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THE NEED FOR REGULATION OF ARTIFICIAL INSEMINATION BY DONOR

Artificial Insemination by Donor is an alternative method of conception for people who are unable or unwilling to conceive children through natural means. Thousands of people are conceived through these means each year, and use of the procedure continues to grow. Although Artificial Insemination by Donor is becoming increasingly significant in today's society, it continues to be practiced by doctors without any guidelines for donor selection or a standardized system of record keeping. This Comment explores the situation and explains the dangers of this haphazard system. Finally, a model statute is presented as a method of regulating the system, while protecting the interests of everyone involved.

INTRODUCTION

Artificial Insemination by Donor (AID)\(^1\) provides an option to people otherwise destined to be childless. The practice is growing rapidly, without regulation by either the medical profession or state legislatures. Expanding with the use of the procedure is the need for regulation to assure that the sperm donors employed are healthy. This need extends to the area of record keeping, which is virtually non-existent. As the number of individuals conceived through AID

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1. "Artificial Insemination may be defined as the introduction of the male semen into the vagina for the sake of procreation by any means other than through the act of copulation. In the human the semen employed in artificial insemination may be from the husband (A.I.H.) or from some other donor (A.I.D.); in medical terminology the former is referred to as homologous and the latter as heterologous insemination." Guttmacher, Artificial Insemination, 18 De Paul L. Rev. 566, 566 (1969). The procedure of AID is very simple, requiring nothing more than a syringe with which to direct semen toward the cervix, and takes only a few minutes to complete. Id. at 574.
grows, an increasingly large percentage of the population of the country will have no paternal medical history, or any way to obtain this information. With the rapid increase in the use of AID, a system of regulation should be established to provide a data base for the future evaluation of currently unforeseen needs. This Comment will propose model legislation to provide guidelines for the regulation of AID.

THE GROWING SIGNIFICANCE OF AID

The practice of artificial insemination by donor is of current and growing significance, as evidenced by the estimates of births through AID, which range from 6,000 to 20,000 children annually. Current figures show that 250,000 people in the United States have been conceived through AID, and it is projected that an additional one and a half million children will be conceived through this procedure by the end of the century.

Current public opinion and social conditions point to a continued increase in the public acceptance of medical intervention in conception. This is also reflected in, and will no doubt be stimulated by, the early signs of interest by the advertising industry, which has begun to study the market.

Many individuals can benefit from the practice of AID. AID is most commonly used to overcome male infertility but may also be

4. Exact figures regarding the growth of birth rates are difficult to assess due to the great secrecy maintained by doctors. Id. at 56.
5. Id. While this figure is broadly cited, realize that it may be much larger by the end of 1985, since the AID population is increasing by as many as 20,000 people annually.
6. Bagne, High-Tech Breeding, MOTHER JONES, Aug. 1983, at 23. This projection is reasonable in light of the growth of AID in recent years. The entire population of AID offspring prior to 1941 is believed to have been 10,000 with annual births increasing to between 1,000 and 1,200 children during the years 1941 through 1963. Comment, Artificial Insemination and the Law, B.Y.U. L. REV. 935, 938 (1982). These figures, when contrasted with the largest available estimate of 20,000 births per year for recent years, show the steady expansion in the use of AID.
7. A 1969 Harris poll found that only 19% of those interviewed were in favor of the principle of AID. Thirty-five percent of those interviewed approved of the procedure if it was the sole means by which a couple could have children. A 1978 Gallup Poll taken after the first successful use of in vitro fertilization (the procedure by which eggs are removed from the ovaries of a female, fertilized outside the body, and then implanted in the uterus of the female) revealed public approval of the procedure by a two-to-one margin. Smith, The Razor's Edge of Human Bonding: Artificial Fathers and Surrogate Mothers, 5 W. NEW. ENG. L. REV. 110 (1982).
8. Pendleton, Sperm Bank Ads in Trades, Consumer Books Next, ADVERTISING AGE, May 14, 1979, at 30. This trade journal views AID as an excellent market and suggests the solicitation ofvertisements from sperm banks and other AID practitioners.
9. Cohen, Lullrel & Shapiro, Current Practice of Artificial Insemination by Do-
used by couples who experience a combination of male and female infertility, if the female is treated before insemination.\textsuperscript{10}

Increased public acceptance of AID is also due to the decreasing number of children available for adoption.\textsuperscript{11} The permanence of this decline is reflected in its causes: the availability of contraception and legal abortion, the decreased stigma of illegitimacy, the increase in child care facilities for single mothers, and the shifting of male attitudes regarding child-rearing.\textsuperscript{12}

Proponents of AID point to factors which they believe make the use of a donor inherently superior to adoption. These include: the absence of a threat that the biological mother will return, the fact that the child is biologically related to one of his parents, the outward appearance that the husband has successfully impregnated his wife, the parents' ability to experience the pregnancy, and the child's resemblance to the parents.\textsuperscript{13} These reasons, coupled with the long delays caused by scarcity of adoptees, make AID an attractive option.\textsuperscript{14}

While infertility is the primary reason for using AID, others have been cited.\textsuperscript{15} The most common of these secondary reasons is the

\textit{nor in the United States, 300 NEW ENG. J. MED. 585 (1979) [hereinafter cited as the Cohen study]. See also W. FINEGOLD, supra note 3, at 18. Approximately one in six American couples are affected by infertility. Gerber, \textit{Semen Abnormalities in Artificial Donor Candidates}, 130 J. OF UROLOGY 266 (1983). See also Wallis, \textit{The New Origins of Life}, NEWSWEEK, Sept. 10, 1984, at 46. An estimated 30\% of all infertility cases are caused solely by the male factor. Wing, \textit{Artificial Donor Insemination: Analysis of 149 Cases at North Carolina Memorial Hospital}, 77 S. MED. J. 607 (1984). This new realization of the importance of the male factor in infertility has made AID a routine procedure in many facilities specializing in the treatment of infertility. Id. at 609.}

10. Wing, supra note 9, at 609.


12. Id. at 466-67. See also Timmons, \textit{Genetic Screening of Donors for Artificial Insemination}, 35 FERTILITY & STERILITY 425 (1981). This decline in available children puts additional strain on those couples wishing to adopt who already face competition of up to 15 couples for each available child. W. FINEGOLD, supra note 3, at 22.


14. Dr. Finegold cites a survey of 395 sterile couples. Of these couples, 215 preferred AID to adoption, 99 preferred adoption, and only 19 were opposed to AID. Id.

15. One widely cited survey noted that while 95\% of AID procedures performed by responding physicians were for male infertility, 40\% of the doctors had provided AID for some other reason. Cohen study, supra note 9, at 585. The Cohen study is of great importance because it is the only thorough, reputable study available on AID. Questionnaires were sent to 711 physicians likely to perform AID. Of the 471 who responded, 379 indicated that they had performed the procedure. Use of AID by these physicians accounted for approximately 3,576 births in 1977. Each questionnaire contained seven sections: frequency of artificial insemination, success rate, donor selection, recipient diagno-
fear of transmitting a genetic disease to the child. AID is also used to overcome problems associated with sexually transmitted diseases and physical limitations that make intercourse impossible. Additionally, AID is used increasingly to provide natural offspring to unmarried women.

**Current Regulation**

Currently, only twenty-four states have passed laws defining the legal status of children conceived through AID. Thus, with fewer than half the states addressing even the most obvious legal issue involving AID, it is apparent that regulation of the system is minimal. Presently, only two governmental entities have attempted to regulate the selection of donors: the State of Oregon, and the City of New York.

The Oregon statute requires that a doctor select the donor and that he not provide his sperm for artificial insemination if he

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1. Id.
2. Id.
3. W. FINEGOLD, supra note 3, at 205.
4. The Cohen study indicated that 9.5% of the doctors had performed AID on single women desiring children. Cohen study, supra note 9, at 585. Compare the Oregon statute cited infra at note 22, which implicitly allows the use of AID on single women by requiring the consent of a husband only if the woman is married, with the statutory counterpart of California, which assumes the woman is married by requiring, without reservation, her husband's consent. For a discussion supporting the use of AID by single women, see Kern, The Fourteenth Amendment's Protection of a Woman's Right to be a Single Parent Through Artificial Insemination by Donor, 7 WOMEN'S RTS. L. REP. 251 (1983). The use of AID by single women is very controversial. It raises many issues, most notably whether a doctor should help a woman conceive a legally illegitimate child. That many of these women are lesbians, who choose AID to avoid sexual contact with men, adds fuel to the debate.

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20. In discussing legal status, the focus herein is primarily on the determination of the child's legal parents, and his legitimacy.
23. NEW YORK CITY, N.Y., HEALTH CODE art. 21 (1949).
24. "Only physicians licensed under this chapter and persons under their supervision may select artificial insemination donors and perform artificial insemination." OR. REV. STAT. § 677.360.
knows of, or has reason to know of, a transmittable genetic defect or a venereal disease. The New York City ordinance is a more pervasive regulatory scheme. This ordinance requires that the donor be tested for gonorrhea and that a blood test be performed to assure Rh compatibility with the recipient. The New York ordinance also prohibits the use of sperm from a donor who has any other venereal

25. "No semen shall be donated for use in artificial insemination by any person who (1) has any disease or defect known by him to be transmissible by genes or (2) knows or has reason to know he has a venereal disease." Id. at § 677.370. One commentator believes this statute implicitly requires that a prospective donor be examined. Comment, Artificial Insemination and Surrogate Motherhood — A Nursery Full of Unresolved Questions, 17 WILLAMETTE L. J. 926 (1981). The wording of the statute sets forth no such requirement, and in light of the absence of a similar requirement in any other state, this interpretation stretches the wording too far. The Oregon statute is worth individual attention, however, because it does make an effort to control the quality of sperm obtained. While many states require that a doctor perform the artificial insemination, the primary addition in the Oregon statute is the quality control provision.

26. Regulations Governing the Providing of Seminal Fluid for Artificial Human Insemination. NEW YORK CITY, N.Y., HEALTH CODE art. 21 (1949).

Regul. 1. A person from whom seminal fluid is to be collected for the purpose of artificial human insemination shall have a complete physical examination with particular attention to the genitalia at the time of the taking of such seminal fluid.

Regul. 2. Such person shall have a standard serological test for syphilis and a smear and culture for gonorrhea not less than one week before such seminal fluid is obtained.

Regul. 3. No person suffering from any venereal diseases, tuberculosis, or infection with brucella organisms, shall be used as a donor of seminal fluid for the purpose of artificial human insemination.

Regul. 4. No person having any disease or defect known to be transmissible by the genes shall be used as a donor of seminal fluid for the purpose of artificial human insemination.

Regul. 5. Before artificial human insemination is undertaken, both the proposed donor and proposed recipient shall have their bloods tested with respect to the Rh factor at a laboratory approved for serology by the Board of Commissioner of Health. If the proposed recipient is negative for the Rh factor, no semen shall be used for artificial insemination other than from a donor of seminal fluid whose blood is also negative for this factor.

Regul. 6. Where artificial human insemination is performed, the physician performing the same shall keep records which shall show:

(1) The name of the physician.
(2) The name and address of the donor.
(3) The name and address of the recipient.
(4) The results of the physical examination and the results of the serological examinations, including the tests for the Rh factor.
(5) The date of the artificial insemination.

Such records shall be regarded as confidential and shall not be open to inspection by the public or by any person other than the Commissioner of Health or such other persons as may be authorized by law to inspect such records. The custodian of any such records, the said Commissioner or any other person authorized by law to inspect such records shall not divulge any part of any such records, so as to disclose the identity of the persons to whom they relate except as provided by law. Id.

27. Id. at art. 21, reg. 2.
28. Id. at art. 21, reg. 5.
disease\textsuperscript{29} or known genetic defect\textsuperscript{30} The wording of this ordinance provides a threshold for mandatory physical examinations of donors, though the statutorily required tests are limited to those for gonorrhea and Rh compatibility. The New York statute also provides for a basic system of record keeping, requiring that the names and addresses of the parties involved, along with the results of the donor’s physical examination, be kept in a confidential file.\textsuperscript{31}

Other proposals for AID regulation have been drafted. For example, the Uniform Parentage Act,\textsuperscript{32} drafted in 1973, seeks to establish uniformity in various legal aspects of the parent-child relationship. Section five of the Act deals with artificial insemination\textsuperscript{33} but is limited to the legal status of the parties involved. The only regulatory requirements of the Act are that a consent form, signed by the husband and wife, be kept with any other records, and that files be kept confidential and sealed.\textsuperscript{34} Other than the requirement of consent, no records are mandated, and no donor screening is established. Eight states have adopted this Uniform Act.\textsuperscript{35}

In 1983 a bill providing a framework for the regulation of sperm banks was introduced before the California State Assembly.\textsuperscript{36} The

\begin{thebibliography}{99}
\bibitem{29} Id. at art. 21, reg. 3.
\bibitem{30} Id. at art. 21, reg. 4. The Oregon statute refers to diseases of which the donors know, or should know. See supra note 25. The New York City ordinance uses no such conditional language; rather, it flatly prohibits the use of diseased sperm. See supra note 26.
\bibitem{31} NEW YORK CITY, N.Y., art. 21, reg. 6 (1949). Although too roughly hewn for purposes of this proposed legislation, the ordinance is far more complete than any other currently in force.
\bibitem{32} UNIF. PARENTAGE ACT (1973).
\bibitem{33} (a) If, under the supervision of a licensed physician and with the consent of her husband, a wife is inseminated artificially with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of a child thereby conceived. The husband’s consent must be in writing and signed by him and his wife. The physician shall certify their signatures and the state of the insemination and file the husband’s consent with the [State Department of Health], where it shall be kept confidential and in a sealed file. However, the physician’s failure to do so does not affect the father and child relationship. All papers and records pertaining to the insemination, whether of the permanent record of a court or of a file held by the supervising physician or elsewhere, are subject to inspection only upon an order of the court for good cause shown.
\bibitem{34} Id. at § 5(a).
\bibitem{35} The eight states which have adopted the Uniform Parentage Act are California, Colorado, Hawaii, Minnesota, Montana, North Dakota, Washington and Wyoming. See, e.g., CAL. CIVIL CODE § 7000 (West 1983).
\bibitem{36} A.B. 1011, Cal. Legis., Assembly Weekly History 604 (Feb. 2, 1984) CHAPTER 4.5 SPERM BANKS 1640. It is the intent of the legislature in enacting this chapter to ensure the health and safety of the public by developing regulations for the operation of sperm banks.
\end{thebibliography}
bill, which attempted to regulate, or at least require a record of the selection of sperm donors, was withdrawn for further study.\textsuperscript{37} While the introduction of this legislation demonstrates a recognition of the need to regulate the growing industry of AID, the withdrawal of the bill illustrates the legislative reluctance to deal with the issue.\textsuperscript{38}

In 1980, the American Fertility Society published a proposal for legislation requiring donor medical histories, physical examinations, and screening for sexually transmitted diseases.\textsuperscript{39} Since publication, this proposal has gone unnoticed by state legislatures, despite its relatively mild reforms and its origin in the medical profession.

These proposals indicate a recognition of the growing significance of AID. Their adoption, however, has been infrequent and limited in scope, due to the failure to perceive the serious consequences of allowing AID to continue unregulated.

\begin{enumerate}
\item 1642. (a) The owner or operator of any sperm bank which is doing business in California shall be licensed by the State Department of Health Services to conduct business in this state.

(b) Effective July 1, 1985, all sperm banks which are doing business in California shall be licensed by the State Department of Health Services to conduct business in this state.

(c) The state department may charge a fee for licensure to cover the reasonable cost of administering and enforcing the provisions of this chapter.

1643. The State Department of Health Services shall adopt such regulations as are necessary to carry out the provisions of this chapter. The regulations shall include the standards and criteria necessary to meet the licensure requirements of Section 1642. The regulations shall also specify, in detail, the physical examination and tests required of a donor pursuant to subdivision (b) of Section 1645.

1644. (a) Every person engaged in obtaining human sperm for use in a sperm bank shall keep sperm from different donors in separate containers.

(b) Each container shall be labeled as follows:

(1) Date of donation.

(2) Name and age of donor.

(3) The physical characteristics of the donor.

1645. (a) All recipients of semen donations from a sperm bank shall be under the care of a licensed physician and surgeon.

(b) All donors to a sperm bank shall have a physical examination, including a blood test, and shall provide a complete medical history, including information of any known genetic diseases in the donor's immediate family.

1646. All records of a sperm bank relative to donors and recipients shall be kept private and confidential. A recipient shall be entitled, upon request, to the medical records of the donor. However, nothing in this chapter shall be interpreted to require or allow for the divulgence of the identity of the donor.

1647. No person shall operate a sperm bank unless the sperm bank complies with all the requirements of this chapter and the regulations adopted pursuant to Section 1643. \textit{Id.}

37. \textit{Id.}

38. Currently, opposing physicians are the only organized force powerful enough to affect AID.

The Donor Screening System

Before the specific areas of proposed regulation are discussed, the basic structure of the sperm donor system should be described. The term “donor” is somewhat misleading, as the men participating in the programs are actually vendors; virtually all sell their product for at least twenty-five dollars, with some donors receiving up to one hundred dollars per ejaculation.\(^4\) This system of remuneration is accepted by the facilities as an operating expense, and is not generally seen as inherently distasteful.\(^4\)

The flaw in this system is found in the donor’s financial motivation. Quite often, the donor is simply asked if he has any transmittable diseases, genetic or otherwise.\(^4\) The incentive to lie in response to such a question has been illustrated in the context of paid blood donors.\(^4\) The analogy between the sale of blood and the sale of sperm would suggest that lying by sperm donors does occur; certainly, no clear evidence exists to show that it does not.\(^4\) The problem is potentially compounded because most sperm banks use medical students as donors.\(^4\) Doctors expect medical students to screen themselves for disease, because their knowledge of diseases and their symptoms is superior to donors without medical training.\(^4\) Hence, the procedure is currently dependent on an assumed expertise on the part of the donor. This system does not take into account donor ignorance\(^4\) or the potential for financial motivation to decrease the thoroughness of self-evaluation.\(^4\) Keeping this shortcoming in mind, the need for donor screening can now be explored.

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40. Annas, supra note 2, at 6.
41. Dr. Finegold suggests that paying donors may actually discourage suitable candidates from coming forward, as highly principled donors may be insulted at the thought of accepting payment. W. FINEGOLD, supra note 3, at 35. However, the prevalence of the practice, and the figures in the Cohen study showing that ninety-seven percent of donors accepted payment, would seem to negate Dr. Finegold’s theory. Cohen study, supra note 9, at 587.
42. Timmons, supra note 12, at 452.
44. Dr. Finegold does cite anecdotal cases of medical students disqualifying themselves due to genetic diseases. W. FINEGOLD, supra, note 3, at 35. However, no studies exist that document how often personal disqualification does not occur when it should.
45. Annas, supra note 2, at 7.
46. Cohen study, supra note 9, at 588.
47. See infra text accompanying notes 53-57.

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Genetic Screening

Currently, no statute requires that a sperm donor be tested for genetic diseases.\textsuperscript{49} Voluntary donor screening for genetic diseases is superficial, although twenty-six percent of all physicians using AID do so because of genetic incompatibility between the husband and wife.\textsuperscript{50} The resulting inconsistency is clear — using AID to avoid a problem without assuring that it does not perpetuate that problem.

Several studies have highlighted the need for improved genetic screening of donors. These studies note that increased use of AID translates into a greater risk of genetic disease transmission.\textsuperscript{61}

Family histories taken of donors usually consist only of a checklist of common genetic conditions, or broad questions asking for the donor's subjective opinion of his family's health.\textsuperscript{51} The shortcomings of this approach were made clear in one study, which asked donors to respond to general questions regarding their family medical history, with the responses being evaluated by the screening doctor.\textsuperscript{52} The results were compared to the traditional genetic disease checklist, which the donors had also completed. Approximately five and a half percent of the donors identified genetic diseases through the checklist, while the screening doctors ascertained genetic problems in an additional twenty-nine and one-half percent of the donor population.\textsuperscript{53} Those donors with medical training did fare better than other donors in the self-assessment of diseases, but still missed two-thirds of the diseases discovered by the screening doctors.\textsuperscript{54} Those donors with perceived genetic problems were either rejected from the program or subjected to complete genetic testing.\textsuperscript{55} This study, besides demonstrating the utility of a well-drafted family history questionnaire, highlights the need for thorough genetic testing in a significant percentage of donors.\textsuperscript{56}

\textsuperscript{49} Deduced from a study of applicable statutes.
\textsuperscript{52} Timmons, \textit{supra} note 12, at 427.
\textsuperscript{53} This study avoided the problem presented in the Cohen study (i.e., doctors who are inadequately trained to make proper evaluations) by requiring that a geneticist be called in whenever there was any doubt regarding a donor's genetic suitability. \textit{Id.} at 454.
\textsuperscript{54} \textit{Id.} at 455.
\textsuperscript{55} \textit{Id.}
\textsuperscript{56} \textit{Id.} at 453.
\textsuperscript{57} The authors of this study stress that the cut-off for genetic abnormalities is an
Another study using medical students was conducted in Hungary. In that study, screening included a thorough family history questionnaire, a sperm analysis and a Wasserman test. Only seventy-seven percent of the potential donors were allowed to contribute after the testing was completed. The authors concluded that genetic screening of donors was clearly necessary to prevent transmission of genetic disorders.

One recent study, however, downplays the need for genetic screening. This study found that the percentage of genetic defects present in the population conceived through AID was no greater than the percentage found in its traditionally-conceived control group. The donor pool in this study underwent blood tests and provided in-depth family medical histories. While less than ten percent of the donor population was rejected for genetic reasons, the study did reach some conclusions in agreement with the studies in which the rejected percentages were much higher. First, all of the studies agreed on the need for taking a thorough medical history of each donor. This is the most cost-effective way to eliminate genetically defective donors. The studies showed that adequate investigation of donors' medical histories is currently lacking. The studies further agreed on the importance of balancing the cost of the screening with the risk to be averted, and the inherently arbitrary nature of that balance.

When evaluating the need for genetic screening, it must be remembered that a couple having children through natural means also accepts the risk of producing a child with physical or mental defects. When individuals approach a doctor and seek help through AID, however, they should be assured that every reasonable precau-

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59. A Wasserman test is a blood test for determining ABO and Rh blood groups, and Q-banded chromosome analysis. Id. at 114.
60. Id.
61. Id. at 115.
63. Id. at 475.
64. Id.
65. Id. After comparing this result to the larger percentages of questionable donors found in other studies, one might reasonably ask if this figure is realistic. Perhaps the rejection criteria were more relaxed in this study than others. To avoid such speculation, however, it is preferable to focus on the similarities of the studies.
66. Czeizel, supra note 58, at 115. See also Verp, supra note 62, at 478.
67. Cohen study, supra note 9, at 587. See also Timmons, supra note 12 at 454.
68. Verp, supra note 62, at 477. See also Timmons, supra note 12, at 455.
69. Verp, supra note 62, at 478.
tion has been taken to safeguard the health of the child conceived.\textsuperscript{70} To allow any less would establish dangerously deficient standards at a time when the use of AID is expanding rapidly.

The variation in study results further emphasizes the need for standard regulations. With each doctor and sperm bank choosing different criteria, it is impossible to assess the specific needs in donor screening. Uniform regulations should be established if for no other reason than to assure a common data base from which accurate appraisals of future needs can be made.\textsuperscript{71}

As a basis for genetic testing, each donor should provide a complete family medical history. Because family histories are often sufficient for screening purposes, this is clearly the most cost-efficient mechanism.\textsuperscript{72} Unfortunately, a medical history alone is not enough to assure the genetic health of every donor. First, a poorly drafted history questionnaire is essentially useless, because adequate screening requires that the questions be neither too open-ended nor too conclusory.\textsuperscript{73} Second, there is always the possibility that the donor has lied to secure payment.

If the questionnaire is well-drafted, it will isolate the segment of the donor population with a high genetic risk. For that segment, selective genetic screening could be used to clarify the risk, or genetically questionable donors could be disqualified \textit{en masse} to avoid the expense of extensive screening.\textsuperscript{74} One authority suggests that ethnic groups should always be tested for diseases for which that group has a disproportionately high risk.\textsuperscript{75} For example, Jewish donors should

\textsuperscript{70} This is particularly true because so many seek AID to avoid genetic problems. Timmons, \textit{supra} note 12, at 451. Also, in doing business with a sperm bank, a woman should be able to expect a lower risk of genetic problems than in choosing her own mate. She has, after all, entered the marketplace seeking to bear a healthy child. The sperm bank has represented itself to her as the facility to provide this service. This situation is entirely different than that of a woman choosing a mate for other reasons, while accepting any genetic risks the couple may face.

\textsuperscript{71} This current shortcoming is exacerbated by the lack of documentation aside from the few studies cited.

\textsuperscript{72} A full medical history of the donor at the time of donation also decreases the need for follow-up examinations. Timmons, \textit{supra} note 12, at 454.

\textsuperscript{73} An example of an open-ended question would be, “How is the health of your family?” Verp, \textit{supra} note 62, at 477. A conclusory question would be found in the checklist variety of family history questionnaire. In such a questionnaire, the inquiry is essentially, “Does your family have a history of genetic diseases?” Timmons, \textit{supra} note 12, at 455. Also, as noted previously, in many instances, even medical students cannot identify genetic diseases.

\textsuperscript{74} Timmons, \textit{supra} note 12, writes of employing selective testing, while Verp, \textit{supra} note 62, seems to favor the cost saving measure of mass disqualification.

\textsuperscript{75} Verp, \textit{supra} note 62, at 478.
be tested for Tay-Sachs, and black donors for Sickle Cell Anemia.\textsuperscript{76} Other general prohibitions could be used to decrease the risk of genetic defects, such as limiting the age of donors to less than forty years.\textsuperscript{77}

\textit{Sexually Transmitted Diseases}

Sexually transmitted diseases can have a devastating effect on both the AID mother and her child.\textsuperscript{78} The diseases known to be transmitted through semen are numerous, and include Neisseria gonorrhoeae,\textsuperscript{79} cytomegalovirus,\textsuperscript{80} hepatitis B agent,\textsuperscript{81} and Trichomonas vaginalis.\textsuperscript{82}

Despite the fact that such diseases have been proven to be communicated through AID,\textsuperscript{83} a review of current statutes and professional practices\textsuperscript{84} shows that there are no guidelines in donor screening for sexually transmitted diseases.\textsuperscript{85}

The potential problems are compounded by the recipient's reasonable belief that the doctor will provide her with a healthy ejaculate. In contrast to other situations where the woman may be wary of contracting a sexually transmitted disease, the AID setting leaves her completely vulnerable to the product provided by the doctor. Clearly, this aspect of AID should be regulated.

\textit{Quality Control}

The cost of one insemination in a doctor's office can be as high as $200.\textsuperscript{86} The procedure must usually be repeated over several menstrual cycles before pregnancy is achieved, and may have to be con-

\textsuperscript{76} Verp also uses the example of testing Greeks and Italians for B-thalassemia.
\textsuperscript{77} Id.
\textsuperscript{78} Advanced paternal age is associated with increased risk of certain dominant mutations and possibly of trisomic offspring. Id.
\textsuperscript{79} See generally MONIF, INFECTIOUS DISEASES IN OBSTETRICS AND GYNECOLOGY (1982).
\textsuperscript{83} Bernfeld, \textit{A Note on Trichomonas Vaginalis and Seminal Fluid}, 48 J. VENereal Disease 144 (1972).
\textsuperscript{84} Mascola, \textit{Should Sperm Donors be Screened for Sexually Transmitted Diseases?}, 309 NEW ENG. J. MED. 1058 (1983).
\textsuperscript{85} Id.
\textsuperscript{87} Bagne, \textit{supra} note 6, at 23. The other end of the cost spectrum was found at a feminist's clinic, where the charge for the entire process, including all inseminations necessary for a successful impregnation, was $300.

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continued for up to ten cycles. Most doctors inseminate the recipient twice per cycle.

At these costs and frequencies, the inseminating doctor is presented with the potential for easy and substantial profits. This potential windfall, along with the need to provide the best available product to the recipient, makes it essential that quality control standards be established for the sperm used. This need becomes even more clear upon analysis of the quality of semen generally available.

The criteria usually used in sperm evaluation are 1) volume, 2) motility, 3) density, and 4) percentage of normal forms. One study, designed to evaluate the semen provided by donors, required only moderate fertility. Seventy-nine percent of the proposed donors failed to meet one or more of the criteria minimums. In a similar study, in which fewer than ten percent of the donors were rejected for genetic reasons, seventy to eighty percent of the remaining donors were disqualified because they lacked the requisite high grade semen.

The need for high quality semen for AID is well recognized in the medical profession, yet, aside from a few isolated studies, no standards for evaluation exist. To protect the recipient from the inconvenience and expense of repeated inseminations, quality control requirements should be drafted. If an instance should arise where the

87. Wing, supra note 9, at 609.
88. Cohen found that 61.4% of the doctors surveyed inseminated women twice per cycle, 17% once per cycle, and 20.5% three times per cycle. Cohen study, supra note 9, at 587.
89. To illustrate, if a recipient is inseminated twice per cycle at $150 per insemination for six cycles, the cost would be $1,800. Using all of the maximum figures the cost would be $6,000 just for impregnation. All of the traditional expenses related to pregnancy remain.
90. The normal parameters are considered to be two to four cubic centimeters in volume, 70% motility, 40-100 million sperm per cubic centimeter, and 80% normal forms. W. Finegold, supra note 3, at 13.
91. Gerber, Semen Abnormalities in Artificial Insemination Donor Candidates, 130 J. Of Urology 266 (1983). This study required a volume of at least two cubic centimeters, 65% motility, 40 million sperm per cubic centimeter (with a minimum total requirement of 120 million sperm) and 70% normal forms.
92. Id. It is interesting to note that the donors were medical students. The researcher notes the possibility that stress decreases sperm quality, and that most medical student donors are under significant stress. Is it possible, then, that these staples of the AID industry are inherently less potent than other possible donors?
93. Verp, supra note 62, at 478. The standards used were 80 million sperm per milliliter, 70% of high grade motility, and 70% normal forms.
94. Guttmacher, supra note 1, at 572.
95. Here, too, the prohibition of donors with certain problems may be in order. For instance, eight to 20% of the male population suffers from varicoceles (varicose veins
only available donors fail to meet the required semen quality standards, the recipient should be allowed to make an informed decision whether or not to continue with the treatment at that time.

THE NEED FOR RECORD KEEPING

Lack of Records

As previously discussed, there are currently no statutory requirements for recording the use of AID. One survey illustrates the reluctance in the medical profession to keep any records on the procedure. Slightly less than thirty-seven percent of those surveyed kept records on the children conceived, and only a little more than thirty percent kept records on the donors. Moreover, eighty-two percent of the doctors surveyed opposed any legislation that would require the keeping of permanent records. Such opposition was based on the assumption that records would deny donors their privacy, and hence discourage donations.

A practice which further frustrates record keeping is the use of sperm from more than one donor per insemination. This is done to assure the anonymity of the biological father.

The Needs Meriting Standardized Record Keeping

Much of the case law and legal theory developed in the context of adoption is also pertinent to a discussion of AID. Typically, both adoptees and children conceived through AID lack any knowledge of at least one biological parent. Like a child conceived through AID, the adoptee has an exceptionally difficult time gaining access to the records of his or her parents. Currently, forty-six states have sealed-record statutes concerning adoption, the majority of which are “closed record” provisions which deny access to court records under any circumstances. Most states have developed one exception to the general restriction; a court may direct disclosure upon a showing...
of "good cause." The records of private adoption agencies are generally not covered by these statutes, but most agencies make access nearly impossible.

Both groups of children face strong opposition to the disclosure of records from the other parties involved. The adoptee is opposed by both the biological and the adoptive parents. The AID child is opposed by the doctors and the donee parents.

There are differences, of course, between the two situations. For instance, records generally exist for the adoptee, but not for the AID child. While adoption records are usually sketchy, they at least provide some basic information. Despite such differences, the two situations are sufficiently similar that information about adoption is useful in evaluating the need for record keeping in AID.

Concern with Hereditary Diseases and Conditions

With the current paucity of donor screening, the AID child can assume nothing about her biological father's medical history. Even with the use of screening, the child will be given few guidelines since any list of excludable genetic diseases will be somewhat arbitrary. Depending on the screening criteria, different potentially adverse ge-

\[\text{104. Id.}\]
\[\text{105. One survey showed that over 99% of agencies will not give an adult adoptee the name of his or her biological parents without the latter's consent. Klbanoff, Genealogical Information in Adoption: The Adoptee's Quest and the Law, 11 Fam. L.Q. 185, 188 (1977).}\]
\[\text{106. Id. at 195-96. This is, of course, a generalization.}\]
\[\text{107. See discussion of privacy concerns, infra at text accompanying notes 134-50.}\]
\[\text{108. The agency file will usually contain reports by social service professionals regarding the circumstances surrounding the surrender of the child, a complete description of the biological mother and father, a medical history of the mother and the birth (if the child was surrendered as an infant), and a report and follow-up on the suitability of the adoptive parents. The court records contain a summary report from the agency, a copy of the surrender documents of one or both parents, proof of notice to the parties, evidence of the birth of the child, and a copy of orders previously issued. Klbanoff, supra note 105, at 187.}\]
\[\text{109. See, e.g., supra note 104 and accompanying text.}\]
\[\text{110. Of course, existence of the records is only of consequence if access to them is possible. Perhaps the inaccessibility of adoption records is the best testimony for the feasibility of maintaining AID records without a loss of confidentiality. The AID child also has full information on one biological parent so that the need for access to records may be less than that of the adoptee. Smith, supra note 102, at 97.}\]
\[\text{111. If certain statutory prohibitions regarding genetic defects were adopted, AID offspring could infer the absence of certain traits in the donor from the doctor's acceptance of the donor after completion of required genetic screening. Without a record of the genetic screening, if any, performed by the inseminating doctor, the AID child is unable to assume anything about his paternal genetic make-up.}\]
Hence, the need for record keeping is inherent in an effective regulatory system. The child must have some access to these records to assure the availability of a meaningful medical history.

In the adoption context, at least one court has held that concern about potential hereditary disease can fulfill the requirements of the "good cause" exception to a closed record statute. In this case, the information disclosed was of a purely medical nature, and did not identify the parents.

This type of concern is just as real for the AID offspring, and she should be entitled to the same non-identifying information. Critics may argue that the AID child cannot establish good cause because access to one parent's (the mother's) records is assured. There is a substantial benefit, however, in having both parents' medical histories. This benefit outweighs the slight burden that providing such anonymous information would impose upon the donor.

If the child has a medical condition that requires data from the father's medical history and no records are kept, the problem is clear. Even if records were maintained, however, it is difficult to get the information needed in every context. Various illnesses or special circumstances may arise which require specific information which is not recorded in the standard medical history. If the donor is anonymous the AID child is forever denied access to any further information.

Conversely, the donor may wish to convey certain information to the AID child. At a later age the donor may discover a congenital disease and desire to notify his offspring. Under the current system, this would be impossible since no records would exist to trace the offspring.

112. See supra note 59. Even with effective standardized screening, the need for the donor's medical history will remain. Medical risks that do not exclude a donor from the program may still be of concern to the child. For example, a history of high blood pressure may not disqualify a donor but could be relevant in diagnosing and treating the child's future medical problems.

113. See supra notes 105-07 and accompanying text. Good cause is a very difficult concept to define. Hence the allowance of disclosure under this exception depends on the standard employed by each jurisdiction.


115. Id.


117. Additionally, the biological link may not be ascertainable because the donor's sperm was mixed with that of other donors at the time of insemination. See supra notes 103-04 and accompanying text.

118. Kern, supra note 18, at 257. Even if records were maintained, however, it is difficult to get the information needed in every context. Various illnesses or special circumstances may arise which require some specific information not recorded in the standard medical history. Id.
Psychological Burdens

Growing up with no knowledge of one biological parent could result in serious emotional trauma to the AID child. In the adoption context, it has long been accepted that a lack of knowledge of one's parents may impede a child's identity development. In either context, tensions can also develop over the possibility of siblings, the existence and number of which can never be known. In the AID context this is especially true because most donors are used for more than one impregnation.

The reality of these psychological burdens borne by adoptees has been recognized by the courts in cases which have required disclosure of the parents' identities. A growing number of courts have shown a willingness to allow access to adoption records. In In Re Ann Carol S. for example, a New York Court held that disclosure was permissible when the adoptee's social adjustment had been hampered by an obsession with finding her biological parents. A New Jersey court went even further, shifting the burden from the adoptee to the state to show that good cause for disclosure did not exist.

Arguably, psychological burdens are not as great for the AID child, who has access to one biological parent and who matures without the social stigma of adoption. Assuming, arguendo; that this contention is true, the need for a disclosure mechanism remains. Perhaps, because of the lesser degree of trauma, valid disclosure demands will be rare. Should an AID child truly be traumatized, however, she should not be absolutely denied access to her ancestry.
simply because no record of it exists. It is time for the child’s interests to be factored into the equation of AID.

Potential for Incest

The possibility of incest is something with which all AID children, as well as some adoptees, must live. There are recorded cases of AID half-siblings marrying, or coming very close to doing so. While the odds of incest are not great, actual occurrences make it clear that this possibility is an issue which must be considered.

Doctors use the same donors repeatedly to inseminate women in the same geographical areas. Moreover, one study noted that only about sixty-six percent of the questionnaire respondents answered a question concerning the number of pregnancies per donor. The authors of the study attributed the poor response to the doctors’ lack of records and, hence, their inability to provide exact figures. With such a haphazard approach to the use of donors, the potential for numerous half-siblings and the consequent risk of incest is difficult to estimate.

Leaving aside the possible moral and medical consequences of inbreeding, the problem also has legal ramifications, because most states explicitly prohibit these marriages. This represents yet another inconsistency in the law — outlawing a marriage that, in the AID context, may be unavoidable due to a lack of records. Similarly, no allowance exists for this possibility in adoption law. To avoid these inconsistencies, the law should be changed to create either an exception to incestual marriage prohibitions in the cases of AID children and adoptees, or a system by which the children may discover their biological relationship.

126. Kern, supra note 18, at 257.
127. In Tel Aviv, Israel, such a marriage actually took place. In this country, a marriage was avoided only by the intervention of a doctor who knew of the couple’s common paternal roots. Hoffer, The Legal Limbo of Artificial Insemination by Donor, MOD. MED., Nov. 1, 1979, at 27.
128. W. Finegold, supra note 3, at 57. The figure suggested by Dr. Finegold was once every one hundred years. With the growing use of AID, however, the odds may be greater than those estimated by the opponents of disclosure.
129. If the subject is a donor for a minority ethnic group in the area, the chances of intermarriage by the children become even greater. Cohen study, supra note 9, at 589. Also, there are no established limits on the number of children one donor can produce. There is evidence that one donor has been used to produce 50 pregnancies. Id. at 587. See also supra note 121.
130. Id.
131. Id. at 589. The authors of the Cohen study express concern that the risk of intermarriage may be greater than popularly believed, because several incidents on record, coupled with other data, contradict the current conservative estimates. Id.
132. Wadlington, supra note 11, at 498.
133. This may be because the possibility of inbreeding was never considered by state legislatures. Id.
Evaluating the Need for Donor Anonymity

The records of an adoptee are sealed for several reasons. This measure is intended to protect the child from intervention by a biological parent, and to shield the child from any stigma related to his or her origins. Concurrently, the biological mother is assured that her decision is final and that she may go on with her life without future disruptions. Similarly, donor anonymity protects the AID child, along with the mother, from any paternal claims by the donor. In the AID setting, however, paternal claims are extremely rare. More often it is the donor who seeks to avoid any contact with or responsibility for the child.

From the donor's standpoint, anonymity is desired primarily to avoid any legal duty to the child. Moreover, the donor generally wishes to be saved from any surprises by his child's appearance at a later point in life. Consequently, the AID industry itself promotes anonymity to assure the future availability of donors.

Fears of numerous lawsuits resulting from the keeping of records, however, do not appear to be merited. As yet, New York City, the only jurisdiction which requires the maintenance of records, has not experienced any serious problems of this nature. Moreover, one

134. Klibanoff, supra note 105, at 188.
135. Id.
136. C.M. v. C.C., 152 N.J. Super. 160, 377 A.2d 821 (1977). In this case, a single woman used the semen from a friend to inseminate herself. She and the donor terminated their relationship, but he returned after the birth of the child and demanded visitation rights. The judge decided in favor of the donor, considering it to be in the best interest of the child.
137. The donor has never known the child as a person, or even experienced the pregnancy (except in the rare circumstances analogous to those of C.M. v. C.C.). The longings that a biological parent might feel in an adoption setting are virtually nonexistent in the AID setting. Smith, supra note 102, at 93.
138. The attitude of the donor at the time of donation is generally one of disinterest. W. Finegold, supra note 3, at 34. The doctors are also greatly concerned with anonymity for donors so as to not endanger their donor pool.
139. Guttmacher, supra note 1, at 175. Also, because only 24 states have established who the legal parents are of the AID child, in many cases such donor concerns may have some merit.
140. This concern would seem to be even more justified than that of the biological mother in the adoption setting, because the donor arguably provided his service so that others might have children, without having to assume the responsibilities of parenthood himself.
141. See supra notes 96-101 and accompanying text.
142. New York City, N.Y., Health Code art. 21 (1949) has been on the books for over 35 years, more than long enough to recognize and correct any major flaws in the legislation. No such changes have been made.
study reported that one-third of doctors administering AID did voluntarily keep records, yet there is no evidence of a rush of inquiries or legal action.\(^{143}\)

Adoptees have used constitutional arguments in their attempts to gain an absolute right of disclosure\(^{144}\) and some commentators have supported this approach.\(^{146}\) At present, however, no court has allowed disclosure based on constitutional grounds.\(^{146}\)

Commentators have noted the development of a “best interest of the child” test regarding the rights of the AID child.\(^{147}\) This concept was first used in *C.M. v. C.C.*,\(^{148}\) where it was found to be in the best interest of the child to allow visitation by the donor.\(^{149}\) *C.M. v. C.C.* is an exceptional case, however, because there was no conflict with the donor’s desire for anonymity. It is, therefore, a poor illustration when assessing the need for keeping, and providing access to, records. There is no evidence that a court, faced with a child’s desire to discover his biological father, would only consider the best interest of the child. In fact, in the AID context it is clear that any favoritism would be directed toward the donor rather than the child.

Nevertheless, the confidentiality of AID records is intended to protect both the donor and the child. In light of this dual purpose, it would be unreasonable to consider only the interests of the donor in determining record keeping and disclosure policies. Rather, the interests of the donor, the child, and the AID mother must all be considered.\(^{160}\) Because all of these interests must be balanced, a blanket policy of either full disclosure or full confidentiality would be unreasonable. Rather, competing disclosure interests must be evaluated when formulating a standardized record keeping system.

**A Proposal for Record Keeping and Disclosure**

The format for a record keeping system should allow the child maximum access, while preserving the donor’s anonymity. Under the proposed system each donor would be given a number that would...
also identify his medical file.\textsuperscript{151} An AID child would have full access to the donor's medical file through this number. Likewise, the donor could provide further information to the child through his medical file without necessitating personal contact. Further, this system would allow AID children to avoid incest by a comparison of donor numbers.\textsuperscript{152}

The names of the donors corresponding to the numbers should be kept in a separate, confidential file. If the child wishes to meet the donor, written consent of the donor would be required before his name would be disclosed. Conversely, if a donor wishes to meet a child, written consent of the offspring would be required before any disclosures could be made.\textsuperscript{153}

A prerequisite to the enactment of this proposal would be the clarification of the child's legal parents as the donee mother and her spouse, in those states which have not enacted legislation on this matter.\textsuperscript{154} Such clarification would be necessary to free the parties from any fear of legal claims by the other parties involved.

Even if record keeping resulted in decreased donor availability, the proposed system should still be established. For too long the primary concern rested on the donor, without considering the interests of the child. The child should not be forever denied basic data solely to insulate the donor.\textsuperscript{155} Even in the highly confidential practice of adoption, records exist, and the possibility of access is becoming more likely.\textsuperscript{156} Denying individuals personal and perhaps crucial information should not be an inherent part of any system. The area of adoption is currently facing the repercussions of this practice.\textsuperscript{157} The opportunity to avoid even greater problems in AID is currently at hand, and a workable, uniform system of record keeping and disclos-

\textsuperscript{151} Bagne, supra note 6, at 27, describes a functioning sperm bank which employs such a system.

\textsuperscript{152} Id. While this proposal is clearly not perfect, it at least provides the mechanism for discovery that is otherwise lacking. A workable system of record keeping will, however, require the end of mixing sperm from more than one donor per insemination. \textit{See supra} note 100 and accompanying text.

\textsuperscript{153} If the offspring is still a minor, written consent of a legal parent would be required.

\textsuperscript{154} This would help to alleviate the donors' fears of any future legal responsibility for a donation.

\textsuperscript{155} \textit{See supra} text accompanying notes 134-50.

\textsuperscript{156} \textit{See discussion of court trends regarding the “good cause” exception to the confidentiality of files, supra text accompanying note 104.}

\textsuperscript{157} Hanley, supra note 145. \textit{See also Comment, Sealed Records in Adoptions: The Need for Legislative Reform, 21 CATH. LAW. 211 (1975).}
ture should be established now in preparation for the future.¹⁵⁸

**The Desirability of a Legislative Solution**

One commentator has called upon the medical profession to establish standards for AID.¹⁵⁹ Action by the medical profession, however, would not adequately deal with the problems presented; it is, after all, the medical profession which has allowed AID to continue in its current state. With a vast majority of doctors opposed to mandatory record keeping¹⁶⁰ and a large number actively attempting to confound any recording efforts,¹⁶¹ it would be unwise to leave the establishment of a regulatory system to them.

A legislative approach is preferable. Because legislators are essentially unaffected, they would be capable of weighing the interests of the various parties.¹⁶² This solution also avoids the inherent prejudices of the medical profession in choosing donors and methods of regulation.¹⁶³ Other authors have suggested that the system is already self-regulating, because doctors will be held to a strict liability standard for poor donor selection.¹⁶⁴ The analogy is made between poor donor se-

¹⁵⁸. The need for immediate action is even more apparent in light of the future growth projections in the use of the AID procedure. See supra notes 2-6 and accompanying text.
¹⁵⁹. Annas, supra note 2, at 13.
¹⁶⁰. Cohen study, supra note 9, at 588.
¹⁶¹. Their efforts are exemplified by poor record keeping and the mixing of several donors' sperm for a single insemination.
¹⁶². The medical profession appears to be concerned only with the donor. Moreover, one of the few proposals from the medical profession for regulation is in the form of a model statute. THE AMERICAN FERTILITY SOCIETY, Report of Ad Hoc Committee on Artificial Insemination 16 (1980).
¹⁶³. "Most doctors (62%) used medical students or hospital residents [as donors]; 10.5% used other university or graduate students, and 17.8% used both. The remaining 9.7% of the doctors who selected their own donors obtained donors from military academies, husbands of obstetric patients, hospital personnel and friends of the physician." Cohen study, supra note 9, at 586. Annas, supra note 2, at 7, feels that these physicians are making subconscious eugenics decisions, because they almost exclusively use medical student donors, despite the availability of other candidates. In other words, they are choosing to reproduce those people that they feel are most desirable, i.e., doctors. (Annas stresses the subconscious nature of this choice, and points out that if lawyers were making the choices, they, too, would choose their own). These facts and observations open a new area to scrutiny. When AID is projected to be such a significant part of the future, should the selection of those to be reproduced be left to one select group of society? Leaving behind the image of a proliferation of medical students, even more basic questions are raised. Should there be intelligence requirements for donors? If not, should everyone, no matter how low his intelligence, be allowed to donate? What if a mother will be inseminated without full knowledge of the situation? What standards should be used in choosing donors: reproduction of the "common man," or an attempt to improve a family's "stock?" All of these questions, and many others, arise when considering the proper selection process. For a discussion of eugenics in the context of AID, see Comment, Eugenic Artificial Insemination: A Cure for Mediocrity?, 94 HARV. L. REv. 1850 (1981).
¹⁶⁴. See, e.g., Shaman, Legal Aspects of Artificial Insemination, 18 J. FAM. L. 1214.
lection and furnishing bad blood to a patient. Unfortunately, this analogy does not withstand scrutiny. The results of poor donor selection are not as immediately obvious as are those of diseased blood. When coupled with the lack of record keeping, an AID child will have difficulty in proving the necessary links for strict liability. Also, the blood donor analogy ignores the fact that genetic defects can never be completely avoided. To impose strict liability for unavoidable consequences would be unfair to the doctor; due to this inequity, it would rarely be applied by the courts. A strict liability format also fails to deal with the possibility of congenital diseases arising later in life, or with the AID child’s desire for a simple medical history of the donor. This approach also ignores the possible psychological traumas that enure to the AID child, as well as the practical reasons for keeping records, such as the possibility of incest.

Comprehensive legislative guidelines are best suited for the regulation of AID. A structured regulatory system will avoid the injustice of strict liability and provide viable remedies for all affected parties. Set forth below is a suggested statutory scheme for regulation of AID donor screening, record keeping, and disclosure.

THE MODEL STATUTE

1. Intent. It is the intent of the legislature in enacting this statute to ensure the health and safety of the public by developing regulations for the operation of Artificial Insemination by Donor.
2. “Sperm bank” means any facility which maintains human sperm for the purpose of artificial insemination, and/or facilities wherein artificial insemination is performed.
   a. The owners or operators of sperm banks will be licensed by the state’s Health Services Department equivalent, to conduct business within the state.

331 (1979).
165. Id. at 347.
166. The possibility of long term congenital defects is of grave concern. Here, also, the issue arises of what defects merit legal liability. The infusion of diseases or incompatible blood is usually obvious and thus avoidable. This is not always the case in sperm donation.
167. Without records it may be difficult to prove the identity of the inseminating physician clearly enough to prevail on a strict liability theory.
168. See supra text accompanying notes 52-77.
169. See supra text accompanying notes 102-10.
170. See supra text accompanying notes 119-25.
171. See supra text accompanying notes 126-33.
b. All sperm banks shall be licensed by the state's Health Service Department equivalent, to conduct business within the state.

c. The State Department may charge a fee for licensure to cover the reasonable cost of administering and enforcing the provisions of this chapter.

3. The Health Service Department shall adopt such regulations as are necessary to carry out the provisions of this statute. The regulations shall include the standards and criteria necessary to meet the licensure requirements of section two. The regulations shall also specify, in detail, the donor screening, record keeping and information disclosure required by sections five and six of this statute.

4. All recipients of semen donations from a sperm bank shall be under the care of a licensed physician.

5. Donor Screening.
   a. General Health.
      i. Each donor shall have a complete physical examination.
      ii. Included in this examination will be a blood test to determine blood type and Rh factor.
      iii. The examination shall include thorough testing for sexually transmitted disease.
   b. Genetic Screening.
      i. All donors shall complete a medical history questionnaire as prescribed by the Department, which will be evaluated by licensed physicians and/or geneticists for the detection of possible genetic defects.
         1) This form shall be standardized for the entire state.
         2) The form shall be compiled by the Department, with the help and review of qualified sociologists and geneticists to assure its efficacy.
      ii. If the donor's genetic background is suspect, based on the questionnaire, the sperm bank may either disqualify the donor or conduct further genetic testing to determine the existence of possibly dangerous genetic diseases.
      iii. All ethnic groups with peculiarly high incidences of certain genetic diseases shall be tested for those diseases, regardless of the results of the initial screening based on the donor's medical history questionnaire.
   c. Quality Control.
      i. Each donation shall be tested to assure adequate potency.
      ii. The Department shall establish minimum standards for:
         1) volume
         2) motility
         3) sperm per cubic centimeter
         4) normal forms
      iii. If donations of the requisite potency are not available the
recipient must be so informed and may be given the option of receiving less potent semen.

6. Record keeping.
   a. Each sperm donor shall be assigned an identifying number which shall be used to identify all records pertaining to that donor. The name of the donor shall be kept in a sealed file by the sperm bank, not to be released without the donor's written consent, or in the event of his death, by court order.
   b. An AID-conceived child or his legal guardian shall have full access to the donor's identification number and medical file.
   c. The written consent of the child shall be required before the donor may be told of the child's identity. If the child is still a minor, the legal parents must give the written consent.

7. The insemination process.
   a. Every person engaged in obtaining human sperm for use in a sperm bank shall keep sperm from different donors in separate containers.
   b. Each container shall be labeled as follows:
      i. Date of donation
      ii. Identification number of donor
   c. The sperm of only one donor shall be used per cycle of inseminations.

CONCLUSION

The need for legislative action in the regulation of AID is clear. Controls are currently lacking and the industry has shown a reluctance to govern itself. In blind allegiance to the donor, the current system has neglected the concerns of the AID child.

No standard screening of donors is performed, and, for the most part, no records are kept. The resultant problems are twofold. First, those children currently conceived through AID are not protected by mandatory donor screening and are destined to live in complete ignorance of the medical condition of their biological fathers. Second, without the requirement of standardized tests and record keeping, there will be no database from which to evaluate the needs of the parties in the future. It is clearly preferable to institute regulations now so that as the practice of AID grows problems which arise may be dealt with adequately.

The model legislation presented above is a simple, workable solution to the problems discussed. It requires the screening of donors, maintenance of records, and the establishment of a data base with-
out sacrificing the privacy of the parties. Immediate regulation is imperative if the future of AID is to be dealt with in an intelligent fashion.

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