Legal Issues Related to Parenthood After Cancer

Susan L. Crockin

Cancer and procreation raise a host of novel legal issues involving the rights of those trying to create families after cancer treatment and any resulting children, as well as the responsibilities of those who assist them. Recent court decisions, although neither consistent nor plentiful, highlight the emerging legal issues for patients, providers, and offspring. This article explores a number of legal issues related to cancer and parenthood, including: 1) patients’ cryopreservation of sperm, eggs, or embryos and subsequent access to and use by them or their former partners; 2) fertility preservation in minor patients; 3) posthumous reproduction and legal parentage issues for children born from cryopreserved embryos or gametes; 4) wrongful life or wrongful birth claims of children born following their parents’ cancer treatments; 5) access to, and discrimination in, medical treatment or alternative family-building options; and 6) professional responsibility and liability for providers relating to the potential fertility impact of cancer treatment. The limited, evolving court decisions, through the application of legal principles such as negligence, malpractice, discrimination, and parentage principles, provide some guidance for patients, providers, and policymakers in approaching the unique challenges presented by fertility preservation in the context of cancer treatments. [J Natl Cancer Inst 2005;97:111–3]

Parenthood following the diagnosis or treatment of cancer raises a host of new legal issues involving fertility preservation before, during, and sometimes after the reproductive years. Fertility preservation may involve protecting reproductive organs and capability or cryopreserving reproductive tissue, gametes, or embryos. When fertility cannot be preserved, cancer patients seeking to become parents may confront other legal issues regarding access to third-party reproductive services or adoption. A small but growing number of courts have ruled on novel issues of posthumous parenthood and advance directives. The limited case law (court decisions) available provides some guidance as to how patients, providers, and policymakers can approach and meet these unique challenges.

Preserving Male Fertility

While relatively common, sperm collection and freezing for male cancer patients nonetheless requires consideration of significant legal issues. These include obtaining additional informed consent of the patient regarding any fertility preservation treatment, protecting the legal status of any resulting children, and avoiding potential liability for the medical provider in connection with failing to offer or advise patients of their fertility preservation options or in the handling of frozen samples.

The standard elements of informed consent are well established: disclosure, comprehension, voluntariness, competence, and consent (1). The need for informed consent beyond a cancer patient’s current treatment arises first in the context of discussing and offering fertility preservation options when a medical provider recognizes that the patient’s medical condition or course of treatment may impact his or her fertility.

Informed consent in the context of cancer treatments that may affect fertility may also be complicated by the frequent absence of therapeutically meaningful treatment options, the time pressure patients may face in making treatment decisions, and the effect that these may have on patients’ abilities to comprehend choices and make decisions voluntarily. Good practice dictates creating a written record of informed consent, and courts frequently look for such written documentation as a reflection of the informed consent process.

According to a 2002 report, out of 201 male cancer patients diagnosed between ages 14 and 40, 60% were warned of the risk of infertility and 51% were given the option to bank sperm (2). While the failure to accurately explain the risks of compromised fertility or to offer available measures to protect fertility may potentially give rise to claims by patients against the medical provider for negligence or malpractice, the author is not aware of any such reported cases to date. Nonetheless, prudent and ethical practice should require consideration of these risks as part of the informed consent process as reflected in written documentation, which may need to be drafted or supplemented to create a clear and accurate written record of informed consent on this specific issue.

The capacity to freeze and store sperm indefinitely also gives rise to unique informed consent issues with respect to sperm cryopreservation, as separate and apart from any cancer treatments. In addition to addressing a patient’s own future use of his sperm during his life, such informed consent documents should also include any consent for use by a specific partner after the patient’s death, along with the patient’s intended legal relationship to any resulting child.

Several years after freezing, the patient may no longer be alive when a medical provider or sperm bank is presented with a request by the patient’s former spouse or partner to release the sperm for procreative use. These issues, which clearly contemplate future events, should be included in the written consent forms and presented to patients at the time of banking to ensure that all options are disclosed and considered and any choices (which should be subject to a change of mind as with any consent issue) recorded at that point in the process. The more specific and comprehensive the consent document executed by the patient during his life, the less likely it will be that disputes will arise among former partners, other family members, medical providers, or sperm banks that might require court involvement for resolution. Additional documentation in the form of agreements between the patient and any partner or future recipient of his genetic material may also be advisable, and patients may benefit from independent legal counsel to advise them on these issues.

Correspondence to: Susan L. Crockin, Esq., Law Office of Susan L. Crockin, 29 Crafts St., Ste. 500 Newton, MA 02460 (e-mail: susan.crockin@crockinlaw.com).
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survivor benefits have arisen in the context of inheritance and federal benefits. In the United States, a child’s entitlement to federal survivor benefits turns on the child’s right to inherit from the deceased under the particular state’s inheritance laws. At least four states have published court decisions: Louisiana, New Jersey, Arizona, and Massachusetts (6). The legal analysis in each case was the same: The court looked to each state’s law on inheritance to determine if the child had a right to inherit, and thereby was entitled to, federal benefits. In some states, the right to inherit requires discerning the decedent’s intent to procreate versus to not procreate and necessitates an evidentiary hearing. This reinforces the advisability of utilizing or drafting explicit written consent forms in all situations that may involve posthumous procreation.

Model legislation has recently been proposed to clarify and bring uniformity to paternity determinations for posthumously conceived children. The most current model Uniform Parentage Act (2002), which is available to individual legislatures to enact as the law of their state, includes a relevant provision: “If a spouse dies before placement of eggs, sperm or embryos, the deceased spouse is not a parent of the resulting child unless the deceased spouse consented in a record that if assisted reproduction were to occur after death, the deceased spouse would be a parent of the child.” Individual states may choose to enact this as part of their state law in order to clarify that consent must be in writing and must explicitly include the intent to parent. Potential legal disputes may nonetheless continue to arise in states that previously had not enacted, or do not enact, this model legislation, as well as in situations involving unmarried parents or indefinite time periods before conception or where there are competing claims by other potential heirs.

**Preserving Female Fertility**

Once medical advances more reliably enable fertility preservation for women through freezing and thawing eggs or ovarian tissue, many of the same legal issues now facing male patients will apply to women as well. Until that time, options to preserve female fertility after cancer treatment are more limited and, other than currently experimental procedures, will typically include creating and freezing fertilized eggs or embryos.

In either case, informed consent principles apply equally to men and women, both of whom should be fully informed as to the effects of treatment on their fertility and the options available to preserve the possibility of genetic or biologic parenthood. The experimental nature of egg and ovarian tissue freezing should be fully explained, along with the uncertainty of the ultimate legal consequences or hurdles concerning use of any such frozen genetic material by patients or surviving family members. Informed consent documents should clearly reflect the patient’s intentions, as well as the attendant medical and legal uncertainties. As with sperm preservation, independent legal advice and supplemental documentation for the patient outside the medical program is likely to be beneficial.

Given the experimental nature of freezing eggs, women may be more likely to elect to create and freeze embryos instead. While medical certainty improves with this option, the legal issues become more complicated. In the most traditional, straightforward scenario, where a married couple creates embryos from their own genetic material, freezes them, and later uses them for the wife to bear a child, there may be few legal complications. However, less traditional or unforeseen future circumstances may give rise to more legal uncertainty, such as if a couple divorces or one partner dies or if the couple was never married.

The majority of judicial decisions relating to frozen embryos have involved divorcing couples’ disagreements over the disposition of their embryos. Courts in various states have analyzed the embryo disposition documents executed by the patients at the time their embryos were frozen, usually without addressing whether the documents were considered contracts or informed consent documents. While not completely consistent, courts have generally found such documents enforceable where the choice selected in the document did not involve procreation (such as to discard the embryos or use them for research) (7). Prior choices to allow procreation by one former spouse or a third party have not been enforced by courts over a contemporaneous objection by the other embryo creator (8). Some courts have construed this as unconstitutional “forced procreation” in refusing to allow it. Thus, cancer patients considering freezing embryos will want to understand that unexpected future circumstances may create new legal impediments and their ability to use the frozen embryos to have a child may not be guaranteed.

Another option for a woman unable to procreate with her own eggs as a result of her earlier cancer treatments may be to use donated eggs to create embryos which are then transferred to her own uterus to carry and allow her to give birth to the child. Only a handful of states have enacted egg donation statutes, and very little case law exists. The laws that are in place generally provide that an egg donor has no parental rights or obligations to any resulting child. Many states that do not have egg donation statutes have sperm donation statutes, which may arguably apply to any gamete donors under equal protection theories and principles. Any patient considering egg donation would be well advised to consult experienced legal counsel for advice about the relevant law in the patient’s state.

Lastly, posthumous motherhood remains at least a theoretical future possibility if eggs or embryos are frozen before death and later transferred to a gestational carrier to carry and give birth to the child. Many of the same issues discussed earlier with respect to
posthumous paternity would apply. Additional legal complications are also likely since the law in most states presumes that a woman who gives birth to a child is the mother of the child. The use of a third party’s assistance would almost certainly necessitate legal steps to attempt to establish the legal maternity of the deceased genetic mother and the outcome would be dependent on the law and public policy then current in the applicable jurisdiction.

**Preserving Children’s Fertility**

Even though the majority of child cancer patients remain fertile, medical providers nevertheless need to be cognizant of the available fertility preservation options and which preservation options involve experimental, rather than proven, techniques. This information should be provided to minor patients and/or their parents as part of the informed consent process, in connection with both the risks involved in any cancer treatments themselves and the availability of any fertility preservation treatments.

The extent to which an informed consent process for minor patients needs to involve the minor’s parents or guardians may vary depending on both the minor’s age and the law of the relevant jurisdiction; all applicable laws as well as practice and ethical standards should be followed. The author is not aware of any legal cases brought by a minor patient based on infertility caused by their cancer treatment; however, liability for failing to inform, offer, or perform a fertility preservation treatment would seem supportive on general malpractice principles, subject to any defenses by the professionals involved.

Claims brought by children born with disabilities or other medical impairments in the context of “wrongful life” cases have generally been unsuccessful. In this type of case, a child (or his representative) typically alleges that, but for a medical provider’s negligence, they would not have been born. Claims for wrongful life have most often been brought against physicians who performed or failed to offer or perform prenatal testing or preconception genetic testing, hospitals or medical practices that employed such physicians, and genetics laboratories that provided or failed to provide the testing services. While every state has its own body of law (either case law or statutes), the majority of states reject such claims and refuse to weigh the value of life with an impairment against nonexistence. In the absence of directly relevant legal precedent, it may be that, at least with respect to a claim by a child alleging medical negligence in connection with their or their parent’s fertility preservation during cancer treatment that preserved their life, courts may apply the same legal analysis.

**Potential Provider Liability**

Medical professionals treating current or former cancer patients face potential liability in a variety of areas. In the initial stages of cancer treatment, as noted earlier, physicians should be certain to provide accurate, complete, and current information on fertility-related issues to patients as part of the informed consent process and to comprehensively document that process to avoid any later claims of negligence for failure to do so.

Medical professionals, fertility clinics, and adoption professionals working with infertile former cancer patients may also face legal liability relating to choices to provide or deny services to a particular individual. The Americans with Disabilities Act (ADA) (9) is a federal statute enacted to prevent disability discrimination in the terms and conditions of employment and benefits by certain defendants under certain circumstances, such as insurers, large employers, and places of public accommodation. A cancer patient or survivor found to have a “disability” under the ADA may therefore be able to bring discrimination claims against providers who refuse treatment to him or her in possible violation of the federal law. State antidiscrimination laws may also exist and apply. While a comprehensive analysis of state and federal discrimination laws is beyond the scope of this article, providers should be cognizant of these potential issues and seek legal advice if treatment or service decisions are questionable.

Providers who store sperm, eggs, ovarian tissue, or embryos for patients also have potential liability for damages in the event of loss or destruction of the genetic material. This concern, while significant for all infertility patients, may involve considerably greater damages for cancer patients who may be unable to replace the lost material, and such claims have been filed.

Lastly, providers may face claims brought against them by children if efforts to preserve the fertility of their parents result in a genetic or other impairment in the child. As noted above, negligence-based “wrongful life” claims have been rejected by the majority of states on the basis that any life, even if impaired, cannot be considered a legally recognizable injury. In contrast, “wrongful birth” claims, which are brought by parents, have been generally successful. Damages are typically intended to address, and are limited to, any extraordinary medical costs associated with the child’s rearing. The success of this type of claim will depend on the relevant state’s laws and evolving public policy.

Both evolving and variable laws make definitive legal guidelines in this area impossible. It is hoped that this discussion of legal issues surrounding fertility and cancer is of use to patients affected by the disease and still hoping to achieve parenthood and to those who treat them.

**References**


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(5) Private consultations with the author of various prospective recipients, hospitals, and ART programs.

(6) Hart v. Charter, No. 94-3944 (E.D. La. dismissed March 18, 1996); In re Estate of Kolacy, MRS-P-14-00 (6/20/00); Woodward v. Comm’r of Soc. Sec., 760 N.E.2d 257 (Mass. 2002); Gillett-Netting v. Barnhart, 371 F 3d 593 (9th Cir. Ariz. 2004).

