Managing issues for fertility patients who are separating or getting divorced

by Natalie Gamble

This seems to be a really hot topic at NGA Law at the moment, with our team getting regular queries from counsellors and other clinic staff grappling with issues which arise when patients separate or get divorced. Sometimes the queries are about understanding patients' rights in relation to stored embryos or gametes. Sometimes they concern consent and legal parenthood, for example where a married woman wants to access treatment without her soon-to-be ex husband's involvement.

Embryos and gametes in storage

Where embryos are in storage which have been created with both partners' gametes, they can only remain stored while both partners consent. If a couple separates and one partner notifies the clinic (in writing) that he or she withdraws consent to storage, then a set of statutory procedural rules kicks in. The other gamete provider must be notified of the withdrawal of consent and (unless he or she agrees to their disposal) the embryos must be kept safe for a 12 month cooling off period. During this time, there is no option to use the embryos in treatment (unless both partners agree) and if consent to storage remains withdrawn at the end of the cooling off period the embryos must be destroyed.

The rules are slightly different where embryos have been created with donor eggs or donor sperm. Only the gamete provider has the formal legal right to withdraw consent to storage. However, an intended recipient who is not a gamete provider must still be notified of a withdrawal of consent to storage, and the cooling off period applies in the same way as if he or she had provided gametes.

The pause which the statutory cooling off period creates is designed to give everyone the chance to draw breath and to think things through before irrevocable steps are taken. We have been involved in a few cases (not many) in which careful discussion has enabled embryos to be used by one partner by agreement following an initial withdrawal of consent. However, sensitive discussions to enable this always take time and care. Sadly, we are often contacted by patients for legal advice only when the cooling off period is about to expire and by then it is far too late to have any productive discussions. Helping patients to understand the importance of exploring their options promptly and not burying their heads in the sand can be absolutely critical.

In cases where neither partner is a gamete provider, the rights of one partner to prevent the other using stored embryos or gametes are much less clear cut. For example women in a same-sex relationship might conceive a child together and keep donor sperm in storage for future siblings, with the possibility of one or either of them carrying a future pregnancy. If they then separate, and perhaps form new relationships, questions can arise over who should be able to use the donor sperm and whose permission is needed. The previous birth mother? Her old partner? Her new partner? Since neither patient is a gamete provider in these circumstances, the law does not provide explicitly for what should happen, and clinics need to decide how to respond on a case-by-case basis. The issues to consider include ethics, the welfare of the child who will be born (as well as of any existing children), the clinic's contractual agreements with their patients, and the limits on the numbers of different families which can be created from the same donor. There is as yet limited case law dealing with it, but it is only a matter of time before a clinic's decision in a case like this is challenged in court, and the reasonableness of decisions made is likely to be a key issue.

Legal parenthood issues

The other big issue involving patients who are separated is legal parenthood. The most common scenario is where a woman wants to pursue having a family on her own with donor sperm even though she is still married. Can she do so without her husband's consent? Does the clinic have a duty to contact her husband to explore his views, and will he be the legal father of any child conceived?

The law says that where a woman conceiving with donor sperm is married, her husband will be the legal father 'unless it is shown' he does not consent. The same applies to same-sex spouses and civil partners. In practice that means that to treat a patient as a single woman in a case where the spouse or civil partner is not involved, a clinic needs to satisfy itself that there is enough evidence to show a lack of consent. HFEA Form LC (lack of consent) deals with this and enables the woman to explain the circumstances and set out the reasons why her spouse does not consent to her treatment. Only she needs to complete this form and, provided the clinic is satisfied on the facts set out in it that her spouse is not involved and not consenting, then it should be enough to enable treatment to proceed (if there is any doubt about this, then legal advice is sensible). There is then no need to

contact the spouse, and doing so could be a breach of confidentiality so clinics should take care.

Given their work on the frontline of supporting patients, counsellors and nurses are often the ones grappling with these kinds of difficult legal questions. It is important to understand that all these scenarios are complex and the law may not be straightforward. They are also situations which are likely to grow in frequency and complexity with more patients in more complex relationship situations all the time.

Natalie Gamble is the founder of NGA Law, the UK's first specialist fertility law team

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All about Fertility - helping people to help themselves

by Kevin McEleny and Eleanor Stevenson

Fertility services are typically female-focused, meaning that care is geared towards the female partner. Additionally, most of the health care professionals who work in the fertility field have a Women's Health background. This is perhaps not unreasonable as most fertility treatments are focused on women. However there is growing recognition that men can feel sidelined during the process and that their needs are not always being met by clinic staff. I (Kevin) have worked for some years now as a Fertility Urologist. Week in and week out I would see couples and explain that what they had always taken for granted may not happen ever and certainly not in the way that they thought it would. Men reacted to this with shock anger, sadness and everything else that you might expect, but what I found surprising was why so few of them (despite repeated recommendations) would opt to see a counsellor. Instead they would all reply that 'it wasn't for them', or that they 'didn't need it', as though they perceived that it was something only for men who were suicidal.

I pondered on this and found that in fact, very little had been written on the male fertility experience and wondered if what we were offering wasn't, for some, quite what was needed. Work carried out in my unit explored how men dealt with the news and how for many, the prior lack of an understanding of reproductive health, compounded by the lack of a clear diagnosis and the uncertainty of outcome led to a lot of anxiety.

Eleanor and I met at the ESHRE annual scientific meeting in London in 2013. (Eleanor is a Professor of Nursing and a fertility researcher) We discussed this issue at length, recognising that there was much to be done to help patients. Following the meeting, we set up a research study that looked at both men and their partners affected by severe male factor infertility in both the UK and the US. Some of the results were expected (all groups were severely affected by the process) and whilst there were some differences, particularly due to the impact of finances on decision-making in the US group and the shorter time to treatment when compared to the UK patients who were treated on the NHS, the experience for men on both sides of the Atlantic was the same for some important areas. Most couples felt that the experience brought them closer, most men were confused by the fact that they couldn't be given a clear diagnosis and also, were worried that the information that they were getting was accurate and unbiased, particularly in regard to information obtained by internet searches.

Most striking of all though, was the finding that male patients did not want to disclose their situation to others and some also did not want to let their partners disclose to others. This means that for some couples, not only did the male partner lack social support, which left them being completely reliant on the female partner, but the male partner also limited the female partner's access to support from family and friends. This meant that some women felt that they had to support themselves and their partner unaided. In general, these men were not