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# **Fathers Anonymous: Beyond the Best Interests of the Sperm Donor**

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GEORGE J. ANNAS\*

Alex Haley concludes his international best seller, *Roots*, with the burial of his father in Little Rock, Arkansas. Walking away from the graveside he ponders the past generations, observing "I feel that they *do* watch and guide." The book inspired whole industries devoted to the development of family trees, and locating one's "roots" has become somewhat of an obsession with many. Because of the current secrecy surrounding the practice of Artificial Insemination Donor (AID), there are an estimated 250,000 children conceived by AID (at the rate of 6-10,000 annually in the United States) who will never be able to find their biological roots. There is almost no data available on these children, their psychological development, or their family life. The entire procedure has been shrouded in secrecy that is primarily justified by fear of potential legal consequences should the fact of AID be discovered.

It is the thesis of this brief paper that most of the informal "policies" concerning AID as it is presently practiced in the United States have come about because of an exaggeration of potential legal pitfalls and a failure to pay sufficient attention to the best interests of the AID child. Accordingly it is at least premature either to legislate "standards" or use AID as a "model" for In vitro-Fertilization. Most commentary on AID has concentrated on theoretical legal problems without paying attention to real psychological problems. Indeed, most of the legal literature reads

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like an answer to the following exercise: "Review all of the case law and statutes relating to AID and discuss all possible lawsuits that any participant or product of AID might have against anyone. If time permits, suggest a statutory scheme that might minimize these problems."<sup>1</sup> Rather than add another answer to this interesting but tangential exercise, this paper will review the rationale for AID, the manner in which donors are selected, and the way records are kept, with a view toward developing policies and practices that maximize the best interests of the child.<sup>2</sup>

### Why Use AID?

The question of indications is almost never addressed in the medical or legal literature beyond assuming it is almost exclusively a "treatment for husband infertility." To find a model for AID one must consult the social satirists of the twentieth century, and the writings of philosophers. In George Orwell's *1984* reproduction by artificial insemination (although not necessarily by donor) was mandatory as part of a program to remove all pleasure from sexual intercourse. Other measures enacted toward this end were Party approval of all marriages (always refused if the couple was physically attracted toward each other) and promotion of the view that sexual intercourse should be seen "as a slightly disgusting minor operation, like having an enema." All children were raised in public institutions.

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1. See, e.g., Healey, J. M., *Legal Aspects of Artificial Insemination by Donor and Paternity Testing* in *GENETICS AND THE LAW* 203-218 (A. Milunsky & G. J. Annas, ed. 1976); Smith, G. P., *Through a Test Tube Darkly: Artificial Insemination and the Law*, 67 MICH. L. REV. 127 (1968); Note, *Artificial Insemination: A Parvenu Intrudes on Ancient Law*, 58 YALE L.J. 426 (1949); Note, *Social and Legal Aspects of Human Artificial Insemination*, 1965 WIS. L. REV. 859; Commentary, *Artificial Insemination: Problems, Policies and Proposals*, 26 ALA. L. REV. 120 (1973); Note, *The Legal Status of Artificial Insemination: A Need For Policy Formulation*, 19 DRAKE L. REV. 409 (1970); Wadlington, W., *Artificial Insemination: The Dangers of a Poorly Kept Secret*, 64 NORTHWESTERN UNIV. L. REV. 777 (1970); but see also, Smith, G. P., *A Close Encounter of the First Kind: Artificial Insemination and an Enlightened Judiciary*, 17 J. FAM. LAW 1 (1978).

2. Currently, at least fifteen states have statutes on the books that mention AID (ALASKA STAT. § 20.20.010; ARK. STAT. ANN. Tit. 61, § 141 (c); CAL. CIV. CODE § 216 (West); FLA. STAT. ANN. § 742.11 (West); GA. CODE ANN. Tit. 74 § 101.1; KAN. STAT. Tit. 23 § 123-130; LA. CIV. CODE ANN. Art. 188 (West); MD. ANN. CODE Art. 43, § 556E; N.Y. COM. REL. LAW § 73 (McKinney); N.C. GEN. STAT. § 49A-1; OKLA. STAT. ANN. Tit. 10 § 551-53 (West); OR. REV. STAT. § 677.355-370; TEX. FAM. CODE ANN. Tit. 12, § 12.03 (Vernon); VA. CODE § 64.1-7.1; WASH. REV. CODE ANN. § 26.26.050). All of these statutes specifically provide that the resulting child is the natural child of the recipient's husband provided he has consented to the procedure. Five states require that the consent be filed with a state agency (Kansas, Oklahoma, Georgia, Washington, and Oregon) and six states, either directly or by

Artificial insemination, however, is only one possible consequence, not a cause, of a totalitarian state of the type envisaged by Orwell. In this regard Joseph Fletcher is quite correct in observing that in such a society "the modes of reproduction would be of a relatively minor concern . . . compared to the many human values certain to be destroyed."<sup>3</sup>

AID is taken more seriously, and viewed with more hope than fear, by Aldous Huxley. In *Brave New World Revisited* he writes that every new advance in medicine will "tend to be offset by a corresponding advance in the survival rate of individuals cursed by some genetic insufficiency . . . and with the decline of average healthiness there may well go a decline in average intelligence." Huxley presents one solution to this problem in his view of the ideal society, *Island*. In that society AID is not mandatory, but is in fact used by almost everyone—at least for the third child, and by most couples who decide to have only two, for their second child. The rationale is the one previously expounded by Huxley: to increase the general IQ of the population instead of allowing it to gradually decrease. In the words of his character, Vijaya:

In the early days there were a good many conscientious objectors. But now the advantages of AI have been so clearly demonstrated, most married couples feel that it's more moral to take a shot at having a child of superior quality than to run the risk of slavishly reproducing whatever quirks and defects may happen to run in the husband's family . . . we have a central bank of superior stocks. Superior stocks of every variety of physique and temperament.<sup>4</sup>

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implication, limit the practice of AID to physicians (California, Oklahoma, Virginia, Washington, Alaska, and Oregon). Only two states specifically provide that the sperm donor is not the father of the child. Oregon has the only criminal statute, making it a Class C misdemeanor, punishable by 30 days in jail, for anyone but a physician to select sperm donors, and for a donor to provide semen if he "(1) has any disease or defect known to him to be transmissible by genes; or (2) knows or has reason to know he has a venereal disease." The only state supreme court to ever rule on AID held a consenting husband liable for child support. *People v. Sorensen*, 68 Cal. 2d 280, 66 Cal. Rptr. 7, 437 P.2d 495 (1968). On the medical aspects of AID see Strickler, R.C., Keller, D.W., Warren, J.C., *Artificial Insemination with Fresh Donor Semen*, 293 NEW ENG. J. MED. 848 (1975); Chong, A.P., Jaymor, M.L., *Sixteen Years' Experience with Therapeutic Donor Insemination*, 26 FERTILITY AND STERILITY 791 (1975); Dixon, R.E., Buttram, V.C., *Artificial Insemination Using Donor Semen: A Review of 171 Cases*, 27 FERTILITY AND STERILITY 130 (1976); Guttmacher, A.F., *Artificial Insemination* 18 DEPAUL L. REV. 566 (1969); Jackson, M.C.N., Richardson, D.W., *The Use of Fresh and Frozen Semen in Human Artificial Insemination*, 9 J. BIOSOC. SCI. 251 (1977); Goss, D., *Current Status of Artificial Insemination with Donor Semen*, 122 AM. J. OBSTET./GYN. 246 (1975); David, A., Avidan, D., *Artificial Insemination Donor: Clinical and Psychological Aspects*, 27 FERTILITY AND STERILITY 528 (1976).

3. FLETCHER, J., *MORALS AND MEDICINE* 134 (1954).

4. HUXLEY, A., *ISLAND* 193-194 (1972).

The problems of selecting such "superior stock" have been discussed, but not resolved. H.J. Muller, for example, argued in 1935 that no intelligent and morally sensitive woman would refuse to bear a child of Lenin—while in later versions Lenin is omitted and Einstein, Pasteur, Descartes, Leonardo, and Lincoln are nominated.<sup>5</sup> Theodosius Dobzhansky has noted that "Muller's implied assumption that there is, or can be, *the* ideal human genotype which it is desirable to bestow upon everybody, is not only unappealing but almost certainly wrong—it is human diversity that acted as a leaven of creative effort in the past and will so act in the future."<sup>6</sup> This is, of course, simply an axiom of evolution and natural selection. The problem of making conscious choices is that we cannot accurately predict what traits future generations will require for survival.

Sociobiologists have recently identified another genetic "truth" in the animal kingdom which may have relevance to the AID situation in man, i.e., that animals will try to maximize the spread of their genes. In the words of Richard Dawkins, "Ideally what an individual would 'like' (I don't mean physically enjoy, although he might) would be to copulate with as many members of the opposite sex as possible, leaving the partner in each case to bring up the children."<sup>7</sup>

In this way the genes of the father are distributed maximally. AID and sperm banking remove the previous physical limitations of such a strategy from the human animal.

On the moral plane AID has been condemned by the Catholic Church (primarily because masturbation is viewed as an unnatural and evil act), and by such writers as Paul Ramsey (on the basis that it is "an exercise of illicit dominion over man").<sup>8</sup> On the other hand, Joseph Fletcher has vigorously defended the morality of AID. He has argued first that there is ample precedent for the practice in the Old Testament (e.g., Deuteronomy 25:5-6, and Genesis 30:1-13) and that it is a licit means toward a highly desirable end (parenthood for the otherwise sterile couple). His conclusions are based on his belief that fidelity of marriage is a personal bond be-

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5. RAMSEY, P., *FABRICATED MAN* 49 (1970).

6. *Id.* at 53.

7. DAWKINS, R., *THE SELFISH GENE* 151 (1976).

8. RAMSEY, P., *supra* note 5 at 48.

tween husband and wife (not primarily a legal contract), and that parenthood is a moral relationship with children, not a material or merely physical one.<sup>9</sup>

Until early this year it was impossible to even speculate with any authority on the indications for AID in contemporary medical practice. In March of 1979, however, Curie-Cohen, Luttrell and Shapiro of the University of Wisconsin published their questionnaire survey of AID practitioners. They located 379 practitioners of AID who accounted for approximately 3,576 births in 1977 and who responded to a series of questions about their practices. The results of this survey provide the only data in existence on the current practice of AID in this country, and the survey, which will be referred to as the "Curie-Cohen survey," will be cited extensively in this paper.<sup>10</sup>

As to indications, their survey findings are instructive: 95 percent of the respondents reported that their primary reason for using AID was for husband infertility. However, at least 40 percent had used AID for other reasons: one-third had used it for fertile couples when the husband feared transmission of a genetic disease (similar to Huxley's *Island* rationale), and almost 10 percent had used it to fertilize single women (removing sex from reproduction altogether, and highlighting fears of many moralists). Therefore, whatever one views as society's rationale for permitting AID to continue, it must be recognized that a large percentage of practitioners are using it for eugenic purposes. In addition, those that use it to fertilize single women or members of lesbian couples are engaged in a practice that most of society would probably condemn because of its implications for the child and the family as a basic unit of society.

The issue of indications needs to be faced directly and clearly by commentators and practitioners alike so that an informed consensus can be reached. It is worth observing, however, that current rationale for servicing the infertile couple, the lesbian couple, and single women all rest primarily on one's definition of the best interests of the couple or prospective parent, and not on the best interests of the child. While many physicians "screen" recipients to determine if their motives are proper and their marriage "stable,"

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9. FLETCHER, J., *supra* note 3, at 116-122.

10. Curie-Cohen, M., Luttrell, L., and Shapiro, S., *Current Practice of Artificial Insemination by Donor in the United States*, 300 NEW ENG. J. MED. 585 (1979).

there is no evidence that they are competent to make these judgments. This is not necessarily to say that AID should not be available to couples in which the husband is sterile: it is only to highlight the fact that we have no data concerning how children born into this situation fare, and to suggest that it is irresponsible to continue the practice of AID for this indication without attempting to gather such data.

### **Donor Selection**

Donor selection may be the most difficult issue in AID, but legal considerations are not controlling. First it should be noted that "donor" is a misnomer. Virtually all respondents in the Curie-Cohen study paid for ejaculates, 90 percent paying from \$20 to \$35 per ejaculate, with 7 percent paying more, up to \$100. Thus a more accurate term would be "sperm vendors." While this distinction may seem trivial, it has legal consequences. For example, it makes no sense to designate the form signed by the "vendor" as a "consent form" since he is not a patient and isn't really consenting to anything. It is a contract in which the sperm vendor agrees to deliver a product for pay. We can debate the elements of the agreement, but most would probably agree that it should spell out the vendor's obligations in terms of his own physical and genetic health, including an accurate family history, the quality of the specimens he is required to produce, the necessity for complete and permanent anonymity of the recipient, and a waiver of any rights in any child resulting from the insemination. In return, the buyer agrees to pay the vendor and protect his anonymity.

The issue of *who* selects the sperm vendor has been given far too little attention. The Curie-Cohen study found two things of interest in this regard. First, 92 percent of practitioners never permit the recipient to select the donor, although the remainder do on rare occasion. Also, 15 percent used frozen semen obtained from sperm banks, and others used sperm from those selected by urologists or other personal associates. The point is that at least in a small minority of cases, someone other than the physician selects the source of the sperm. More significant, however, is the fact that almost all physicians make their own selection, most using medical students. Sixty-two percent used medical students or hospital residents; 10 percent used other university or graduate students; 18

percent used both, and the remaining 10 percent used donors from military academies, husbands of obstetric patients, hospital personnel, and friends.

Physicians in all of these situations are making eugenic decisions—selecting what they consider “superior” genes for AID. In general they have chosen to reproduce themselves (or those in their profession), and this is what sociobiologists like Dawkins would probably have predicted. While this should not surprise us, it should be a cause of concern, since what may be controlling is more than just convenience. Physicians may believe that society needs more individuals with the attributes of physicians, but it is unlikely that society as a whole does. Lawyers would be likely to select law students; geneticists, graduate students in genetics; military personnel, students at the military academies, etc. The point is not trivial. Courts have found in other contexts that physicians have neither the training nor the social warrant to make “quality of life” decisions. In the *Houle* case, for example, a physician’s decision not to treat a defective newborn was overruled on the basis that “the doctor’s qualitative evaluation of the value of the life to be preserved is not legally within the scope of his expertise.” Selecting donors in this manner, rather than matching for characteristics of the husband, for example, seems to be primarily in the best interests of the physician rather than the child, and can probably not be justified. Nor can the argument that medical students know more about genetics than other graduate students stand analysis. They are probably also just as susceptible to monetary influence as are some of the blood sellers described in Richard Tittmuss’s classic study, *The Gift Relationship*. Perhaps national guidelines, developed by a committee made up of a random sample of the population, would be more appropriate.

The Curie-Cohen survey also revealed that even on the basis of simple genetics, physicians administering AID “were not trained for the task” and made many erroneous and inconsistent decisions. Specifically, 80 to 95 percent of all respondents said they would reject a donor if he had one of the following traits, and more than 50 percent of all respondents would reject the same donor if one of these traits appeared in his immediate family: Tay-Sachs, hemophilia, cystic fibrosis, mental retardation, Huntington’s, translocation or trisomy, diabetes, sickle-cell trait, and alkap-

tonuria. This list includes autosomal recessive diseases in which carriers can be identified, and those in which they cannot, dominant, X-linked, and multigenic diseases.

The troubling findings are that the severity and genetic risk of the condition were not reflected in rejection criteria, and that genetic knowledge appears deficient. For example, 71 percent would reject a donor who had hemophilia in his family, even though this X-linked gene could *not* be transmitted unless the donor himself were affected. Additionally, although 92 percent said they would reject a donor with a translocation or trisomy, only 12.5 percent actually examined the donor's karyotype. Similarly, while 95 percent would reject a carrier of Tay-Sachs, fewer than 1 percent actually tested donors for this carrier state. In fact, only 29 percent performed any biochemical tests on donors other than blood typing, and these tests were primarily for communicable diseases. The conclusion must be that while prevention of genetic disease is a goal, it cannot be accomplished by the means currently in use. The findings also raise serious questions about the ability of these physicians to act as genetic counselors, and suggest that other nonmedical professionals may be able to do a better job in delivering AID services in a manner best calculated to maximize the interests of the child.

Since there is almost uniform agreement that certain genetic conditions contraindicate use of a person's sperm for AID, it is likely that a court would find a physician negligent in using such sperm even though few physicians actually test to make sure the sperm vendor is not affected.<sup>11</sup> "There are precautions so imperative that

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11. While there is no specific legal standard for screening sperm donors, when done by a physician the general law of specialists is applicable:

One holding himself out as a specialist should be held to the standard of care and skill of the average member of the profession practicing in the specialty, taking into account the advances in the profession. *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968).

A recent analogous case involved an individual who received two cornea transplants. *Ravenis v. Detroit General Hospital*, 63 Mich. App. 79, 234 N.W.2d 411 (1975). The transplanted corneas turned out to be infected, and caused total and permanent blindness in the recipient. He sued the hospital and the resident who had removed the donor's eyes. The jury found in favor of the resident, but against the hospital. In affirming the jury's verdict against the hospital, the court noted that while the hospital had "no printed or published checklist which could be used as a guideline for determining the suitability of a prospective donor" there was testimony that published criteria did exist and was "fairly uniform throughout the nation." The court further concluded that had this criteria been applied to the donor in this case, the jury could have rightfully decided that he would have been rejected:

The jury heard expert testimony to the effect that cadavers with a history of certain types of illnesses are not generally wise choices for cornea donation. It follows that whoever may

even their universal disregard will not excuse their omission.”<sup>12</sup> This is an area in which uniform standards need to be developed within the profession.

Two other related issues concerning the donor or sperm vendor merit mention because they have apparently been dealt with strictly on the basis of fear of legal liability rather than any social or medical rationale or concern for the best interests of the child: consent of the donor’s wife and record keeping.

### *The Donor’s Wife*

The American Medical Association, the British Medical Society, and authorities in Australia all agree, as do almost all legal commentators, that the wife of the sperm donor must sign the “consent” form “because marital interests are involved.” None of these sources or commentators, however, provides any further explanation. This type of advice can be viewed as a paradigm of legalism based on fear and ignorance.

I do not know what the original source of this recommendation is, but it may be Joseph Fletcher’s comments in 1954: “. . . it is clearly a requirement of personal integrity, of love and loyalty, that the donor’s wife should be consulted by him (the donor) and agree to the role he plays.”<sup>13</sup> Perhaps. But however one comes out on this pronouncement, it is not a legal requirement, and does not seem to serve any useful social purpose. In terms of liability on the part of the physician, the potential grounds appear to be two: (1) an action in contract to recover a portion of the money received by the husband for his sperm on the grounds that the wife has a property interest in her husband’s sperm; and (2) an action for alienation of affections by the wife against the physician on the basis that her

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have had the responsibility of determining the suitability of the cornea for transplant would have been *required*, in the exercise of due care, *to review carefully and exhaustively the medical history of the proposed donor*. . . . The jury could have determined that Detroit General was negligent in failing to set up a procedure which could assure that the party responsible for determining the suitability of the cornea for transplant would have *access to all the relevant medical records of the proposed donor*. (emphasis supplied)

Applied to AID donors, this case indicates that hospitals and physicians are responsible for determining the suitability of donors and, if they don’t have a reasonable policy of their own, will be held to whatever policy has been accepted by other professionals engaged in the same activity.

12. T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932); and *see Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974).

13. Fletcher, J., *supra* note 3, at 129.

husband prefers masturbation for pay to intercourse with her, or some other fantasy he may have developed that interferes with the marriage. Both of these strike me as being too silly to worry about, and any woman who would bring either action is not likely to be discouraged by the fact that she has signed a "consent" (read contract) form. In addition, such a requirement is at odds with more recent United States Supreme Court decisions that refuse to permit one spouse to have veto power over procreation decisions made by the other spouse. Specifically, a husband may not be required to consent to his wife's abortion by state law because her right to make this decision is constitutionally protected.<sup>14</sup>

### *Record Keeping*

While the Curie-Cohen survey found that 93 percent of physicians kept permanent records on recipients, only 37 percent kept permanent records on children born after AID (fewer than the 50 percent who provided obstetric care for their inseminated patients), and only 30 percent kept any permanent records on donors. Moreover, 83 percent opposed any legislation that would mandate the keeping of records because it would make protection of anonymity of the donor more difficult. The fear of record keeping seems to be based primarily on the idea, common in the legal literature, that if identifiable, the donor might be sued for parental obligations (e.g., child support, inheritance, etc.) by one of his "biological children" sired by the AID process, and that this suit might be successful. The underlying rationale is that without anonymity assured, there would be no donors. There are a number of responses to this argument: (1) It is important to maintain careful records to see how the sperm "works" in terms of outcome of the pregnancy. If a donor is used more than once, a defective child should be grounds for immediately discontinuing the use of the sperm for the protection of potential future children. Since the survey disclosed that most physicians have no policy on how many times they use an individual donor, and 6 percent had used one for more than 15—with one using a donor for 50 pregnancies—this issue is much more likely to affect the life of a real child than the highly speculative lawsuit is to affect a donor. (2) No meaningful study of the characteristics of

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14. For a fuller discussion of this issue see Glantz, L., *Recent Developments in Abortion Law in GENETICS AND THE LAW II* (A. Milunsky & G. J. Annas, ed. 1980).

donors can ever be made if there are no records kept concerning them. (3) In those cases where family history is important (and it is important enough to ask *every* donor about his) the AID child will *never* be able to respond accurately. (4) Finally, and most importantly, if no records are kept, the child will *never*, under any circumstances, be able to determine its genetic father. Since we do not know what the consequences of this will be, it cannot be said that destroying this information is in the best interests of the child. The most that can be said for such a policy is that it is in the best interests of the donor. But this is simply not good enough. The donor has a choice in the matter, the child has none. The donor and physician can take steps to guard their own best interests, the child cannot.

Given the recent history of adopted children, it is likely that if AID children learn they are the products of AID, they will want to be able to identify their genetic father. It is now relatively accepted practice to tell adopted children that they are adopted as soon as possible, and make sure they understand it. This is because it is thought they will inevitably find out some day, and the blow will be a severe one if they have been lied to. In AID, the consensus seems to be not to tell on the basis that no one is ever likely to find out the truth, since to all the world it appears that the pregnancy proceeded in the normal course.

Moralists would probably agree with Fletcher that the physician should not accept the suggestion that a husband's brother be used as a donor without the wife's knowledge (his intent is to keep the blood line in his children) because this is a violation of "marital confidence." It seems to me a similar argument can be made for consistently lying to the child—i.e., that it is a violation of parental-child confidence. There is evidence that AID children do learn the truth, and the only thing all fifteen states with legislation on AID agree on is that it should legitimize the child—an issue that will never arise unless the child's AID status is discovered. If AID is seen as a loving act for the child's benefit, there seems no reason to taint the procedure with a lie that could prove extremely destructive to the child.

A number of policies would have to be changed to permit open disclosure of genetic parenthood to children. The first is relatively easy: a statute could be enacted requiring the registration of all AID children in a court in a sealed record that would only be available to the child; the remainder of the statute would provide that the

genetic father had no legal or financial rights or responsibilities to the child. A variation on this would be to keep the record sealed until the death of the donor, or until he waived his right to privacy in this matter. In the long term, a more practical solution may lie in only using the frozen sperm of deceased donors. In this case full disclosure could be made without any possibility of personal or financial demands on the genetic father by the child.<sup>15</sup>

Worry about donors, in any event, is probably out of proportion to reality. There have been *no* suits against any donor by any child even though almost one-third of physicians engaging in AID keep permanent records of the donors. No matter what steps are taken to protect them, it seems essential to me that, in the potential best interests of the child, such records be kept and that their contents be based on the development of professional standards for such records.

Not keeping records can also lead to other bizarre practices. For example, some physicians use multiple donors in a single cycle to obscure the identity of the genetic father. The Curie-Cohen survey found that 32 percent of all physicians utilize this technique which could be to the physical detriment of the child (and potential future of a donor with defective sperm) and cannot be justified on any genetic grounds whatsoever.<sup>16</sup>

### **Summary and Conclusions**

Current AID practices are based primarily on consideration of protecting the interests of practitioners and donors rather than recipients and children. The most likely reason for this is found in exaggerated fears of legal pitfalls. It is suggested that policy in this area should be dictated by maximizing the best interests of the resulting children. The evidence from the Curie-Cohen survey is that current practices are dangerous to children and must be modified. Specifically, consideration should be given to the following:

1. removing AID from the practice of medicine and placing it in the hands of genetic counselors or other nonmedical personnel

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15. Sperm banks may soon be able to market sperm directly to consumers, bypassing physicians and adding to current confusion in practice. See *Advertising Age*, May 14, 1979, at 30.

16. A more encouraging finding was that only two physicians in the entire sample mixed donor sperm with the husband's semen. This apparently once common practice has died, probably because it is now known to be medically contraindicated. See Quinlivan, W.L.G., Sullivan, H., *Spermatozoal Antibodies in Human Seminal Plasma as a Cause of Failed Artificial Donor Insemination*, 28 *FERTILITY AND STERILITY* 1082-85 (1977).

(alternatively, a routine genetic consultation could be added for each couple who request AID);

2. development of uniform standards for donor selection, including national screening criteria;

3. a requirement that practitioners of AID keep permanent records on all donors that they can match with recipients; I would prefer this to become common practice in the profession, but legislation requiring filing with a governmental agency may be necessary;

4. as a corollary, mixing of sperm would be an unacceptable practice; and the number of pregnancies per donor would be limited;

5. establishment of national standards regarding AID by professional organizations with input from the public;

6. research on the psychological development of children who have been conceived by AID and their families.

Dr. S.J. Behrman concludes his editorial on the Curie-Cohen survey by questioning the "uneven and evasive" attitude of the law in regard to AID, and recommending immediate legislative action:

The time has come—in fact, is long overdue—when legislatures must set standards for artificial insemination by donors, declare the legitimacy of the children, and protect the liability of all directly involved with this procedure. A better public policy on this question is clearly needed.<sup>17</sup>

I have suggested that agreement with the need for "a better public policy" is not synonymous with immediate legislation. The problem with AID is that there are many unresolved problems with AID, and few of them are legal. There is no social or professional agreement on indications, selection of donors, screening of donors, mixing of donor sperm, or keeping records on sperm donations. Where there is agreement, such as in requiring the signature of the donor's wife on a "consent" form, the reasons for such agreement are unclear.

It is time to stop thinking about uniform legislation and start thinking about the development of professional standards. Obsessive concern with self-protection must give way to concern for the child.<sup>18</sup>

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17. Behrman, S.J., *Artificial Insemination and Public Policy*, 300 *NEW ENG. J. MED.* 619-620 (1979).

18. The argument is not based on any alleged action for "wrongful life" that the child may have (I do not believe this would ever be recognized by a court in the absence of legislation), but on the theory that we should do what we can to protect the interests of "innocent" third parties whenever their interests are in conflict with those who have the ability to affect them.

