

IV. REPRODUCTIVE TECHNOLOGY AND GENETICS

A. PROCEDURES

MARY Z. PELIAS & MARGARET M. DEANGELIS, THE NEW GENETIC TECHNOLOGIES: NEW OPTIONS, NEW HOPE, AND NEW CHALLENGES

45 Loyola L. Rev. 287, 289-91 (1999).

The new reproductive technologies are used both for medical treatment of infertility and for helping people circumvent the threat of conceiving and bearing a child with a genetic problem. Most of these technologies are founded in the technique of in vitro fertilization. This method involves the retrieval of mature egg cells and subsequent fertilization of these egg cells in a glass dish in the laboratory. Once fertilization takes place, the resulting conceptus can be carefully monitored in the laboratory for evidence of healthy cell division and growth. Further, its genetic material can be examined to determine the presence or absence of a grave genetic risk should the conceptus ever become part of a pregnancy that is carried to term birth. In vitro embryos are subsequently transferred into the uterus of the woman who expects to become pregnant and bear a child.

One approach to avoiding the possibility of genetic difficulties in offspring is gamete donation, or the use of gametes, either egg cells or sperm cells, that have been harvested from donor individuals. Egg cells may be harvested from the woman who expects to become the mother or from a woman who agrees to donate some of her own eggs to other women who either cannot furnish their own eggs or who do not wish to risk transmitting their own genes to their offspring. Fertilization is accomplished with semen collected either from the prospective father or from an anonymous sperm donor, depending on the needs of the individual couple. While retrieval of egg cells is of necessity more difficult than collecting sperm samples, both types of gametes can now be stored at

An alternative to in vitro fertilization is the relatively simple procedure of gamete intrafallopian transfer (GIFT). This technique permits healthy gametes, either sperm or both eggs and sperm, to be introduced into the mother's reproductive tract before fertilization, so that fertilization can take place in its natural locus. Any resulting conceptuses may then reach a receptive uterus and implant to establish a pregnancy. Depending on the reasons for the procedure, gametes may be those of the couple, or they may be gametes donated by healthy, usually unidentified third persons. In any event, fertilization and implantation proceed according to natural biological pathways with less dependency on laboratory technologies and skills.

B. GENETIC SCREENING IN THE CONTEXT OF ASSISTED REPRODUCTION

MINIMAL GENETIC SCREENING FOR GAMETE DONORS, APPROVED BY THE BOARD OF DIRECTORS OF THE AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

70 Fertility and Sterility 12-13 (1998). See also <http://www.asrm.com/Media/Practice/gamete.html#Appendix>.

I. The donor:

- A. Should not have any major mendelian disorder. Mendelian disorders fall into the following categories:

how extracted
(called harvesting)

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ZIFT

ultra-low temperatures for use in the future by persons not yet identified. In the event that a clinic or laboratory stores gametes for donations to third persons, the careful assembly of genetic histories of donors is critical to ensuring, within the limits of available tests and technologies, that donors are themselves free of genes that could cause problems in the children of gamete recipients.

Another approach to assuring the birth of healthy children is *preimplantation genetic diagnosis* (PGD) to examine the genetic status of an in vitro embryo before the embryo is transferred to the woman who expects to become pregnant. PGD includes *blastomere analysis before implantation* (BABI) which is the technical union between in vitro fertilization and the molecular examination of the DNA of a very early in vitro embryo. This technique depends on sufficient knowledge of the molecular structure of a gene to allow identification of an embryo that has a significant deleterious genetic risk. Parents who know that they are both carriers of a deleterious recessive gene, for example, may opt for in vitro fertilization, using their own gametes, so that the genotypes of the resulting embryos can be examined before the embryos are transferred to the mother. Embryos that are determined to have a deleterious gene from both parents can be discarded before the embryo transfer procedure so that only embryos which are free from deleterious genes will have a chance to develop into a healthy infant.

PGD
+
BABI

Timeline

C. LIABILITY IN REPRODUCTIVE TECHNOLOGY

JOHNSON v. SUPERIOR COURT OF LOS ANGELES COUNTY

95 Cal.Rptr.2d 864 (Cal.App.2000).

MALLANO, J.

Petitioners Diane L. Johnson and Ronald G. Johnson, along with their minor daughter Brittany L. Johnson, filed an action against real parties in interest, California Cryobank, Inc., Cappy M. Rothman, M.D., and Charles A. Sims, M.D., claiming that real parties failed to disclose that the sperm they sold came from a donor with a family history of kidney disease called Autosomal Dominant Polycystic Kidney Disease (ADPKD). That sperm was used to conceive Brittany who has been diagnosed with this serious kidney disease.

* * *

The novel issue presented here is whether parents and their child, conceived by the sperm of an anonymous sperm donor, may compel the donor's deposition and production of documents in order to discover information relevant to their action against the sperm bank for selling sperm that they alleged transmitted ADPKD to the child.

* * *

Petitioners sued Cryobank, as well as its employees, officers, and directors, Doctors Sims and Rothman, for professional negligence, fraud, and breach of contract. In their second amended complaint, petitioners allege as follows. Diane and Ronald Johnson decided to conceive a child through the use of a sperm donor upon the recommendation of their infertility doctors. The Johnsons contacted Cryobank's sperm bank facility in Los Angeles. Ultimately, Cryobank sold the Johnsons frozen sperm specimens donated by donor No. 276. At or near the time of sale, the Johnsons signed Cryobank's form agreement that provided, in relevant part, that "Cryobank shall destroy all information and records which they may have as to the identity of said donor, it being the intention of all parties that the identity of said donor shall be and forever remain anonymous."

*new suit against
sperm bank*

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At the time of their purchase, Cryobank assured the Johnsons that the anonymous sperm donor had been fully tested and genetically screened. The Johnsons' doctors then implanted the purchased sperm in one of Diane Johnson's fallopian tubes. The procedure was successful and Brittany was born on April 18, 1989. In May 1995, the Johnsons were informed that Brittany was positively diagnosed with ADPKD.

As neither Ronald nor Diane Johnson has ADPKD or a family history of the disease, it was donor No. 276 who genetically transmitted ADPKD to Brittany. At the time donor No. 276 sold his sperm to Cryobank in December 1986, Doctors Sims and Rothman at Cryobank interviewed him and learned that the donor's mother and his mother's

sister both suffered from kidney disease and hypertension, and the donor's mother suffered a 30 percent hearing loss before the age of 60. The presence of multiple instances of kidney disease coupled with hypertension and neurological disorders, such as deafness, are red flag indicators of the presence of ADPKD in donor No. 276's family, and thus, Cryobank and Doctors Sims and Rothman knew that donor No. 276's sperm could be at risk of genetically transferring kidney disease.

* * *

During the course of the action, petitioners propounded discovery to Cryobank seeking information regarding donor No. 276, including his name, address, and medical history. Cryobank objected to providing any information regarding donor No. 276, claiming the donor's right to privacy and his physician-patient privilege. Cryobank did, however, produce two donor consent agreements that were in use at the time donor No. 276 sold his sperm. Both of these agreements state that the donor will be compensated for each sperm specimen, that he will not attempt to discover the identity of the persons to whom he is donating his sperm, and that his identity "will be kept in the strictest confidence unless a court orders disclosure for good cause...." Cryobank also produced a document showing that on September 6, 1991, Cryobank informed Diane Johnson that donor No. 276 had been withdrawn from the donor program because "new information on his family members ... indicates that he is at risk for kidney disease" and that a "few small cysts were found" after performing a "renal ultrasound." Cryobank's responses to interrogatories indicated that donor No. 276 had sold 320 deposits of his semen to Cryobank. Donor No. 276's agreement with Cryobank indicated that he received approximately \$35 per semen specimen. Donor No. 276 thus received a total of \$11,200 for his sperm.

* * *

THE SCOPE OF DISCOVERY

Code of Civil Procedure section 2017 provides the framework for discovery in civil cases. Unless otherwise limited by court order, "any party may obtain discovery regarding any matter, not privileged, that is relevant to the subject matter involved in the pending action ... if the matter either is itself admissible in evidence or appears reasonably calculated to lead to the discovery of admissible evidence." This same section further provides that "[d]iscovery may be obtained of the identity and location of persons having knowledge of any discoverable matter, as well as of the existence, description, nature, custody, condition, and location of any document...."

* * *

THE PHYSICIAN-PATIENT PRIVILEGE

In order for a party to invoke the physician-patient privilege under Evidence Code section 994, there must be a patient. A "patient" is

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defined under section 991 as "a person who consults a physician or submits to an examination by a physician for the purpose of securing a diagnosis or preventative, palliative, or curative treatment of his physical or mental or emotional condition." Therefore, if a person does not consult a physician for diagnosis or treatment of a physical or mental ailment, the privilege does not exist. (Kizer v. Sulnick, [248 Cal. Rptr. 712 (Cal.App.1988)] [persons were not patients when they consulted with a physician as part of a study to determine whether residents shared similar medical complaints to determine further whether the presence of a waste facility was the cause of these symptoms because purpose was not to obtain a diagnosis].)

Real parties in interest have failed to demonstrate that the physician-patient privilege is applicable in this case. The evidence presented to the trial court revealed that donor No. 276 visited Cryobank for the sole purpose of selling his sperm. That he consulted with Cryobank's physicians and medical personnel as part of the process of donating his sperm does not change the dominant purpose for his visit. There was no evidence presented to the trial court that donor No. 276 visited Cryobank "for the purpose of securing a diagnosis or preventative, palliative, or curative treatment of his physical or mental or emotional condition." Thus, we conclude that the physician-patient privilege has no application here.

JOHN DOE'S STATUS AS THIRD PARTY BENEFICIARY

John Doe next claims that petitioners are not entitled to discover his identity because their contract with Cryobank prohibits it. John Doe argues that petitioners' agreement with Cryobank providing that the sperm donor's identity would never be disclosed was made for his benefit and thus, as a third party beneficiary, he is entitled to keep his identity confidential as the agreement requires. While we agree that John Doe is a third party beneficiary, we disagree that the agreement precludes disclosure of his identity or related information under any circumstance.

* * *

The express terms of Family Code section 7613, subdivision (a) provide that a husband's written consent to the insemination must be retained by the physician "as part of the medical record." "All papers and records pertaining to the insemination" wherever located—which we construe as being broader than, and including, the "medical record" previously mentioned—are subject to being inspected "upon an order of the court for good cause." Such "papers and records pertaining to the insemination" would be expected in most cases to include the name and address and related information of the sperm donor whose sperm is used in the insemination, as is apparently the case here.

* * *

And enforcement under all circumstances of a confidentiality provision such as the one in Cryobank's contract with the Johnsons conflicts

with California's compelling interest in the health and welfare of children, including those conceived by artificial insemination. There may be instances under which a child conceived by artificial insemination may need his or her family's genetic and medical history for important medical decisions. For example, such genetic and medical history can lead to an early detection of certain diseases and an increased chance of curing them. In some situations, a person's ability to locate his or her biological relative may be important in considering lifesaving transplant procedures. While in most situations the donor's genetic and medical information may be furnished without the need of disclosing the donor's

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identity, there may be other situations that require disclosure of the donor's identity in order to obtain the needed information. In either event, a contract that completely forecloses the opportunity of a child conceived by artificial insemination to discover the relevant and needed medical history of his or her genetic father is inconsistent with the best interests of the child.

We conclude that Cryobank's agreement with the Johnsons precluding disclosure of the donor's identity and other information pertaining to the donor under all circumstances is contrary to public policy and therefore unenforceable.

THE CONSTITUTIONAL RIGHT OF PRIVACY

Finally, real parties in interest contend that petitioners are precluded from deposing John Doe because to do so would violate his constitutional right of privacy under the federal and California Constitutions. We agree with real parties that donor No. 276 has a right of privacy in his medical history and his identity. We disagree, however, that such a right precludes his deposition and the production of the records requested in the deposition subpoena.

The California Constitution expressly provides that all people have the inalienable right to privacy.

* * *

"Legally recognized privacy interests are generally of two classes: (1) interests in precluding the dissemination or misuse of sensitive and confidential information ('informational privacy'); and (2) interests in making intimate personal decisions or conducting personal activities without observation, intrusion, or interference ('autonomy privacy')."

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A person's medical history undoubtedly falls within the recognized zones of privacy.

* * *

We conclude that although donor No. 276 does indeed have a limited privacy interest in his identity as a sperm donor and in his medical history, under the circumstances of this case, it would be unreasonable for donor No. 276 to expect that his genetic and medical history, and possibly even his identity, would never be disclosed.

* * *

Petitioners seek to take John Doe's deposition in order to learn of all relevant facts he disclosed to Cryobank regarding his medical history of kidney disease. Petitioners also seek all of John Doe's records pertaining to "his family's affliction with [ADPKD], ... secondary health problems diagnosed as being caused or related to ADPKD," and "the history of deponent's medical health as it relates to symptomology of ADPKD...." As a result, what is at stake here is not only the disclosure of John Doe's identity and medical history, but of his family's as well. We conclude that such disclosure would involve an invasion of privacy unless reasonably curtailed.

Because discovery orders involve state-compelled disclosure, such disclosure is treated as a product of state action. Consequently, whenever the compelled disclosure treads upon the constitutional right of privacy, there must be a compelling state interest.

We conclude that there are compelling state interests in this case. First, the state has a compelling interest in making certain that parties comply with properly served subpoenas and discovery orders in order to disclose relevant information to the fullest extent allowable. Second, the state has an interest in seeking the truth in court proceedings. "The state has enough of an interest in discovering the truth in legal proceedings, that it may compel disclosure of confidential material." This includes medical records. Third, the state has a compelling interest in ensuring that those injured by the actionable conduct of others receive full redress of those injuries. Petitioners have demonstrated a compelling need to depose the only independent percipient witness that apparently can reveal the extent of information donor No. 276 disclosed to Cryobank. Such information is not only directly relevant to petitioners' claims, but is also relevant to Cryobank's affirmative defense of comparative fault. Thus, where, as here, the information sought "is essential to the fair resolution of the lawsuit, a trial court may properly compel such disclosure."

* * *

While donor No. 276 has an interest in maintaining the confidentiality of his identity and medical history, we hold that in the context of the particular facts of this case the state's interests, as well as those of petitioners, outweigh donor No. 276's interests. Accordingly, John Doe must appear at his deposition and answer all questions and produce documents that are relevant to the issues raised in the litigation. But

this does not mean that John Doe's identity must automatically be disclosed if he indeed is donor No. 276.

* * *

For example, an order could be fashioned which would allow John Doe's deposition to proceed and documents produced on matters relevant to the issues in the litigation but in a manner which maintains the confidentiality of John Doe's identity and that of his family. Attendance at the deposition could be limited to the parties' counsel and the deposition transcript might refer simply to "John Doe" as the deponent. But we leave it to the trial court to craft the appropriate order.

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We conclude that the trial court abused its discretion in denying petitioners' motion to compel John Doe's deposition and production of documents and in granting real parties' motion to quash. The trial court failed to consider the state and petitioners' countervailing interests that favor disclosure and failed to consider an order with "partial limitations rather than [an] outright denial of discovery." Petitioners are entitled to take John Doe's deposition and inquire whether he is donor No. 276, and if he is, delve into his and his family's health and medical history, and his communications with Cryobank, but only as to those issues which are relevant to the pending litigation. Similarly, we conclude that petitioners are entitled to the production of documents identified in their renote of John Doe's deposition which are relevant and in the possession, custody, or control of John Doe. But John Doe's identity is to be protected to the fullest extent possible and the identities of his family members are not to be disclosed.

HARNICHER v. UNIVERSITY OF
UTAH MEDICAL CENTER

962 P.2d 67 (Utah 1998).

HOWE, J.

Plaintiffs David and Stephanie Harnicher, parents of triplets born after in vitro fertilization using donor sperm, brought this action for medical malpractice alleging negligent infliction of emotional distress against defendant University of Utah Medical Center for using sperm from a donor other than the one that the couple had allegedly selected. The trial court found no evidence of physical injury or illness to support an action for negligent infliction of emotional distress and granted summary judgment in favor of the Medical Center. The Harnichers appeal.

David and Stephanie Harnicher sought treatment for infertility at the University of Utah Medical Center Fertility Clinic. Artificial insemination using David's sperm yielded no results. The Harnichers then contacted Dr. Ronald L. Urry of the Fertility Clinic regarding the possibility of in vitro fertilization. Dr. Urry suggested a procedure known as "micromanipulation" wherein holes are drilled in the mother's harvested ova to facilitate fertilization. The ova are then placed in a petri dish with harvested sperm and the fertilized ova are subsequently implanted in the uterine wall, enabling the mother to bear her own child. Dr. Urry recommended using a mixture of the husband's sperm and donor sperm.

The Harnichers agreed. The micromanipulation method increased the chances that Stephanie would bear David's biological child. Additionally, the "mixed sperm" procedure potentially allowed the couple to believe and represent that any child born would be David's because if the donor closely matched David in physical characteristics and blood type, the parents would never be sure which sperm actually fertilized the ovum. Therefore the Harnichers evaluated the donor information provided by the Medical Center on that basis. The Medical Center maintains that the couple narrowed the selection to four donors and signed consent forms acknowledging that their doctor would make the final selection. The Harnichers assert, however, that they specifically and exclusively selected donor #183. Stephanie testified that when clinic employee Doug Carroll informed her that only frozen sperm, which has a lower success rate than fresh, was available from donor #183 and asked her if she still wanted to do the donor backup, she replied, "Only if you can get 183.... I'll take my lower chances. Let's just go with 183."

The procedure was performed, and Stephanie gave birth to triplets, two girls and one boy. Shortly after their birth, one of the babies became ill, requiring blood tests. Two of the children's blood type revealed that they could not possibly have been the children of either David or donor #183. A DNA test on one of the children established that the father was actually donor #83, another donor on the Harnichers' list.

Donor #183, like David, had curly dark hair and brown eyes. Donor #83 had straight auburn hair and green eyes. One of the triplets has red hair. The Harnichers maintain that the Medical Center's mistaken use of the wrong donor thwarted their intention of believing and representing that David is the children's biological father. They brought this action against the Medical Center alleging that they have "suffered severe anxiety, depression, grief, and other mental and emotional suffering and distress which has adversely affected their relationship with the children and with each other." However, both David and Stephanie testified in their depositions that they had not experienced any bodily harm as a result of the mistake.

The Harnichers contend that their disappointment in their children has caused them severe emotional distress to the point of mental illness. They ask us to hold that "diagnosed mental illness," standing alone, is sufficient to support a claim for negligent infliction of emotional distress.

As a result of their fertility treatment, the Harnichers became the parents of three normal, healthy children whom the couple suggest do not look as much like David as different children might have and whose blood type could not be descended from his. This result thwarted the couple's intention to believe and represent that the triplets are David's biological children. Exposure to the truth about one's own situation cannot be considered an injury and has never been a tort. Therefore, destruction of a fiction cannot be grounds for either malpractice or negligent infliction of emotional distress.

The Harnichers' assertion that David did not want children unless they were biologically his own is belied by the couple's knowing consent to the use of donor sperm. Stephanie testified that she could say "with probability," without ever having seen either donor, that the children of donor #183 would have been better looking than her triplets and that in her mind, she was damaged by that fact.

* * *

Realistically, however, it is impossible to know whether the children of donor #183 would have been superior in any way to the triplets or, indeed, whether the same number of babies or none at all would have resulted from the use of the less effective frozen sperm. The supposition that the road not taken would have led to a better result is a common human fallacy; it cannot support an action for negligent infliction of emotional distress. The Harnichers do not allege that the triplets are unhealthy, deformed, or deficient in any way. Nor do they claim any racial or ethnic mismatch between the triplets and their parents. In fact, the couple has presented no evidence at all that the physiological characteristics of three normal healthy children, which could not have been reliably predicted in any event, present circumstances with which "a reasonable [person,] normally constituted, would be unable to adequately cope."

* * *

DURHAM, J., dissenting.

* * *

The majority appears to be reluctant to view the Harnichers' response to their asserted loss as a damaging one, in view of the fact that they do indeed have three healthy and loved children despite the University's negligence in performing this procedure. The alleged facts, however, clearly meet the traditional standard for negligence: 1) the existence of a duty on the part of the University to use the donor sperm selected by the Harnichers that would have permitted them to believe the children to be their full biological children; 2) a breach of that duty through the University's mistake in using sperm from the wrong donor; 3) injury consisting of the Harnichers' loss of the opportunity to believe their children to be their full biological offspring; and 4) damages in the

Why?

form of mental illness requiring treatment, accompanied by physical symptoms....

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In conclusion, I believe that a compensable loss and eligible damages have been asserted by plaintiffs and that they are entitled to have their cause of action tried by a jury. I would reverse.

Notes and Questions

1. What type of genetic screening of gamete donors is appropriate? Should donors be liable if they knew (or should have known) that they risked passing on a certain genetic disease to the resulting children? Should a donor's confidentiality be protected? Should a blood sample of each donor be kept for later genetic testing? Should a donor be required to update the clinic on subsequently-discovered genetic diseases in his or her family so that the children can be warned?

2. The Utah Supreme Court justices decided three to two that the Harnichers could not collect damages when artificial insemination helped them produce three children who were healthy, but did not resemble the husband. Was the case rightly decided? Does this case seem consistent with, or at odds with, the wrongful birth cases?

The dissenting justices in *Harnicher* suggests that if a couple requests sperm from a certain donor, and are given sperm from another donor, that mistake is actionable. Would such an analysis apply if the couple chose sperm or eggs from a donor whom they chose for certain genetic characteristics (e.g., intelligence or perfect pitch), but instead were given gametes from a donor who was not so gifted?

3. The following informed consent form is provided in the Oregon Statute governing artificial insemination, Or. Rev. Stat. § 677.365 (1999). What additional information would you advise a clinic to add so that couples using artificial insemination by donor will be adequately protected?

5. Should sperm and egg donors be compensated for their genetic material? Such payment is banned in many European countries, but generally not in the United States. Should higher payments be allowed to donors thought to have "better" genes? An ad ran in the Ivy League college newspapers offering \$50,000 to an egg donor who was tall, athletic and had scored at least 1400 out of a perfect 1600 SAT score. Kenneth Weiss, The Egg Brokers, L. A. Times, May 27, 2001 at A1. Is such an approach reminiscent of eugenics?

6. Sperm donors are often unmarried medical students who do not yet have children of their own. On occasion, donor insemination produces a child with a rare recessive genetic disorder when the donor did not realize he was a carrier. Should he be told that fact so that he can take it into consideration when making his own reproductive plans? What if, as is often the case, the infertility clinic has told him in advance that they will not let him know if his sperm results in a pregnancy (so that he will not track down any resulting child)? In a study of sperm banks faced with the issue of contacting donors, half tracked down the donor to warn of the genetic risk and half did not.

SEX SELECTION

LORI B. ANDREWS, THE CLONE AGE: ADVENTURES IN THE NEW WORLD OF REPRODUCTIVE TECHNOLOGY

142-144 (2001).

In many parts of the world, technology is making the admission standards for birth tougher and tougher. In India, China, Taiwan, and Bangladesh, technicians with portable ultrasound machines go from village to village scanning pregnant women who are desperate to learn whether they are carrying a boy. Many abort when they fail to see a penis on the tiny out-of-focus screen. In Bombay alone, 258 clinics offered amniocentesis for sex selection. In one study of 8,000 abortions in India, 7,999 were female fetuses, leading human rights activists to protest this clear evidence of "gyne"cide. In China, when the one-child policy was strictly enforced, families so preferred males that the sex ratio changed to 153 males for each 100 females.

At Dr. John Stephens's clinics in California, Washington and New York, Western couples too can have prenatal testing for sex selection. One Australian client actually terminated a pregnancy because she couldn't get to Stephens's clinic in time to learn the sex of the fetus. She carried the next pregnancy to term when Stephens vetted it as a boy. Although most couples want a boy, an Israeli couple went to great lengths to have a girl out of fear of losing a son in a military engagement. They aborted a fetus when they learned it was a boy. In the next pregnancy, the wife was carrying twins, a boy and a girl. She used selective reduction to abort only the boy.

Thirty-four percent of U.S. geneticists said they would perform prenatal diagnosis for a family who want a son, and another 28 percent said they would refer the couple to another doctor who would perform such testing. Dorothy Wertz, the social scientist at the Shriver Center for Mental Retardation in Waltham, Massachusetts, who conducted the study, said the percentage of practitioners willing to respond to sex selection request had increased 10 percent from 1985 to 1995. "Autono-

my just runs rampant over any other ethical principle in this country," Wertz says. "And it's only going to increase."

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What if a sexual imbalance occurred in the United States, as is now happening in China and India? Sociologist Amitai Etzioni speculated that since women consume more culture and men commit more crimes, sex selection would create a more frontierlike society—with less art and more violence. Since men are more likely to vote Republican, politically there would be a shift to the right.

The overwhelming tilt toward boys is not as pronounced yet in the United States as it is in other countries, but social psychologist Roberta Steinbacher of Cleveland State University worries about the effect on society if couples were able to predetermine their baby's sex. Twenty-five percent of people say they would use a sex selection technique, with 81 percent of the women and 94 percent of the men desiring to ensure their first-born would be a boy. Since other research reveals firstborns are more successful in their education, income, and achievements than latterborns, Steinbacher worries that "second class citizenship of women would be institutionalized by determining that the firstborn would be a boy."

absent at other times. In one case, the umbilical cord was found to be clamped on newborns' umbilical cords rather than being cut. See When sued, two hospitals offered a \$2 million settlement to each family. See *at 11 of Switched Baby Sues for \$2M*. Wash. Post, Aug 25, 1999, at B1.

IV. PATERNITY AND ASSISTED REPRODUCTION

PEOPLE v. SORENSEN

437 P.2d 495 (Cal.1968).

McCOMB, J.

Defendant appeals from a judgment convicting him of violating section 270 of the Penal Code (willful failure to provide for his minor child), a misdemeanor.

The settled statement of facts recites that seven years after defendant's marriage it was medically determined that he was sterile. His wife desired a child, either by artificial insemination or by adoption, and at first defendant refused to consent. About 15 years after the marriage defendant agreed to the artificial insemination of his wife. Husband and wife, then residents of San Joaquin County, consulted a physician in San Francisco. They signed an agreement, which is on the letterhead of the physician, requesting the physician to inseminate the wife with the sperm of a white male. The semen was to be selected by the physician, and under no circumstances were the parties to demand the name of the donor. The agreement contains a recitation that the physician does not represent that pregnancy will occur. The physician treated Mrs. Sorenson, and she became pregnant. Defendant knew at the time he signed the consent that when his wife took the treatments she could become pregnant and that if a child was born it was to be treated as their child.

A male child was born to defendant's wife in San Joaquin County on October 14, 1960. The information for the birth certificate was given by the mother, who named defendant as the father. Defendant testified that he had not provided the information on the birth certificate and did not recall seeing it before the trial.

For about four years the family had a normal family relationship, defendant having represented to friends that he was the child's father and treated the boy as his son. In 1964, Mrs. Sorenson separated from defendant and moved to Sonoma County with the boy. At separation, Mrs. Sorenson told defendant that she wanted no support for the boy, and she consented that a divorce be granted to defendant. Defendant obtained a decree of divorce, which recites that the court retained "jurisdiction regarding the possible support obligation of plaintiff in regard to a minor child born to defendant."

In the summer of 1966 when Mrs. Sorenson became ill and could not work, she applied for public assistance under the Aid to Needy Children program. The County of Sonoma supplied this aid until Mrs. Sorenson was able to resume work. Defendant paid no support for the child since the separation in 1964, although demand therefore was made by the district attorney. The municipal court found defendant guilty of violating section 270 of the Penal Code and granted him probation for three years on condition that he make payments of \$50 per month for support through the district attorney's office.

From the record before us, this case could be disposed of on the ground that defendant has failed to overcome the presumption that "A child of a woman who is or has been married, born during the marriage or within 300 days after the dissolution thereof, is presumed to be a legitimate child of that marriage. This presumption may be disputed only by the people of the State of California in a criminal action brought under Section 270 of the Penal Code or by the husband or wife, or the descendant of one or both of them. In a civil action, this presumption may be rebutted only by clear and convincing proof."

The only testimony as to defendant's sterility was that of defendant and his wife that it had been medically determined seven years after the marriage that defendant was sterile. In their written request to the doctor that he artificially inseminate Mrs. Sorenson, dated August 12, 1959, the Sorensens said: "We make this request since we realize that Mr. Sorenson is sterile, adequate laboratory tests having been performed...." There was no medical testimony by a scientific expert in the field of male reproduction that defendant was sterile at the time of conception. However, in view of the settled statement, the only question for our determination is:

Is the husband of a woman, who with his consent was artificially inseminated with semen of a third-party donor, guilty of the crime of failing to support a child who is the product of such insemination, in violation of section 270 of the Penal Code?

The law is that defendant is the lawful father of the child born to his wife, which child was conceived by artificial insemination to which he consented, and his conduct carries with it an obligation of support within the meaning of section 270 of the Penal Code.

Under the facts of this case, the term "father" as used in section 270 cannot be limited to the biologic or natural father as those terms are generally understood. The determinative factor is whether the legal relationship of father and child exists. A child conceived through heterologous artificial insemination² does not have a "natural father," as that term is commonly used. The anonymous donor of the sperm cannot be

2. There are two types of artificial insemination in common use: (1) artificial insemination with the husband's semen, homologous insemination, commonly termed - A.I.H. and (2) artificial insemina-

tion with semen of third-party donor, heterologous insemination, commonly termed A.I.D. Only the latter raises legal problems of fatherhood and legitimacy.

considered the "natural father," as he is no more responsible for the use made of his sperm than is the donor of blood or a kidney. Moreover, he could not dispute the presumption that the child is the legitimate issue of Mr. and Mrs. Sorensen, as that presumption "may be disputed only by the people of the State of California or by the husband or wife, or the descendant of one or both of them." With the use of frozen semen, the donor may even be dead at the time the semen is used. Since there is no "natural father," we can only look for a lawful father.

It is doubtful that with the enactment of section 270 of the Penal Code and its amendments the Legislature considered the plight of a child conceived through artificial insemination. However, the intent of the Legislature obviously was to include every child, legitimate or illegitimate, born or unborn, and enforce the obligation of support against the person who could be determined to be the lawful parent.

* * *

[A] reasonable man who, because of his inability to procreate, actively participates and consents to his wife's artificial insemination in the hope that a child will be produced whom they will treat as their own, knows that such behavior carries with it the legal responsibilities of fatherhood and criminal responsibility for nonsupport. One who consents to the production of a child cannot create a temporary relation to be assumed and disclaimed at will, but the arrangement must be of such character as to impose an obligation of supporting those for whose existence he is directly responsible. As noted by the trial court, it is safe to assume that without defendant's active participation and consent the child would not have been procreated.

* * *

The documentary evidence in this case consisted of the written agreement between husband and wife that the physician inseminate the wife with the sperm of a white male, the birth certificate listing defendant as the father, and a copy of the interlocutory decree of divorce. While defendant testified that he did not know the contents of the birth certificate, this testimony was not sufficient to raise a reasonable doubt that he was the father. Therefore, since the word "father" is construed to include a husband who, unable to accomplish his objective of creating a child by using his own semen, purchases semen from a donor and uses it to inseminate his wife to achieve his purpose, proof of paternity has been established beyond a reasonable doubt.

* * *

The question of the liability of the husband for support of a child created through artificial insemination is one of first impression in this state and has been raised in only a few cases outside the state, none of them involving a criminal prosecution for failure to provide. Although other courts have found some existing legal theory to hold the "father" responsible, results have varied on the question of legitimacy. In Gursky

v. Gursky, 242 N.Y.S.2d 406 (N.Y. Sup.Ct. 1963), the court held that the child was illegitimate but that the husband was liable for the child's support because consent to the insemination implied a promise to support. The court held that the child was illegitimate but that the husband was liable for the child's support because consent to the insemination implied a promise to support.

In Strnad v. Strnad, 78 N.Y.S.2d 390 (N.Y. Sup.Ct. 1948), the court found that a child conceived through artificial insemination was not illegitimate and granted visitation rights to the husband in a custody proceeding.

It is less crucial to determine the status of the child than the status of defendant as the father. Categorizing the child as either legitimate or illegitimate does not resolve the issue of the legal consequences flowing from defendant's participation in the child's existence. Under our statute, both legitimate and illegitimate minors have a right to support from their parents. The primary liability is on the father, and if he is dead or for any reason whatever fails to furnish support, the mother is criminally liable therefor. To permit defendant's parental responsibilities to rest on a voluntary basis would place the entire burden of support on the child's mother, and if she is incapacitated the burden is then on society. Cost to society, of course, is not the only consideration which impels the conclusion that defendant is the lawful father of the offspring of his marriage. The child is the principal party affected, and if he has no father he is forced to bear not only the handicap of social stigma but financial deprivation as well.

The construction thus placed upon the word "father" does not distort the statutory language, and it achieves the statutory objective of providing support for the child and prevents an obvious injustice that would result were a child artificially conceived excluded from the protection of a law intended to benefit all minors, legitimate or illegitimate, born or unborn.

The public policy of this state favors legitimization and no valid public purpose is served by stigmatizing an artificially conceived child as illegitimate. An illegitimate child is one "not recognized by law as lawful offspring; . . . born of parents not married to each other; conceived in fornication or adultery"; illegitimacy is defined as "the state or condition of one whose parents were not intermarried at the time of his birth;" "the status of a child born of parents not legally married at the time of birth."

In the absence of legislation prohibiting artificial insemination, the offspring of defendant's valid marriage to the child's mother was lawfully begotten and was not the product of an illicit or adulterous relationship. Adultery is defined as "the voluntary sexual intercourse of a married person with a person other than the offender's husband or wife." It has been suggested that the doctor and the wife commit adultery by the process of artificial insemination. Since the doctor may be a woman, or the husband himself may administer the insemination by

a syringe, this is patently absurd; to consider it an act of adultery with the donor, who at the time of insemination may be a thousand miles away or may even be dead, is equally absurd. Nor are we persuaded that the concept of legitimacy demands that the child be the actual offspring of the husband of the mother and if semen of some other male is utilized the resulting child is illegitimate.

In California, legitimacy is a legal status that may exist despite the fact that the husband is not the natural father of the child. The Legislature has provided for legitimization of a child born before wedlock by the subsequent marriage of its parents, for legitimization by acknowledgment by the father, and for inheritance rights of illegitimates, and since the subject of legitimization as well as that of succession of property is properly one for legislative action, we are not required in this case to do more than decide that, within the meaning of section 270 of the Penal Code, defendant is the lawful father of the child conceived through heterologous artificial insemination and born during his marriage to the child's mother.

The judgment is affirmed.

JHORDAN C. v. MARY K.

224 Cal.Rptr. 530 (Cal.App.1986).

KING, J.

I. HOLDING

By statute in California a "donor of semen provided to a licensed physician 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." (Civ. Code, § 7005, subd. (b).) In this case we hold that where impregnation takes place by artificial insemination, and the parties have failed to take advantage of this statutory basis for preclusion of paternity, the donor of semen can be determined to be the father of the child in a paternity action.

Mary K. and Victoria T. appeal from a judgment declaring Jhordan C. to be the legal father of Mary's child, Devin. The child was conceived by artificial insemination with semen donated personally to Mary by Jhordan. We affirm the judgment.

II. FACTS AND PROCEDURAL HISTORY

In late 1978, Mary decided to bear a child by artificial insemination and to raise the child jointly with Victoria, a close friend who lived in a nearby town.¹ Mary sought a semen donor by talking to friends and acquaintances. This led to three or four potential donors with whom Mary spoke directly. She and Victoria ultimately chose Jhordan after he had one personal interview with Mary and one dinner at Mary's home.

1. As many as 20,000 women each year are artificially inseminated in the United States. By one estimate some 1,500 of these women are unmarried.