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Test-Tube Parents: Collaborative Reproduction in Minnesota

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COMMENT—TEST-TUBE PARENTS: COLLABORATIVE REPRODUCTION IN MINNESOTA

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*[T]he law, equity and justice must not themselves quail
and helpless in the face of modern technological
marvels presenting questions hitherto unthought of.¹*

I. INTRODUCTION

Recent breakthroughs in reproductive technology have turned infertility² in the United States into a \$2 billion a year business.³ The demand is there: out of more than three million people who visit fertility specialists each year, 40,000 receive assisted reproductive treatment.⁴ The supply is there: technological advances include a wide range of advanced reproductive methods, such as in vitro fertilization, egg donation, and even embryo cryopreservation.⁵ What is missing in most states, including Minnesota, is legislative clarity on basic legal questions that may arise when children are born as a result of a collaborative reproduction procedure involving an anonymous third-party egg or sperm donor.

Minnesota's one statute that addresses collaborative reproduction is disturbingly silent regarding issues of anonymity and privacy that directly affect parties involved in these reproductive procedures.⁶ What safeguards, for example, ensure the preservation and confidentiality of anonymous donor and recipient patient records? What guarantee do donors have that their records will be kept anonymous in the future? What right, if any, do children of collaborative reproduction have to information about their anonymous donor

1. *In re Quinlan*, 70 N.J. 10, 44, cert. denied, 429 U.S. 922 (1976).

2. A couple is considered "infertile" after attempting to conceive a child, without success, for one year. GEOFFREY SHER, M.D. ET AL., FROM INFERTILITY TO IN VITRO FERTILIZATION 21 (1988).

3. *Big Business*, NEWSWEEK, June 12, 1995, at 67 (relying on information from the National Center for Health Statistics and the American Society for Reproductive Medicine).

4. Sharon Begley, *The Baby Myth*, NEWSWEEK, Sept. 4, 1995, at 40. "[One] out of 6 couples in the United States is infertile or fails to conceive within 1 year of deciding to have a child." H.R. 5397, 101ST CONG., 2D SESS. 26 (1990).

5. The American Society for Reproductive Medicine (formerly the American Fertility Society) defines "advanced reproductive technologies" as "all treatments which include the laboratory handling of human oocytes and/or embryos." American Fertility Society, *Revised Minimum Standards for In Vitro Fertilization, Gamete Intrafallopian Transfer, and Related Procedures*, 53 FERTILITY & STERILITY 225 (1990). An "oocyte" is a female sex cell, also called an egg or ovum. Mayo Foundation for Medical Education and Research, *Assisted Reproductive Technology* (Mayo Foundation for Medical Education and Research, Rochester, Minn.) 15, (1994). For a discussion of in vitro fertilization and egg donation, see *infra* Part II.B. Embryo cryopreservation is a procedure used to preserve and store embryos by freezing. *ART: Assisted Reproductive Technologies* (Serono Symposia, USA, Norwell, Mass.) 20 (1994) [hereinafter Serono Symposia].

6. MINN. STAT. § 257.56 (1994); see *infra* note 125 and accompanying text.

parent? These questions are unanswered in Minnesota law. Moreover, the Minnesota statute on point covers only artificial insemination.⁷ No comparable state statute defines the legal rights and obligations of parties involved in egg donation.

Minnesota's silence on these matters is not unusual in the infertility industry.⁸ Throughout the United States, little legislative or judicial attention has been paid to anticipating and resolving potential legal ramifications of physician-assisted reproduction.⁹ State courts have generally responded with ad hoc policy to case-specific disputes.¹⁰ In fact, not until recently has there even been much serious discussion about the lack of regulation or monitoring in the infertility industry.¹¹ Although professional medical organizations issue guidelines for fertility clinics and associated facilities, compliance with these guidelines is voluntary.¹² In effect, practitioners of reproductive technology are free to set their own standards and procedures and regulate themselves.¹³

The need for legislative guidance in the infertility industry is evident in the patient and donor consent agreements drawn up by many U.S. fertility clinics.¹⁴ These agreements typically acknowledge the legal uncertainty¹⁵ surrounding a particular reproductive procedure and ask the parties to indemnify the medical facility from any liability

7. MINN. STAT. § 257.56 (1994).

8. See *infra* notes 93-94 and accompanying text.

9. See Anne R. Schiff, *Solomonic Decisions in Egg Donation: Unscrambling the Conundrum of Legal Maternity*, 80 IOWA L. REV. 265, 267 (1995); see also Jean Macchiaroli Eggen, *The "Orwellian Nightmare" Reconsidered: A Proposed Regulatory Framework for the Advanced Reproductive Technologies*, 25 GA. L. REV. 625, 709 (1991).

10. See Schiff, *supra* note 9, at 267.

11. See generally Eggen, *supra* note 9, at 692 (describing the current infertility industry as fragmented and inconsistent, led by state political interests, unenforceable clinical standards, and a federal government with a history of ignoring issues relating to infertility).

12. See *infra* notes 32-35 and accompanying text.

13. The American Society for Reproductive Medicine, the Society for Assisted Reproductive Technology (SART), and the American Association of Tissue Banks have each issued standards and quality control guidelines regarding the use of reproductive technologies. Membership in these organizations, however, is voluntary, as are their standards and guidelines. Eggen, *supra* note 9, at 671-73.

14. See, e.g., Debbie K. Lerner, *New Reproductive Technology and Wisconsin Law: Fertility Clinics Making Law*, 75 MARQ. L. REV. 206, 225 (1991) (discussing the policies of Wisconsin fertility clinics and the need for in vitro fertilization legislation). "In a sense, the consent forms themselves bear the most persuasive argument for state action. Implicit in the various risks signaled is a myriad of unexpected and unwanted repercussions which may ensue in a court of law." *Id.*

15. *Id.*

resulting from the lack of existing laws concerning the procedure.¹⁶ Before they consent to a reproductive procedure, fertility patients and third-party donors are entitled to accurate information about legal complications that could arise as a direct result of the procedure.¹⁷ In many situations, however, this information is unavailable because no state law addresses these issues. Therefore, in consenting to procedures without adequate information about the legal implications of their decisions, fertility patients and donors do so at their own risk.¹⁸

Only a handful of cases nationwide have addressed problems raised by assisted reproductive technology.¹⁹ None of these cases has been in Minnesota. Still, Minnesota's infertility business is growing rapidly.²⁰ The state inevitably will be faced with first impression cases concerning the legal rights of parties in the infertility process. The Minnesota Legislature can anticipate these cases by addressing reproductive technology issues today that each state will need to address in the future. In so doing, Minnesota can take a leading role in this challenging area of biotechnology and law.

This Comment looks at the infertility industry in Minnesota and the balancing act between the interests of infertile patients, third-party donors, and the often overlooked offspring. Part II presents an overview of two procedures behind most collaborative reproduction: artificial insemination and egg donation. It then surveys the status of these reproductive procedures in Minnesota. Part III reviews legal

16. See, e.g., Mayo Clinic, Consent to Participation in Donor Oocyte Program: Recipient (1995) (consent agreements available at Mayo Clinic).

17. The doctrine of informed consent requires doctors to give patients sufficient information for the patients to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgical procedure. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 189-93 (5th ed. 1984). "True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each." *Canterbury v. Spence*, 464 F.2d 772, 780-81 (D.C. Cir. 1972), cert. denied, 409 U.S. 1064 (1973). This could include, for example, information given to patients regarding their infertility problems and prognosis, the short- and long-term risks they assume in taking fertility drugs and undergoing surgical procedures, the decisions they may have to make in terms of selective reduction in the event of multiple embryos induced by these drugs, and the odds of successfully achieving a viable pregnancy. It could also include the legal ramifications of conceiving and bearing a child as a result of these procedures. These ramifications concern the rights and obligations of all parties involved: the parent(s), donor, and resulting offspring.

18. See Lerner, *supra* note 14, at 214.

19. Based on on-line searches of collaborative/assisted reproduction cases. See *infra* notes 94-97 and accompanying text.

20. Telephone Interview with Amy Hill, Member of the National Board of RESOLVE, Inc. (Jan. 10, 1996) [hereinafter Hill Telephone Interview]. RESOLVE, Inc., founded in 1973, is a national non-profit advocacy, referral, and support organization for infertile couples. *Id.*

aspects of collaborative reproduction, particularly with respect to anonymity and recordkeeping, starting with federal regulation and including case and statutory law. Part IV examines the shortcomings and omissions in Minnesota law regarding artificial insemination and egg donation. Finally, Part V recommends several measures Minnesota can take to define the basic rights and obligations of parties involved in collaborative reproduction procedures and to protect the legitimate interests of these parties regarding anonymity and disclosure.²¹

II. OVERVIEW OF COLLABORATIVE REPRODUCTION PROCEDURES

Infertile patients today face a bewildering array of technological acronyms representing various reproductive techniques. Rapid advances in reproductive technology include in vitro fertilization and embryo transfer (IVF-ET), gamete intrafallopian transfer (GIFT), intrauterine insemination (IUI), zygote intrafallopian transfer (ZIFT), tubal embryo transfer (TET), frozen embryo transfer (FET)²² and intracytoplasmic sperm injection (ICSI).²³ Each of these procedures involves manipulations of sperm, eggs, or both in an attempt to create a fertilized embryo. If one or both of the prospective parents has a fertility problem, the sperm and eggs of third-party donors are used in the procedures.²⁴ These gametes are obtained through either artificial insemination or egg donation.²⁵ Thus, the resulting embryo

21. Other legal issues not addressed in this Comment include custody and adoption rights, fetal research, property and inheritance claims, and surrogate/donor collaborative child-rearing and visitation issues.

22. See generally Serono Symposia, *supra* note 5 (describing procedural elements of and variations among the advanced reproductive technologies, including recent statistical data).

23. See Geoffrey Cowley, *The Future of Birth*, NEWSWEEK, Sept. 4, 1995, at 42-43 (describing the ICSI technique).

24. JOHN ROBERTSON, CHILDREN OF CHOICE 255 n.4 (1994). Patients use donor insemination for several reasons: low sperm count, Rh incompatibility, and the risk of passing on a serious genetic disorder. LAWRENCE KAPLAN & ROSEMARIE TONG, CONTROLLING OUR REPRODUCTIVE DESTINY: A TECHNOLOGICAL AND PHILOSOPHICAL PERSPECTIVE 226 (1994). Patients use egg donation for a variety of reasons as well, including inheritable genetic disease, the high risk of defective eggs, nonfunctioning ovaries, and poor access to ovaries. Schiff, *supra* note 9, at 268. See generally U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, INFERTILITY: MEDICAL AND SOCIAL CHOICES 59, 60-82 (1988) (reviewing medical factors contributing to infertility).

25. Gametes are sperm and eggs, the cells of reproduction. Mayo Foundation for Medical Education and Research, Assisted Reproductive Technology (Mayo Foundation for Medical Education and Research, Rochester, Minn.) 15 (1994). This Comment focuses on the two collaborative reproductive procedures most commonly used: donor insemination and egg donation. A recent procedure not yet widely available, and even more rife with legal uncertainties, is embryo donation. In this technique, a couple unable to produce sperm or eggs have a donated embryo placed in the woman's uterus and brought to term. ROBERTSON, *supra* note 24, at 129-30. This Comment does not

may have a genetic link to only one, or neither, parent.

A. Artificial Insemination

Artificial insemination is both the most common and the most "low-tech" collaborative reproductive procedure available today.²⁶ Approximately 600,000 procedures are conducted each year with donor sperm, with a success rate of approximately ten percent.²⁷ In this procedure, a physician typically introduces frozen semen from an anonymous donor into a woman's cervical canal or directly into her uterus to help her conceive.²⁸ The advantages of this procedure are its simplicity and relatively low cost in comparison with other assisted reproductive techniques.²⁹ From a medical perspective, the process simply entails obtaining sperm from donors, and then testing, freezing, and maintaining it until the time of insemination, when it is thawed for use.³⁰ Due to the growing popularity of donor insemination, approximately 11,000 private physicians currently perform this procedure in the United States, using more than 400 commercial sperm banks.³¹

address embryo donation.

26. Artificial insemination is performed with either semen from a woman's husband (called homologous artificial insemination or AIH) or from a donor not married to her (called heterologous artificial insemination, donor insemination, or AID). Michael J. Yaworsky, Annotation, *Rights and Obligations Resulting From Human Artificial Insemination*, 83 A.L.R. 4th 295, 300 (1994). This Comment focuses on donor insemination.

27. See Begley, *supra* note 4, at 41.

28. Hollace S.W. Swanson, *Donor Anonymity in Artificial Insemination: Is It Still Necessary?*, 27 COLUM. J.L. & SOC. PROBS. 151, 151-52 (1993); see MINN. STAT. § 257.56, subd. 1 (1994) (requiring only the supervision of a licensed physician).

29. See Begley, *supra* note 4, at 41 (comparing the average costs per reproductive procedure: \$300 per donor insemination; \$6,000 to \$10,000 per in vitro fertilization cycle or gamete intrafallopian transfer attempt; \$8,000 to \$10,000 per zygote intrafallopian transfer attempt; and \$10,000 to \$12,000 per intracytoplasmic sperm injection attempt); see also Daniel Wikler & Norma J. Wikler, *Turkey-baster Babies: The Demedicalization of Artificial Insemination*, 69 MILBANK Q. 5, 8 (1991) (discussing the simplicity of a procedure that requires only a syringe and can be performed with as basic a utensil as a turkey-baster).

30. SUSAN L. COOPER & ELLEN S. GLAZER, *BEYOND INFERTILITY: THE NEW PATHS TO PARENTHOOD* 178 (1994). Prior to the AIDS epidemic, most donor insemination was performed using fresh, rather than frozen sperm, since fresh sperm is more viable. As a health safeguard, the American Fertility Society issued guidelines in 1986 recommending that all donation be done with frozen sperm that has been quarantined for at least 180 days and then retested. *Id.*

31. Estimates vary widely on the number of commercial sperm banks in the United States. Compare *id.* at 179 (speculating that the number could be well in the hundreds) and Judith Gaines, *A Scandal of Artificial Insemination*, N.Y. TIMES, Oct. 7, 1990, § 6, at 23 (estimating the number to be 400) with Margery Stein, *Making Babies or Playing God?*, FAMILY CIRCLE, Sept. 20, 1994, at 67 (citing an American Association of Tissue Banks estimate that the number could be as great as 1,100). Only 25 university-based and

The exact number of private sperm banks nationwide is unknown since sperm banks can set up shop without being licensed or registered with any professional organization.³² Throughout the country, sperm banks and laboratories operate free of any official oversight or regulation.³³

1. Sperm Donor Recordkeeping

The American Society for Reproductive Medicine³⁴ and the American Association of Tissue Banks issue guidelines on recordkeeping and other sperm-bank procedures such as donor screening and selection, but as with fertility clinic guidelines, compliance is simply voluntary.³⁵ Sperm banks need not be registered or accredited through these professional organizations, or submit to any on-site inspections, in order to operate.³⁶ Recent scandals involving the spread of disease and poor recordkeeping at sperm banks highlight

commercial sperm banks operated in the United States in 1986. Terra Ziporyn, "Artificial" Human Reproduction Poses Medical, Social Concerns, 255 JAMA 13, 13 (1986).

32. A state, however, may require a sperm bank to be registered with it. See, e.g., ILL. ANN. STAT. ch. 20, 2310/55.46(a) (Smith-Hurd 1993). New York and California are the only two states that require sperm banks to be licensed. COOPER & GLAZER, *supra* note 30, at 179.

33. COOPER & GLAZER, *supra* note 30, at 179.

34. Until 1995, the American Society for Reproductive Technology was known as the American Fertility Society. This Comment identifies the Society's pre-1995 publications by its former name.

35. The American Society for Reproductive Medicine recommends that donors be in good health, free of systemic diseases and genetic abnormalities, and of legal age but below the age of forty. They should not be in a high-risk group for AIDS. Also, they should provide a complete family and medical history, and submit to screening for sexually transmitted diseases, cytomegalovirus, and HIV antibodies. American Fertility Society, *Guidelines for Therapeutic Donor Insemination: Sperm*, 62 FERTILITY & STERILITY 101S-102S, 104S (Supp. Nov. 1994) [hereinafter *Guidelines for Donor Insemination*]. RESOLVE, Inc. recommends that donors be screened for additional medical conditions, such as sickle cell anemia and Tay-Sachs disease. Hill Telephone Interview, *supra* note 20. The federal Centers for Disease Control and Prevention also has guidelines for sperm banks, but these too are voluntary. Elizabeth Neus, *Human Egg Donations Pose Moral, Ethical Dilemma*, GANNET NEWS SERV., Nov. 21, 1994 (available in 1994 WL 11243780).

36. According to Dr. John H. Mattox, FACOG, Chairman, Obstetrics and Gynecology, Good Samaritan Regional Medical Center and Medical Director, Samaritan Institute of Reproductive Medicine, Phoenix: "Typically, unaccredited sperm banks follow American Association of Tissue Banks guidelines as well as guidelines recommended by the American Society of Reproductive Medicine. However, a patient has only the word of a sperm bank that these guidelines are being followed. There is no on-site inspection to prove it." John H. Mattox, M.D., *Sperm-Bank Patients Can Protect Selves With Knowledge*, ARIZ. REPUBLIC, Sept. 1, 1995, at B6.

problems that can occur under this current system.³⁷ Not only are there no laws requiring sperm banks to obtain the medical records of donors, but there are no laws to compel banks to preserve these records.³⁸ As a result, banks often have little or no reliable data on the number of live births per donor. This information could benefit prospective recipients and provide useful feedback to the banks regarding donor sperm quality.³⁹ Even more importantly, however, detailed medical, genetic, and sometimes psychological histories of donors are left in limbo, since no legal safeguards exist to ensure the permanent security and confidentiality of this information.⁴⁰ The lack of federal oversight of sperm banks also has several consequences in terms of donor screening and selection, as seen in the quality and quantity of information banks obtain about donors.⁴¹ In addition to being tested for a variety of diseases, donors are generally asked about their medical and genetic histories, educational background, and career or profession.⁴² The accuracy of much of this information

37. In July 1995, the largest sperm bank in New York was ordered to close after a State Supreme Court justice found it had repeatedly violated health laws and regulations. Esther B. Fein, *Sperm Bank is Ordered Closed and Denied a License Hearing*, N.Y. TIMES, July 19, 1995, at B3. In a 1993 inspection, investigators for the Health Department discovered that the sperm bank Idant Laboratories had failed to screen sperm donors properly for sexually transmitted diseases. "The inspection showed that the company had, in fact, made available semen from men who had tested positive for hepatitis, chlamydia, and gonorrhea, that it had not taken complete medical and sexual histories of its donors and that it performed tests in unlicensed laboratories." *Id.*

38. New York is the only state that mandates that insemination results be reported back to the sperm banks. See Stein, *supra* note 31, at 67.

39. See *id.* (quoting John Critser, chairman of American Association of Tissue Banks, on his organization's lack of authority to require physicians to communicate with it and the resulting lack of comprehensive data on pregnancies).

40. See Swanson, *supra* note 28, at 154 (presenting a historical overview of donor anonymity and recordkeeping and concluding that past reasons for anonymity are no longer valid today).

41. See generally KAPLAN & TONG, *supra* note 24, at 227-28 (describing the Sperm Bank of Northern California, which is committed to providing artificial insemination to any healthy woman, and The Repository for Germinal Choice, a.k.a. the Nobel Prize-Winners Sperm Bank, which obtains sperm from persons of prominence, achievement, and genius so specially selected infertile couples can use it to produce "superior" children). See also Susan V. Seligson, *Seeds of Doubt*, THE ATLANTIC, Mar. 1995, at 28 (discussing questions raised by a successful donor-insemination service that caters exclusively to single women).

42. See RESOLVE, INC., *Questions to Ask Sperm Banks and Donor Insemination Programs* (RESOLVE, Inc., Somerville, Mass.) 1995. Basic information about each donor's physical characteristics, race, and ethnicity/culture is commonly listed in donor catalogs. *Id.* More personal information such as the donor's religious background and favorite pastimes or hobbies may also be included. *Id.*

depends largely on the word of the donor.⁴³ Under the current system, employers and insurance companies often do a more comprehensive background check of prospective employees or policyholders than do many sperm banks of donors.⁴⁴ Also, the amount of information obtained from donors varies from sperm bank to sperm bank as is apparent in the donor catalogs that sperm banks distribute to consumers.⁴⁵

In effect, then, patient-recipients who use donor sperm must make a "giant leap of faith."⁴⁶ They must trust that their physician is working with a reputable sperm bank that screens, selects, and monitors donors responsibly.⁴⁷ They must also trust that the donor they choose has been truthful in the information he has disclosed about himself, his background, and his medical and genetic history. Finally, they must trust that at no time in the future will they or their offspring need access to any additional information about the donor.

2. Sperm Donor Anonymity

Donors typically participate in sperm bank programs with the understanding that their anonymity will be protected and identity never disclosed to the parties involved.⁴⁸ Many physicians and sperm banks contend that without a guarantee of anonymity, they will be unable to attract sufficient numbers of donors.⁴⁹ The reasons for anonymity have traditionally been to shield all parties from emotional distress and the invasion of privacy, and to protect donors from inheritance claims and legitimacy issues.⁵⁰

Over the last few years, however, the policy of secrecy that has surrounded artificial insemination has begun to change. A recent study of sperm donors reveals donors to be less concerned about

43. Hill Telephone Interview, *supra* note 20; Telephone Interview with Cryogenic Laboratories personnel (Jan. 10, 1996).

44. *Id.* (confirmed in both interviews).

45. See generally COOPER & GLAZER, *supra* note 30, at 181-85 (surveying donor information catalogs from three of the largest and most reputable sperm banks in the country).

46. *Id.* at 179.

47. *Id.* The American Society for Reproductive Medicine (ASRM) recommends that each sperm bank establish ongoing procedures for monitoring the health of donors. For example, ASRM guidelines require that donors be tested every six months for serum hepatitis B antigen, hepatitis C antibody, cytomegalovirus, and HIV antibodies (the human immunodeficiency virus that causes AIDS). *Guidelines for Donor Insemination*, *supra* note 35, at 103S.

48. See COOPER & GLAZER, *supra* note 30, at 179.

49. See Swanson, *supra* note 28, at 171.

50. *Id.* (citing Martin Currie-Cohen et al., *Current Practice of Artificial Insemination by Donor in the United States*, 300 NEW ENG. J. MED. 585, 589 (1979)).

guaranteed anonymity than was previously believed.⁵¹ Ninety-six percent of the donors surveyed said they would grant the recipient couple and offspring access to non-identifying information about themselves,⁵² and fifty-nine percent of them would agree to having their identities disclosed to offspring who were at least eighteen years old.⁵³ Before they use donor insemination, parents should decide whether they will tell their offspring of the sperm donation, taking into account the related complications that could follow such a disclosure.⁵⁴ Regardless of their decision (and the desire of the donor and the offspring), the matter is moot unless information on the donor is in some way preserved and safeguarded.

B. Egg Donation

Human egg (or oocyte) donation is an advanced reproductive procedure where eggs are removed from one woman (the donor) and transferred to another woman (the recipient).⁵⁵ The technique enables an infertile woman to gestate and bear a child from another woman's fertilized egg.⁵⁶ The most common method of egg donation is by in vitro fertilization (IVF),⁵⁷ although it can also be performed

51. See Patricia Mahlstedt & Kris Probasco, *Sperm Donors: Their Attitudes Toward Providing Medical and Psychosocial Information for Recipient Couples and Donor Offspring*, 56 *FERTILITY & STERILITY* 747, 749-52 (Oct. 1991).

52. *Id.* at 749. This nonidentifying information would include the donor's medical, social, educational, and personal histories. *Id.*

53. *Id.* at 750; see also Ken Daniels, *Artificial Insemination Using Donor Semen and the Issue of Secrecy: The Views of Donors and Recipient Couples*, 27 *SOC. SCI. MED.* 377-81 (1988) (describing a 1985 Swedish law that requires sperm donor records to be safeguarded for seventy years and to be made available to resulting offspring at eighteen years of age, and concluding that the lack of donor anonymity does not result in a shortage of donors). See generally Ken Daniels, *Semen Donors in New Zealand: Their Characteristics and Attitudes*, 5 *CLINICAL REPRODUCTIVE FERTILITY* 177-90 (1987) (summarizing the results of a study of donors, including their thoughts about anonymity and disclosure).

54. See ROBERTSON, *supra* note 24, at 123.

55. See Schiff, *supra* note 9, at 268. The first birth of a child conceived through egg donation occurred in 1983. *Id.* at 268 n.12.

56. See generally John A. Robertson, *Technology and Motherhood: Legal and Ethical Issues in Human Egg Donation*, 39 *CASE W. RES. L. REV.* 1 (1988-89) (presenting a comprehensive overview of egg donation and its social, political, and legal ramifications).

57. KAPLAN & TONG, *supra* note 24, at 255. The term, which means "fertilization in glass," is used to denote all fertilization procedures that occur outside the human body. It is widely recognized as "test tube baby" technology. *Id.* at 256. With in vitro fertilization, a doctor removes an egg from a woman's ovarian follicle, fertilizes it in a laboratory dish by combining it with sperm, and then transfers the resulting embryo into either the original (i.e., genetic) woman's uterus or that of a gestational surrogate. See generally GENA COREA, *THE MOTHER MACHINE: REPRODUCTIVE TECHNOLOGIES FROM ARTIFICIAL INSEMINATION TO ARTIFICIAL WOMBS* 1-3, 20-23, 34-36, 219-25 (1985)

through embryo transfer or gamete intrafallopian transfer.⁵⁸

The egg donation procedure is not only considerably more complex than artificial insemination, but it is time-consuming, physically invasive, and potentially risky for both donor and recipient.⁵⁹ Nevertheless, the enhanced success rate of this reproductive method⁶⁰ has resulted in a dramatic rise in the number of egg donation procedures performed over the last decade.⁶¹ As techniques for cryopreserving (freezing) eggs improve, the prospect of future egg banks, similar to today's sperm banks, becomes increasingly likely.⁶²

Egg donor programs are offered at the IVF centers of many fertility clinics, which are often hospital-based.⁶³ As with sperm banks, these programs operate without federal oversight or regulation.⁶⁴ Clinics

(discussing the revolutionary impact of in vitro fertilization since the birth in 1978 of Louise Brown, the first IVF baby).

58. See Robertson, *supra* note 56, at 4-6.

59. To induce ovulation at a specified time, a donor must undergo several weeks of drug therapy, closely monitored to ensure that the ovaries are not hyperstimulated. Long-term studies on the effects of the fertility drugs commonly used in this procedure have yet to be done. In a few recent nonconclusive tests, the fertility drug Clomid has been linked with ovarian cancer. See, e.g., Alice S. Whittemore, et al., *Invasive Epithelial Ovarian Cancers in White Women*, 136 AM. J. EPIDEMIOLOG. 1184-203 (1992). But see Richard P. Marrs & Stuart C. Hartz, *Comments on the Possible Association Between Ovulation Inducing Agents and Ovarian Cancer* (The American Fertility Society, Birmingham, Ala.) 1993 (describing limitations of the Whittemore et al. study). In addition to the risks from drug therapy, egg donors must go through outpatient surgery for the eggs to be recovered, which carries with it the potential risk of infection and complications from anesthesia. COOPER & GLAZER, *supra* note 30, at 205.

60. Individual clinics report that the success rate of this procedure today is approximately 50%. Jan Hoffman, *Egg Donations Meet a Need and Raise Ethical Questions*, N.Y. TIMES, Jan. 8, 1996, at A1. The rate has continued to climb. For example, a 1991 survey reported a 25.6% delivery success rate per cycle in which eggs were retrieved. Society for Assisted Reproductive Technology (SART) & American Fertility Society (AFS), *Assisted Reproductive Technology in the United States and Canada: 1991 Results from the Society for Assisted Reproductive Technology Generated From The AFS Registry*, 59 FERTILITY & STERILITY 956, 960 (1993).

61. Andrea M. Braverman, *Survey Results on the Current Practice of Ovum Donation*, 59 FERTILITY & STERILITY 1216, 1216 (1993). Approximately 2,400 procedures involving donated eggs were performed in 1993 alone. Susan Kelleher & Michelle Nicolosi, *Egg-donor Programs Lack Uniform Criteria*, ORANGE COUNTY REGISTER, Oct. 12, 1995, at B6.

62. See Katheryn D. Katz, *Ghost Mothers: Human Egg Donation and the Legacy of the Past*, 57 ALB. L. REV. 733, 737 (1994); Cowley, *supra* note 23, at 42 (describing future trends in reproductive medicine).

63. In 1993, 135 fertility clinics in the United States offered egg donor services. Hoffman, *supra* note 60, at A1 (noting that this is the last year for which the American Society for Reproductive Medicine has statistics).

64. Organizations like RESOLVE, Inc., encourage egg donation patients to use IVF/fertility clinics that are members of the American Society for Reproductive Medicine's Special Interest Group for Assisted Reproductive Technologies. Nevertheless, clinics do not need to be members of this organization to perform egg donation.

and physicians recruit anonymous egg donors by word-of-mouth or through advertisements in college or local newspapers, parenting magazines, nursing journals, and other publications.⁶⁵ The American Society for Reproductive Medicine (ASRM) has voluntary guidelines for clinics regarding the medical screening and selection of these donors.⁶⁶ Again, since these guidelines are not mandatory, the quality and quantity of information obtained from egg donors can vary greatly from clinic to clinic.

1. *Egg Donor Anonymity and Recordkeeping*

Anonymous egg donors and recipients typically sign consent agreements that state they will not attempt to discover each other's identity. Although clinics and independent physicians may be more inclined than sperm banks to keep confidential records on their patients and anonymous egg donors, no laws require that any person or facility retain this information.⁶⁷ Thus, egg donor records have as little legal protection in terms of safeguarding and preservation as do sperm bank records.

2. *Legal Uncertainties*

The American Society for Reproductive Medicine urges clinics to inform patients and donors that the laws regarding egg donation,

See Diane N. Clapp, *Questions to Ask About Assisted Reproductive Technology (ART) Programs* (RESOLVE, Inc., Somerville, Mass.) May 1995 (consumer education sheet).

65. See COOPER & GLAZER, *supra* note 30, at 204. Recruitment methods vary from clinic to clinic. At Minnesota's Mayo Clinic, for example, anonymous egg donors are recruited from the hospital through internal communications. Telephone Interview with Sharon Stevens, IVF Nursing Coordinator, Mayo Clinic (Jan. 11, 1996) [hereinafter Stevens Telephone Interview]. According to another Minnesota clinic, all its prospective anonymous donors to date have contacted the clinic to volunteer their services. Telephone Interview with Sue Hemme, Director of Egg Donor Program, Midwest Center for Reproductive Health (Jan. 11, 1996). The word "donor" in this context is misleading, since the typical egg donor receives \$1,500 to \$2,000 per cycle. Schiff, *supra* note 9, at 271. Also, anonymous donors make up only one category of potential egg donors (e.g., women undergoing IVF treatment where excess eggs are retrieved, women undergoing tubal ligation or other abdominal surgery, and known donors, such as friends or family members of the recipients). *Id.* at 270.

66. Screening requirements include routine serological testing performed for syphilis, hepatitis B and C, and HIV I-II, genetic testing and (unlike sperm donors) psychological testing. *Guidelines for Oocyte Donation*, 62 FERTILITY & STERILITY 105S-07S (Supp. Nov. 1994) [hereinafter *Guidelines for Oocyte Donation*]. See generally Braverman, *supra* note 61, at 1216-20 (discussing survey results of ovum donor program management, screening, and implementation practices and concluding that "[m]ore guidelines are needed to provide uniformity for the current practice of ovum donation").

67. A distinction must be drawn here between information regarding the procedure, such as written consent agreements by the parties, and information regarding the donor.

particularly when third parties are involved in the reproductive process, have not been definitely established.⁶⁸ Donors, for example, may be unaware that, as in adoption, laws can change that could allow the resulting offspring access to information about the donor at a later age.⁶⁹ To prevent misunderstanding and ensure that patients and donors are fully informed, the Society recommends that clinics:

[Make all parties] fully aware of the legal situation, including legal uncertainty, existing in their jurisdiction . . . execute documents that state the commitment, on the part of the donor, to give up all rearing rights and duties in any offspring and on the part of the recipient, to take on all the rights and duties of legal mother . . . [and advise each party] to consult an attorney for further clarification and protection of their legal interests.⁷⁰

Some consent forms recommend that patients or donors secure legal advice if they need additional information about their legal interests.⁷¹ In the absence of law, however, lawyers can do little more than urge parties to exercise caution before consenting to a procedure and to put in writing their intentions regarding their parental rights and obligations, anonymity, disclosure, and related issues.

C. *The Minnesota Connection*

Currently at least five medical clinics in Minnesota offer specialized infertility treatment.⁷² Each of these clinics provides artificial insemination, which is viewed as a generalized treatment, and four of these clinics offer egg donor programs, which involve a considerably more specialized treatment.⁷³ Although some Minnesota clinics have andrology labs that provide patients with donor sperm, most anonymous donor sperm samples are procured from either the one in-state commercial sperm bank or other out-of-state sperm banks.⁷⁴ The

68. Diane N. Clapp, *Questions to Ask Before Starting in a Donor Egg Program* (RESOLVE, Inc., Somerville, Mass.) 1995 (consumer education sheet).

69. *Id.*

70. See *Guidelines for Oocyte Donation*, *supra* note 66, at 107S.

71. See, e.g., Mayo Clinic, Consent to Participation in Donor Oocyte Program: Recipient (1995) (consent agreement available at Mayo Clinic); Mayo Clinic, Consent to Participation in Donor Oocyte Program: Anonymous Donation-Donor (1995) (consent agreement available at Mayo Clinic).

72. Hill Interview, *supra* note 20. These include the Mayo Clinic, Abbott Northwestern Hospital (Center for Reproductive Health and IVF Minnesota), the University of Minnesota Hospital (Women's Health Center), the Midwest Center for Reproductive Health, and Reproductive Health Associates. *Id.*

73. Telephone Interviews with Minnesota Fertility Clinic personnel (Oct. 1995). All but the University of Minnesota Hospital and Midwest Center for Reproductive Health have active anonymous egg donor programs. *Id.*

74. *Id.* Donor banks commonly used by Minnesota clinics are located in California, Massachusetts, Ohio, and Utah. *Id.*

Minnesota clinics generally provide patients with the names of sperm banks to consult if the patients do not wish to use the clinic's donor samples.⁷⁵

Cryogenic Laboratories, Inc. is the only commercial sperm bank located in Minnesota.⁷⁶ This sperm bank, which has maintained a donor semen program since 1972, has been inspected, accredited, and licensed by the American Association of Tissue Banks and the New York State Department of Health, and is a Laboratory Improvement Act Inspected/Certified Laboratory.⁷⁷ Several Minnesota fertility clinics, including the Mayo Clinic, use the services of Cryogenic Laboratories.⁷⁸ According to its literature, the bank retains identifying donor information, including medical and genetic records, for an indefinite period of time.⁷⁹

The egg donation procedure itself is so new that Minnesota's largest fertility clinics have only recently established egg donor programs.⁸⁰ Each of the clinics offering this procedure began with known egg donors, and then moved to anonymous donors.⁸¹ The Minnesota medical profession's uncertainties regarding the future legal status and

75. *Id.*

76. Cryogenic Laboratories, Inc. is located in Roseville, Minnesota.

77. Cryogenic Laboratories, Inc. (Roseville, Minn.) 1995 (letter to physicians). Donors are evaluated using criteria established by the Standards of the American Association of Tissue Banks, American Society for Reproductive Medicine, and the State of New York Department of Health. Cryogenic Laboratories, Inc. (Roseville, Minn.) 1995 (consumer information packet). Cryogenic Laboratories has an unusual approach to donor selection and recordkeeping. It markets a donor data management software system called DADS (data-assisted donor selection) to physicians and patients. With DADS software, patients can select donors based on desired characteristics, including anatomical features, personality traits, skills, abilities, preferences, and goals, and also compare data on other donors. Cryogenic Laboratories, Inc., *Cryogenic Communique* (Cryogenic Lab., Inc., Roseville, Minn.) Sept. 1995. Printouts of non-identifying donor profile reports are also available for additional cost upon patient request. *Id.*

78. Stevens Telephone Interview, *supra* note 65; Telephone Interview with Sue Hemme, Midwest Center for Reproductive Health (Jan. 11, 1996); University of Minnesota, (Center for Reproductive Health Laboratory, Minneapolis, Minn.) 1995 (product literature regarding therapeutic donor insemination).

79. Telephone Interviews with Cryogenic Laboratories personnel, (Jan. 10, 1996); see also Cryogenic Laboratories, Inc., *Semen Donor Catalogue* (Cryogenic Lab., Inc., Roseville, Minn.) 1995. "Standard Procedures . . . Medical/genetic histories are retained indefinitely." *Id.*

80. Stevens Telephone Interview, *supra* note 65. The Mayo Clinic, for example, started its known egg donor program in 1992 and its anonymous egg donor program in 1995. Reproductive Health Associates began its anonymous egg donor program in 1993. (Reproductive Health Associates, P.A., St. Paul, Minn.) 1995 (product literature). Abbott Northwestern Hospital began its anonymous program in 1993. *IVF Minnesota* (Abbott Northwestern Hospital, Center for Reproductive Medicine Minneapolis, Minn.) 1994 (product literature).

81. *Id.*

rights of the parties involved in egg donation are reflected in their patient consent agreements. For example, the following language from a donor's written agreement to participate in an anonymous egg donor program includes these statements:

I understand that Mayo will not give me information about the Recipient or about whether my donation resulted in implantation of a fertilized egg or a pregnancy. I understand that Mayo will not voluntarily reveal my identity to any recipient *It is my intent and hope* that under no circumstances will I have any responsibility for any offspring, either financial or otherwise. However, *I understand that there are no existing laws that specifically protect egg donors from the responsibilities of a parent.* I understand that it is my responsibility to consult an attorney for further clarification and protection of my legal interests.⁸²

Recipient couples in an anonymous egg donor program at another hospital sign a similar consent agreement:

We understand that the IVF Team and Abbott Northwestern Hospital do not make any guarantee of the reliability of the information provided by the Ovum Donor in the above described screening process. We understand and agree that the IVF Team and Abbott Northwestern Hospital will not be responsible for the reliability of information obtained from the Ovum Donor in the screening process We understand and agree that by signing this document, we waive all rights in equity or at law for past, present or future information regarding the Ovum Donor. We further agree not to try to obtain any information about the identity of the Ovum Donor not known to us.⁸³

Nothing in this language, of course, addresses the rights of the collaborative offspring or precludes such offspring from seeking information about the donor.

82. Mayo Clinic, Consent to Participation in Donor Oocyte Program: Anonymous Donation - Donor (1995) (consent agreement available at Mayo Clinic) (emphasis added). The corresponding agreement for recipients states

[I]f any child or children born through this program should seek support or payment from the donor, Mayo Clinic, or Mayo staff, we shall indemnify and hold them harmless from any such liability. We understand that there are no existing laws that specifically address parental rights following ovum donation, although the donor has agreed not to assert any right to any child born.

Mayo Clinic, Consent to Participation in Donor Oocyte Program: Recipient (1995) (consent agreement available at Mayo Clinic).

83. IVF Minnesota/Center for Reproductive Medicine/Abbott Northwestern Hospital, Informed Consent and Agreement for In Vitro Fertilization and Embryo Placement With Donated Eggs (1995) (consent agreement available at Abbott Northwestern Hospital).

III. MINNESOTA LAW ON COLLABORATIVE REPRODUCTION

A. *The Issue of Federal Regulation*

Although Minnesota enjoys a national reputation as a leading health care provider, its infertility industry is no more immune from problems than it is in states like California and New York, where recent fertility clinic and sperm bank scandals have occurred.⁸⁴ These controversies have renewed debate on the need for federal regulation in the infertility industry. Until now the federal government has tended to respond at a glacial pace to problems relating to reproductive technology. In 1988, for example, the Office of Technology Assessment issued a comprehensive report on infertility⁸⁵ that identified a need to standardize the reporting of infertility clinic success rates and establish uniform clinic criteria.⁸⁶ In response, Congress passed the Fertility Clinic Success Rate and Certification Act in 1992.⁸⁷ Four years later, however, this significant first-step measure has yet to be

84. See, e.g., Susan Kelleher & Kim Christensen, *Investigation Says Fertility Center Did Not Track Eggs or Consent As It Should Have*, ORANGE COUNTY REG., June 4, 1995, at A01 (describing allegations that clinic doctors took human eggs without consent, fertilized them, and transferred the embryos to other patients); Corrine Bayley & Jack Glaser, *Orange County Voices; Commentary on Ethics; Allegations Regarding Fertility Clinic Shock Even the Hardened*, L.A. TIMES, Aug. 13, 1995, at B9 (discussing missing human eggs and embryos in a prestigious California fertility clinic which were allegedly transplanted into the wrong patients); see also Diane M. Gianelli, *Fertility Doctor's Conviction Fuels Issue of Self-Policing*, AMERICAN MEDICAL NEWS, Mar. 23, 1992 (describing a fertility doctor in Virginia who inseminated unknowing patients with his own sperm). See generally Dorothy M. Robins, Comment, *When the Gleam in Your Eye Becomes a Glare: Capped Damages in Fertility Malpractice Actions*, 26 U.S.F. L. REV. 717 (1992) (discussing deceptive claims many fertility clinics make about the success rate of the fertility services and procedures they offer). For sperm bank scandals, see *supra* note 37.

85. CONGRESS OF THE UNITED STATES, OFFICE OF TECHNOLOGY ASSESSMENT, *INFERTILITY: MEDICAL AND SOCIAL CHOICES* (1988). For a historical overview of the regulation of reproductive technology, see Eggen, *supra* note 9, at 625.

86. CONGRESS OF THE UNITED STATES, OFFICE OF TECHNOLOGY ASSESSMENT, *INFERTILITY: MEDICAL AND SOCIAL CHOICES* (1988); see also Begley, *supra* note 4, at 40. "[F]rom 1991 to today, the Federal Trade Commission has obtained cease-and-desist orders against 11 clinics whose advertising implied that a baby was almost as easy to get as a tattoo." *Id.*; cf. Nancy McVicar, *Debate Rages on Infertility Labs*, FT. LAUDERDALE SUN-SENTINEL, July 2, 1995, at 12A (citing a recent case in the Netherlands illustrating dangers of poorly supervised infertility labs where a Dutch couple became the parents of twins, one white and one black, apparently because sperm from a Caribbean islander was accidentally mixed with sperm from the husband).

87. The Fertility Clinic Success Rate and Certification Act of 1992, Pub. L. No. 102-493, 106 Stat. 3146 (1992) (codified at 42 U.S.C. § 201). The purpose of the act is to require infertility clinics to report the pregnancy success rates of their assisted reproductive technology programs and to certify embryo laboratories. *Id.*

implemented.⁸⁸

Governmental regulation might appear an attractive alternative to the industry's current system of self-regulation, but it is also problematic. Many in the industry fear that federal regulation could have a chilling effect on individual rights to reproductive privacy,⁸⁹ restrict patient access to the latest reproductive technology, and interfere with the medical profession's pioneering of new technologies.⁹⁰ At a recent conference of the American Society of Reproductive Medicine (ASRM), officials stressed their belief that regulation would not prevent unethical conduct in the industry.⁹¹ Nevertheless, both the ASRM and the College of American Pathology have announced plans to draft model state legislation to regulate the nation's fertility clinics.⁹²

B. Common Law on Collaborative Reproduction

Regulatory measures may help Minnesota's medical profession and infertility patients by ensuring quality control and consumer protection, but these measures primarily address procedural matters, such as how these reproductive technologies are conducted. Meanwhile, many substantive matters regarding the technologies themselves remain. What, in effect, is being regulated? In many states, including Minnesota, the legal status and rights of parties in collaborative technologies are still ill-defined. Legislation has taken such a backseat to these technologies that to date only five states (Florida, North

88. McVicar, *supra* note 86, at 12A. Congress gave the federal Centers for Disease Control and Prevention (CDC) in Atlanta the job of overseeing the implementation of the new law. *Id.* Since Congress did not appropriate funding, the CDC turned the job over to the American Society for Reproductive Medicine, based in Birmingham, Alabama. *Id.*

89. *See* Roe v. Wade, 410 U.S. 113, 153 (1973) (holding that the right to abortion is grounded in the constitutional right of privacy); *see also* Eggen, *supra* note 9, at 687 (stating "[t]he specter of the government stepping into the bedroom to regulate reproductive choices has proved unpalatable in decisions not to procreate; similarly, governmental intrusion into the bedrooms of those who choose affirmatively to procreate is equally unacceptable"). *Id.* at 687-88.

90. *See* Eggen, *supra* note 9, at 689.

91. *See* Warren King, *Law Can't Stop Abuse, Infertility Doctors Say*, SEATTLE TIMES, Oct. 10, 1995, at B1. "You can't regulate against aberrant or disruptive behavior. If you could, you would have no crime in this country." *Id.* (quoting Dr. Victor Knutzen, president of the American Society for Assisted Reproductive Technology).

92. *See* Susan Kelleher & Michelle Nicolosi, *Fertility Group Drafting Self-Policing Legislation / SCANDAL: The UCI Affair and Advances in the Science Prompt the Society to Tighten the Reins*, ORANGE COUNTY REG., Oct. 10, 1995, at A01; James V. Grimaldi & Michael Hershaft, *Panel's Action Adds to Regulatory Push / HEALTH: The Ethics Board Announces Plans to Write Model Legislation for States*, ORANGE COUNTY REG., Oct. 21, 1995, at B04.

Dakota, Oklahoma, Texas, and Virginia) have laws on egg donation.⁹³

Comparatively little case law exists on issues related to collaborative reproduction.⁹⁴ Even artificial insemination, which is the oldest and most widely used of these techniques, has rarely been the subject of lawsuits. The few artificial insemination cases that have arisen have questioned whether it constitutes adultery,⁹⁵ whether the resulting offspring are illegitimate,⁹⁶ and whether the husband should be obliged to support the offspring.⁹⁷ Most states have enacted statutes to resolve these and other issues related to artificial insemination.⁹⁸

C. *The Intent-Based Model*

Although so far Minnesota courts have not had to deal with the problems of collaborative reproduction, Minnesota's infertility industry is still in its infancy. Given the growing number of Minnesotans undertaking collaborative reproduction, future litigation seems inevitable unless the Minnesota Legislature addresses basic issues in this area. For example, issues that remain unresolved in Minnesota law include the legal status of an egg donor versus a birth (gestational) mother, and the rights of offspring to obtain information about their

93. See FLA. STAT. ANN. §§ 742.11(2)-742.14 (West Supp. 1996); N.D. CENT. CODE ANN. §§ 14-18-01 to 14-18-07 (1991 & Supp. 1995); OKLA. STAT. ANN. tit. 10, §§ 554-55 (West Supp. 1996); TEX. FAM. CODE ANN. § 151.102 (West 1995) (available on Lexis and Westlaw); VA. CODE ANN. §§ 20-158 (Michie 1995).

94. More law review and academic journal articles have appeared on potential problems resulting from assisted reproductive technologies than have published decisions. There have, however, been a few widely publicized cases involving the disposition of frozen pre-embryos. See, e.g., *Davis v. Davis*, 842 S.W.2d 588, 604 (Tenn. 1992), *cert. denied*, 113 S. Ct. 1259 (1993) (involving a divorcing couple's suit over control of their frozen embryos, where the Tennessee Supreme Court held that the father's interest in avoiding procreation outweighed the mother's interest in donating the embryos to an infertile couple). Although debate over custody of embryos may develop as a result of an anonymous egg donation, this Comment does not address that issue. Nevertheless, legislation clarifying the rights of parties involved in such a transaction is also needed in this area.

95. See Swanson, *supra* note 28, at 155 (citing *Doornbos v. Doornbos*, 23 U.S.L.W. 2308 (Ill. Super. Ct. Dec. 13, 1954) unreported, *appeal dismissed*, 139 N.E.2d 844 (Ill. 1956) (holding that artificial insemination was adulterous because it was "contrary to public policy and good morals")).

96. See *Gursky v. Gursky*, 242 N.Y.S.2d 406, 408 (N.Y. Sup. Ct. 1963) (holding that even with the husband's consent, children conceived by artificial insemination were illegitimate).

97. See *People v. Sorenson*, 437 P.2d 495, 501 (Cal. 1968) (holding that it would be "patently absurd" to find that artificial insemination by donor constituted adultery, that "no valid purpose is served by stigmatizing an artificially conceived child as illegitimate," and that it was the husband's duty to support that child).

98. See Swanson, *supra* note 28, at 151, 156-64 (presenting an overview of key common law cases and statutes on artificial insemination by donor).

anonymous donor parents.

A recent landmark California decision that involved a custody dispute could have a significant effect on the way Minnesota addresses future issues of parentage in collaborative reproduction arrangements. In *Johnson v. Calvert*,⁹⁹ a married couple contracted with a surrogate to bear a child conceived from the wife's egg and the husband's sperm.¹⁰⁰ When the surrogate decided to claim the child as her own, the California Supreme Court relied on the original rearing intentions of the parties in determining that the genetic mother was the natural, i.e., legal mother.¹⁰¹ In its analysis, the court concluded that "in a true 'egg donation' situation, where a woman gestates and gives birth to a child formed from the egg of another woman with the intent to raise the child as her own, the birth mother is the natural mother under California law."¹⁰²

The *Johnson* case resulted in at least one court's considered opinion regarding the legal maternity of parties involved in a collaborative reproduction situation. The intent-based approach applied in the *Johnson* decision is likely to be used as a model in future collaborative reproduction cases.¹⁰³ Its appeal lies in the emphasis it places on pre-conceptual agreements where parties indicate in writing their intentions regarding the collaboration. Thus, if disputes arise once the arrangement is made, the court is predisposed to recognize those initial intentions as legally binding.¹⁰⁴ Although the California

99. 851 P.2d 776 (Cal.), *cert. denied*, 114 S. Ct. 206, *cert. dismissed*, 114 S. Ct. 374 (1993).

100. *Id.* The surrogate, Anna Johnson, agreed in writing that the child born would be taken by the couple "as their child" and that she would "relinquish 'all parental rights'" to the child in favor of the couple. *Id.* at 778. In return, the couple agreed to pay Johnson \$10,000 in a series of installments, with the final payment six weeks after the baby's birth, along with a \$200,000 life insurance policy. After Johnson became pregnant as arranged, relations between the parties deteriorated. Even though Johnson had not yet given birth, she demanded the balance owed to her. In response, the couple sought a declaration determining that they were the unborn child's legal parents. Johnson countersued, seeking to be declared the mother. In the meantime, the child was born. *Id.*

101. *Id.* The California Supreme Court decided that although both women had plausible maternity claims under state law governing the determination of a child's parentage, only one could be the "natural mother." *Id.* at 782.

102. *Id.* at 782 n.10.

103. *See, e.g.,* *McDonald v. McDonald*, 608 N.Y.S.2d 477, 480 (A.D. 1994) (applying the *Johnson* intent-based model to conclude that a married woman who bore twins with her husband's sperm and another woman's donated eggs was their legal mother and entitled to custody in divorce proceedings). The *McDonald* court relied on the preconception intention of the parties that the non-genetic, gestational mother would not only bear, but raise the children. *Id.*

104. *See generally* ROBERTSON, *supra* note 24, at 119-45 (1994) (discussing the benefits of using an intent-based approach in resolving many collaborative reproduction

Supreme Court acknowledged its responsibility to decide the *Johnson* case as best it could in light of possible consequences,¹⁰⁵ it made a point of noting that "the proper forum for resolution of this issue is the Legislature, where empirical data, largely lacking from this record, can be studied and rules of general applicability developed."¹⁰⁶

D. Statutory Law on Collaborative Reproduction

While the federal government has been passive in regulating reproductive technologies, state governments, such as Minnesota's, have been largely reactive. Legislatures have typically responded to issues raised in collaborative reproduction cases by enacting and then revising statutes on an *ad hoc* basis. The most uniformly adopted statutes in this area are those on artificial insemination.¹⁰⁷ Thirty-five states, including Minnesota, have legislation that addresses parental rights and responsibilities with respect to donor insemination.¹⁰⁸ In the typical donor statute, the husband of the woman who has undergone insemination is considered to be the legal father of any children resulting from the insemination.¹⁰⁹ Such a statute serves to

disputes).

105. *Johnson*, 851 P.2d at 785.

106. *Id.* at 784-85.

107. See Swanson, *supra* note 28, at 162.

108. See ALA. CODE § 26-17-21 (1992); ALASKA STAT. § 25.20.045 (1995); ARIZ. REV. STAT. ANN. § 12-2451(B) (1994); ARK. CODE ANN. § 9-10-201 (Michie 1993); CAL. CIV. CODE § 7613 (West 1994 & Supp. 1996); COLO. REV. STAT. ANN. § 19-4-106 (1990 & Supp. 1996); CONN. GEN. STAT. §§ 45a-771 to 75 (1992); FLA. STAT. ANN. § 742.11 (West 1986 & Supp. 1996); GA. CODE ANN. §§ 19-7-21 (1991 & Supp. 1995), 43-34-42 (1994); IDAHO CODE §§ 39-5401 to 408 (1993); ILL. ANN. STAT. ch. 750, para. 40/3 (Smith-Hurd 1993); KAN. STAT. ANN. §§ 23-128 to 130 (1988 & Supp. 1994); LA. CIV. CODE ANN. art. 188 (West 1993); MD. CODE ANN., EST. & TRUSTS § 1-206(b) (1991); MASS. ANN. LAWS ch. 46, § 4B (Law Co-op. 1994); MICH. COMP. LAWS § 333.2824(6) (1992 & Supp. 1995); MINN. STAT. § 257.56 (1993); MO. ANN. STAT. § 210.824 (Vernon Supp. 1996); MONT. CODE ANN. § 40-6-106 (1995); NEV. REV. STAT. ANN. § 126.061 (Michie 1995); N.H. REV. STAT. ANN. § 168-B:3(e) (1994); N.J. STAT. ANN. § 9:17-44 (West 1993); N.M. STAT. ANN. § 40-11-6 (Michie 1994); N.Y. DOM. REL. LAW § 73 (McKinney 1988 & Supp. 1996); N.C. GEN. STAT. § 49A-1 (1984); N.D. CENT. CODE § 14-18-03 (1991 and Supp. 1995); OHIO REV. CODE ANN. §§ 3111.3111.30-38 (Page 1989 & Supp. 1995); OKLA. STAT. tit. 10, §§ 551-553 (1994); OR. REV. STAT. §§ 109.239, 109.243 (1990 & Supp. 1994); OR. REV. STAT. §§ 677.355-370 (1989 & Supp. 1994); TENN. CODE ANN. § 68-3-306 (1992); TEX. FAM. CODE ANN. § 151.101 (West Supp. 1995); VA. CODE ANN. §§ 20-156-165 (Michie 1995); WASH. REV. CODE ANN. § 26.26.050 (West 1986 & Supp. 1996); WIS. STAT. ANN. § 891.40 (West Supp. 1995); WYO. STAT. § 14-2-103 (1994). List compiled in part by Anne Reichman Schiff, *Frustrated Intentions and Binding Biology: Seeking AID in the Law*, 44 DUKE L.J. 524, 534 n.31 (1994). The remaining fifteen states with no state statute resolve issues of parentage resulting from artificial insemination by traditional family law. *Id.* at 534-35.

109. Schiff, *supra* note 108, at 535.

protect both the sperm donor from the obligations of parenthood and the recipient from the donor's assertion of the rights of parenthood.

Minnesota, along with twelve other states,¹¹⁰ models its artificial insemination statute on the Uniform Parentage Act (UPA).¹¹¹ The basic purpose of the UPA is to protect children born out of wedlock from the stigma of illegitimacy.¹¹² By clarifying the parental status of the parties involved in this procedure, the UPA acknowledges that married couples will occasionally need to resort to donor insemination to bear children. Section 5 of the UPA states that the legal relationship of the child and husband of the inseminated wife is based on three conditions: 1) the couple is married; 2) the woman's husband consents to the procedure; and 3) the insemination is carried out under the supervision of a licensed physician.¹¹³ The UPA does not address donor anonymity or the preservation of confidential donor records. It requires only that the husband's consent and the date of insemination be filed with the State Department of Health and kept in a sealed file.¹¹⁴

The drafters of the UPA are well aware of the deficiencies in section 5, the statutory equivalent to Minnesota Statute section 257.56.¹¹⁵ The comment to section 5 acknowledges that the "Act does not deal with many complex and serious legal problems raised by the practice of artificial insemination" and points out that "[f]urther consideration of other legal aspects of artificial insemination has been urged on the National Conference of Commissioners on Uniform State Laws and is recommended to state legislators."¹¹⁶

Still, even though current UPA-based statutes on artificial insemination may be shortsighted in light of society's changing attitudes towards donor anonymity and related issues, at least these statutes are on the books. The husband of the woman practicing this method of assisted conception is the legal father of the resulting child and the mother is the legal mother. Patients, however, who undergo egg donation generally do so in a legal vacuum. While many major fertility clinics

110. *Id.* at 534 n.32. The twelve other states with similar statutes modeled on the UPA are Alabama, California, Colorado, Illinois, Missouri, Montana, Nevada, New Jersey, New Mexico, Washington, Wisconsin, and Wyoming. *Id.*

111. UNIF. PARENTAGE ACT, 9B U.L.A. 287 (1987).

112. The UPA was enacted to ensure "substantive legal equality [for] all children regardless of the marital status of their parents." UNIF. PARENTAGE ACT, 9B U.L.A. 287, 288 Prefatory Note (1995).

113. *Id.* § 5, at 301.

114. *Id.*

115. UNIF. PARENTAGE ACT § 5 cmt., 9B U.L.A. at 302 (1995); *see also* MINN. STAT. § 257.56 (1994) (adopting the Uniform Parentage Act).

116. UNIF. PARENTAGE ACT § 5 cmt., 9B U.L.A. at 302 (1995).

across the United States practice egg donation,¹¹⁷ only a few states have laws that establish legal maternity and protect the donor from future child support claims or the recipient mother from loss of custody on the grounds she is not the legal mother.¹¹⁸

The reluctance of state lawmakers to address the legal issues involved in egg donation may be partially due to political considerations, including the mistaken assumption that the same issues related to abortion or fetal research are related to collaborative reproduction procedures.¹¹⁹ Legislative inaction may also be simply a cautious response to the relative speed with which these technologies have been developed and introduced. Moreover, the medical profession in some states, including Minnesota, may be reluctant to pursue regulatory measures, fearing that some lawmakers will react to any proposed legislative involvement by attempting to outlaw procedures such as egg donation in their state.¹²⁰ Regardless of the reason for their past silence, however, legislators have recently begun to consider the role government can play in resolving some of the problems and unanswered legal questions raised by the new reproductive technologies.

IV. PROBLEMS WITH MINNESOTA COLLABORATIVE REPRODUCTION LAW

A. *Failure to Address Egg Donation and Related Parental Issues*

Minnesota's statute on artificial insemination is the state's one piece of legislation that acknowledges and attempts to address key legal issues raised by collaborative reproduction.¹²¹ Unfortunately, Minnesota has not broadened the statute to include egg donation, or even adopted a new statute so parties participating in this latest reproductive method might enjoy the same legal protection as parties in donor insemination.¹²² Thus no Minnesota law exists to legitimize the

117. See *Assisted Reproductive Technology in the United States and Canada: 1991 Results from the Society for Assisted Reproductive Technology Generated from The American Fertility Society Registry*, 59 FERTILITY & STERILITY 956, 960 (1993) (indicating that 75 of 215 fertility clinics surveyed used donated eggs in their programs in 1993); see also *supra* note 80 and accompanying text (describing growth of egg donor programs in Minnesota).

118. Stevens Telephone Interview, *supra* note 65.

119. Eggen, *supra* note 9, at 687.

120. Stevens Telephone Interview, *supra* note 65. Louisiana, for example, has a statute that provides a detailed regulatory system that covers the entire in vitro fertilization process, and that expressly prohibits the sale of a human ovum (i.e., anonymous egg donation). See LA. REV. STAT. ANN. §§ 9:122, 9:126, 9:127, 9:130 (West 1991). "The sale of a human ovum, fertilized human ovum, or human embryo is expressly prohibited." LA. REV. STAT. ANN. § 9:122 (West 1991).

121. MINN. STAT. § 257.56 (1994).

122. *Id.*

mother who has borne a child from a donated egg. As was seen in the two-mother case of *Johnson v. Calvert* where gestation trumps genetics,¹²³ these situations are far from easy to resolve. A legal approach such as the *Johnson* court's intent-based model¹²⁴ would encourage parties undergoing collaborative procedures to put in consent agreements their intentions regarding parental rights and responsibilities.

B. *Failure to Require Confidential Recordkeeping*

In donor insemination the interests of the parents and donors in preserving their anonymity have historically outweighed any offspring interests to donor information. This emphasis upon secrecy and privacy is implicit in Minnesota's artificial insemination statute:

Subdivision 1. 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 biological father of a child thereby conceived. The husband's consent must be in writing and signed by him and his wife. *The consent must be retained by the physician for at least four years after the confirmation of a pregnancy that occurs during the process of artificial insemination.*

All papers and records pertaining to the insemination, whether part 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.

Subdivision 2. The donor of semen provided to a licensed physician for use in artificial insemination of a married woman other than the donor's wife is treated in law as if he were not the biological father of a child thereby conceived.¹²⁵

This statute is close to a complete adaptation of section 5 of the Uniform Parentage Act.¹²⁶ Minnesota's only modification to the UPA language concerns the retention by the physician of the couple's consent agreement.¹²⁷ The UPA requires that the State Department of Health store this confidential information indefinitely.¹²⁸ In contrast, the Minnesota statute only requires that the physician retain

123. This phrase is borrowed from Daniel S. Strouse, *Egg Donation, Motherhood and State Law Reform: A Commentary on Professor Palmer's Proposals*, 35 JURIMETRICS J. 31, 43 (1994).

124. *Johnson v. Calvert*, 851 P.2d at 782-83.

125. MINN. STAT. § 257.56 (1994) (emphasis added).

126. UNIF. PARENTAGE ACT § 5, 9B U.L.A. 301 (1987).

127. See MINN. STAT. § 257.56 subd. 1 (1994).

128. UNIF. PARENTAGE ACT § 5, 9B U.L.A. 301 (1987).

the consent agreement for a limited period of time.¹²⁹ In effect, three years after a child has been born through donor insemination, a Minnesota physician could legally destroy the parties' consent agreement. Moreover, the statute states only that confidential records and files relating to the procedure should be disclosed upon court order for good cause; it says nothing about requiring this information to be kept in the first place.¹³⁰

Many physicians are likely to retain medical records of insemination patients if for no other reason than fear of legal liability. Nevertheless, under this statute they are not legally obliged to do so. Moreover, physicians might not include in their records donor information that could be useful and valuable to offspring in later years—information that may not have been disclosed to the recipient parents. Under Minnesota law, physicians are not required to collect any detailed information on anonymous donors, let alone retain confidential records on inseminations for any specified length of time. Although many sperm banks have a vested interest in preserving donor anonymity, they have no similar interest in safeguarding donor records indefinitely.¹³¹ Thus, adult offspring of donor insemination may in later years seek critical information regarding a donor's medical, genetic, or psychological history, and be unable to find it because it simply does not exist.¹³² Even the American Society for Reproductive Medicine has expressed concern about the safeguarding of confidential donor information:

Because of the lack of model legislation and uncertain medicolegal status protecting the interests of the donor, an ideal record keeping system is not currently available. However, it is highly desirable to maintain permanent confidential records of donors, including a genetic workup and other nonidentifying information, and to make the anonymous record available on request to the recipient and/or any resulting offspring.¹³³

129. MINN. STAT. § 257.56 subd. 1 (1994).

130. *Id.*

131. As noted earlier, Cryogenic Laboratories, Inc. has a policy of preserving donor records indefinitely. See Cryogenic Laboratories, Inc., *supra* note 79. Many Minnesotans undergo insemination using the services of sperm banks that may place less importance on recordkeeping.

132. See Katz, *supra* note 62, at 733 (discussing problems that can arise when genetic links are permanently severed). “[C]hildren born as a result of the egg implantation are ‘out of luck’ if twenty years from now they seek the identity of their mothers. The anonymity of donors and recipients is ‘guarded ferociously’ according to Dr. Daniel Navot, a pioneer in *in vitro* fertilization in this country” *Id.* at 739 (citing Molly Gordy, *Egg Donors Offer the Gift of Life: A Solution to Infertility*, NEWSDAY, Apr. 20, 1992, at 21).

133. See *Guidelines for Donor Insemination*, *supra* note 35, at 104S.

C. Failure to Address Single Party Issues

Among its other shortcomings, the Minnesota statute on artificial insemination presumes that only married women will use this procedure. It thus excludes the single woman who uses an anonymous donor from a sperm bank or clinic, as well as the single woman who uses a known donor. A 1987 government survey indicates that approximately 8,600 single women in the United States used donor insemination to date.¹³⁴ Given the overall growth in the use of donor insemination since then and the increased social acceptance of artificial insemination as an option for unmarried women, this figure is likely to be much higher today.¹³⁵ Under the current statute, donors have no legal protection when single women are inseminated and could theoretically be held liable for child support. Also, the legal status of the child is in question.¹³⁶

The statutory silence surrounding donor insemination of single women in Minnesota has not escaped the attention of fertility clinics. For example, the Mayo Clinic's consent agreement for a single woman undergoing donor insemination includes the following waivers:

I agree to never seek to discover the identity of any donor. . . .
 . . . I understand that Minnesota law concerning artificial insemination does not address paternity rights when a single woman is inseminated. . . .
 I agree that I will not seek support or any other payment for the child or children from either the donor, Mayo Clinic, or any Mayo staff involved. In addition, if a child or children born through the TDI [Therapeutic Donor Insemination] Program should seek support or any other payment from the donor, Mayo Clinic or any Mayo staff, I shall indemnify and hold them harmless from such liability.¹³⁷

Minnesota's refusal to address the issue of insemination by single women is particularly striking in light of medical reality. All of the five major fertility clinics in the state offer donor insemination to single

134. Vicki L. Henry, *A Tale of Three Women: A Survey of the Rights and Responsibilities of Unmarried Women Who Conceive by Alternative Insemination and a Model for Legislative Reform*, 19 AM. J.L. & MED. 285 (1993) (citing U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, ARTIFICIAL INSEMINATION: PRACTICE IN THE UNITED STATES: SUMMARY OF A 1987 SURVEY: BACKGROUND PAPER 3 (1988)). Although this survey is dated, it contains some of the most recent data compiled on this topic. The lack of reliable recordkeeping in the infertility industry makes it difficult to do more than estimate this figure.

135. See, e.g., Stein *supra* note 31 (summarizing results of a study conducted by Princeton Survey Research Associates regarding American society's growing acceptance of various advanced reproductive technologies).

136. See generally Henry, *supra* note 134 (discussing the law's deficiencies in protecting the rights of unmarried biological mothers and their offspring).

137. Mayo Clinic, Consent to Therapeutic Donor Insemination: Single Woman (1995) (consent agreement available at Mayo Clinic) (emphasis added).

women.¹³⁸ Moreover, nine of the twelve other states that model their artificial insemination statutes on the UPA omit the word "married" in their statutes.¹³⁹ Minnesota should do likewise.

D. Lack of Uniformity in Consent Agreements

Although medical professional organizations have established numerous guidelines for the fertility industry, compliance to date remains voluntary. Individual clinics, sperm banks, and egg donor programs typically draw up their own consent agreements. These agreements are at the heart of the informed consent issue, since they document the information infertility patients receive about their treatment and possible future legal complications. If later disputes arise, consent agreements provide evidence of each party's original intentions and understanding regarding treatment. Because consent agreements vary in terms of clarity and comprehensiveness from clinic to clinic, infertility patients and donors often have incomplete ideas about their legal rights and liabilities. Consent may be given, but it is not informed with respect to the legal implications of their decision. Moreover, as a direct result of today's uncertain legal climate, clinics insert many disclaimers and waivers in these agreements to guard against future lawsuits. Until the laws are more settled, the vagueness and general exculpatory language of these consent agreements will continue.

V. RECOMMENDATIONS

Given the considerable sacrifices infertility patients make in terms of time, money, privacy, psychological stress, and physical discomfort, they may be more easily misled than most consumers about the benefits of the service they seek.¹⁴⁰ Their intense desire for a biological child often drives them to enter treatment regimens and agree to medical

138. Telephone interview with representative of Mayo Clinic (Jan. 10, 1996); Telephone interview with representative of Midwest Center for Reproductive Health (Nov. 1995); Telephone interview with representative of Reproductive Health Associates (Nov. 1995); Telephone interview with representative of Center for Reproductive Health and IVF Minnesota, Abbott Northwestern Hospital (Oct. 1995); Telephone interview with representative of Women's Health Center, University of Minnesota Hospital (Oct. 1995).

139. Schiff, *supra* note 108 at n.40. The states with such statutes are California, Colorado, Illinois, New Jersey, New Mexico, Ohio, Washington, Wisconsin, and Wyoming. See CAL. CIV. CODE § 7613 (West 1994 & Supp. 1996); COLO. REV. STAT. § 19-4-106 (1990 & Supp. 1996); ILL. ANN. STAT. ch. 750, para. 40/3 (Smith-Hurd 1993); N.J. STAT. ANN. § 9:17-44 (West 1996); N.M. STAT. ANN. § 40-11-3 (Michie 1994); OHIO REV. CODE ANN. § 3111.31 (Page's 1989 & Supp. 1995); WASH. REV. CODE § 26.26.050 (West 1986 & Supp. 1996); WIS. STAT. § 891.40 (Supp. 1995).

140. See Eggen, *supra* note 9, at 648-49.

procedures without adequately informing themselves about the physical risks of the treatment provided, let alone the legal ramifications discussed in this Comment.¹⁴¹ The following recommendations are an attempt to address those areas where fertility patients and donors may be most legally vulnerable, and where the state's role in protecting the general welfare of its citizens and consumers is most apparent.

A. *Systemic Approach to Fertility Clinic and Sperm Bank Standards*

While other states have coped with fertility clinic scandals and often bizarre first-impression lawsuits triggered by this new technology, Minnesota's infertility industry has remained unscathed. Yet as the number of patients undergoing reproductive procedures increases, so does the potential for problems. Although this Comment has focused on major fertility clinics in Minnesota that offer both donor inseminations and egg donation, many physicians perform donor inseminations in their offices.¹⁴² Moreover, while emphasis has been put on the in-state Cryogenic Laboratories, Minnesotans use sperm banks from around the country. Thus, a systemic approach on a national, rather than state, level would ensure that the fertility clinics and sperm banks used by Minnesotans meet uniform standards of quality control. Implementation of the Fertility Clinic Success Rate and Certification Act would be a definite step in the right direction.¹⁴³

B. *More Inclusive Legislation*

Minnesota legislators should either revise Minnesota Statutes section 257.56 to address egg donation, or introduce a new statute that is more inclusive of current reproductive technologies and practices (such as single women using donor insemination). Equal protection alone compels such legislation.¹⁴⁴ Donors in both donor insemination and egg donation procedures, for example, typically provide gametes with the intention that they will have no rearing rights or duties with respect to the offspring. In turn, recipient parties in both procedures receive the eggs and sperm with the intention that they will assume all rearing rights and duties. Minnesota should thus give the same legal protection to the intentions of parties in egg donation as it does to the intentions of parties in donor insemination. To establish legal paternity or maternity in these situations, lawmakers should consider applying the *Johnson* court's intent-based contractual approach, which

141. See Begley, *supra* note 4, at 40.

142. Hill Telephone Interview, *supra* note 20.

143. See *supra* notes 87-88 and accompanying text.

144. See Mary Lynne Birck, *Modern Reproductive Technology and Motherhood: The Search for Common Ground and the Recognition of Difference*, 62 U. CIN. L. REV. 1623, 1653 (1994).

focuses on the original preconception intentions of the parties in entering into collaborative reproduction arrangements.¹⁴⁵

In the 1996 legislative session, a bill entitled the Uniform Status of Children of Assisted Conception Act was introduced for consideration.¹⁴⁶ The bill's primary focus is to legalize surrogacy parenting, where the surrogate is the gestational parent.¹⁴⁷ In addition to providing for court approval of surrogacy agreements, the bill would recognize the intended parents in a surrogacy agreement as the child's legal parents upon court order following the birth.¹⁴⁸ The bill does not address egg donation explicitly, but it does provide standards that can be applied to determine the parentage of a child born as a result of egg donation, and other "assisted conception" procedures.¹⁴⁹ Since this legislation is at least an attempt to resolve some of the legal ambiguities in current collaborative reproduction, the Minnesota Legislature should give this bill due consideration.

C. *Informed Consent and Education*

Minnesota physicians, fertility clinics, and sperm banks should be compelled to disclose in consent agreements any unresolved legal issues that could reasonably affect a party's decision to undertake a collaborative reproduction procedure. Patients and donors should identify in written consent agreements who they intend the offspring's legal (rearing) parent(s) to be. The prospective parents should also consider seriously whether or not they intend to tell their child that he or she was created as a result of collaborative reproduction.¹⁵⁰ They should indicate in writing whether or not they would like the child to be given the option of obtaining identifying information about the

145. See *supra* note 99-102 and accompanying text.

146. S.F. No. 1772, 79th Leg. Sess. (1995) (proposed coding for new law as Minnesota Statutes, Chapter 258A). Borrowing heavily from adoption proceedings, the bill requires that a child welfare agency conduct home studies of the intended parents and surrogate donor prior to the procedure and file a copy of the home study report with the court. *Id.* § 258A.06(b)(3). It also requires that the court appoint a guardian ad litem to represent the interest of a child to be conceived by the surrogate through assisted conception and recommends that the court appoint an attorney to represent the interests of the surrogate. *Id.* § 258A.06(a). Finally, it proposes that "a report of the results of any medical or psychological examination or genetic screening agreed to by the parties or required by law [be] filed with the court and made available to the parties." *Id.* § 258A.06(b)(8).

147. *Id.* § 258A.05-08.

148. *Id.* § 258A.01-05.

149. *Id.*

150. See Susan C. Klock et al., *A Prospective Study of Donor Insemination Recipients: Secrecy, Privacy, and Disclosure*, 62 FERTILITY & STERILITY 477, 481-83 (1994) (discussing factors that influence donor insemination recipients in their decision to tell a child of his or her donor origin).

donor when the child reaches adulthood. Donors too should be given the option of either preserving their anonymity or allowing identifying information about themselves to be disclosed at some time in the future.

D. Recordkeeping and Information Access Requirement

Minnesota legislators should require physicians practicing collaborative reproduction procedures to collect and retain permanent records of parties who undergo these procedures.¹⁵¹ The records should contain both nonidentifying and identifying information.¹⁵² Detailed nonidentifying information such as medical, genetic, and psychological histories, should be made available to recipient parents prior to conception. Identifying information, such as the Social Security number of the recipient parents and anonymous third-party donors, should also be obtained and preserved. Both identifying and nonidentifying information should be safeguarded in confidence by the physician who performs the procedure¹⁵³ until the offspring reach adulthood and all involved parties¹⁵⁴ consent in writing that this information be disclosed.¹⁵⁵ Waiting until offspring are at least eighteen years old gives them an opportunity to form a stable family unit and, at the same time, helps minimize the emotional tensions and conflicts that can accompany open adoption. With this approach, the recipient-parents and the donor both have an equal choice in deciding whether any resulting child should have access to the donor's records when the child becomes an adult. Moreover, the child also has a choice in the matter. Thus, only with the mutual consent of all parties concerned will disclosure take place.¹⁵⁶

151. See John A. Robertson, *Embryos, Families and Procreative Liberty: The Legal Structure of the New Reproduction*, 59 SO. CAL. L. REV. 939, 1015-18 (1986) (comparing the rights of adopted children to information about their birth parents with those of collaborative offspring).

152. See MINN. STAT. § 259.79 (1994) (regarding confidential identifying information in adoption records). "All adoption records shall be retained on a permanent basis under a protected record system which ensures confidentiality and lasting preservation." *Id.* at subd. 3.

153. Minnesota Statutes § 257.56 already requires that all papers and records pertaining to an insemination be held. The language is vague as to who is required to hold this information and where it is to be held. The legislature should settle the accountability issue by assigning doctors and clinics the responsibility for collecting and safeguarding this information. See MINN. STAT. § 257.56 subd. 1 (1994).

154. "All involved parties" includes the donor, offspring, and the parent(s) who undertook the collaborative reproduction procedure (as defined by the author).

155. Swanson, *supra* note 28, at 184-90 (discussing mandatory recordkeeping and access to information).

156. In a 1989 Canadian study, 89% of adoptive women surveyed approved a "registry which helped unite birth-parents and their adopted children when both

VI. CONCLUSION

Rapid advances in reproductive technology may raise moral, social, and ethical concerns; they may prove bizarre, challenging, controversial, and perplexing; they may frighten, confuse, anger, and excite patients, doctors, and lawmakers alike; but they will not go away. The Minnesota Legislature has an opportunity and an obligation to address many of the legal questions that continue to surround these technologies. By collaborating with Minnesota medical professionals, Minnesota lawmakers can develop legal guidelines to ensure that those who consent to these new reproductive procedures are as informed as possible about their rights and obligations, and the implications of their decision.

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parties, as well as the adoptive parents, registered their consent to such a reunion." *Id.* at 180.