF CULTURE 1, 41–45, 191–92 (2010) (describing the emerging "Blue Family" model, which highlights the relationship between egalitarian gender roles, and therefore equal participation in the workforce, and delayed marriage and childbearing).

With hormone treatments, women today can give birth after menopause as long as they have access to viable eggs.⁵⁵ Some IVF clinics will only accept patients under the age of fifty, whether they intend to use their own eggs (frozen or fresh) or donor eggs. Clinics' legal and ethical role in making these types of age-based decisions remains unclear. As egg freezing allows women to birth genetically-related children well into their forties, fifties, and beyond, we should consider whether and when delayed parenthood becomes detrimental to children, parents, and society. The answers to these questions will inevitably help shape the legislation that new assisted reproductive technologies demand.

c. Health-Related Motives for Egg Freezing

Egg freezing was not always available for “elective use.”⁵⁶ Egg freezing was first offered to preserve fertility for cancer patients.⁵⁷ Although some fertility clinics continue to offer egg freezing only to women with cancer,⁵⁸ most clinics now offer egg freezing to women delaying pregnancy for a wide range of reasons.⁵⁹ Numerous legal and ethical issues surround egg freezing as an elective “insurance strategy” for postponing pregnancy and parenthood, yet many people believe that pre-chemotherapy egg freezing “is clearly justified and does not raise any ethical issues.”⁶⁰ This Note focuses mainly on elective egg freezing; however, many of the legal issues that pertain to

55. Fertility Options, INT'L ASSISTED REPROD. CENTER, http://www.fertilityhelp.com/index.php?option=com_content&view=article&id=109&Itemid=108 (last visited Mar. 9, 2015) (“With proper hormone replacement, post-menopausal women can now maintain uterine function as efficiently as women in their early reproductive years.”). These women can thus give birth post-menopause, using fresh donor eggs or their own previously frozen eggs, so long as those eggs are still viable.

56. See Cil et al., *supra* note 51, at 497 (differentiating between oocyte cryopreservation used by cancer patients before undergoing treatment and oocyte cryopreservation used “electively” by non-cancer patients, since women may choose to delay childbearing and preserve their eggs outside of the cancer treatment context).

57. See generally Rudick et al., *supra* note 42.

58. See *Fertility Preservation in Cancer Patients*, *supra* note 44 (“Our reproductive and oncology specialists are leaders in preserving fertility in cancer patients.”).

59. See Rudick et al., *supra* note 42, at 2642 (finding that even as early as 2009, sixty-four percent of clinics offered elective egg freezing for “women of advancing maternal age”).

60. Sobotka, *supra* note 49, at 5, 6.

elective egg freezing also apply to women who freeze their eggs before undergoing cancer treatment.

2. Reactions to Egg Freezing Range from Enthusiastic to Disapproving

Reactions to egg freezing range from praise and gratitude to skepticism and criticism.⁶¹ While egg freezing provides relief for some, it induces only pain and debt for others.⁶² The steep cost of egg freezing (and subsequent IVF treatments) is often noted as a drawback;⁶³ the physical price that women pay, however, is commonly overlooked.⁶⁴ Furthermore, egg freezing is simultaneously celebrated and faulted for suggesting that women can “have it all” by delaying parenthood now, and having children later.⁶⁵

a. Arguments in Favor of Egg Freezing

Women in favor of egg freezing seem to share the sentiment that they are grateful for the chance to delay pregnancy and focus on themselves, careers, and partners, without worrying about the viability of their eggs, no matter the price they pay.⁶⁶ Generally, delayed motherhood is associated with numerous benefits, including a more stable family environment,

61. Compare Hodgekiss, *supra* note 8 (selling the idea of keeping “20 beautiful eggs in the freezer”), with Cross, *supra* note 8 (asserting that egg freezing is not at all an appropriate gift for young women), and Goodwin, *supra* note 17, at 2–3 (“ART treatments pose very serious health risks to mothers and fetuses, and thus are not real options, but illusory choices of motherhood and career advancement.”).

62. Compare RICHARDS, *supra* note 1, at 212 (admitting that after spending \$50,000 freezing eggs that were never thawed, the author cringed to think about how that money “could have covered . . . down payments and student loans”), with Steinberg, *supra* note 4 (noting that egg freezing is meant to “buy time”).

63. See Steinberg, *supra* note 4 (calling attention to the steep costs associated with egg freezing).

64. See, e.g., HennyA, Comment to Lara Naaman, *Now That Everyone’s Freezing Their Eggs . . . Should You?*, GLAMOUR, (Mar. 21, 2013), <http://www.glamour.com/health-fitness/2013/03/now-that-everyones-freezing-their-eggs-should-you> (claiming that egg freezing is more detrimental to patients’ bodies than clinics will tell them).

65. See Goodwin, *supra* note 17, at 5 (highlighting issues with our “social system [which] fails to equitably accommodate women, families, and children by masquerading complex and even dangerous medical options as naturally positive alternatives”).

66. See generally RICHARDS, *supra* note 1 (describing multiple women’s positive experiences with egg freezing, even though not all of them ended up thawing their eggs, or carrying a baby to term).

higher income and socioeconomic position, better living conditions, and superior parenting practices.⁶⁷ For many, egg freezing promises actual and symbolic freedom, security, and time.⁶⁸ These arguments are perhaps indicative, though, of overly optimistic attitudes and the need for legal safeguards to ensure that women are truly giving *informed* consent before freezing their eggs.

b. Arguments Against Egg Freezing

Egg freezing does not necessarily deliver freedom, security or time. The idea of freedom disregards, at least in part, the reliance on ongoing ART: first, the appointments and hormone treatments; second, the egg retrieval surgeries; third, storage and thawing; and finally, IVF treatments to achieve fertilization and attempt implantation.⁶⁹ The hormone treatments are no small investment. One woman describes the “dear price” her body paid for egg freezing:

My legs and hips were bruised from the generic hormone injections . . . injected deep into my muscles . . . I had gained about eight pounds . . . My hair was thinning, a side effect from one of the hormones. My cheeks had dark patches . . . On top of it all, a head cold caused me to sneeze frequently, which made my tender ovaries spasm. I was [also] sick of the bloat, which started on about the fifth day of stimulation and lasted until my period came nearly two weeks later.⁷⁰

In addition to these short-term consequences, it remains unclear whether and how the administration of fertility drugs will affect women’s future health.⁷¹ Research is currently being conducted to determine potential long-term risks of ovarian,

67. See Sofia Gameiro, *Is There a Need for Oocyte Cryopreservation: The Psychological Viewpoint*, in SYMPOSIUM PROCEEDINGS, *supra* note 49, at 33, 36.

68. See generally *Spring Promotion*, *supra* note 2.

69. For an explanation of the many steps of egg freezing and IVF, see RICHARDS, *supra* note 1. See Goodwin, *supra* note 17, at 42 (dispelling the myth that ART finally allows women to have it all: “The selective imagery of ‘happy,’ heterosexual, white, middle-class parents obscures other truths about ART, including considerably high costs, high divorce rates, maternal health risks, fetal complications, [and] invasive procedures with speculative success . . .”).

70. RICHARDS, *supra* note 1, at 212.

71. See generally InVia Fertility Specialists, *Assisted Reproductive Technologies Program Oocyte Cryopreservation—Consent*, <http://www.inviafertility.com/docs/Oocyte%20Freezing%20Consent.pdf> (last visited Mar. 9, 2015).

endometrial, or colon cancers.⁷² At this time, “hardly anything is known”⁷³ about long-term risks.⁷⁴

Furthermore, despite short-term and potential long-term health consequences, egg freezing cannot ensure women the ability to achieve pregnancy later in life. Egg freezing is said to provide women the freedom to control their reproductive goals despite the immediate pressure of aging, yet freezing eggs at a young age cannot guarantee women that they will get pregnant using those eggs in the future.⁷⁵ If women freeze their eggs at a young age, they may be compromising their bodies and depleting their savings accounts⁷⁶ despite their ability to conceive for years to come without relying on ART.⁷⁷ One woman’s account exemplifies this concern:

I recently [froze my eggs and] . . . think it was a bad decision. It . . . is more harmful to your body than they will tell you Most people won’t use [their frozen] eggs and it did not do anything to relieve my anxiety about having children. I think it possibly increased it. There is a social pressure to do this now if you’re single, highly educated, and in your mid-thirties living in metropolitan areas [B]efore you

72. *Id.* One physician, whose daughter died at a young age of colon cancer after taking hormones as an egg donor, is now evaluating a possible connection between the colon cancer and fertility drugs. Jennifer Schneider, *Fatal Colon Cancer in a Young Egg Donor: A Physician Mother’s Call for Follow-Up and Research on the Long-Term Risks of Ovarian Stimulation*, FERTILITY & STERILITY (2008), <http://www.jenniferschneider.com/pdf/JS%20FertSter%20Fatal%20Colon%20Cancer.pdf> (last visited Mar. 9, 2015).

73. Jennifer Schneider, *It’s Time for an Egg Donor Registry and Long-Term Follow-Up*, CENTER FOR GENETICS AND SOC’Y (Nov. 14, 2007), <http://www.geneticsandsociety.org/article.php?id=3820>.

74. *Id.* (arguing that little is known about the long-term risks of hormonal fertility treatments because with egg donors, “once a young woman walks out of an IVF clinic, she is of no interest to anyone”).

75. See Cross, *supra* note 8 (“[I]nfertility can happen at any age. I’ve been struggling to get pregnant for over two years now. I’m 26-years-old.”). Beyond the fact that some women may already be infertile at a young age, there is also the grave issue that some women who *could* have gotten pregnant in their twenties or thirties will wait until their forties or fifties to try and get pregnant, relying specifically on their previously frozen eggs. Then, if they do not achieve pregnancy at that later date, *because* they are older or their eggs did not thaw properly, then they will have missed their opportunity to gestate and birth a genetically-related child, precisely because they relied on egg freezing as an insurance policy. This possibility is alarming.

76. It is possible, however, that if egg freezing becomes more routine, it will also either become less expensive, or clinics will offer more promotions, discounts, or financing schemes based on participation in egg sharing programs or future IVF treatment.

77. See Sobotka, *supra* note 49, at 20 (acknowledging the likelihood that women who freeze their eggs will “achieve spontaneous pregnancy or that the ART use may not result in the delivery of live birth”).

give up your \$15K and your health I would think extra carefully about why you're doing this and be extremely wary of the pressure and advice from friends and medical professionals.⁷⁸

This warning is chilling. Even when women *do* return to use the eggs that they froze in their mid-thirties, “it takes about 20 frozen eggs to be reasonably sure of a *single* pregnancy”⁷⁹ Finally, when pregnancy from frozen and thawed eggs occurs, delaying parenthood nevertheless “reduces the chance that both parents will survive until their children reach adulthood, marry, or become parents themselves and it increases the likelihood of the need [for the state] to provide care to both child and parents.”⁸⁰ Ultimately, accounts vary greatly whether elective egg freezing is truly ideal. In light of this uncertainty, it is especially important that legal regulations shield patients from unnecessary harm, and insulate fertility clinics from unnecessary liability issues.

C. THE CURRENT REGULATORY SCHEME

ART “is a multibillion-dollar business that is thriving on its own terms.”⁸¹ There is little federal oversight of ART; in fact, “[t]he only existing federal inquiry is whether a successful pregnancy resulted from ART”⁸² This question “inevitably overlooks growing medical and legal concern about ART safety, health risks to fetuses and subsequent children, high costs, [and] conflicts of interests between doctors who have financial interests in fertility treatment and their patients.”⁸³ Some states actively pass legislation governing ART, but most do not.⁸⁴ The piecemeal legal scheme that currently governs frozen

78. HennyA, *supra* note 64.

79. Hass, *supra* note 27 (emphasis added).

80. Gameiro, *supra* note 67, at 35.

81. CAHN, *supra* note 23, at 25.

82. Goodwin, *supra* note 17, at 3. Occasionally, the Food and Drug Administration asserts jurisdiction over ART-related transactions, such as fresh sperm donation. *See, e.g.*, Nadeem Shaikh, *Sperm Donor Told To Halt Production by US Regulator*, BIONEWS (Dec. 12, 2011), http://www.bionews.org.uk/page_115221.asp (describing the FDA's order that a man “cease manufacturing” his sperm, since he had donated his sperm to over forty-five recipients in four years; the sperm donor claimed that his “one-man operation [did not come] under the FDA's rules regarding commercial operations . . .”).

83. Goodwin, *supra* note 17, at 3; *see also* DAAR, *supra* note 35, at 659 (describing the Fertility Clinic Success Rate and Certification Act of 1992, which requires that fertility clinics make pregnancy success rates available to the government and the public).

84. For example, California is active in regulating ART through statutes, perhaps because it is home to fifty-one of the nation's three hundred and sixty

eggs, then, combines precedent set by frozen embryo disputes (that addresses disposition), statutes related to family law and inheritance (that define parentage), and basic contract law principles (which govern clinic-patient disputes and provide gap-fillers in the absence of other applicable legal terms). Across the country, legislatively-mandated, ART-specific informed consent standards are rare, and there do not appear to be regulations regarding the disposition of frozen eggs when progenitors die, or concerning how to calculate breach of contract damages involving gametes.⁸⁵

1. The American Society for Reproductive Medicine

The ASRM, a non-profit organization, endorses or disapproves of various reproductive technologies, and sets corresponding guidelines, but lacks any “real enforcement” mechanism.⁸⁶ Although the ASRM does not have the power to create enforceable guidelines governing ART,⁸⁷ it is composed of over seven thousand physicians, technicians, nurses, researchers, and other professionals with significant expertise in reproductive medicine.⁸⁸ The ASRM conducts research, publishes reports, sponsors educational outreach programs, and drafts policy guidelines for ART.⁸⁹ For example, the ASRM drafting committee produced guidelines for obtaining informed consent for IVF, which would affect women freezing their eggs, if adopted by clinics, states, or Congress.⁹⁰

fertility clinics. See Judith Daar, *Regulating the Fiction of Informed Consent in ART Medicine*, in DAAR, *supra* note 35, at 226–27. In 2000, California’s proposed statute not only sought to mandate the use of specific forms, but also set up an egg donor registry, therefore creating the necessary infrastructure for ART. *Id.* at 226.

85. See Victor Ali, *Consent Forms As Part of the Informed Consent Process: Moving Away from “Medical Miranda,”* 54 HASTINGS L.J. 1575, 1575–76 (2003) (discussing and criticizing general informed consent standards: “The current state of the law of informed consent represents a failure of legal efforts to implement a bioethical doctrine [C]onsent forms [are] both an example of the ills of the harm-avoidance model . . . as well as an area in which measures can be implemented to bring informed consent in line with the ethical ideals it is meant to enact”).

86. See DAAR, *supra* note 35, at 665; *Vision of ASRM*, REPRODUCTIVEFACTS.ORG, <http://www.reproductivefacts.org/about> (last visited Mar. 9, 2015).

87. See DAAR, *supra* note 35, at 665.

88. ASRM Lifts Experimental Label, *supra* note 30.

89. See *Vision of ASRM*, *supra* note 86.

90. See DAAR, *supra* note 35, at 673–75 (suggesting that informed consent should be obtained in writing, be witnessed, provide for the disposition of eggs,

After lifting the experimental designation from egg freezing in October 2012, the ASRM published a press release highlighting the probabilities of live birth after using either the slow freeze or vitrification technique, as they correspond with patient age.⁹¹ This press release likely played a substantial role in helping increase the popularity of egg freezing since it publicized, for the first time, promising statistics about the recent success of vitrification.⁹² Egg freezing finally became a valid alternative to embryo freezing.⁹³

2. Legal Lessons Learned from Embryo Disputes

Egg freezing allows women to preserve their fertility without fertilizing their eggs to create frozen embryos.⁹⁴ In the 1990s and 2000s, embryo freezing led to a wave of disputes and litigation, specifically regarding disposition after the progenitors divorced.⁹⁵ Frozen embryo disputes often left divorced women unable to use their cryopreserved embryos when their ex-husbands revoked their prior consent.⁹⁶ While egg freezing avoids disputes between co-progenitors, future frozen egg disputes will likely be resolved in relation to precedent regarding frozen embryo disposition. Issues common to both frozen embryos and frozen eggs include: the types of disposition that should be available to progenitors; the role of informed consent;

and include information about success rates, possible risks, financial obligations, alternative procedures, and federal reporting requirements).

91. See ASRM Lifts Experimental Label, *supra* note 30.

92. See ASRM Probability of Live Birth, *supra* note 46 (“Women whose [slow freeze] eggs were preserved before age 30 had a greater than 8.9% likelihood of implantation per embryo which declined to 4.3% for embryos from eggs frozen after 40. For vitrification cycles, implantation success declined from 13.2% for embryos from eggs frozen at 30 to 8.6% for embryos from eggs frozen at 40.”).

93. See 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, 1194 (2009) (explaining that eggs previously did not freeze “nearly as well as embryos”).

94. See DAAR, *supra* note 35, at 541.

95. For a useful introduction to frozen embryo disputes, see DAAR, *supra* note 35, at 573–653.

96. See Strasser, *supra* note 93, at 1194 (exploring courts’ unwillingness to favor one progenitor’s right to procreate over the other progenitor’s right not to become a parent); Bonnie Miller Rubin & Angie Leventis Lourgos, *High-Tech Reproduction Gives Birth to Court Case*, CHI. TRIB. (Sept. 18, 2013), <http://www.chicagotribune.com/health/ct-met-embryo-battle-20130918,0,472522.story> (“[T]he Tennessee Supreme Court . . . decided [as early as] 1992 that fatherhood would be a greater burden for the ex-husband than destroying the embryos would be for his ex-wife.”).

clinics' abilities to withhold gametic material (for example, if storage costs are not paid); inheritance rights; limits on posthumous reproduction; and damages for breach of contract.⁹⁷

3. Betting on Uncertain Outcomes⁹⁸: The Landscape of ART-Related Statutes, Cases, and Contracts

Generally, disputes over sperm or eggs can be resolved either through private agreements or according to public regulation by legislatures or courts.⁹⁹ Theoretically, "providers may draft [contracts] setting out their intentions . . . [and states] may enact legislation establishing either override rules that mandate certain outcomes, such as prohibition on destruction of the material, or default rules that control in the absence of an expression of contrary intent."¹⁰⁰ Courts and legislatures appear reluctant to set guidelines related to reproduction, although clinics and women freezing their eggs would both benefit from greater uniformity and predictability.

a. *Statutory and Common Law*

For decades, ART-related laws have been in "catch-up mode," rather than in "shaping mode."¹⁰¹ Statutes and common law do not yet address many of the concerns that egg freezing creates. For example, although statutes regulate inheritance, it is unclear how frozen eggs should be treated upon a progenitor's death, since gametic material is unlike other types of property.¹⁰² Numerous questions may remain unanswered when a progenitor dies: did she want her parent or partner to use her eggs, or to have that option? Did she want a child conceived after her death to inherit from her estate? Did she want her assets to pay for the continued storage of her eggs?¹⁰³ In most

97. See generally DAAR, *supra* note 35 (addressing the inheritance rights of donor-conceived persons, limits on posthumous reproduction, and breaches of ART-related contracts).

98. See Sobotka, *supra* note 49, at 23 (warning that egg freezing is "a long-term investment with an uncertain outcome").

99. See CAHN, *supra* note 23, at 19.

100. *Id.*

101. *Id.* at 2.

102. See generally Carole M. Bass, *Estate Planning for Frozen Eggs*, EGGSURANCE.COM (May 17, 2012), <http://www.eggsurance.com/estate-planning-for-frozen-eggs> (exploring the "myriad of estate planning issues raised by egg freezing").

103. *Id.*

states, the law has only “minimally responded” to these and similar questions.¹⁰⁴

b. Contracts: Seeking To Enforce the Unenforceable

Contract law is used to fill in the gaps created by nonspecific, or entirely nonexistent, ART-related legislation and case law.¹⁰⁵ As embryo disputes proved, however, contracts regarding gametic material raise legal and ethical questions that are distinct from concerns surrounding other types of personal property.¹⁰⁶ In the context of egg freezing specifically, patients and clinics often enter contractual agreements.¹⁰⁷ Whether these contracts are legally enforceable and ethically sound is the ultimate question. Some scholars suggest that the federal government¹⁰⁸ or state governments should adopt a standardized consent form for ART procedures.¹⁰⁹ Scholars further recommend that state statutes require “word-specific, written informed consent for any ART procedure . . . geared toward creating and maintaining a fair, open, and balanced relationship between doctors[, clinics,] and patients.”¹¹⁰ In the meantime,

104. See CAHN, *supra* note 20, at 2; see also CAL. PROB. CODE § 249.5 (2013) (clarifying that a decedent must specify, in writing, that it is his or her intent that the genetic material be used for posthumous conception; the statute also includes multiples conditions, such as: “a person [must be] designated by the decedent to control the use of the genetic material”); *Hecht v. Superior Court*, 16 Cal. App. 4th 836, 846 (1993) (holding that the decedent had an interest in his cryogenically preserved sperm, “which falls within the broad definition of property”).

105. See, e.g., *Kass v. Kass*, 91 N.Y.2d 554 (1998) (implementing the contract approach to solve a frozen embryo dispute).

106. See Rubin & Lourgos, *supra* note 96 (“This is not like other contracts—[an embryo is] not a car or a house—and for the . . . court to say that this is a matter of contract law is to dismiss the difference entirely.”).

107. See, e.g., *InVia Fertility Specialists*, *supra* note 71.

108. Although some states have enacted statutes that mandate specific information be provided in relation to particular medical services, Congress has not passed similar nation-wide statutes. Compare Heartbeat Informed Consent Act, H.R. 3130, 112th Cong. § 3402 (2011) (proposing that Congress enact provisions that would require all “abortion provider[s] in or affecting interstate or foreign commerce . . .” to perform an ultrasound, show the patient the ultrasound, and provide a medical description of the ultrasound images, in order to qualify as informed consent), with *Informed Consent*, UNIV. ILL. CHIC. COLL. MED., <http://www.uic.edu/depts/mcam/ethics/ic.htm> (last visited Mar. 9, 2015) (highlighting that the Supreme Court of the United States has upheld states’ rights to mandate that physicians provide specific information to women before performing abortions).

109. See DAAR, *supra* note 35, at 675 (debating the ability of standardized consent forms to ensure equal access to medical information).

110. Judith Daar, *Regulating Reproductive Technologies: Panacea or Paper*

however, women continue to enter into egg freezing agreements with clinics that are ethically troubling and potentially void or unenforceable. Uniformity, predictability, and security are startlingly absent from the current regulatory scheme. Part II surveys this issue, illustrating the need for default rules and uniform egg freezing contracts.

II. UNIFORMITY, PREDICTABILITY, AND SECURITY: WHAT THE CURRENT REGULATORY SCHEME LACKS

The current lack of ART-specific regulation should be reexamined in light of the relatively new egg freezing technology. This section highlights the legal and ethical reasons necessitating greater regulation. Without more structure, both clinics and women freezing their eggs remain at risk. Clear legal guidelines for egg freezing must be implemented in order for clinics and patients¹¹¹ to benefit from increased uniformity, predictability, and security.

Section A identifies the problems associated with the current lack of regulatory oversight of egg freezing. Section B weighs options that have been suggested to prevent legal and ethical issues from arising within egg freezing and other ART transactions. Section C focuses specifically on how the current regulatory scheme fails to protect ART patients, while Section D concludes by addressing how clinics are left vulnerable without further regulation.

A. ISSUES ARISING FROM THE CURRENT LACK OF LEGAL REGULATION: THE SAMANTHA HYPOTHETICAL

Absent legislation mandating the use of form contracts for egg freezing, clinics are left to decide whether and how to create and use contracts on a highly individualized basis. This lack of uniformity, predictability, and clarity can quickly lead to legally and ethically disturbing situations. Consider, hypo-

Tiger?, in DAAR, *supra* note 35, at 656; *see also* MINN. STAT. § 148F.01 (2013) (defining non-ART-specific informed consent as “an agreement between a provider and a client that authorizes the provider to engage in a professional activity affecting the client . . .” and that requires “the provider to give the client sufficient information so the client is able to decide knowingly whether to agree to the proposed professional activity . . .” among other requirements).

111. “Patients,” “progenitors,” and “women freezing their eggs” might presumably be used somewhat interchangeably. These terms, however, take on subtle differences in the context of egg freezing. Thus, in the following discussions about clinic-assisted egg freezing, “patients” will be the term used to refer to women freezing, or considering freezing, their eggs.

thetically, that Samantha's parents celebrated her college graduation by treating her to three rounds of egg freezing at Clinic A, in Minneapolis, Minnesota.¹¹² Samantha's parents received a 30% discount on the egg freezing procedures because Samantha agreed that if she used her eggs for IVF in the future, she would use them at Clinic A.¹¹³ Eighteen years later, Samantha is forty-years-old and lives in Austin, Texas. She recently became seriously involved with a romantic partner and they started trying to conceive without the use of ART. Samantha's first pregnancy resulted in a miscarriage.

The miscarriage was devastating, but Samantha took comfort in the fact that she still had eggs stored at Clinic A. Then, Clinic A increased its storage costs. A week after Samantha received notice of the increase in storage costs,¹¹⁴ she lost her job. Imagine, now, that Clinic A offers Samantha a discount on storage fees if she consents within the next month to donate half of her frozen eggs to an anonymous recipient.¹¹⁵ Or, suppose that Samantha's physician tells her that the miscarriage she recently suffered was due to a medical condition that may have been triggered by the hormone injections and egg retrieval process performed at Clinic A decades earlier.¹¹⁶ This condition may cause Samantha to continue to face difficulties carrying a fetus to term. Lastly, imagine that due to the miscarriage, Samantha wants to hire a surrogate carrier to gestate an embryo created from her own frozen eggs.¹¹⁷ Samantha thus wants

112. See, e.g., Hodgekiss, *supra* note 8 (suggesting that egg freezing be every father's college graduation present to his daughter).

113. See *supra* notes 2–3 (giving examples of current egg freezing discounts offered by fertility clinics).

114. See, e.g., *Storage Fee Pledge & Policy*, REPROTECH LIMITED, <http://www.reprotech.com/storage-fee-pledge-and-policies.html> (last visited Mar. 9, 2015) (guaranteeing that its storage prices will remain the same for two years). Many women, however, will store their frozen eggs for much longer than two years.

115. For a description of a UK program that offers women free storage if they donate half of their eggs to anonymous recipients, see Atalla, *supra* note 3.

116. See *supra* Part I.B.2.b (highlighting the unknown long-term risks of hormonal stimulation for egg retrieval).

117. It is common for women to turn to surrogacy after first experiencing pregnancies that ended in miscarriage. See, e.g., Meghan Rabbitt, *2 Moms, 4 Miracles: A Story of Surrogacy*, PARENTING.COM, <http://www.parenting.com/article/2-moms-4-miracles-a-story-of-surrogacy> (last visited Mar. 9, 2015) (describing one woman's experience miscarrying eleven times, before ultimately becoming a mom through surrogacy).

to transfer her eggs from Clinic A to Clinic B, in Austin.¹¹⁸ Clinic A tells Samantha that she will have to pay thousands of dollars to transfer her eggs to Clinic B, because of the original discount that her parents received, which was contingent on future IVF treatment at Clinic A. Suppose that Samantha is at a loss for what to do, and does not respond to Clinic A within a month; she also does not pay the increased storage fees.

Unfortunately, Samantha's scenarios illustrate entirely real possibilities. Since there is no state or federal oversight of egg freezing, the contract that Samantha signed with Clinic A (if a contract was executed at all) may have addressed known short-term risks without fully addressing undetermined long-term risks.¹¹⁹ The contract may also have incompletely discussed disposition options, the consequences of the conditional discount, default, or damages. Now, Samantha faces numerous undesirable results, including: (1) the possibility that Clinic A will dispose of her eggs (since Samantha has failed to pay for the increased storage rates after losing her job); or (2) the risk that Clinic A will hold her eggs "hostage" in Minnesota until Samantha has enough money to pay her way out of default, pay Clinic A the thousands of dollars that her parents originally saved, and pay to transfer the eggs to Clinic B.¹²⁰ By the time Samantha finds new employment and can afford these costs, it may be too late for her to attempt to gestate embryos created by her frozen eggs.¹²¹ Alternatively, Samantha may have reached an age where she is no longer able or willing to raise babies gestated by a carrier.

Samantha is not the only party disadvantaged by the uncertainty of this situation. Assuming that an original contract existed but did not address informed consent, disposition, the

118. See, e.g., *York v. Jones*, 717 F. Supp. 421, 427 (E.D. Va. 1989) (holding that plaintiffs properly alleged a cause of action in detinue, for wrongfully detained property, when their fertility clinic refused to release their stored, cryopreserved embryos to another clinic). *York* suggests that holding frozen eggs "hostage" may be unconscionable. *Id.*

119. See *supra* Part I.B.2.b (describing the unknown long-term risks of egg freezing and the unpredictability of women's fertility).

120. Even if the default clause is unenforceable, Samantha may not realize that unless she consults a lawyer. Ultimately, "if an ART patient is unhappy . . . she can file suit against her . . . clinic." DAAR, *supra* note 35, at 664. That option, though, requires time and money, which Samantha arguably does not have.

121. See Judith Daar, *Death of Aging Mother Raises More Questions About IVF Rules*, in DAAR, *supra* note 35, at 244 ("[M]ost clinics do impose age restrictions on patients A typical ceiling is 55 for women").

consequences of the conditional discount, default, or damages, Clinic A may face serious liability concerns. Clinic A is a business, intending to make money. It may not be legally or ethically appropriate, though, to dispose of Samantha's frozen eggs once she fails to make storage payment.¹²² What should Clinic A do if her payment arrives three days late? A month late? Four months late? What if Samantha fails to pay for storage for two years, and is unreachable via mailing address and e-mail? The clinic is suddenly forced to make uncomfortable determinations about its patient's genetic material that could also lead to grave liability issues.¹²³

Furthermore, if Samantha did not specify in the contract how she wants her eggs to be disposed of if she dies or becomes unreachable, then should Clinic A continue to lose money storing them, or should Clinic A donate them, use them for research, or destroy them? Currently, there are no default rules or regulations in place to guide clinics in drafting egg freezing contracts or avoiding legally troubling and unethical outcomes when disputes arise.

122. It is important to note the difference between destruction of embryos (whether negligent or intentional) and destruction of gametes (either eggs or sperm). Gametes are the only human cells that have the "reproductive capacity to form a new human life." *Human Embryos and Gametes*, ADELAIDE CENTRE FOR BIOETHICS AND CULTURE, <http://www.bioethics.org.au/Resources/Resource%20Topics/Human%20Embryos%20and%20Gametes.html> (last visited Mar. 9, 2015). Eggs and sperm alone, however, cannot create life; they must be combined to create an embryo, fetus, and potentially, a baby. Embryos, however, are one crucial step closer to producing a child; conception has already occurred. "The moral status of human embryos is the central question in determining what should or should not be done to them . . . There are strongly polarized views on this question that have lead to very different legislative regimes in different [states and] countries." *Id.* While cases have arisen from the negligent destruction of embryos, there do not yet appear to be similar cases regarding gametes. It remains uncertain how the unique status of gametes relates to ethical considerations regarding embryos. *Id.* For Samantha, though, her frozen eggs may not be like embryos from a right-to-life perspective, but destruction of those eggs would be as devastating as destroying embryos, because the eggs represent her only remaining chance to have genetically-related offspring.

123. See, e.g., ETHICS COMM. OF THE AM. SOC'Y FOR REPROD. MED., *Disposition of Abandoned Embryos: A Committee Opinion*, http://www.sart.org/uploadedFiles/ASRM_Content/News_and_Publications/Ethics_Committee_Reports_and_Statements/abandonedembryos.pdf (last visited Mar. 9, 2015) (describing similar ethical concerns, and potential legal liability, when clinics must decide what to do with abandoned frozen embryos).

B. WEIGHING OPTIONS: STATUTES, CONTRACTS, AND DEFAULT GUIDELINES

Numerous interrelated options exist for providing much-needed structure to the currently unregulated egg freezing procedures and processes. Egg freezing can be regulated by the federal government directly or indirectly, by states directly or indirectly, or by continued self-regulation by the ASRM and fertility clinics.¹²⁴ The best solution likely involves a combination of all of these options. Federal guidelines have the potential to provide uniformity and compel transparency across the states.¹²⁵ State legislation has the ability to fit requirements to state-specific priorities and treatment of ART.¹²⁶ The ASRM's involvement as an influential body of experts is crucial, although it lacks the authority to enforce recommendations; patients and clinics both need enforceability and predictability.¹²⁷ Lastly, fertility clinics should have the ability to self-regulate to an extent, so long as they are abiding by baseline requirements regarding, for example, informed consent and success rate disclosures.¹²⁸

Overall, greater regulation of egg freezing, on all of these levels, would arguably benefit four main groups: patients, physicians and clinics, future offspring, and society.¹²⁹ In addition to continued self-regulation by clinics in line with ASRM guidelines,¹³⁰ this Note proposes a contractual solution that high-

124. See DAAR, *supra* note 35, at 659–65 (listing categories for possible ART regulation).

125. See *id.* at 662 (identifying current federal regulations that “dabbled at the edges of ART regulation,” such as the Federal Trade Commission’s promulgation of truth in advertising in interstate commerce, and the Food and Drug Administration’s involvement in regulating human tissue donation, including eggs).

126. See *id.* at 663 (describing a handful of state laws that highlight a range of priorities, from Virginia’s law mandating success rate disclosures to Louisiana’s law requiring providers to adhere to ASRM guidelines).

127. See *Vision of ASRM*, *supra* note 86.

128. Current reporting requirements, however, lack stringent penalties for nonreporting. “On average, about 10% of all U.S. fertility clinics do not report their success rates to the [Centers for Disease Control and Prevention]” and the Act requiring reporting “simply requires that the name of the nonreporting clinic be included in the annual report.” DAAR, *supra* note 35, at 660.

129. See DAAR, *supra* note 35, at 668 (exploring the need for ART regulation).

130. Clinics “self-regulate” for a range of reasons. For example, clinics may make an effort to use federally approved techniques in order to qualify for federal funding, insurance reimbursements, and other incentives. Doctor-patient

lights the importance of implementing additional federal- or state-mandated requirements. Legislation regulating egg freezing would reflect ASRM recommendations and bring uniformity and predictability to clinics' currently inconsistent practices.

State-by-state legislation is arguably most feasible. General medical issues, such as what constitutes informed consent, as well as ART-specific matters, such as the legality of surrogacy, are already managed at the state level.¹³¹ Furthermore, states have the ability to enact statutes that mandate the use of form contracts.¹³² Mandatory form contracts for egg freezing would provide essential structure by targeting the areas most likely to create legal and ethical issues between patients and clinics.¹³³ By providing a mandatory form contract, states would create both a polished tool for clinics to use and a clear mechanism for enforcement: patients and clinics would have a better understanding of their risks, roles and obligations, and courts would have guidelines for enforcing egg freezing contracts and requiring certain provisions in the event of patient-clinic disputes.¹³⁴

relationships are also subject to the law of torts and informed consent, which creates incentives for clinics to regulate these relationships with contracts. Finally, consumer protection laws apply to clinics, creating another need for self-regulation, even if ART itself is under-regulated. *See generally* Aaron D. Levine, *Self-Regulation, Compensation, and the Ethical Recruitment of Oocyte Donors*, 40 HASTINGS CTR. REP. 25, 25–36 (2010) (evaluating the effectiveness of self-regulation efforts).

131. *See supra* note 110.

132. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 125315 (2013) (requiring that patients receive “timely, relevant, and appropriate information to allow the individual to make an informed and voluntary choice regarding the disposition of any human embryos . . .” and that patients receive, at a minimum, a list of options for embryo disposition *enumerated in the statute itself*); COLO. DEPT OF REGULATORY AGENCIES, *Real Estate Contracts and Forms*, COLORADO.GOV, <http://cdn.colorado.gov/cs/Satellite/DORA-DRE/CBON/DORA/1251627670428> (last visited Mar. 9, 2015) (mandating that real estate brokers use state-approved contracts and forms for real estate transactions); *see also* Leon Kass, *Reproduction & Responsibility: The Regulation of New Biotechnologies*, in DAAR, *supra* note 35, at 693–96 (quoting the President’s Council on Bioethics’ 2004 report suggesting that the Fertility Clinic Success Rate and Certification Act would be “greatly improved by providing for the promulgation of easy-to-read model consent forms”).

133. *See infra* Part III.

134. *See* President’s Council on Bioethics, *Reproduction & Responsibility: The Regulation of New Biotechnologies*, in DAAR, *supra* note 35, at 693–96 (finding that enhanced reporting requirements, combined with model forms and stronger penalties for noncompliance would create numerous benefits).

C. THE CURRENT SCHEME FAILS ART PATIENTS

The current regulatory scheme fails to address egg freezing,¹³⁵ yet egg freezing is a medical technology that poses significant benefits and risks to patients.¹³⁶ California, which is home to about fourteen percent of the fertility clinics in the United States, attempted to pass a bill addressing risks to egg donors, who go through the same hormone treatments and retrieval process that other women go through for their own egg freezing purposes.¹³⁷ The legislature passed this first-of-its-kind bill, but it was ultimately vetoed by Governor Davis.¹³⁸ Had the bill passed, it would have allowed egg donors to “join the ranks of other medical patients whose . . . decisions are made in the face of full and fair risk disclosure.”¹³⁹ It is concerning that the law does not better protect the interests of women going through ovarian stimulation and egg retrieval.

The lack of regulation over egg freezing poses concerns about the health and safety of patients and future offspring. ART-specific, and procedure-specific, regulations should exist, the primary goal of which “should be to promote and ensure the safety and effectiveness of the medical technologies utilized, with an eye toward the health of both patients and children.”¹⁴⁰ More specifically, if states mandate by statute that clinics use a form egg freezing contract that includes certain informed consent provisions, patients will be more aware of the impact of egg freezing on their current and future health and ability to reproduce.¹⁴¹

135. See generally CAHN, *supra* note 20 (calling for comprehensive regulation of the fertility market, to provide guidelines for assessing potentially conflicting rights of ART providers and patients).

136. See generally RICHARDS, *supra* note 1 (providing a detailed discussion of the benefits and risks of egg freezing).

137. See Judith Daar, *Regulating the Fiction of Informed Consent in ART Medicine*, in DAAR, *supra* note 35, at 226–27 (describing State Senator Tom Hayden’s introduction of Senate Bill 1630).

138. *Id.* at 226.

139. *Id.* at 227.

140. Judith F. Daar, *Regulating Reproductive Technologies, Panacea or Paper Tiger?*, in DAAR, *supra* note 35, at 657.

141. See *infra* Part III.

1. There Is a Current Lack of ART-Specific Informed Consent Requirements

Current laws addressing informed consent largely, if not entirely, ignore ART patients.¹⁴² Although the general concept of informed consent dates back to the early twentieth century,¹⁴³ ART patients face the risks of state-of-the-art technologies that require a greater disclosure of information and warnings than is provided under basic informed consent statutes.¹⁴⁴ Informed consent statutes typically require providers to supply patients with information about proposed courses of action, alternative courses of action, and the benefits and risks associated with each option.¹⁴⁵ Physicians providing ART services, though, should be mandated by state statutes to provide ART patients with greater amounts of information about specific risks and obligations, in order to fulfill general informed consent requirements.

For example, the ASRM recommends that egg donors “should be advised explicitly of the risks and adverse effects of ovarian stimulation and [egg] retrieval, with such counseling documented . . . in the patient’s permanent medical record.”¹⁴⁶ In 2000, California’s Senate unsuccessfully recommended that ART providers specifically disclose “the risk of decreased fertility and the risks associated with using the drugs, medications, and hormones prescribed for ovarian stimulation”¹⁴⁷ These wise recommendations acknowledge that due to the unique nature of ART, and the unknown long-term effects of hormonal

142. See generally MINN. STAT. § 148F.14 (2013) (exemplifying a non-ART-specific state statute concerning informed consent).

143. *Informed Consent*, STAN. ENCYCLOPEDIA PHIL. (Sept. 20, 2011), <http://plato.stanford.edu/entries/informed-consent> (“In clinical practice, the doctrine of informed consent rose to dominance during the course of the 20th century.”); Alan Meisel & Mark Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156 ARCHIVES INTERNAL MED. 2521, 2521 (1996) (“The origins of informed consent in medicine are somewhat murky. Its antecedents can be traced to early 20th-century American law.”).

144. See, e.g., *id.* (requiring primarily that providers inform patients of the goals, purposes, and duration of treatment, fee schedules, limits on privacy, and significant risks and benefits).

145. See generally *Informed Consent*, *supra* note 108.

146. The Practice Comm. of the Am. Soc’y for Reprod. Med. & Practice Comm. of the Soc’y for Assisted Reprod. Tech., *Recommendations for Gamete and Embryo Donation: A Committee Opinion*, 99 FERTILITY & STERILITY 47, 58 (2013).

147. Judith Daar, *Regulating the Fiction of Informed Consent in ART Medicine*, in DAAR, *supra* note 35, at 226–27.

stimulation, egg donors and women freezing their eggs should be educated *in depth* before they can give informed consent. It is troubling that the ASRM's recommendations for informed consent are unenforceable, and that state legislatures hesitate to touch ART-related issues.¹⁴⁸ The ASRM recommendations, or similar ART-specific informed consent guidelines, should be mandated by state legislation.¹⁴⁹

2. ART-Specific Informed Consent Requirements Are Necessary

ART-specific informed consent requirements are necessary for a variety of reasons. Women seeking egg freezing services are likely unaware of the true risks, benefits, and obligations involved in egg freezing. There are no reporting requirements for egg freezing success rates; the only federal ART-related regulation requires that pregnancy success rates be made available to the public.¹⁵⁰ In addition, popular magazines geared towards female audiences tend to embellish and distort the benefits and risks of egg freezing.¹⁵¹ Most clinics also sugar-coat the egg freezing process, or ignore associated risks altogether, in order to promote their services.¹⁵²

State-implemented ART-specific or egg-freezing-specific informed consent requirements would ensure that women are appropriately educated about what is known, and unknown, about egg freezing, before they pay an exacting physical, psychological, and financial toll. The legal and ethical issues that arise when unforeseen circumstances come to fruition—exemplified above with Samantha and Clinic A—are preventable.

D. THE CURRENT SCHEME FAILS TO PROTECT CLINICS

It may initially appear that “[t]he lack of a comprehensive ART regulatory scheme . . . [is an] entirely favorable system for

148. See generally The Practice Comm. of the Am. Soc’y for Repro. Med. & Practice Comm. of the Soc’y for Assisted Repro. Tech., *supra* note 146 (making non-binding recommendations).

149. See *id.*

150. See *supra* note 83 and accompanying text.

151. See, e.g., Hass, *supra* note 27; Naaman, *supra* note 64; Richards, *supra* note 26.

152. See, e.g., *Spring Promotion*, *supra* note 2; see also Judith Daar, *Regulating the Fiction of Informed Consent in ART Medicine*, in DAAR, *supra* note 35, at 225 (“[M]ost programs do not volunteer risk information and many provide inaccurate or incomplete risk information when queried . . .”).

practitioners who enjoy total freedom to practice reproductive medicine untethered by burdensome and time-consuming external rules and requirements.”¹⁵³ ART physicians, however, are stuck in a messy middle-ground, subject to general licensing and malpractice standards, but lacking ART-specific guidelines for providing egg freezing services.¹⁵⁴ Greater regulation would protect ART physicians and clinics by clarifying how they must, should, or should not act, and by detailing what they must or should disclose to patients before providing egg freezing services.¹⁵⁵

While individual cases would eventually provide “legal signposts,”¹⁵⁶ physicians would benefit more from broad legislation. The current lack of regulation leaves providers unable to predict what their obligations are, as ART services typically fall “somewhere in between the regulatory-free practice of natural conception and the regulatory-heavy institution of adoption.”¹⁵⁷ Beyond providing instructive criterion, which relate to potential clinic liability, regulation of egg freezing also has the potential to enhance public confidence in the procedure, and strengthen the demand for services. Consequently, regulation of egg freezing would not only benefit patients, but would also provide security to clinics.

III. ENDORSING A CONTRACTUAL SOLUTION: PROPOSING A FORM OOCYTE CRYOPRESERVATION AGREEMENT TO AVOID DISPUTES, AMBIGUITY, AND UNCONSCIONABLE OUTCOMES

State statutes should require fertility clinics offering egg freezing services to use a form contract that thoroughly addresses informed consent,¹⁵⁸ allows each patient to clarify her

153. See DAAR, *supra* note 35, at 686.

154. See *id.* (summarizing standards to which reproductive medical doctors are held).

155. See *id.* (suggesting generally that increased regulation of ART will protect reproductive medicine doctors).

156. CAHN, *supra* note 20, at 2.

157. See DAAR, *supra* note 35, at 690–91.

158. Although states have not yet regulated egg freezing, some states have enacted statutes that mandate the use of certain forms for other assisted reproductive technologies. See, e.g., CAL. HEALTH & SAFETY CODE § 125315 (2013) (mandating that “[a] physician and surgeon or other health care provider delivering fertility treatment shall provide his or her patient with timely, relevant, and appropriate information to allow the individual to make an informed and voluntary choice regarding the disposition of any human embryos . . .” and listing options that shall be provided to patients for disposition).

wishes regarding the disposition of leftover or pre-deceased eggs, and delineates appropriate damages in the event that either party breaches the contract. A form contract would create uniformity among clinics and from state to state, which is crucial to protect the interests of clinics, patients, and society, as the market for egg freezing continues expanding. Beyond providing uniformity, form contracts are necessary to ensure that patients are fully aware of the many steps and risks involved in egg freezing, and that clinics are fully educated about each patient's intent. Section A provides a general description of the components that should be included in a form egg freezing contract.¹⁵⁹ Section B addresses informed consent, specifically, and how the form egg freezing contract should explicitly delineate the steps and risks involved in both cryopreservation and future IVF. Section C describes how the form contract can provide patients with flexible, multiple-choice options that indicate their intent regarding the disposition of their leftover, abandoned, or pre-deceased eggs. Section D addresses how the form contract should handle promotional offers and liquidated damages. Section E considers overarching recommendations that relate to the implementation of form contracts for egg freezing. Lastly, Section F highlights the feasibility of contract-based regulation.

A. NECESSARY COMPONENTS OF A FORM EGG FREEZING CONTRACT

A form contract for egg freezing should be comprehensive, regardless of length.¹⁶⁰ It is crucial that traditional provisions, as well as provisions tailored particularly to ART services and egg freezing, be included in the contract. Egg freezing contracts should include sections regarding important legal, medical, and ethical matters, including, at the very least: (1) Description of

159. The sample form contract that appears in this section is based on other types of ART-related contracts. See generally *In Vitro Fertilization: Process, Risk, and Consent*, ASSISTEDFERTILITY.ORG (Dec. 1, 2013), <http://www.assistedfertility.org/forms.html> (follow "IVF, ART Informed Consent Part 1" hyperlink); InVia Fertility Specialists, *supra* note 71; *Reproductive Material Cryostorage Agreement*, SPERM BANK, INC., http://www.spermbankcalifornia.com/media/Reproductive_material_cryostorage_agreement.pdf (last visited Mar. 9, 2015); *Sample GS Contract*, ALL ABOUT SURROGACY, http://www.allaboutsurgacy.com/sample_contracts/GScontract1.htm (last visited Mar. 9, 2015). Unless specifically footnoted, though, the language of the sample form contract is my own.

160. ART contracts are often lengthy. For an example of an eighteen-page model surrogacy contract, see *Sample GS Contract*, *supra* note 159.

Oocyte Cryopreservation; (2) Variable Success; (3) Short-Term Effects and Risks; (4) Long-Term Effects Unknown; (5) Costs; (6) Disposition of Oocytes; (7) Clinic Liability; (8) Confidentiality; (9) Counsel; (10) Entire Agreement; (11) Written Amendments Required; (12) Severability; (13) Breach; (14) Liquidated Damages; (15) Enforceability; (16) Mediation Requirement; and (17) Voluntary Signing.

These sections can be grouped into four main categories: sections one through five address risks and informed consent; section six covers a range of appropriate options for disposition; sections thirteen and fourteen pertain to damages for breach of contract; and sections seven through twelve and fifteen through seventeen cover miscellaneous contractual safeguards and formalities. The first three categories will be explained in greater detail below, yet all seventeen sections should be included in a state-mandated form contract for egg freezing. It would also be prudent for states to clarify at the top of each form contract that the form has important legal consequences and the parties should consult legal counsel before signing. This boilerplate language is customarily found on state-mandated legal contracts.¹⁶¹

B. INFORMED CONSENT SHOULD SPECIFICALLY ADDRESS THE PROCESS AND RISKS OF CRYOPRESERVATION

Informed consent is arguably the most important and complex issue to be addressed by the form contract for egg freezing. The first provision of the contract should broadly state the nature of the agreement. For example:

I, _____[patient name], hereafter PATIENT, understand that cryopreservation (freezing) of human oocytes (eggs) is an assisted reproductive technology that can preserve oocytes so that they may be stored, thawed, fertilized (via in vitro fertilization), and transferred for implantation at a later time. I understand that by signing this form, I evidence my consent to the retrieval and cryopreservation of my oocytes, by embryologists at _____[clinic name], hereafter CLINIC, in accordance with the following descriptions and provisions.

The next step is to ensure that the egg freezing process is clearly defined, that the variable chances of successfully freezing

161. See, e.g., *Contract To Buy and Sell Real Estate (Residential)*, COLORADO.GOV, <http://cdn.colorado.gov/cs/Satellite/DORA-DRE/CBON/DORA/1251627670428> (follow “Contract to Buy and Sell, Residential” hyperlink under “Sales Contracts”) (last visited Mar. 9, 2015) (exemplifying that it is common for state-mandated contracts to recommend, rather than require, parties to seek legal counsel).

(and later thawing and fertilizing) eggs is made explicit, that the physical and psychological risks are expressed, and that the patient's financial obligations are plainly set out in the agreement.

1. Description of Oocyte Cryopreservation

The first major section of the form contract should describe egg freezing, both broadly and step-by-step. Including this description is essential, especially considering the plethora of incomplete or false information that potential patients are likely to have previously encountered regarding egg freezing.¹⁶²

A simple description of oocyte cryopreservation should be followed by a provision that patients must initial, indicating their understanding that their oocytes will be retrieved, frozen, stored, and thawed according to medically appropriate standards. Requiring patients to initial key provisions throughout the contract will compel them to slow down, and will encourage them to focus on important information bit-by-bit and ask questions as they arise. This strategy will help ensure that patients are processing and absorbing the intricacies of the contract, rather than rushing through unaware of significant provisions.

Next, the contract should include a heading titled "*Oocyte cryopreservation involves the following steps,*" followed by this list (modified as appropriate to conform to a clinic's exact methods):

1. Preliminary administration of hormones to PATIENT to stimulate her ovaries.
2. Retrieval of oocytes from PATIENT's ovary(s) by inserting a needle into the ovary(s), using ultrasound guidance.
3. Freezing and storage of the oocytes in liquid nitrogen (- 196 degrees C).¹⁶³

Immediately after this list, there should be a provision that patients must initial, evidencing they understand that cryopreservation involves the three abovementioned steps.

It is not enough, however, to merely list the steps of oocyte cryopreservation, since each patient's end goal is by nature to achieve pregnancy and live birth. Patients should clearly understand the additional steps that will be required for them to use their frozen eggs when attempting to have children in the future. Therefore, the next subheading should be "*Use of cryo-*

162. See *supra* note 151 and accompanying text.

163. See InVia Fertility Specialists, *supra* note 71.

preserved oocytes involves the following steps." The section should include these steps:

1. Thawing of individual or numerous cryopreserved oocytes.
2. Determination of viability of thawed oocytes.
3. Injection of partner's sperm or (purchased) donor's sperm into viable, thawed oocytes (if any oocytes are viable after being thawed).
4. If fertilization occurs, the embryos must grow for several cell divisions until determined by the embryologist(s) and/or physician(s) at CLINIC to be fit for transfer into PATIENT or surrogate carrier's uterus or fallopian tube(s).
5. Ultrasound examinations of PATIENT (or surrogate carrier) and blood tests of PATIENT (or surrogate carrier) to determine suitability of her uterine lining for the reception of embryos.
6. Transfer of the embryo(s) to the recipient's uterus or fallopian tubes.

(Note: Steps 2–6 constitute in vitro fertilization.)¹⁶⁴

Again, patients should be encouraged to pay special attention to these future requirements to make use of their frozen eggs. Thus, there should be two provisions following this list that require patients to initial (a) that they understand that the use of cryopreserved oocytes to achieve pregnancy involves the abovementioned steps, including future IVF, and may not result in successful pregnancy(s); and (b) that they understand that they may get pregnant through natural conception at any time and ultimately choose not to attempt to use their cryopreserved oocytes. Provision (b) is important because it highlights that patients' considerable expenditure of time, energy, and money is not essential to achieve pregnancy in the future, any time before menopause.¹⁶⁵

2. Variable Success

The next main section should articulate, "oocyte cryopreservation is performed with variable success."¹⁶⁶ The first sub-heading should state, "*Known factors that may prevent preg-*

164. See generally *id.* (describing the steps of oocyte cryopreservation and in vitro fertilization).

165. See Richards, *supra* note 26.

166. See Kotz, *supra* note 34 and accompanying text (comparing the success rates of fresh versus frozen eggs, which are now comparable when the vitrification technique is used for freezing).

nancy include, but are not limited to,” and be followed by a list that includes, at a minimum:¹⁶⁷

1. Poor or no survival of viable oocytes after undergoing thawing.¹⁶⁸
2. Poor or no fertilization of the thawed oocytes.
3. Poor or no development of fertilized embryos.
4. Genetic abnormality(s).
5. Equipment failure leading to the loss or damage of oocytes or embryos.
6. Human error leading to the loss or damage of oocytes or embryos.
7. Technically difficult, impossible, or prohibited embryo transfers.
8. Failure of embryos to implant and continue developing.¹⁶⁹

Patients should initial next to separate provisions drawing attention to (a) the fact that neither pregnancy nor a successful outcome of pregnancy can be assured as a result of oocyte cryopreservation (and subsequent IVF); (b) that it is possible that no oocytes will be viable after being frozen and thawed; (c) that it is possible that no viable eggs will become fertilized to produce embryos; and (d) that no guarantees have been made to the patient regarding the possible success of oocyte cryopreservation.

The second subheading should focus on the various possible results of pregnancy, listing “*Pregnancy(s) may result in*”:¹⁷⁰

1. Multiple births (i.e., more than one fetus is carried to term during a single pregnancy, resulting in the birth of twins, triplets, or other multiples).¹⁷¹

167. See, e.g., *In Vitro Fertilization: Process, Risk, and Consent*, *supra* note 159, at 5 (listing numerous factors that may prevent pregnancy, despite the clinic taking “reasonable precautions”).

168. There are two main reasons why eggs may not be viable after undergoing thawing: (1) the eggs may not have been viable before they were frozen; or (2) the eggs may have been damaged during the freezing process (although this is becoming more rare). See Hass, *supra* note 27 (noting that “women of all ages produce many eggs that are unusable,” and “the slow-freezing method that was successful for cryopreserving embryos created ice crystals that destroyed [frozen and thawed] eggs”). But see Cil et al., *supra* note 51, at 498 (describing more recent success with vitrification, which does not appear to damage frozen and thawed eggs).

169. See InVia Fertility Specialists, *supra* note 71 (illustrating a similar list of “Reasons for Adverse Results”).

170. See *In Vitro Fertilization: Process, Risk, and Consent*, *supra* note 159, at 8 (listing numerous risks to IVF-conceived offspring, including birth defects and multiple births).

171. See *Twins, Triplets, Multiple Births*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/twinstripletsmultiplebirths.html> (last visited Mar. 9, 2015) (describing multiple births); see also Laurie Tarkan, *Lowering Odds of Multiple Births*, N.Y. TIMES (Feb. 19, 2008), <http://www.nytimes.com/2008/02/19/health/19mult.html> (highlighting the “soaring” rate of multi-

2. Ectopic pregnancy (i.e., the fertilized egg implants somewhere outside of the uterus, causing the loss of the pregnancy. If left untreated, ectopic pregnancies may lead to life-threatening blood loss or diminished chances of healthy, future pregnancies).¹⁷²
3. Miscarriage (i.e., the spontaneous loss of a fetus before the twentieth week of pregnancy).¹⁷³
4. Stillbirth (i.e., the loss of a fetus after the twentieth week of pregnancy).¹⁷⁴
5. Birth of a child(ren) with congenital abnormalities (which may be caused by chromosome or single-gene abnormalities, certain maternal illness during pregnancy, a combination of genetic and environmental influences, and/or other unknown causes).¹⁷⁵

Women investing in egg freezing should be aware of the numerous barriers that potentially stand in the way of successful pregnancies, especially since multiple steps are required to attempt pregnancy through assisted reproductive technologies.

3. Short-Term Effects and Risks

The form contract's third section should focus on short-term effects and risks. Physical effects and risks should be described, beginning with a statement alerting the patient that she will be responsible for giving herself hormone injections every ___ () days, for ___ () days/weeks, to stimulate her ovaries prior to each oocyte retrieval procedure.¹⁷⁶ The contract should stipulate that these hormone treatments may have short- or long-term effects, including, but not limited to: (1) bruising and/or soreness; (2) weight gain; (3) loss or thinning of

ple births in the United States due to IVF treatments, and noting: "It is not that twins or triplets are undesirable . . . [b]ut multiple pregnancies often lead to risky preterm births and other complications."

172. See Mayo Clinic Staff, *Ectopic Pregnancy*, MAYO CLINIC (Jan. 20, 2015), <http://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/basics/definitions/con-20024262> (defining ectopic pregnancy).

173. See Mayo Clinic Staff, *Miscarriage*, MAYO CLINIC (July 9, 2013), <http://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/basics/definition/con-20033827> (defining miscarriage).

174. See *Stillbirth*, FREE DICTIONARY, <http://www.medical-dictionary.thefreedictionary.com/stillbirth> (last visited Mar. 9, 2015) (defining stillbirth).

175. See *Congenital Abnormalities*, HEALTHYCHILDREN.ORG, <http://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/pages/Congenital-Abnormalities.aspx> (last updated July 31, 2014) (defining congenital abnormalities).

176. See Mayo Clinic Staff, *What You Can Expect*, MAYO CLINIC, <http://www.mayoclinic.org/tests-procedures/egg-freezing/basics/what-you-can-expect/prc-20014144> (last visited Mar. 9, 2015) (describing the use of synthetic hormones to stimulate women's ovaries to produce multiple eggs in one cycle, rather than solely one egg, prior to egg retrieval).

hair; (4) melasma (i.e., dark skin discoloration¹⁷⁷); (5) bloating; and (6) tender ovaries.¹⁷⁸ This section should conclude with a provision that a patient must initial, indicating that she understands that hormone treatments, as well as the oocyte retrieval procedure(s), may have short-term effects on her body.

Psychological effects and risks should also be indicated under the short-term risks heading. The patient should initial that she understands that oocyte cryopreservation and the use of future assisted reproductive technology may be psychologically stressful and may result in anxiety and depression, and that oocyte cryopreservation will require months of time and commitment.¹⁷⁹

4. Long-Term Effects Unknown

Another key component of informed consent is the patient's understanding that the long-term effects of the administration of fertility drugs are not known. Specifically, the potential risk of ovarian or endometrial cancers are still being evaluated.¹⁸⁰ The form contract should briefly explain that long-term effects remain unknown, and leave space for patients to initial that they understand this situation.

5. Costs

The final aspect of informed consent that must be included in the form contract is costs. Patients should pay special attention to their financial obligations. The form contract should include an overview of costs and fees, noting that costs will be associated with every step of the egg freezing (and future storage and IVF) processes. The clinic should provide an appendix that lists current costs and fees, but should note that these amounts may vary and/or be adjusted by the clinic based upon market factors. In addition, the form should clearly state that the fee for each storage period shall be paid in advance, and that unused storage fees are non-refundable (if this is the case).

177. See *Melasma*, AM. ACAD. DERMATOLOGY, <https://www.aad.org/dermatology-a-to-z/diseases-and-treatments/m---p/melasma> (last visited Mar. 9, 2015) (defining melasma).

178. See RICHARDS, *supra* note 1, at 212.

179. See generally, e.g., *In Vitro Fertilization: Process, Risk, and Consent*, *supra* note 159 (demonstrating how ART contracts may address psychological effects and risks).

180. See InVia Fertility Specialists, *supra* note 71.

A separate section should address default. The default section should specify: “If, at any time, CLINIC has not received the full payment of all amounts due from PATIENT on or before thirty (30) days after the beginning of any storage period, PATIENT is in default;” and “In the event of default, CLINIC agrees to attempt to contact PATIENT, according to the disposition provisions” and may “at its sole discretion, refer PATIENT’s account to any attorney or collection agency for collection.” The form may further stipulate that PATIENT agrees to pay all costs and fees reasonably associated with such collection.¹⁸¹

C. MULTIPLE-CHOICE OPTIONS FOR THE DISPOSITION OF EGGS

The issue that perhaps has the greatest potential to create ethical dilemmas is egg disposition. Both patients and clinics should be determined to clarify provisions regarding disposition well before the egg freezing procedures begin. This is a challenging yet necessary undertaking.

A form egg freezing contract should include a section specifically dedicated to disposition of oocytes. The first subheading should state, “If PATIENT should die while any of her oocytes remain in storage,” and be followed by these options¹⁸²:

I, _____ [PATIENT NAME], wish for any and all oocytes that remain in storage to (*check all those that apply*):

(a) ___ be *thawed and disposed of*, in a professional and ethically accepted manner according to the fertility clinic’s guidelines, not inconsistent with American Society for Reproductive Medicine guidelines. Disposed of oocytes cannot and will not be used for reproductive purposes on behalf of any person(s).

(b) ___ be *donated to a single woman* for reproductive use.

(c) ___ be *donated to a couple* for reproductive use.

___ I intend “couple” to refer to married partners of the opposite-sex, only.

___ I intend “couple” to refer to married or non-married partners of the opposite-sex, only.

___ I intend “couple” to refer to married partners of the same-sex, only.

___ I intend “couple” to refer to married or non-married partners of the same-sex, only.

___ I intend “couple” to refer to married partners of the opposite- or same-sex.

181. See, e.g., *Reproductive Material Cryostorage Agreement*, supra note 159 (illustrating how cryopreservation agreements may address default).

182. See, e.g., *id.* (allowing patient to “[c]hoose one of the following”).

____ I intend “couple” to refer to married or non-married partners of the opposite- or same-sex.

(d) ____ be *donated to research*.

____ I wish to donate the oocytes to research with no restrictions on future use.

____ I wish to donate the oocytes to research with the following restrictions on future use.¹⁸³

____ The oocytes shall not be fertilized.

____ Other:

OR,

(e) ____ become the property of _____ [NAME], my _____ [RELATION], unless the circumstances surrounding my relationship with this person drastically change (e.g., separation, divorce, lack of contact for over one (1) year). I expressly intend that my eggs *not* transfer to this person if:

____ (DESCRIPTION OF SPECIFIC CIRCUMSTANCES THAT SHALL AUTOMATICALLY TRIGGER REVOCATION).

____ I intend for this person to pay for remaining storage fees.

____ I intend for storage fees to be paid out of my estate for as long as possible, and then I intend for this person to pay for remaining storage fees.

____ I intend for any child(ren) created from my cryopreserved oocytes within five (5) years of my death to inherit from my estate.

____ I do not intend for any child(ren) created posthumously from my cryopreserved oocytes to inherit from my estate. I do not expect or want to be considered their legal mother.

____ [PATIENT INITIALS] I understand that should the circumstances surrounding my relationship with the abovementioned person drastically change, any remaining cryopreserved oocytes shall be disposed of according to my second choice, option ____ (CHOOSE FROM OPTIONS (a)–(d)), as described above.

____ [PATIENT INITIALS] I understand that my will should reflect my intent regarding posthumous disposition of my cryopreserved oocytes, but fully intend for this document to be legally binding and enforceable upon my death.

____ [PATIENT INITIALS] I understand that should I change my mind at any time regarding the disposition of my cryopreserved oocytes up-

183. See also, e.g., *Stanford University Research Consent Form*, STAN. U., <http://hesc.stanford.edu/donations/2%20Stanford%20IVF%20Sperm%20Research%20Consent%20-Sept%202014.pdf> (last visited Mar. 9, 2015) (including the potential for sperm donors to restrict research on their genetics and cell biology).

on my death, I must contact the fertility clinic immediately and sign a new form, clearly stating my intent, otherwise, this form shall govern.

These extensive provisions will help ensure that patients consider possible future circumstances, so that their wishes are carried out, and so that clinics are not forced to make ethically difficult decisions about patients' eggs.

Similarly, another subsection should address what should happen if the patient becomes unreachable. There should be a provision that a patient initials indicating that she agrees to promptly update her contact information if it should change. Then, a detailed description of clinics' obligations to reach out to patients for a certain length of time (e.g., five months), and attempt contact at least ___ times (e.g., once every two weeks), should be stated. Lastly, patient should initial that she understands that if she remains unreachable for that length of time, the clinic may dispose of her oocytes according to her wishes (expressed in the contract), so long as the clinic has attempted contacting her according to the stated provisions.

D. PROMOTIONAL OFFERS AND PROVISIONS FOR LIQUIDATED DAMAGES SHOULD BE DESCRIBED IN EACH CONTRACT

The issue with many ART agreements is that when disputes arise, specific enforcement is often not an option. It would be unconscionable to force a woman to gestate a fetus, go through IVF, or keep her eggs in a storage facility. The issue, then, is what the consequences should be for breach of contract. This Note recommends that the form egg freezing contract specifically address breach and liquidated damages.

Liquidated damages clauses appear in numerous types of contracts.¹⁸⁴ Typically, liquidated damages provisions are enforceable if:

- (1) it appears that the parties intended to liquidate damages; (2) . . . the amount of damages specified was a *reasonable* estimate of the presumed actual damages that would result from a breach; and (3) at the time of contracting, it was difficult to ascertain the amount of damages that would result from a breach of the agreement.¹⁸⁵

184. See, e.g., Deborah S. Coldwell et al., *Liquidated Damages*, 29 FRANCHISE L.J. 211, 211 (2010); Jeffrey B. Coopersmith, *Refocusing Liquidated Damages Law for Real Estate Contracts: Returning to the Historical Roots of the Penalty Doctrine*, 39 EMORY L.J. 267 (1990); Scott M. Tyler, *No (Easy) Way Out: "Liquidating" Stipulated Damages for Contractor Delay in Public Construction Contracts*, 44 DUKE L.J. 357 (1994).

185. Coldwell et al., *supra* note 184, at 211 (emphasis added).

Excessive liquidated damages provisions are generally deemed unenforceable because they essentially create a penalty for breaching the contract, which is not the true purpose behind enforcing liquidated damages.¹⁸⁶ Instead, the purpose is to promote good faith dealings, to prevent inequality between bargaining parties, and to provide fair, certain recoveries.¹⁸⁷

Liquidated damages in the form egg freezing contract could be broken into two subsections: (1) “*Damages to be Recovered by Patient;*” and (2) “*Damages to be Recovered by Clinic.*” Subsection (1)(a) should list amounts to be paid from the clinic to the patient in the event that the clinic’s negligent, grossly negligent, or intentional acts lead to the patient’s inability to use her cryopreserved oocytes¹⁸⁸ (e.g., \$10,000 per unusable or wrongly disposed of oocyte, plus the reasonable costs and fees that patient expended on the cryopreservation of that oocyte). Subsection (1)(b) should state the amounts to be paid from the clinic to the patient if the patient’s oocytes are wrongly (whether accidentally or intentionally) implanted in the wrong woman, or wrongly disposed of (e.g., \$15,000 per wrongly used or wrongly disposed of oocyte). A provision may cap all of the patient’s (or her heir’s or estate’s) recovery, by providing that she may only recover under section (1)(a) or (1)(b), whichever amount is greater. The agreement should specifically state that this provision caps *all* damages, including recovery for the loss of ability to procreate, pain and suffering, and any potential future amounts not currently contemplated.¹⁸⁹

Subsection (2) should specifically address damages that the patient will be expected to owe the clinic if she defaults on storage payment, especially if she receives a discount that is contingent on future acts. For example:

If PATIENT receives a discount on services (e.g., oocyte preservation and/or oocyte storage) on the condition that PATIENT also agrees to use CLINIC for future services (e.g., for future IVF treatments), or agrees to donate extra eggs in the future, and PATIENT ultimately

186. See Coopersmith, *supra* note 184, at 268.

187. *Id.*

188. See, e.g., *Hebert v. Ochsner Fertility Clinic*, 102 So. 3d 913, 915–16 (La. Ct. App. 2012) (illustrating, similarly, how fertility clinic negligence led to patients’ inability to use their cryopreserved embryos).

189. See, e.g., *Contract Provisions Can Limit Liability for Damages, If Properly Drafted*, NOWAK & STAUCH, <http://www.ns-law.net/Contract-provisions-can-limit-liability-for-damages-if-properly-drafted.shtml> (last visited Mar. 9, 2015) (“By including a limited liability clause, a company seeks to cap the amount of damages that may be recovered in any subsequent claim based on the subject of the contract.”).

decides to use a different clinic for future services, or does not donate her extra eggs, contrary to the conditional agreement, PATIENT shall pay CLINIC 105% of the amount of money that she originally saved, plus interest on the amount of money that she originally saved, in the amount of ___ %.

While this provision sets up clear guidelines that ideally will be enforced if breach occurs, it is critical to note that clinics are better off avoiding discounts contingent upon future performance. Instead, if clinics choose to offer discounts, they should promote savings that are applied up front. For example, “If you undergo three rounds of egg freezing, you will receive a 20% discount on the third round,” or “Pay for two years of storage costs up front and receive the first three months, free.” These schemes avoid the issue of clinics holding patients’ genetic materials “hostage” while patients struggle to pay back discounts that they originally received, even decades earlier, under drastically different circumstances.¹⁹⁰ In the event that discounts *are* offered that are contingent on future acts, the form contract should require the inclusion of provisions for liquidated damages.

E. SUGGESTIONS FOR IMPLEMENTATION

Clinics may be concerned that if statutes require the use of standard egg freezing contracts, they may face an extra financial burden. The use of standard egg freezing contracts, however, should be relatively inexpensive to implement and will likely save clinics from having to make legally and ethically troublesome (and costly) decisions in the future. In addition, clinics have the ability to create policies that will foster patient confidence, and lead to safer business practices and better health care. For example, clinics might benefit by suggesting that patients take a certain number of days to look over the egg freezing contract on their own time, either at home or with a lawyer. This could potentially shield clinics from liability, and would also encourage women to review their options on their own time frame, in a calm environment, and possibly with legal assistance. Clinics might even stress the importance of patients seeking legal counsel before completing the contract.¹⁹¹ For example, the clinic might include in the contract:

190. See *supra* Part II.A.

191. See, e.g., *Reproductive Material Cryostorage Agreement*, *supra* note 159 (including in the contract: “YOU ARE ADVISED TO CONSULT WITH YOUR ATTORNEY Our forms . . . [do] not constitute providing any legal advice”).

PATIENT understands that CLINIC strongly urges her to independently consult with an attorney knowledgeable about assisted reproductive technology.

____ [PATIENT INITIALS] I understand that it is recommended that I seek independent legal advice before signing this Agreement.

____ [PATIENT INITIALS, IF APPLICABLE] I have, in fact, sought independent legal counsel regarding oocyte cryopreservation, and have reviewed this Agreement with an attorney.

Clinics also have the ability to determine how they will provide women with the opportunity to update or modify their preferences once patients have completed the contract and frozen their eggs. An initial contract will not necessarily prevent disputes if women cannot revise their preferences over a potentially long period of time, while their eggs are in storage. If information is accessible to patients, indicating how they can update their preferences, both clinics and women freezing their eggs will benefit. The clinic may, for example, require written amendments, or require an entirely new agreement to be completed and signed.

Finally, the standard form contracts should be viewed as setting a floor for the types of information that women freezing their eggs should be provided with before undergoing the procedure. Clinics should consider on an individual basis how they may tailor, implement, improve, and explain the egg freezing contract to patients, to best address their patients' needs and concerns.¹⁹² This in turn will reflect particular clinics' practices, and prevent against disputes, ambiguity, and unconscionable outcomes.

F. THE FEASIBILITY OF STATE LEVEL, CONTRACT-BASED REGULATION

There are certainly arguments that can be made against the abovementioned solution. Perhaps no steps should be taken

192. Allowing clinics to add to the form contract presents some risk that additions would negate the benefits originally produced by the mandated provisions. However, the benefits likely outweigh potential risks. If the form contract presents a floor, clinics can add particularly relevant contractual provisions for certain patient groups (e.g., based on patients' age group, patients' prior infertility issues, pending cancer treatment, clinic location, etc.). Mandating that clinics include all potentially relevant information in a single, one-size-fits-all contract would likely interfere with providing informed consent. It would create more confusion and delay, which can occur in contracts that read: "If you answered YES to Question 2, please proceed to Question 3. If you answered NO to Question 2, please skip ahead to Question 4." Thus, a form contract that sets the floor is ideal.

to encourage egg freezing, as they may merely provide women with “false hope,” or inappropriately insinuate either that women cannot be “good employee[s] without delaying [motherhood],” or that they must freeze their eggs or future infertility will somehow be their “fault.”¹⁹³ Keeping in mind, though, that ASRM, the most influential body overseeing reproductive medicine in the United States, has heralded egg freezing as an “exciting” new technology, women are increasingly rushing to freeze their eggs.¹⁹⁴ Thus, assuming that some sort of legal action should be taken to safeguard women and fertility clinics as this technology takes off, state-based mandatory form contracts are a promisingly feasible solution.

First, contracts have already been used to protect the interests of patients and fertility clinics.¹⁹⁵ They are a familiar tool for working out both legally and ethically complex issues, while memorializing parties’ understanding and intent. Second, states have historically used form contracts to set minimal requirements, both within and beyond the medical sphere.¹⁹⁶ Third, the form contract suggested in this Note would benefit both patients and fertility clinics, serving to prevent costly and morally troubling disputes from arising. Clinics will have the flexibility to tailor contracts to fit their needs, while maintaining key safeguards set out by legislatures, and patients will be better informed before investing their bodies, minds, and savings in egg freezing. Lastly, egg freezing is unlikely to inspire particularly charged political disagreement; it is much more akin to the benign issue of freezing sperm than it is to the controversial issue of freezing embryos.¹⁹⁷

Ultimately, it is no longer appropriate for egg freezing to proliferate without implementing legal safeguards. Mandatory form contracts provide an expedient, manageable, and flexible solution that will prevent conflict without prohibiting growth.

193. Seema Mohapatra, *Using Egg Freezing To Extend the Biological Clock: Fertility Insurance or False Hope?*, 8 HARV. L. & POL’Y REV., 381, 403 (2014).

194. ASRM Lifts Experimental Label, *supra* note 30.

195. *See supra* note 159 (describing an IVF contract, gestational surrogacy agreement, and sperm cryopreservation contract).

196. *See supra* notes 110, 132, 161 and accompanying text.

197. *See supra* note 14 and accompanying text.

CONCLUSION

Whether egg freezing should be celebrated as “a really good insurance policy,”¹⁹⁸ or condemned as a risky “shot in the dark,”¹⁹⁹ the reality is that many women are embracing the new assisted reproductive technology to delay pregnancy.²⁰⁰ Despite growing popularity, egg freezing remains startlingly unregulated, leaving patients and clinics vulnerable. Consequently, this Note urges states to enact statutes that mandate fertility clinics’ use of a specific form contract for egg freezing.

The form contract should be drafted specifically to avoid unanticipated and unethical outcomes, and should clearly address: (1) patients’ risks and obligations; (2) patients’ wishes regarding disposition of extra, abandoned, or pre-deceased eggs; and (3) liquidated damages to be paid in the event of a breach of contract. Requiring the use of a specialized form contract will provide much-needed structure to the largely unregulated area of ART and egg freezing. The regulation will bring uniformity and predictability, which will benefit patients, clinics, and society more generally, by helping prevent legal and ethical controversies from arising as egg freezing continues to expand.

198. Alison Motluk, *Growth of Egg Freezing Blurs ‘Experimental’ Label*, NATURE (Aug. 23, 2011), <http://www.nature.com/news/2011/110823/full/476382a.html>.

199. *Id.*

200. *See generally* RICHARDS, *supra* note 1.