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(Mis)Conceptions:
Unjust Limitations on Legally Unmarried Women's
Access to Reproductive Technology and Their Use
of Known Donors

Justyn Lezin*

I. INTRODUCTION

A. A TALE OF TWO WOMEN AND THEIR KNOWN SPERM DONOR

Joanna and Kathy, a fictional couple, had been together ten years. Following their commitment ceremony six years ago, they began the process of preparing to have children. Each had always wanted to bear children, so they started to think about how Kathy would conceive, with the understanding that Joanna would do so a few years later. Kathy and Joanna wished that their children would be biologically related to one another through their biological father. They were uncomfortable about using a sperm bank, where neither they nor their children would know their sperm donor.¹ They wanted to feel certain that they could carefully choose a sperm donor who, in addition to having gone through thorough medical and genetic screening, also reasonably met their personal ideals. They sought someone who would be comfortable forfeiting his parental rights, but who would nonetheless play some small role in the lives of their children, allowing the children to know their biological father, albeit not as a parent. They were looking for someone they knew and could trust. When a good

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¹ Some sperm banks now allow the release of anonymous donor names when resulting children attain certain ages. Two banks that have adopted that approach include Pacific Reproductive Services in San Francisco, California, and Rainbow Flag Health Services in Alameda, California. See Pacific Reproductive Services, at http://www.hellobaby.com/ (1997).
friend offered to play this role, they began a careful process of sorting through every issue they could think of with him. After two years of elaborate discussion, they all felt ready to make a commitment. Joanna and Kathy had a contract drawn up to make their plans to inseminate with their friend concrete and to establish that they, and any children they were to have, would have ongoing, occasional contact with the friend, but that he would not retain paternity rights or responsibilities.

Originally, Kathy and Joanna wanted to perform inseminations at home. After consulting with their attorney, Joanna and Kathy learned that their state, California, having adopted a previous version of the Uniform Parentage Act, allowed that if the prospective donor first provided his sperm to a licensed physician who would then in turn hand it off to the couple; the donor would not be treated in law as the child’s natural father, allowing both the biological and the non-biological mother to become the

2. The history and impact of the Uniform Parentage Act (UPA) is worthy of its own discussion. Drafted by the Uniform Law Commissioners, the UPA is intended as a model rule for states to adopt, with the goal of holding parents, not the state, responsible for their offspring. However, in recent years the UPA has been subject to considerable debate and substantial revision, particularly regarding assisted reproduction. The former UPA (1973) had a provision that a sperm donor for a married woman was not to be treated in law as the father of any resulting offspring, but only if the sperm was first provided to a physician. UNIF. PARENTAGE ACT § 5, 9B U.L.A. 407 (1973). California adopted that provision with modifications by eliminating the requirement that the woman be married. CAL. FAM. CODE § 7613 (West 2001).

The UPA was revised in 2000, and then revised again in 2002. In 2000, the Uniform Law Commissioners changed the UPA’s section 702 to state simply, “A donor is not a parent of a child conceived by means of assisted reproduction.” UNIF. PARENTAGE ACT § 702, 9B U.L.A. 355 (2000). This eliminated the requirement that a physician intermediary be used to effectively bar future assertions of the donor’s legal parentage. On the other hand, section 702 isolated an unmarried biological mother as the only parent where donor sperm was used. See id. § 702 cmt. This seemed to preclude by omission the possibility of an unmarried partner establishing parentage based on her/his intentions to co-parent the child. Some argued that the effect for same-sex couples worked contrary to the UPA’s goals, which are, wherever possible, to identify two responsible adults for each child where those adults intended to be the child’s parents.

In the 2002 UPA, section 702 remains unchanged. See UNIF. PARENTAGE ACT § 702, 9B U.L.A. 16 (Supp. 2002). However, the revised version is worth noting, in part for its changed stance regarding intent to parent as determinative of legal parentage, especially as it relates to unmarried, heterosexual partners or co-parents. Per the 2002 UPA, a man can establish legal parentage to a child conceived through assisted reproduction with a woman not his wife, not only by providing sperm and announcing his intent to parent, but by entering into a parenting agreement with that woman before conception. UNIF. PARENTAGE ACT § 703-704, 9B U.L.A. 16 (Supp. 2002). Although the UPA continues to be silent regarding same-sex couples in this context, the concept of establishing legal parentage based on preconception intent between unmarried, heterosexual partners who use assisted reproduction may be easily widened in the future to include same-sex couples.

3. UNIF. PARENTAGE ACT § 5(b), 9B U.L.A. 301 (1973). “The donor of semen provided to a licensed physician for use in artificial insemination of a married woman other than the donor’s wife is treated in law as if he were not the natural father of a child thereby conceived.” Id.
child’s legal parents. Joanna and Kathy called every doctor in their town, but none agreed to perform this service of “handing off” the sperm. Some doctors conveyed that they were uncomfortable with the alternative nature of Kathy and Joanna’s family. Most were unwilling to deal with fresh semen, which, due to the difficulties of HIV testing, could not be guaranteed to be HIV-free. Other physicians would only receive the sperm if they then inseminated Kathy in their offices, protesting that the hand-off service was not sufficiently medical to merit their attention. It would be entirely different, they all said, if Kathy were married to her donor. She wouldn’t require the hand off, and she would be free to use fresh sperm in any procedure they could provide.

The couple and their donor decided to use the donor’s frozen sperm. For months prior to insemination, their donor had stored up frozen sperm samples. The donor signed over the samples to Joanna and Kathy per their contract. After eight months of inseminations for Kathy, the couple and their sperm donor grew anxious. After both Kathy and the sperm donor submitted to rigorous fertility testing, it became clear that their donor had significant fertility impediments - his sperm count was dismally low. Not enough sperm could survive the freezing process.

Although their fertility specialist told them that there were numerous effective treatments for compensating for low sperm count, these processes weren’t available to Kathy and the sperm donor. In order to make the inseminations viable, they needed to use fresh semen so that the viable sperm could be culled using a laboratory procedure. According to their physician at the fertility practice, the law simply didn’t allow for the “medical” use of fresh sperm between unmarried people. Although he didn’t know how or where to find the statute, the physician said that the law required that donors not married to their recipients were required to use frozen samples at least three months old to allow sufficient time for follow-up testing. Kathy and Joanna, after years of planning and trying with their

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4. As state-registered domestic partners, each woman could then anticipate adopting her partner’s biological children through a relatively streamlined process of stepparent adoption. See CAL. FAM. CODE § 9000 (West 2002).

5. For clarity, semen, also known as seminal fluid or ejaculate, is the fluid through which individual sperm cells are conducted out of the penis. Sperm and semen appear to be used interchangeably as they most often coexist, but are, on occasion, separated, as in intrauterine insemination (IUI) procedures, described infra at note 6.

6. As discussed infra, there are now a broad range of assisted reproductive technologies. In the instant case, the intrauterine insemination procedures (IUI) proposed to the couple involve a process of spinning semen in a centrifuge to remove healthy sperm from the fresh semen so that it can be inserted directly into the recipient’s uterus. Another increasingly common method of preparing sperm for IUI is using a “swim-up” method, whereby semen is placed in a viscous solution in a test tube. The test tube is incubated for approximately an hour, and viable sperm literally swim through the solution to be extracted, semen-free, from the top of the test tube and inserted into the uterus. As compared to the elaborate and expensive procedures associated with in vitro fertilization, the IUI process is simple and comparatively non-invasive.
donor, were devastated. They wanted to conceive their baby with the person they had consciously, carefully selected, and were willing and able to contract for relatively "low-tech" fertility services using fresh sperm, but those services weren't available to them because Kathy was not married to her sperm donor.

B. ASSISTED REPRODUCTION AND THE LEGALLY UNMARRIED

Assisted reproduction has grown vastly both in concept and practice in the last twenty years. What were previously barriers to conception can now be sidestepped thanks to processes ranging from non-medical and "low-tech," to medical and complex. Through a combination of social, cultural, and legal factors, ever-increasing numbers of lesbians and/or single women, in addition to scores of heterosexually partnered women, are choosing to seek pregnancy through assisted reproductive technologies (ART). Unlike many heterosexually partnered couples who anticipate being mutually biologically related to their offspring, lesbians and/or single women, subsequent to their choice whether to have primary partners, must make secondary decisions regarding their future children. While many women choose to use sperm from anonymous donors, many elect to inseminate with known donors – men with whom they are not otherwise sexually or romantically intimate. But as deliberate as many of these


8. Issues that previously compromised fertility, e.g., low sperm count, irregular cycle, and even a failure to produce viable ova, are all often overcome through the use of assisted reproductive technology. Elizabeth L. Gibson, Artificial Insemination by Donor: Information, Communication and Regulation, 30 J. FAM. L. 1, 1 (1991-92); see also GENA COREA, THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL Wombs 6 (1985); JOHN A. ROBERTSON, CHILDREN OF CHOICE: FREEDOM AND THE NEW REPRODUCTIVE TECHNOLOGIES 1 (1994).


10. See ROBERTSON, supra note 8, at 1 (estimating that 20,000-30,000 babies are conceived each year in the United States using artificial insemination); Carmen B. Sella, When a Mother is a Legal Stranger to Her Child: The Law's Challenge to the Lesbian Nonbiological Mother, 1 UCLA WOMEN'S L.J. 135, 140 (1991) (estimating that 5,000-10,000 lesbians have conceived through artificial insemination); Dollens supra note 7, at 214.

11. See KIM TOEVS & STEPHANIE BRILL, THE ESSENTIAL GUIDE TO LESBIAN CONCEPTION, PREGNANCY AND BIRTH 129-45 (2002). Historically, all donor insemination was anonymous, as physicians encouraged married couples using donor insemination to pretend that their children were biologically related to the husbands. See also Katheryn D. Katz, The Clonal Child: Procreative Liberty and Asexual Reproduction, 8 ALB. L.J. SCI. & TECH. 1, 19 n.95 (1997) (citing extreme secrecy regarding donor anonymity as "one of the hallmarks of physician control"). Still, many legally unmarried women prefer anonymous donors because it guards against the physical and emotional upheaval that could be caused by a biological father's threat to custody, privacy, or general well-being.

12. See ELIZABETH NOBLE, HAVING YOUR BABY BY DONOR INSEMINATION 90-92 (1987). A 1987 survey conducted by the U.S. Office of Technology Assessments reported that 80,000 women had used donor insemination, leading to roughly 30,000 pregnancies. Vickie
women are in making reproductive choices, they find that their autonomy is considerably impaired, particularly in comparison to their heterosexual, married counterparts who make up the majority of consumers of ART. Where married women are free to consent to using methods most likely to result in conception, legally unmarried women, through a combination of excessive physician discretion and lack of legal protections, are frequently barred from choosing their preferred options for conception.

Lesbians and/or single women seeking to procreate are entitled to pursue the same reproductive options, with their accompanying risks and benefits, that are afforded to heterosexually partnered women. This note will critique the paternalistic roles of doctors in permitting or restricting heterosexually unpartnered women's access to nontraditional methods of reproduction. Secondly, it will explore legally unmarried women's constitutional protections as consumers of ART and will suggest legislative reform to correct current private discrimination, using California as an example of a current misapplication of good law and a model for proposing regulatory reform.

This note argues that lesbians and/or single women are entitled to the full range of reproductive technologies that married couples enjoy access to. Clearly, the state retains a strong interest in clarifying parentage and discouraging litigation and other burdens on the state when children are not fully accounted for by legal parents. This note argues that this state interest is best served by honoring the preconception intent of each adult who took part in conception, regardless of his/her biological role. Part II will identify the history and definitions of current reproductive technologies, the roles of medical providers in this history, and some ways in which these roles affect lesbians and/or single women as consumers of ART. Part III will explore the questions of constitutional and state protections for unmarried people who wish to conceive noncoitally. Part IV will consider the right to enter contracts and its implications regarding reproductive technology and establishing parentage. Part V will examine California state law as a multifaceted example of good legislation, needed legislation, and frustrations of legislative intent by overentitled medical professionals. Part VI will elaborate on proposed regulatory schemes, designating who should

L. Henry, A Tale of Three Women: A Survey of the Rights and Responsibilities of Unmarried Women Who Conceive by Alternative Insemination and a Model for Legislative Reform, 19 AM. J.L. & MED. 285, 288 (1993). About 8,600 of those women were unmarried, and of those, around 1,700 reported being lesbians. Id.

13. "Legally unmarried women" will be used interchangeably with "lesbians and/or single women," recognizing that many lesbian couples see themselves as married, even when the state has yet to reflect this reality. While the term "single" technically describes the legal standing of women who are not in state-sanctioned marriages with men, it does not sufficiently match many partnered women's identities and is therefore not preferable here. While many of the unmarried women seeking access to ART are indeed unpartnered, many are actually in stable, long-term relationships, either with female or male partners. Additionally, some consumers of ART are both lesbian and single.
control questions of access to reproductive technologies in a realm that is simultaneously legal, medical, social, and moral.

II. DEFINITIONS OF ART AND THE ROLE OF THE MEDICAL PROFESSION

A. ASSISTED REPRODUCTIVE TECHNOLOGY

Assisted reproductive technology (ART) refers to a wide range of processes designed to enable conception of sperm and egg when coital reproduction is either not possible or not desirable.\(^{14}\)

1. Insemination

Artificial insemination, also known as alternative fertilization,\(^ {15} \) refers to the process of inserting sperm into a woman's vagina or uterus.\(^ {16} \) Frequently, medical professionals and legislatures make a distinction between two kinds of insemination: Insemination by a woman's husband

\(^{14} \) See Daar, supra note 9, at 614. The majority of people using ART today are upper-middle class, heterosexual married couples who have encountered considerable difficulty in conceiving through sexual intercourse. See generally Christo Zouves & Julie Sullivan, Expecting Miracles: On the Path to Hope from Infertility to Parenthood (1999). Many observers have pointed out the significant financial cost of ART and the fact that few health insurance plans cover ART. Lynda Beck Fenwick, Private Choices, Public Consequences: Reproductive Technology and the New Ethics of Conception, Pregnancy, and Family 203 (1998). The expense undoubtedly results in ART being available primarily to upper-middle class people who have substantial amounts of expendable income. Although not all users of ART are upper-middle class white people, they comprise a significant majority of ART users. A substantial minority of women using ART are lesbians and/or single women, whose initial use of ART derives from their aspiration to reproduce noncoitally with donor sperm. In some cases, however, some of these sperm recipients use more advanced technology to address infertility issues on their part, on their donor's part, or both. See Toevs & Brill, supra note 11, at 348-367.

\(^{15} \) Nomenclature for the process of taking sperm into one's reproductive tract through noncoital means continues to change. An advocate from the San Francisco-based group Prospective Queer Parents argues that the term “artificial insemination” reveals value judgments that should be changed:

First of all, since the process of wanting to insert sperm into the vagina or directly to the uterus without copulating is a perfectly natural process, there is no reason to refer to it as “artificial.” It is not the most common way of getting pregnant, so it is reasonable to refer to it as an “alternative” method.

Secondly, the word “insemination” derives from the root word meaning “semen.” This implies that the process of having a baby is focused more on the sperm than on the egg, when in fact, both are required and equally important. For that reason, the term “fertilization” is a more unbiased and accurate term for the process.

Alternative fertilization is a process used by thousands of people for a wide variety of reasons. There is no need to consider it abnormal or focused solely on sperm as suggested by the use of artificial insemination.


(AIH), and insemination by "donor" (DI), using the sperm of a man who is not the woman recipient's husband.

Furthermore, there are different methods of insemination, and depending on the fertility of both the sperm and egg in question, they may yield positive pregnancies at different rates. The most commonly used method is standard vaginal insemination. Although women may have legal or personal incentives to have doctors perform this form of insemination, the process itself is simple and often easily performed outside medical settings. Some people who have concerns about compromised fertility or are simply eager to use a more efficient method of insemination choose to use intrauterine insemination (IUI). In IUI, semen is placed in a centrifuge (usually housed in a medical laboratory), where the sperm are "washed," extracted from the semen, and inserted directly into a woman's uterus via a long, sterile catheter syringe. This procedure, although not required by law to be performed by a physician, requires substantial training in that the conditions under which it should be performed are highly specific. Although IUI is somewhat more invasive, expensive, and medically complex than standard vaginal insemination, the odds of conception are considerably higher, particularly where the sperm samples in question yield lower than average numbers of motile sperm.

2. In Vitro Fertilization

In addition to insemination procedures, more complex technology is...
sometimes available when fertility appears to be significantly compromised. This can include in vitro fertilization, where ova are “harvested” from a woman’s uterus following a detailed daily regimen of hormone treatments, fertilized in a petri dish in a medical laboratory, and implanted back in her (or another woman’s) uterus for gestation.26

3. Fresh Versus Frozen Sperm and HIV Screening

All fertility procedures described here feature either “fresh,” recently ejaculated sperm, or thawed “frozen” or “cryopreserved” sperm. The distinction between fresh and frozen sperm samples is important for a number of reasons. From a fertility standpoint, fresh semen contains the highest concentration of sperm, and its use is more likely to contribute to a positive pregnancy result than the use of frozen samples.27 Where a particular man’s sperm quality or quantity is in question, fresh sperm may be the only option for conception through insemination, as the freezing and thawing process will render the sample virtually useless.28 On the other hand, the freezing process does not have the same deleterious effect on sperm samples with initially high numbers of motile sperm, in that a decrease in quantity does not mean that using the sample would be futile.29 Furthermore, sperm can be frozen indefinitely,30 allowing for comprehensive screening of the donor for any STDs, including HIV.31 Because HIV antibodies can take up to six months to be detectable by a standard HIV test, donors cannot be certain that a negative test result at the time of their sperm donation means that they are, in fact, HIV-free.32 By freezing the sample then testing the donor six months later, one can

26. ROBERTSON, supra note 8, at 8-9. Much of ART, particularly in vitro fertilization and related techniques, is prohibitively expensive, and is therefore utilized disproportionately by the wealthy. FENWICK, supra note 14, at 203. There are now a number of highly sophisticated technologies available, but they are beyond the scope of this note. For detailed definitions of processes like in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), intracytoplasmic sperm injection (ICSI), and the implications for surrogate gestation, see id. For a discussion of the complex feminist issues raised by this new technology, see generally COREA, supra note 8. This kind of technology reflects how developments have been largely weighted toward “fixing” prospective gestational mothers when fertility is problematic in either sperm donor or recipient. See generally GERMAINE GREER, SEX AND DESTINY: THE POLITICS OF HUMAN FERTILITY (1984).

27. Brenda Bordson et. al., Comparison of Fecundability with Fresh and Frozen Semen in Therapeutic Donor Insemination, 46 FERTILITY & STERILITY 466, 468 (1986); D.A. Iddendum et al., A Prospective Randomized Study Comparing Fresh Semen and Cryopreserved Semen for Artificial Insemination by Donor, 30 INT. J. FERTILITY 50, 54-56 (1985); Leslee Subak et al., Therapeutic Donor Insemination: A Prospective Randomized Trial of Fresh Versus Frozen Semen, 166 AM. J. OBSTETRICS & GYNECOLOGY 1597, 1603 (1992).

28. Subak et al., supra note 27, at 1605.

29. Id.

30. NOBLE, supra note 12, at 102.

31. See id. at 109-10.

32. Id.
conclusively determine that the donor was HIV negative at the time of the emission, eliminating any risk of transmitting HIV to the prospective sperm recipient.\textsuperscript{33}

There is another way to remove the risk of transmission of sexually transmitted diseases like HIV, even where the use of fresh semen may be deemed necessary. Sexually transmitted diseases live in semen, but cannot be communicated through sperm themselves.\textsuperscript{34} In the course of preparing sperm for IUI, the washing and spinning process extracts sperm and eliminates semen for purposes of insemination. In fact, IUI has been repeatedly used by “discordant” couples, where the male is HIV positive and the female is HIV negative, to conceive successfully without risking exposing the female to HIV.\textsuperscript{35}

B. USE OF ART BY LESBIANS AND/OR SINGLE WOMEN

Of the many lesbians and/or single women using ART, untold numbers are most likely flying under the radar of state legislatures and physicians: They are doing it at home. Because vaginal insemination is simple and does not require formal training,\textsuperscript{36} as long as they have access to sperm, women may inseminate themselves (with or without assistance) at home.\textsuperscript{37}

Lesbians and/or single women also comprise a percentage of women who seek to utilize more complex technologies. Some wish to use IUI instead of vaginal insemination because of the better odds of conception that IUI yields.\textsuperscript{38} Others seek advanced treatment when their known sperm donors have male infertility complications that might be resolved through the therapies described above.\textsuperscript{39} Some women use IUI as part of “washing” fresh semen and sperm that was sent in a special “buffer” solution to preserve the sperm from known donors who live at a distance from their recipients.\textsuperscript{40} Some lesbians and/or single women, not unlike some of their...

\textsuperscript{33} \textit{Id.}.
\textsuperscript{34} See discussion at \textit{supra} note 5.
\textsuperscript{36} See \textit{NOBLE}, \textit{supra} note 12, at 93.
\textsuperscript{37} \textit{TOEVS AND BRILL}, \textit{supra} note 11, at 343-45.
\textsuperscript{38} \textit{RACHEL PEPPER, THE ULTIMATE GUIDE TO PREGNANCY FOR LESBIANS: TIPS AND TECHNIQUES FROM CONCEPTION TO BIRTH} 49-50 (1999).
\textsuperscript{39} Although there have been some advances in treating specific manifestations of male infertility, the general course of treatment for male infertility is to treat the prospective gestational female. For a feminist critique of ART and the ways in which it underscores societal exploitation of women “as sex object and child bearers,” see generally \textit{COREA, supra} note 8; \textit{JANICE G. RAYMOND, WOMEN AS WOMBBS: REPRODUCTIVE TECHNOLOGIES AND THE BATTLE OVER WOMEN’S FREEDOM} (1994); Norma Juliet Wikler, \textit{Society’s Response to the New Reproductive Technologies: The Feminist Perspectives}, 59 S. CAL. L. REV. 1043 (1986).
\textsuperscript{40} Rainbow Flag Health Services, Overnite Male, at http://www.gayspermbank.com/overnite.html (last visited May 1, 2003).
heterosexually married counterparts, have critical fertility problems due to complications of age, physiology, or unknown causes. They may pursue therapy in the form of fertility drugs, in vitro fertilization, or other advanced treatments. Lastly, some lesbian couples have used in vitro fertilization/embryo transfer together, where one partner provided her eggs for fertilization, and the other her uterus and body for pregnancy.

1. Anonymous Donors

Some women choose to use the sperm of an anonymous donor, either procured through a sperm bank or acquired through a private third party. Typically, the use of an anonymous donor eliminates the possibility of either party (the biological mother or the sperm donor) from later emerging to assert the sperm donor's paternity.

2. Use of Known Donors

Other women consciously choose known donors — men with whom they agree to work toward noncoital reproduction. Known donor relationships may be based on a wide variety of pre-conception understandings. Some donors agree to share parenting of future children, participating equally and openly with the biological mother. Others intend to be known to future children as a biological parent, but not to play a daily parenting role. Some donors wish to inseminate, but agree that the sperm recipients will not reveal their donor's identity outside a select number of people, if at all. In some states, like California, if women and their known donors intend that the donors will not be recognized as their children's legal or natural parents, the law provides that they may do so by having a licensed physician play an intermediary role between the donor and recipient.
and the recipient.  

C. HISTORY OF THE ROLE OF PHYSICIANS IN ART  

The first U.S. case of documented physician-performed human insemination by donor occurred in 1884, to a woman who knew neither that her resulting pregnancy was the product of insemination nor that her subsequent child was not biologically related to her husband. This inauspicious event was emblematic of the legacy of physician control over women’s reproductive choices that continues to manifest today throughout the United States.

While the degree of control and discretion exerted by physicians has loosened somewhat (since the day when physicians were performing donor insemination on unsuspecting female patients), it certainly hasn’t disappeared. Legally unmarried women are seeking to use ART in unprecedented numbers, but many find that their range of choices is restricted by their physicians, despite their availability to married women. In the absence of substantial regulation to establish standards for evaluating prospective patients of ART, physicians themselves fill in the gaps. Many physicians and ART facilities have a policy of denying insemination or other ART services to single women, insisting that the most legitimate indicator for using ART is a male spouse’s infertility.

50. CAL. FAM. CODE § 7613 (West 2001). “The donor of semen provided to a licensed physician and surgeon for use in artificial insemination of a woman other than the donor’s wife is treated in law as if he were not the natural father of a child thereby conceived.” Id. § 7613(b). Colorado, Illinois, New Jersey, New Mexico, Washington, Wisconsin, and Wyoming have similar statutes. NATIONAL CENTER FOR LESBIAN RIGHTS, supra note 41, at app. F.

51. COREA, supra note 8, at 12 (Describing how a doctor, believing that his patient’s infertility was due to the poor quality of her husband’s sperm, brought her in for an “examination,” anesthetized her, and inseminated her with the semen of a medical student. Although the procedure resulted in a pregnancy, the patient was never told about the insemination, and believed her husband to be the biological father.).

52. COREA, supra note 8, at 307; Katz, supra note 11, at 33; Holly J. Harlow, Paternalism Without Paternity: Discrimination Against Single Women Seeking Artificial Insemination by Donor, 6 S. CAL. REV. L. & WOMEN’S STUD. 173, 178, 194 (1996) (referring to the American Fertility Society’s overall inclination to “allow physicians to make individual moral decisions” for their patients seeking ART).


54. See Daar supra note 9, at 641-42 (explaining that Congress and the states are reluctant to regulate ART for fear of “interfering with procreational choices” as “fundamental rights” and suffering the subsequent repeal of such regulation).

55. Although physicians are private actors not bound by the same constitutional restraints as state actors, women still may retain the right to access ART through public accommodations laws. See Harlow, supra note 52, at 204-06 (suggesting that where state laws bar owners or agents of any place of public accommodations from withholding services on the basis of sex or marital status, and where such laws apply to hospitals and clinics, physicians are barred from preventing legally unmarried women from using fertility services otherwise offered to married women).

56. Id. at 188-94; see also Henry, supra note 12, at 288-89 (citing Office of Technology Assessments’ survey where ART providers reported that their most common reasons for
Ultimately, physicians are allowed to impose their own home-grown perceptions of morality on (prospective) patients, thereby overly shaping and censoring others’ important procreative options.

Even in states where lawmakers specifically intended to allow for single women to be able to use insemination services,\(^{57}\) physicians and ART clinic practitioners may choose whether or not to allow access (or to condition it upon certain factors) based on their personal assessment of their patient’s moral character, including their legal marital status.\(^{58}\) With little recourse, prospective patients who are denied reproductive services on moral grounds are powerless to access services that their otherwise “morally acceptable” counterparts are free to receive.

On the other hand, physicians and others cogently argue that placing regulatory restraints on physicians’ autonomy regarding moral decision-making could not only misdirect power toward the state,\(^{59}\) but could undermine the importance of physicians’ individual emphases on medical ethics.\(^{60}\) In fact, if political trends significantly informed such regulatory restraints, doctors might not only become unwilling agents of the state, but could be forced to say or do things which they and others find morally repugnant, e.g., being forced by law to refuse specific reproductive services to legally unmarried people.\(^{61}\)

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57. For example, the official annotation to California Family Code section 7613 (a single woman's ability to ensure that her sperm donor's paternity is not legally recognized if the donor provides his sperm to her physician as intermediary) states: “There is no public policy in California prohibiting the artificial insemination of an unmarried woman.” CAL. FAM. CODE § 7613 (Deering 2002).

58. See Harlow, supra note 52, at 189-90 (Describing one physician’s circular reasoning for not allowing single women to use insemination services. Because he believes that a single woman who wants a baby through donor insemination must be “emotionally and psychologically imbalanced,” this physician claims that he has yet to see an unmarried patient who was an appropriate candidate for donor insemination.); see also ZOUVES & SULLIVAN, supra note 14, at 209. Dr. Zouves, a physician in a well-known ART facility, claims to have begun one of the first “ethics advisory boards” in a private clinic. Id. Here, the private facility has its own board, convened specifically to review ethical concerns raised by Zouves’ assisted reproduction practice. Id. The existence of this board underscores the importance of the complex ethical decisions surrounding the practice of ART and physician autonomy. Id. In this filed, complicated ethical matters are contemplated and resolved not by regulatory bodies exercising oversight over the field, but rather by individual physicians, operating somewhat like islands. Id.; see also Katz, supra note 11, at 33-34.

59. See David Orentlicher, The Influence of a Professional Organization on Physician Behavior, 57 ALB. L. REV. 583, 587 (1994). “There is a real danger of overreaching when the government establishes guidelines on ethical issues; the government may be easily tempted to use its ethics pronouncements to serve other policy goals ....” Id.

60. See id. at 586. “If physicians are responsible for establishing their own ethical code, they are much more likely to view ethics as an integral part of the practice of medicine.” Id.

61. See infra, Part III(A), for discussion on the right to reproduce as included in the right to privacy.
In this case however, physicians are too easily able to make unimpeded moral decisions regarding their clientele’s methods of assisted reproduction, with no assurance that their decisions are based on anything other than the physician’s whim. Medical providers should concede that they are rarely, if ever, in a position to determine a prospective parent’s future ability to parent competently. A person’s marital status doesn’t guarantee that that person will not contract a sexually transmitted disease, let alone make a fit parent, so discrimination between patients of different marital status is not only unfair, it’s futile. Like California, states should legislatively assert that “there is no public policy ... prohibiting the artificial insemination of an unmarried woman,” and medical providers should approach prospective patients in accordance with that policy.

III. PROCREATIVE RIGHTS OF THE LEGALLY UNMARRIED

The Supreme Court has yet to speak directly to the question of whether there is an affirmative constitutional right to use ART. However, there are a number of salient arguments that the Constitution protects citizens’ reproductive liberties such that they are entitled to pursue reproductive technologies. First, there is the rights-based theory of protection which posits that people are entitled to broad reproductive liberty as a function of their right to privacy. Second, there is the perception that the right to privacy is not an individual right, but an associational right that protects intimate adult, consensual relationships from state intervention until such time as material disputes arise. Third, it is in the interest of the state and its children to honor preconception agreements which may bar donors’ future paternity rights and to grant parental rights to biologically unrelated adults who intend to bear protective responsibility for future children. Fourth, although the Constitution doesn’t explicitly confer on unmarried people the affirmative right to procreate (through ART or otherwise), states can and should enact and/or enforce public accommodations laws to bar private providers of ART from denying services on the basis of marital status or sexual orientation.

A. THE RIGHT OF PRIVACY AS A RIGHT TO REPRODUCE

While legally married persons clearly have the right to regulate their reproduction free from state interference, the question here is whether or

62. CAL. FAM. CODE § 7613 (Deering 2002).
65. Harlow, supra note 52, at 204.
not that right extends to unmarried people. In *Eisenstadt v. Baird*, the Supreme Court expanded the right of privacy to include unmarried people’s reproductive choices in the realm of access to birth control. Justice Brennan, writing for the Court, held that, “If the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted government intrusion into matters so fundamentally affecting a person as the decision whether or not to bear or beget a child.”

Not only has the Court held that women’s right to terminate pregnancy is “central to the right to privacy,” but it has continued to emphasize the significance of individual freedom to make choices in matters of reproduction.

Some scholars argue that if the Constitution safeguards the freedom to avoid or terminate pregnancy, all protected individuals, including unmarried women, retain a parallel right to pursue procreation, whether through coital or noncoital reproduction. But John A. Robertson, a leading legal thinker in the field of reproductive liberty, explains: “Although the Supreme Court has recognized the rights of persons to use birth control and terminate pregnancies, this is a right to avoid pregnancy and reproduction. It does not necessarily imply a right to engage in coitus in order to get pregnant.” Nonetheless, public policy dictates strong reasons for protecting unmarried persons’ right to reproduce:

Unmarried persons also have needs or desires to have and rear biological descendants, and may be as competent parents as married couples. They may not be able or willing to satisfy this desire. Indeed, banning coital or noncoital conception by single persons seems absurd when unmarried sexual relations are common and when single women cannot be forced to use contraception or to abort after pregnancy has occurred. Surely capable rearers should not be denied the opportunity just because they are unmarried.

The right to procreate, as included in the right to privacy, is neither absolute nor yet recognized by the Supreme Court. Certainly, the

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67. 405 U.S. 438, 453 (1972). The Court overturned a statute prohibiting the distribution of contraceptives to unmarried persons on basis of equal protection. *Id.*
68. *Id.*
72. ROBERTSON, *supra* note 8, at 38.
73. Robertson, *supra* note 63, at 962-63. Practically speaking, “With over 28 percent of births in 1990 occurring out of wedlock, it is unrealistic to think that laws prohibiting nonmarital sex or penalizing unmarried reproduction would accomplish much.” ROBERTSON, *supra* note 8, at 38.
recognized right to avoid procreation, as in Eisenstadt, does not conversely equal a negative right to seek procreation through any means necessary.\textsuperscript{75} Another significant argument is that the state is not compelled to insist that private entities accommodate others.\textsuperscript{76} Additionally, the state may intervene on one’s reproductive choices if it deems that such choices would inflict substantial harm to others.\textsuperscript{77} Some argue that the universal “harm” done to children being raised in single parent and/or lesbian families is substantial, but there is significant empirical evidence to refute those charges.\textsuperscript{78} The data are so compelling, in fact, that it is unlikely that the state could now justify interference with the right to procreate for lesbians and single women on the basis of substantial harm to their children.

B. PUBLIC ACCOMMODATIONS LAWS AND BARRING PRIVATE DISCRIMINATION AGAINST LEGALLY UNMARRIED WOMEN CONSUMERS OF ART

States can enact specific laws to prevent private providers of ART from discriminating against prospective patients on the basis of sexual orientation or marital status. State public accommodations laws are implemented to ban discrimination in businesses, facilities, and other entities that furnish services and materials to the public.\textsuperscript{79} For instance, one state’s statute makes discrimination illegal when it serves “to deny any person the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of a place of public accommodation because of race, color, creed, religion, disability, national origin, marital status, sexual orientation, or sex.”\textsuperscript{80} However, courts’

\textsuperscript{75} See id. at 989-95. Although Sunstein has a strong argument that the right to avoid procreation doesn’t create a positive right to procreate, Skinner v. Oklahoma indicates otherwise. 316 U.S. 535 (1942). There the Supreme Court struck down a state law which forced specific felons to be sterilized, asserting that “marriage and procreation are fundamental to the very existence and survival of the race.” Id. at 541. Sunstein also argues that the Supreme Court’s decisions in Griswold, 381 U.S. 479 (1965), and Eisenstadt, 405 U.S. 438, 453 (1972), do establish “a presumptive right against government intrusions into the decision how and whether to produce children,” but are easily distinguishable from cases like Bowers v. Hardwick, 478 U.S. 1039 (1986). Sunstein, supra note 74, at 993. Here however, the matter is significantly more complicated. The prospective parents’ sexual conduct may be entirely separate from the matter or manner of procreating. Yet, the conduct is nonetheless so potently non-traditional that it may be conflated with an attempt to procreate, and the attempt itself may therefore be unprotected.

\textsuperscript{76} This argument can be frustrated, however, by the implementation of state public accommodations laws. See infra Part III(B).

\textsuperscript{77} ROBERTSON, supra note 8, at 37. Such harm could include severe overpopulation, but the state intervention would need to be designed to decrease compulsion and unwanted bodily invasion. Id.

\textsuperscript{78} See Harlow, supra note 52, at 196-203 (citing numerous studies that show that children of single parent and lesbian families are not disadvantaged by that status). Note, Reproductive Technology and the Procreation Rights of the Unmarried, 98 HARV. L. REV. 669, 685 n.80 (1985).

\textsuperscript{79} Harlow, supra note 52, at 204.

\textsuperscript{80} MINN. STAT. ANN. § 363.03.3 (West 1991 & West Supp. 2003).
enforcement of such laws against private providers of ART may be contingent upon finding a strong legislative public policy statement that intends to protect unmarried women’s rights to access ART.\footnote{81} Where, as in California, the legislature also makes it clear that, “There is no public policy... prohibiting the artificial insemination of an unmarried woman,”\footnote{82} plaintiffs alleging discrimination by private ART providers on the basis of marital status or sexual orientation should succeed in garnering the protection of the state against such discrimination.\footnote{83}

But California’s explicit statement of public policy protecting unmarried women’s right to use ART isn’t necessary to bar such private discrimination if a public accommodations law exists.\footnote{84} The combination of protection from a public accommodations law, banning discrimination on the basis of marital status and sexual orientation, added to statutory protections of all women who seek access to ART, would mean that private providers would no longer retain unmitigated discretion in determining who could reproduce through their services and who could not.\footnote{85}

C. ASSOCIATIONAL RIGHT OF PRIVACY

Another privacy right framework that supports access by legally unmarried women and their known donors to reproductive technologies is the concept of the right to privacy as an associational right. Professor Radhika Rao writes that the right of privacy has been mistakenly understood as an individual right, where, in fact, it attaches only to entire relationships.\footnote{86} Rao states, “In the context of assisted reproduction,
therefore, the right to privacy shelters procreation, but only when it occurs within the confines of a close personal association.” 87 Furthermore, while adult relationships and the reproductive decisions which spring from them are protected from state intrusion by the right to privacy, that shelter ceases to exist when the individuals in those relationships become at odds with one another. 88 Rao suggests that assisted reproduction is not protected exclusively through this associational right to privacy, but through a confluence of “the rights of privacy, bodily integrity, and equal protection.” 89 Where two people (such as a known donor and sperm recipient) elect to attempt to procreate, whether through sexual intercourse, alternative insemination, or laboratory procedures like in vitro fertilization, that decision is conduct resulting from a consensual relationship, and is therefore protected by the associational right to privacy. Where a woman becomes pregnant via insemination with sperm from her known donor, her choices regarding her pregnancy are protected through her rights to bodily integrity and equal protection, as underscored in seminal cases like Roe v. Wade and Planned Parenthood v. Danforth. 90

In this case, where the question entails the rights of lesbians and/or single women to the same level of access to assisted reproduction as married couples, the necessary ingredient for protection is the presence of this “close personal association.” Thus lesbians and/or single women should enjoy these rights as well. But this extension of protection has yet to be endorsed by the Supreme Court, so, as of yet, lesbians and/or single women seeking to have children through assisted reproduction have no sanctioned right to do so.

Clearly, the courts have yet to extend the right of privacy past traditional family relationships. Bowers v. Hardwick speaks directly to this lack of protection. 91 In Bowers, the Court held that deeply held historical values could justify withholding judicial protection, and upheld the state’s right to make and enforce laws against consensual [homosexual] sodomy, even where it is conducted within the confines of the home. 92 Where

87. Id. at 1079.
88. Id.
89. Id. at 1114.
90. Planned Parenthood v. Danforth, 482 U.S. 52 (1976) (Court implicitly emphasized women’s right to bodily integrity by holding that a woman’s right to choose abortion could not be impeded by her husband’s conflicting privacy interest in sustaining her pregnancy); Roe v. Wade, 410 U.S. 113 (1973) (weighing the rights of bodily integrity and equal protection for pregnant women and fetuses in their comparable rights to privacy); see also Rao, supra note 64, at 1107-10.
91. 478 U.S. 186 (1986).
92. Id. at 195-96. Although the Georgia statute in question in Bowers prohibited anal or oral sexual conduct altogether, the Court limited its discussion to the law’s effect and enforcement regarding sexual relations between members of the same sex. Id. at 188, 200-01.

The Court is currently revisiting the issues raised in Bowers. Lawrence v. State, 41
western society has manifested an historical opposition to homosexual sexual behavior, the Court ruled that a state can properly outlaw such behavior that would otherwise be constitutionally protected. Importantly, in *Michael H. v. Gerald D.*, the Court again affirmed, in a plurality opinion, its overwhelming inclination to guard the traditional family structure over non-traditional family constellations. There, the Court held that the importance of the two-parent, different-sex family overrode a third party’s biological and relational connection to his biological child where the mother was married to a man presumed by state law to be her child’s father.

Supreme Court jurisprudence notwithstanding, donor relationships, contracted knowingly between consenting adults who have, by definition, formed a “close, personal association” should be protected from state intrusion under the associational right to privacy, and free to dictate the terms and conditions under which assisted reproduction is to occur. If, for example, a legally unmarried woman wishes to use fresh sperm for insemination (perhaps because her known donor’s sperm count is low and will not survive freezing), she should be entitled to do so as long as she knowingly consents to the attendant risks of using that sperm.

Even if this right were to extend to known sperm donors, recipients, and even recipients’ partners, what would happen after a child is born if subsequent disputes arise between the biological parents? Rao posits that even where “the right to privacy extends to use of the technique of artificial

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S.W.3d 349 (Tex. App. 2001) (cert. granted, Lawrence v. Texas, 123 S. Ct. 661 (2002)). *Lawrence* deals directly with a Texas statute that prohibits “deviate sexual intercourse” (defined as “any contact between any part of the genitals of one person and the mouth or anus of another person; or ... the penetration of the genitals or the anus of another person with an object”) between same-sex individuals. *Id.* at 350. The Supreme Court has granted certiorari, and as of the time this note is going to press, has already heard oral argument. The outcome of this case, whether decided on equal protection or substantive due process/privacy grounds, may change the discussion here considerably. It is the author’s hope that those changes are beneficial to same-sex partners and their families.

95. *Id.* at 131.
96. Rao, supra note 64, at 1117-18. Rao cautions, however, that women using known donors risk enfolding them in the relationship protected by the right to privacy. *Id.* at 1120. This would expose such women to weakened protection if their donors later contradict their stated preconception intentions and assert themselves as legal parents entitled to associated privileges and responsibilities. *Id.* But as this Note argues, where women and their known donors have demonstrated their unequivocal preconception intent to shield the known donor from legal parentage permanently, the state should weigh heavily that intent in deciding to preserve the integrity of the women’s families over the donor’s biological “investment” in the children of those families.

97. Indeed, the point here is that sperm recipients should be allowed to make informed choices, just as legally married recipients may do. Where ART providers will allow the use of fresh sperm between spouses (and sometimes heterosexually intimate partners) even though the risk of HIV may exist, they deny lesbian sperm recipients the option to make those same choices with their known donors.
insemination with donor sperm in order to conceive a child, it does not also empower one biological parent to bar the other from contact with a child born from assisted reproduction. ...” 98 However, many theorists counter this argument by stressing individuals’ right to contract in the form of preconception agreements, where a party may, as a function of reproductive liberty, legitimately forfeit any future parental rights and responsibilities despite a biological relationship to his/her child. 99 Given the current judicial adherence to traditional family values, prospective parents using donor insemination should emphasize the legitimacy of their contractual agreements as a way to gain protection for their nontraditional families.

IV. RIGHTS GROUNDED IN CONTRACT THEORY

A. STATE ENFORCEMENT OF PRECONCEPTION AGREEMENTS

The current judicial treatment of preconception contracts and arrangements, even where provided for by law, is far from consistent. For women using donor insemination, California law provides a method of enforcing a preconception agreement to prevent the donor from being recognized as the children’s natural father. California Family Code section 7613, subsection (b), states: “The donor of semen provided to a licensed physician and surgeon for use in artificial insemination of a woman other than the donor’s wife is treated in law as if he were not the natural father of a child thereby conceived.” 100

But, if a woman was unable to use a physician as an intermediary, the donor’s “paternity rights” can prevail, even if a preconception agreement to the contrary was bargained for, drafted, and executed to the fullest extent

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98. Rao, supra note 64, at 1085.
100. CAL. FAM. CODE § 7613 (West 2001). In practice, this law is not understood to require that a physician perform the insemination, but merely that the physician touch the semen container before the recipient does. Some medical practices in San Francisco are known to provide mere hand-off services, in addition to inseminations, for clients who wish to fulfill the statutory requirements described above. Interview with Valerie Curtis Blau, M.D., former staff member at UCSF Fertility Clinic in San Francisco, California (Jan. 10, 2002). Currently seven other states have comparable statutes that apply to all women, regardless of their marital status. Those states are Colorado, Illinois, New Jersey, New Mexico, Washington, Wisconsin, and Wyoming. NATIONAL CENTER FOR LESBIAN RIGHTS, supra note 41, at app. F.
possible. In Jhordan C. v. Mark K.,\textsuperscript{101} a single woman used a known donor who agreed by contract that he would not assert his paternity should their insemination result in a child.\textsuperscript{102} Later, after the birth of the child, the donor changed his mind and sued to establish paternity and visitation rights.\textsuperscript{103} The Court refused to honor the parties' preconception contract and recognized paternity, reasoning that the parties had failed to use a physician as intermediary as prescribed by statute.\textsuperscript{104}

The holding in Jhordan C. naturally leads many sperm recipients and known sperm donors to believe that using the physician intermediary, where provided for by statute, is the most legally sound method for effectively barring the sperm donor from being considered a legal parent. In re R.C.,\textsuperscript{105} however, was a case where the law in question had identical language to California's, but the fact pattern was the converse of Jhordan C. There, a single woman had a physician perform both the hand-off and the insemination of sperm from a known donor, but had not prepared a preconception agreement (which was not required by law).\textsuperscript{106} The donor filed suit after the birth of the woman's child, alleging that the woman had promised him he would retain parental rights should there be a child.\textsuperscript{107} The Court refused to apply the statute and acknowledged the donor's paternity, asserting that the statute did not apply to known donor situations.\textsuperscript{108}

Clearly, the holdings in Jhordan C. and R.C. reflect an ongoing struggle among the courts to assign parental roles where both biology and intent to parent have deviated from the traditional family structure. In each case, the courts found a way to acknowledge the paternity of the known donor, even though the parties had clearly acted before conception to prevent that from happening. It appears that many courts are simply not ready to address these nontraditional families on their terms, and are still attempting to have them fit older, traditional models of families. As more of these cases arise, courts should look more to the intent expressed by the parties before (and to some extent, after) conception through contractual agreements than to whether or not the families can be forcibly reshaped to adhere to traditional, two-parent, heterosexual models.

B. MEETING THE STATE INTEREST IN CLARIFYING PARENTAGE BY LOOKING TO INTENT TO PARENT

It is well established that the state retains a strong interest in ensuring

\begin{enumerate}
\item Jhordan C. v. Mark K., 224 Cal. Rptr. 530 (Ct. App. 1986).
\item Id. at 532.
\item Id. at 533.
\item Id. at 535.
\item In re R.C., 775 P.2d 27 (Colo. 1989) (en banc).
\item Id. at 28.
\item Id.
\item Id. at 35.
\end{enumerate}
that children are accounted for by legal parents. Although courts do not consistently weigh intent to parent as heavily as they should, they would do well to apply traditional notions of contract theory in determining who bears parental rights and responsibilities for planned children.

Historically, parentage was generally established through biological relationship. As reproductive technology and family structures continue to evolve, however, the use of biology as a tool for clarifying parentage is decreasingly instructive. Recent surrogacy cases are clearly analogous to the consideration of parenthood based on procreative intention, but courts have yet to broadly apply standards announced in that context to ratification of preconception intent.

In *Johnson v. Calvert*, a husband and wife contracted with a surrogate to carry their embryo. Relations between the surrogate and the couple soured, and all vied for a determination that they were the child's legal parents. The California Supreme Court affirmed that the couple were the child's natural parents, and upheld the surrogacy contract against the surrogate's claims. There, the court asserted that although both genetic consanguinity and gestation are means of establishing a "parent-child relationship," if those roles are divided between two people, the one who intended to bring about the birth of the child and raise it as her own is the natural mother.

In *In re Marriage of Buzzanca*, a married couple entered into a surrogacy contract with a woman that specified that none of the parties were to contribute ovum or sperm, but the embryo would be donated. While the surrogate carried the non-genetically related fetus, the couple's marriage faltered. Upon seeking a divorce, the husband disclaimed any parental responsibility to the child. The wife asserted that both she and her estranged husband were the legal parents. The surrogate/gestational mother, per the contract, stipulated that she was not biologically related to the child. Relying on archaic notions that biology determines parenthood, the trial court found that the child, whose sperm and egg donors were presumably permanently anonymous, had no lawful parents

110. 851 P.2d 776 (Cal. 1993).
111. *Id.* at 778.
112. *Id.* at 787.
113. *Id.* at 785.
115. *Id.*
116. *Id.*
117. *Id.*
118. *Id.*
whatsoever. Entirely dissatisfied with that result, the Court of Appeal reversed, holding that, were it not for the intent and agreement of the married couple to become parents, the child would not exist. The court held that California Family Code section 7613 should be applied to a wife and non-biological mother in the same way it applies to a non-biological father and husband, and acknowledged that the same logic might be extended to apply to a legally unmarried couple. Reflecting the courts' consistent concern that children have a "natural," i.e. legal, mother and father, the Court of Appeal reversed, holding that both of the Buzzancas (just like the husband whose wife conceives through donor insemination under California Family Code section 7613) are the lawful parents based on their exclusive intent to bring the child into the world as their own. However, while the court pointed to a number of cases related to lesbian parents, it refused to speculate as to the impact that its holding in Buzzanca would have on them. The Buzzanca court explicitly distinguished such cases from the case at bar on the grounds that Buzzanca only grappled with legally married couples.

For same-sex parents, traditional notions of family still limit the extent of judicial support their families receive. Widespread societal preference for two-parent, two-gender families appears to limit courts' willingness to uphold donor and parenting agreements where no father would otherwise exist. As in the cases of Jhordan C. and In re R.C., California and Colorado courts acknowledged legal paternity of known donors even though the donors and recipients had specifically contracted to permanently release the donors from all privileges and responsibilities of fatherhood. Again, where the donor had even a marginal or casual relationship to the children, the courts overwhelmingly preferred to extend that relationship

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119. Id. at 289.
120. In re Marriage of Buzzanca, 72 Cal. Rptr. 2d 280, 293 (Ct. App. 1998).
121. Id. at 286.
122. Id.
123. Id. at 287.
124. Id.
125. See C.M. v. C.C., 377 A.2d 821, 824 (N.J. Juv. & Dom. Rel. 1977). "The courts have consistently shown a policy favoring the requirement that a child be provided with a father as well as a mother." Id.
126. NATIONAL CENTER FOR LESBIAN RIGHTS, supra note 41, at 6.

The courts have consistently shown a policy favoring the requirement that a child be provided with a father. When there is no husband to assume that role, some judges have been known to place a burden beyond the requirements of the statute on single women to demonstrate that the donor did not intend to be the father of the child (such as a written agreement by the donor to relinquish his parental rights), otherwise the donor may be considered a natural father entitled to visitation with respect to an "illegitimate" child.

Id.
with legal parentage.\footnote{127}

In some jurisdictions of California, however, courts are recognizing couples consisting of biological and non-biological prospective parents who sought to conceive through donor insemination as legal parents under California Family Code section 7613. Although this recognition has yet to be thoroughly tested in the courts, its mere existence underscores the courts’ increasing and appropriate emphasis on assigning parentage based on intent, regardless of the gender of the parents. This is a hopeful direction, and one that other jurisdictions would do well to follow. Ultimately, if courts express a preference for two-parent homes (not just families), this preference is best met by acknowledging legal parents based on their preconception intent rather than on their biological relationship (or

\footnote{127. Until 2001, many courts in California, upon the specific recommendation of the California Department of Social Services, authorized “modified” independent adoptions, allowing same-sex partners of biological parents to attain legal parentage status of their partners’ children. Until recently, many California courts allowed these adoptions under California Family Code sections 8617 and 8819, which allow biological parents to independently relinquish and assign parental rights directly to adoptive parents. See CAL. FAM. CODE §§ 8617, 8819 (West 2002). The Department of Social Services had devised a form which amended the independent adoption process by clarifying that, in situations like the instant case, the biological parent was not so much relinquishing her own parental rights as assigning parental rights to a second, adoptive parent.

However, In Sharon S. v. Superior Court, this adoptive process was thwarted, pending imminent review by the California Supreme Court. 113 Cal. Rptr. 2d 107 (Ct. App. 2002) (review granted and opinion superseded by Sharon S. v. Superior Court, 39 P.3d 512 (2002)). Sharon S. and Annette F. were longtime partners and legal parents to Sharon’s biological child. Id. at 110. Annette and Sharon together planned and participated in every stage of the insemination process, and after the child was born, Annette adopted the child through the second parent adoption process described above. Id. A few years later, the couple planned for Sharon’s second pregnancy. Id. Sharon gave birth to the second child, and the couple began the process to petition for a second parent adoption for Annette. Id. Unfortunately, the relationship between the two women faltered, and Sharon sought to bar Annette’s pending adoption of the second child, asserting that none of the California adoption statutes permitted second parent adoptions. Id. at 111-12.

The Court of Appeal rejected modified independent adoptions for second parents, holding that California law does not provide for such adoptions. Id. at 115. Although the Department of Social Services asserted that it was merely considering adoption cases on a “case-by-case basis,” without using marital status as a determining factor, the court rejected that rationale, finding that there was no legislative intent to allow second parent adoptions. Id. at 112-15. As noted, the California Supreme Court has granted review of Sharon S. Sharon S. v. Superior Court, 39 P.3d 512 (2002). In the interim, the California legislature enacted Assembly Bill 25 (2002), explicitly granting state-registered domestic partners the ability to adopt their partners’ biological children through stepparent adoption under California Family Code section 9000. CAL. FAM. CODE § 9000 (West 2002)).

In In re Marriage of Buzzanca, discussed supra, the court was willing to extend the logic of California Family Code section 7613 to include non-biological mothers to keep parentage consistent with preconception intent, but that case involved maintaining parentage so that the child there had a legal mother and father. In re Marriage of Buzzanca, 72 Cal. Rptr. 2d 280, 286-87 (Ct. App. 1998). In Sharon S., however, the court was far less concerned with maintaining parentage so that the child had its two intended parents, given that those parents were the same-sex, and hence legally unmarried. Sharon S., 113 Cal. Rptr. 2d at 113-15.}
lack thereof) to their children.

C. PHYSICIAN CONTROL AND THE CATCH-22\textsuperscript{128}

Even if the statutory language in California and Colorado does apply to known donor situations, it still may present a substantial problem for legally unmarried women. Where the statute compels legally unmarried women to use a physician as an intermediary to protect the donor from paternal rights and responsibilities, physicians themselves frequently refuse to provide their services on the basis of marital status and/or sexual orientation.\textsuperscript{129}

V. CALIFORNIA REGULATION OF ACCESS TO ART AND THE EXAMPLE OF FRESH VERSUS FROZEN SPERM

Users of basic reproductive technologies like vaginal and intrauterine insemination, married or not, should be equally entitled to consent to such procedures. An illuminating example is the issue of fresh and frozen sperm, how its use is treated by the law, and how its use is controlled by physicians and other ART providers.

A. FRESH SPERM FOR ALL KNOWN DONORS

Where male fertility is compromised, the difference in rates of conception between fresh and frozen sperm is considerable since frozen semen samples with low sperm counts may yield few to no sperm upon thawing. In many cases, women looking to conceive with men whose semen samples reflect low sperm counts may learn that their best odds of conceiving through insemination are through intrauterine insemination using fresh sperm.\textsuperscript{130} Physicians will not only perform inseminations on married women using their husband’s fresh sperm; they often insist on it for the increased odds of pregnancy that fresh sperm yields. Most, however, refuse to perform the procedure for legally unmarried recipients with their known donors’ sperm.\textsuperscript{131}

In some known donor relationships, recipients’ selection of their donors is a long, thoughtful process, many years in the making. There are a myriad of factors evaluated in choosing a donor. Recipients may choose a known donor because there is a close relationship between the parties, there is an increased possibility of using the same donor for future children, or even for genetic reasons.\textsuperscript{132} Regardless as to their reasons for selecting a

\textsuperscript{128} Harlow, supra note 52, at 214.
\textsuperscript{129} See id.
\textsuperscript{130} TOEVS & BRILL, supra note 11, at 345.
\textsuperscript{131} Informal poll, conducted by author, of fifteen ART clinics in California (Feb. 5-12, 2002) (on file with author).
\textsuperscript{132} Henry, supra note 12, at 301 (noting that an unmarried woman might choose a known donor to have access to their medical background, to establish a biological relationship between siblings born to the recipients, or to resolve any mystery that children would
particular donor, these recipients are as entitled to select the donor of their choice as are women who “choose” their husbands.

Although the use of fresh sperm involves some risk that HIV could be communicated, this is a risk that millions of informed Americans are entitled to take whether they reproduce coitally or noncoitally with fresh semen. When a donor is found to have a low sperm count, recipients and donors should be as entitled as married couples to pursue IUI, and California law explicitly allows for their use of fresh sperm.

California Health and Safety Code section 1644.5 provides that all tissue transfers shall be done only if the donor has been screened and found negative for evidence of infection with HIV, hepatitis, and syphilis. For sperm donors, however, section 1644.5, subsection (c), provides a relevant exception:

1. A recipient of sperm, from a sperm donor known to the recipient, may waive a second or other repeat testing of that donor if the recipient is informed of the requirements for testing donors under this section and signs a written waiver.

2. A recipient of sperm may consent to therapeutic insemination of sperm or use of sperm in other advanced reproductive technologies even if the sperm donor is found reactive for hepatitis B, hepatitis C, or syphilis if the sperm donor is the spouse of, partner of, or designated donor for that recipient.

This law clearly establishes that it is the prerogative of the recipient, whether or not she is otherwise sexually involved with her known donor, to waive a retest of the donor once he has been tested for HIV and other diseases. Nonetheless, many physicians and ART facilities refuse to

otherwise incur if their sperm donor were forever unknown to them).

133. See Noble, supra note 12, at 102-03.

134. Cal. Health & Safety Code § 1644.5 (West 2001). Subdivision (a) of that code section provides:

No tissue shall be transferred into the body of another person by means of transplantation, unless the donor of the tissues has been screened and found nonreactive by laboratory tests for evidence of infection with HIV, agents of viral hepatitis (HBV and HCV) human T lymphotrophic virus-I (HTLV-I), and syphilis. The State Department of Health may adopt regulations requiring additional screening test of donors or tissues when in the opinion of the State Department, the action is necessary for the protection of the public, donors, or recipients.

Id. § 1644.5(a).

135. Id. § 1644.5(c) (emphasis added).

136. The California Legislature had every intention of making this law applicable to women who were working with known donors. Had the goal been to restrict it to spouses and sexually intimate partners, it would have used only the terms “spouse” and “partner.” “Designated donor” can only mean “known donor” as it is used here.
allow recipients access to technologies to which they are entitled by law.137

B. PHYSICIANS’ DISCREPANT UNDERSTANDING OF LAW

Assisted reproductive technology (ART) is currently progressing far faster than the law. As a result, a good deal of ART is unregulated. While there are few laws or medical guidelines which dictate the conditions under which ART may be performed, physicians and tissue banks, following either accreditation standards or privately generated guidelines, often believe that they are acting in accordance with laws which do not exist.

When several ART providers in California were asked if they would provide any services (insemination, in vitro fertilization, or otherwise) for a recipient using her known donor’s fresh sperm, the majority said that they could only use fresh sperm when the recipient and donor were married.138 Each provider grounded this policy in their expressed (however mistaken) belief that California law prohibited the use of fresh sperm between donors and recipients who were not otherwise “sexually intimate.” Although the law specifically uses the language, “or designated donor,” many physicians and other ART providers seem to be under the impression that they cannot allow recipients of known donors’ sperm to waive a retest. This may have something to do with the suggested guidelines put forth by the American Association of Tissue Banks (AATB), a scientific, nonprofit peer group organization. The organization suggests that all known donor sperm be screened and frozen for at least six months, in the same ways that anonymous sperm should be treated, and that sperm of recipients’ intimate partners need not be screened in such a fashion (if at all).139

This is not to say that there are not legitimate concerns associated with

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137. In a troubling recent development, a new Food and Drug Administration regulation may codify this practice into law. See Suitability Determination for Human Cellular and Tissue-Based Products, 64 Fed. Reg. 52,626 (Sept. 30, 1999) (to be codified at 21 C.F.R. pts. 210, 211, 820, 1271). A proposed rule would require that all known donors’ semen would be necessarily frozen and quarantined for six months, effectively disallowing the use of fresh sperm from known donors who are not the sexual partners of the recipients, even where sperm are not viable after freezing. Id. at 52,706 (to be codified at 21 C.F.R. pt. 1271.80(d)). Furthermore, the proposed rule goes much further: It proposes to ban donations from anyone identified as having a risk factor or clinical evidence of communicable disease. Id. at 52,722 (to be codified at 21 C.F.R. pt. 1271.75(c)). Both aspects of this proposed rule have been subject to considerable criticism, but the public comment period for the rule closed on December 29, 1999. Id. at 52,626. The formal rule has yet to be issued.

138. Informal poll, conducted by author. Among twenty-eight California ART providers queried, two ART providers said that it was their policy (mistakenly), under law, to confine the use of fresh sperm to donors and recipients who were otherwise sexually intimate partners, not necessarily legally married. Id.; see also Interview with Dr. Victor Fujimoto, UCSF Fertility Clinic, San Francisco, California (July 30, 2001); Telephone interview with Sharon Mills, Director, Pacific Reproductive Services, San Francisco, California (Feb. 4, 2002).

139. See generally, American Association of Tissue Banks, Reproductive Tissue, at http://www.aatb.org (last visited May 1, 2003).
the use of fresh sperm. Again, using fresh sperm means that donors cannot be tested for the presence of HIV at the time of the sperm donation (since a test performed at that time can only show conclusively that the donor was HIV negative six months prior to the test). This presents some risk that the recipient (and even a resulting fetus, if it develops) could contract HIV, but this risk exists for all sperm recipients. When a known donor agrees and contracts with the intended recipient to refrain from risk behavior for sexually transmitted diseases upon being screened for the presence of HIV and other sexually transmitted diseases, it is up to the recipient to determine whether she is willing to trust that particular donor based on her understanding of his trustworthiness. Similarly, this is the case with other married and otherwise sexually intimate donors and recipients. A woman who is using her sexual partner's sperm to reproduce, whether coitally or not, must make an independent determination as to whether she trusts her partner to have refrained from any behavior that could have subjected him to HIV transmission since his last test (and the six months prior to that). If sexually intimate partners are able to make the determination to use fresh sperm for procreative purposes, recipients of known donors’ sperm should be entitled to make that same determination. Furthermore, where either donor or recipient has concerns that the use of fresh sperm could transmit HIV, she/he should be able to choose to have the sperm “washed” in order to significantly reduce the risk of transmission.

VI. PROPOSED REGULATION TO PROTECT UNMARRIED WOMEN'S ACCESS TO ART

Despite the size of the ART industry, there is a striking paucity of regulation controlling it. Among a large number of unregulated areas, there are two areas that merit more attention and regulation in regard to legally unmarried women’s access to ART: 1) supervision of the relationship between providers and consumers; and 2) clarification of the responsibilities and rights of legally unmarried women and their donors.

A. REGULATION OF THE RELATIONSHIP BETWEEN PROVIDERS AND CONSUMERS

As argued above, ART providers exercise far too much discretion in

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140. This is true in every state except Illinois, which requires that “all donors of semen for purposes of artificial insemination be tested for evidence of exposure to human immunodeficiency virus (HIV) or any other identified causative agent of acquired immunodeficiency syndrome (AIDS) prior to the semen being made available for that use.” 20 ILL. COMP. STAT. 2310/2310-325 (2001). This means that all sperm from all sperm donors, married or not, must be frozen so that the donor can be retested for HIV before the sperm is released.
142. Daar, supra note 9, at 639.
143. Id. at 637.
determining "appropriate" patients. Regulation of ART practitioners, in setting standards for licensure of ART physicians and support staff, could make licensure contingent upon practitioners' refraining from discriminating against prospective patients on the basis of marital status and/or sexual orientation. As in California, states can require that practitioners obtain written informed consent before performing services, especially where there is any risk of significant bodily harm, including the communication of sexually transmitted disease.

B. CLARIFICATION OF THE RESPONSIBILITIES AND RIGHTS OF LEGALLY UNMARRIED WOMEN AND THEIR KNOWN DONORS

Although the focus here is on equalizing access to various forms of ART, the future for women and their children conceived through ART is an important element of initial access. It is critical that states enable women and their donors to make binding preconception agreements. Legally unmarried women should be permitted to use known donors without running the risk of paternity suits. States should, at minimum, pass legislation similar to California's to enable elimination of future paternity if sperm samples pass through licensed physicians or other specified professionals.

This strategy soundly rejects the rationale behind the famous case of In re Baby M., where the New Jersey Supreme Court asserted that the natural rights of biological parents cannot and should not be bargained away. In Baby M., the court held that surrogacy contracts were void for public policy reasons in that neither children nor rights to parentage should be bought or sold.

The California case of Johnson v. Calvert provides a more apt model than Baby M. for evaluating the rights of lesbian and single women in forming their families. Whereas Baby M. prohibits parties from contracting away their natural parentage, Johnson v. Calvert is far more

144. Id. at 639.
145. Henry, supra note 12, at 301.
146. Although it is not preferable to continue to put physicians at the center of otherwise non-medical processes (like standard vaginal inseminations), this would occur with the understanding that physicians could no longer discriminate based on marital status and sexual orientation, and that many ART processes should require a physician. Some advocates of unmarried women's access to ART maintain that it is still better to place physicians at the center of the insemination dynamic to ensure that proper medical screening of the donor and recipient can occur. See Note, supra note 78, at 685 n.16.
148. Id. at 1240.
149. Johnson v. Calvert, 851 P.2d 776 (Cal. 1993). In Johnson, the court held that surrogacy contracts do not sell a "mother's" rights, but are agreements to "provide a necessary and profoundly important service without (by definition) any expectation that she will raise the resulting child as her own." Id. at 787. Furthermore, any payments in relation to such contracts are made for the service of gestation, not for the purchase of parental rights. Id. at 784.
engaged with current realities, recognizing that the state itself benefits from acknowledging that intended, responsible parents and biological or gestational parents are not always, and should not always be, one and the same. It is far better for the state to encourage parties to establish parentage before the birth of a child, thereby preventing the many costs and risks of messy litigation to both the child and the state. There is also another factor to the strategies advocated here that is distinguishable from Baby M. There, the court was particularly concerned with the notion of placing parentage rights on the open market. Here, however, there is no suggestion that donor and preconception contracts are commercial in nature—parentage rights are not for sale. They are to be assigned without payment, legally and permanently.

States should follow burgeoning judicial practices by allowing written preconception agreements, notarized or ratified by the courts (through, for example, family law magistrates) to designate future parental roles as binding unless all contracting parties agree later to modify their agreement. This way, parties could avoid the intrusion, expense, and interference that one or more required visits to a physician might impose. It would also include “the involvement of an objective third party [who] ‘can serve to create a formal, documented structure for the donor-recipient relationship, without which . . . misunderstandings between the parties regarding the nature of their relationship and the donor’s relationship to the child will be more likely to occur.’” Most importantly, it would provide the stability and parental responsibility that is in the best interest of both the child and the state.

VII. CONCLUSION

Lesbians and/or single women are legitimate consumers of ART, but have been restricted by physician discretion and bias. Because ART and access to ART remains largely unregulated, and because there are so few professional guidelines or standards in this arena, many physicians feel free to exercise personal judgment in determining who should have access to reproductive technologies and to what extent that access should be granted. It is unrealistic, in this era of accepted and abundant single parenting, for states to refuse to protect legally unmarried people’s ability to procreate in the manner they see fit. As California has done, states need to pass explicit legislation that makes legally unmarried people’s access to ART a matter of public policy. Following California’s model, legislatures should ensure that there are concrete ways for sperm recipients and their donors to effectively bar future acknowledgment of paternity. States can pass

150. Henry, supra note 12, at 301.
151. Daar, supra note 9, at 301 (quoting arguments of defendant mother in Jhordan C. v. Mark K., 224 Cal. Rptr. 530, 535 (Ct. App. 1986)).
legislation to enforce written preconception agreements and designate legal parentage based on those agreements, not on biology.

By passing and enforcing public accommodations laws, states will endow lesbians and/or single women with a legal remedy for the damage they incur when their reproductive autonomy is impeded by physician bias. When ART providers mistakenly (or willfully) invoke nonexistent law to enforce discriminatory policies, patients who have been refused services should have authority to resist those policies.