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# The Potential for Products Liability Actions When Artificial Insemination by an Anonymous Donor Produces Children with Genetic Defects

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## I. Introduction

Although accounts of successful artificial insemination using the semen of the recipient's husband date back to the late eighteenth century,[1] inseminating women with the semen of an anonymous donor has only become a common practice in the past several decades.[2] The American legal system has recognized this trend in a variety of ways, but the response has been neither uniform nor comprehensive. Many states have enacted statutes modeled after the Uniform Parentage Act of 1973[3] to define the relative parental rights and duties of the recipient parents and the sperm donor,[4] and several have explicitly delineated the inheritance rights of children conceived through artificial insemination

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1. The person credited with the first successful human artificial insemination was British physician John Hunter, who advised a man who was suffering from hypospadias to fill a syringe with his semen immediately following intercourse and inject it into his wife's vagina "while the female organs were still under the influence of the coitus." DOUGLAS J. CUSINE, NEW REPRODUCTIVE TECHNOLOGIES: A LEGAL PERSPECTIVE 12, 13 (1988). The man complied, and his wife became pregnant as a result. While the date of this event is somewhat unclear, it appears to have taken place between 1780 and 1799. *Id.* at 12. The earliest known mention of artificial insemination as a means of conception can be found in the Babylonian Talmud, which tells of a rabbi in the second century A.D. who suggested that a pregnant woman might still be worthy of marrying a high priest if her pregnancy had resulted not from sexual intercourse, but from bathing in water into which a man had ejaculated. *See id.* at 11.

2. *See infra* Part II.

3. "If, under the supervision of a licensed physician and with the consent of her husband, a wife is inseminated artificially with semen donated by a man not her husband, the husband is treated in law as if he were the natural father of a child thereby conceived." UNIF. PARENTAGE ACT § 5(a) (1973).

4. *See* ALA. CODE § 26-17-21 (1993); ALASKA STAT. § 25.20.045 (1993); ARIZ. REV. STAT. ANN. § 12-2451 (1993); ARK. CODE ANN. § 9-10-201 (Michie 1993); CAL. FAM. CODE § 7613 (West 1994); COLO. REV. STAT. § 19-4-106 (1993); CONN. GEN. STAT. §§ 45a-774 to 775 (1992); FLA. STAT. ANN. § 742.11 (West 1993); GA. CODE ANN. § 19-7-21 (1993); IDAHO CODE § 39-5405 (1993); 750 ILL. COMP. STAT. ANN. 40/2 (Michie 1993); KAN. STAT. ANN. § 23-129 (1992); LA. CIV. CODE ANN. art. 188 (West 1992); MASS. ANN. LAWS ch. 46 § 4B (Law. Co-op. 1993); MICH. COMP. LAWS § 333.2824 (1993); MINN. STAT. § 257.56 (1993); MO. ANN. STAT. § 210.824 (Vernon 1992); MONT. CODE ANN. § 40-6-106 (1993); NEV. REV. STAT. ANN. § 126.061 (Michie 1993); N.H. REV. STAT. ANN. §§ 168-B:3(II) and B:11 (1993); N.J. STAT. ANN. § 9:17-44 (West 1993); N.M. STAT. ANN. § 40-11-6 (Michie 1993); N.Y. DOM. REL. LAW § 73 (Consol. 1993); N.C. GEN. STAT. § 49A-1 (1993); N.D. CENT. CODE §§ 14-18-03, 14-18-04 (Michie 1993); OHIO REV. CODE ANN. § 3111.37 (Anderson 1993); OKLA. STAT. ANN. tit. 10, §§ 552, 554, 555 (1993); OR. REV. STAT. §§ 109.239, 109.243 (1991); TENN. CODE ANN. § 68-3-306 (1993); TEX. FAM. CODE ANN. § 12.03 (West 1993); VA. CODE ANN. § 32.1-257(D) (Michie 1993); WASH. REV. CODE ANN. § 26.26.050 (West 1992); WIS. STAT. § 891.40 (1992); WYO. STAT. 14-2-103 (1993).

by donor ("AID").[5] Still others have created legal obligations for AID practitioners to test sperm donors for the HIV virus prior to using their semen.[6] However, states have not yet adequately determined whether any duty exists on the part of the physician, the sperm bank, or the sperm donor to ensure that these children are born free of genetic defects[7] and diseases that could be passed to them through the donor's semen. Thus far, Georgia is the only state that has enacted a law expressly addressing physicians' liability for the results of artificial insemination procedures, declaring that no liability will attach except in cases of negligence.[8]

To date, no cases have been reported involving children who were conceived through AID and later were born with genetic defects or abnormalities.[9] This may, however, convey a false sense of security to potential recipients of donor semen. First, there have been several instances in which sexually transmissible diseases, including the HIV virus,[10] have been contracted by women artificially inseminated with

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5. *See, e.g.*, ARK. CODE ANN. § 28-9-209(c) (Michie 1993); CONN. GEN. STAT. §§ 45a-777 to 778 (1993); MICH. COMP. LAWS ANN. § 700.111(2) (West 1993); N.D. CENT. CODE §§ 14-18-06, 14-18-07 (Michie 1993); VA. CODE ANN. § 64.1-7.1 (Michie 1993).

6. *See, e.g.*, DEL. CODE ANN. tit. 16 § 2801(b) (1993); GA. CODE ANN. § 44-5-151(b) (Harrison 1993); IDAHO CODE § 39-3703 (Michie 1993); IND. CODE ANN. § 16-41-14-5 (Burns 1993); MD. HEALTH GEN. CODE ANN. § 18-334 (1993); MONT. CODE ANN. § 50-16-1008(1) (1993); N.C. GEN. STAT. § 130A-148(c) (1993); OHIO REV. CODE ANN. § 3701.246 (Anderson 1993); OKLA. STAT. ANN. tit. 63, § 2151.1 (West 1993); R.I. GEN. LAWS § 23-1-38 (1993); WIS. STAT. § 146.025 (1993).

7. For purposes of this Comment, the term "genetic defect" will be used to refer to serious medical conditions, such as hemophilia and Huntington's disease, which can be passed genetically to one's offspring. The term is not intended to encompass genetically-linked traits, such as eye color, which are not ordinarily associated with medical problems.

8. The relevant Georgia provision provides as follows:

> Any physician or surgeon who obtains written authorization signed by both the husband and the wife authorizing him to perform or administer artificial insemination shall be relieved of civil liability to the husband and wife or to any child conceived . . . for the . . . results of said artificial insemination, provided that the written authorization provided for in this Code section shall not relieve any physician or surgeon from any civil liability arising from his own negligent administration or performance of artificial insemination.

GA. CODE ANN. § 43-34-42(b) (1993).

9. *But see* Stiver v. Parker, 975 F.2d 261 (6th Cir. 1992) (involving a surrogate mother who gave birth to a child with genetic defects caused by a venereal disease transmitted through the known donor's sperm). Although *Stiver* does not raise many of the products liability issues discussed in this Comment, it illustrates a potential for legal liability when artificial insemination produces children with birth defects.

10. Responding to the AIDS (Acquired Immune Deficiency Syndrome) crisis, the American Fertility Society and the American Association of Tissue Banks recommend that all semen donations be frozen for at least six months prior to use since the HIV antibody may be undetectable for up to three months. AMERICAN FERTILITY SOCIETY, GUIDELINES FOR GAMETE

donor semen.[11] Second, many genetic disorders, such as Huntington's disease, often do not appear until late in life, and therefore some AID children may carry such traits and not yet be aware of them. Third, statistics as to miscarriages and stillbirths are scarce. Accordingly, genetic factors may have prevented some AID fetuses from even achieving viability. Fourth, but most importantly, it is probably only a matter of time before a genetically abnormal child *is* born as a result of AID. The rate of genetic defects in naturally conceived live-born children is approximately six to seven percent,[12] and studies show that most sperm banks and physicians do not screen donors adequately enough to effectively reduce this percentage in children conceived through AID.[13]

The seemingly inevitable consequence of the deficient donor screening process is the eventual birth of a genetically impaired child. When this occurs, the child's mother[14] may very well sue any party who had an opportunity to discover the defect in the semen and failed to do so. This could include the physician who performed the procedure, the sperm bank that distributed the semen, and the donor himself.[15] Under the current state of the law, a products liability

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DONATION: 1993 at 4S [hereinafter AFS GUIDELINES: 1993]; AMERICAN ASS'N OF TISSUE BANKS, STANDARDS FOR TISSUE BANKING, Reproductive Council Addendum, C1.334 (1993) [hereinafter AATB STANDARDS]. At least two states have codified this recommendation as well. *See* IND. CODE ANN. § 16-41-14-7 (Burns 1993); MICH. COMP. LAWS § 333.16273 (1992).

11. Laurene Mascola & Mary E. Guinan, *Semen Donors as the Source of Sexually Transmitted Diseases in Artificially Inseminated Women: The Saga Unfolds*, 257 JAMA 1093 (1987) [hereinafter Mascola & Guinan, *The Saga Unfolds*]. Disease transmissions to the recipient also increase the risks of spontaneous abortion, prematurity, stillbirth, and malformation, as well as potentially infecting the fetus. Laurene Mascola & Mary E. Guinan, *Screening to Reduce Transmission of Sexually Transmitted Diseases in Semen Used for Artificial Insemination*, 314 NEW ENG. J. MED. 1354, 1354 (1986). Even though semen recipients have contracted HIV, no fetuses conceived through artificial insemination have apparently been infected. G.J. Stewart et al., *Transmission of Human T-Cell Lymphotropic Virus Type II (HTLV III) by Artificial Insemination by Donor*, ii LANCET 581 (1985) (stating that of eight women in Australia who were inseminated with HIV-infected semen, four developed seropositivity for the virus but none of their children were infected).

12. Terra Ziporyn, *'Artificial' Human Reproduction Poses Medical, Social Concerns*, 255 JAMA 13 (1986).

13. *See infra* notes 19-27 and accompanying text.

14. For purposes of this Comment, all claims will be treated as those of the mother even though these claims can theoretically be brought by both the birth mother of a child conceived through artificial insemination and her husband (since the husband is treated as the legal father of the child in most states, *see supra* note 4). This treatment merely simplifies the discussion and recognizes that many recipients of donor semen are unmarried.

15. For a general discussion of the discoverability of donors' identities, see *infra* notes 33-34 and accompanying text.

action has a substantial chance of success against any or all of these classes of defendants.

The purpose of this Comment is to discuss the potential success of a products liability claim, the consequences of allowing recovery in such cases, and the need for proactive measures to settle some of these issues before they ever arise or, ideally, to prevent them from arising at all. Part II of this Comment will present an overview of the current practice of AID in the United States. Part III will discuss the legal theories on which a products liability claim could be based. Parts IV and V will discuss the obstacles to establishing a plaintiff's prima facie case and the defenses available to the various defendants. Finally, Part VI will present recommendations for legal intervention in this area.

## II. Current Practice of Artificial Insemination by Donor

According to a 1960 survey by Britain's Feversham Committee, doctors in the United States rarely performed AID prior to 1920, and as of 1959, only eight physicians reported using the procedure.[16] Whether these statistics are attributable to physicians' reluctance to provide AID services or their reluctance to admit that they did, the low figure illustrates the negative light in which the practice was viewed.[17] By contrast, a 1987 survey revealed that from 1986 to 1987 roughly 11,000 physicians in the United States had performed artificial inseminations on a total of nearly 172,000 women, resulting in 35,000 births from artificial insemination using the husband's semen and 30,000 births from AID.[18]

Even with the increasing numbers of AID procedures, the screening of sperm donors has proven to be insufficient for various reasons. The United States has not implemented a uniform set of laws with respect to sperm donor screening. Two private groups, The American Fertility Society (AFS) and The American Association of Tissue Banks (AATB),

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16. *Report of the Departmental Committee on Human Artificial Insemination*, FEVERSHAM COMMITTEE, app. 1, para. 4 (1960).

17. As recently as 1981, artificial insemination with donor semen was illegal in Indiana, Minnesota, New York, Virginia, and Wisconsin. R. SNOWDEN & G.D. MITCHELL, THE ARTIFICIAL FAMILY: A CONSIDERATION OF ARTIFICIAL INSEMINATION BY DONOR 19 (1981) (providing a general discussion of society's negative perceptions of artificial insemination by donor a little more than a decade ago).

18. U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, INFERTILITY: MEDICAL AND SOCIAL CHOICES (1988) [hereinafter OTA REPORT]. Although artificial insemination success rates vary from one practitioner to the next, an average of nearly 75% of patients eventually become pregnant, most of them by the sixth cycle of inseminations. Lori B. Andrews & Lisa Douglass, *Alternative Reproduction*, 65 S. CAL. L. REV. 623, 655 (1991).

have published recommended standards,[19] but compliance is completely voluntary. In many institutions, sperm donor screening is grossly inadequate.[20] For example, in a 1987 survey, 26% of responding AID practitioners stated that they would accept semen from a donor with a family history of Huntington's disease, a condition with a 50% chance of appearing in that donor's offspring.[21] In a similar study conducted in 1979, 94.7% of physicians polled stated that they would reject a donor who carried Tay-Sachs disease, yet less than 1% of the physicians tested donors for that disease.[22] Only 28.8% of the physicians in the latter study performed any biochemical testing on donors beyond blood tests, the rest of them relying heavily on the donors' candor in filling out medical history questionnaires.[23] However, many sperm donors are paid only if their semen is deemed acceptable for use in inseminations, creating a monetary incentive to withhold information on these questionnaires.[24] Furthermore, even if a donor is completely forthright with his answers, he may still be carrying a defect or disease of which he is unaware. While the majority of sperm donors are medical students,[25] studies have shown that as a

19. Copies of the AATB STANDARDS and the Reproductive Council Addendum, *supra* note 10, can be obtained by writing to the AATB at 1350 Beverly Road, Suite 220-A, McLean, VA 22101. Copies of the AFS GUIDELINES: 1993, *supra* note 10, are available from the American Fertility Society at 1209 Montgomery Highway, Birmingham, AL 35216-2809.

20. Mostly it is the smaller sperm banks that are neglecting to follow recommended procedures. OTA REPORT, *supra* note 18, at 141, Table 8.1.

21. *See* OTA REPORT, *supra* note 18.

22. Martin Curie-Cohen et al., *Current Practice of Artificial Insemination by Donor in the United States*, 300 NEW ENG. J. MED. 585, 588 (1979). Tay-Sachs disease, most commonly found in children of Eastern European Jewish parents, is a painful condition in which children appear normal at birth but begin to rapidly deteriorate after only a few months, in most cases dying by the age of three. *See* Curt S. Rush, Note, *Genetic Screening, Eugenic Abortion, and Roe v. Wade: How Viable is Roe's Viability Standard?*, 50 BROOK. L. REV. 113, 115 n.11 (1983). The children suffer a great deal during their short lives. "During the degenerative period, they develop a hypersensitivity to sound, so that even small noises will evoke violent reactions, and they frequently give the impression of suffering both physical pain and fear as they develop blindness and paralysis and lose mental contact with their environment." *Id.* (quoting Macintyre, *Genetic Risk, Prenatal Diagnosis, and Selective Abortion*, ABORTION, SOCIETY AND THE LAW 223 (Walbert & Butler eds., 1973)).

23. Curie-Cohen et al., *supra* note 22, at 588.

24. By analogy, blood donors who receive payment tend to be less honest on their medical questionnaires than unpaid volunteers. *Id.*

25. The majority of doctors (62%) obtain semen exclusively from medical students and hospital residents. *See* Curie-Cohen et al., *supra* note 22, at 586. Other common sources include university and non-medical graduate students, military cadets, husbands of obstetric patients, hospital personnel, and friends of practitioners. *Id.*

group they have proven to be only slightly more accurate in identifying their own genetic risk factors than donors with no medical training.[26]

Given these faults in the sperm donor screening process used by many practitioners, it is amazing that there have not yet been any reported instances in which children conceived through AID have been born with serious genetic defects. Absent drastic change, however, that unfortunate day is sure to come. When it does, the courts are certain to hear about it.

## III. Theories Under Which Products Liability Claims May Be Brought

### *A. Negligence*

Under certain circumstances, the mother of a child who has inherited a genetic defect from a sperm donor is likely to prevail in a products liability action against the artificial insemination practitioner, the sperm bank, or the donor under a negligence theory. This approach is most likely to succeed when the defendant knew or should have known that the donated semen carried a genetic abnormality. For instance, if a sperm donor knew that he has a familial history of sickle-cell anemia or if he could find out upon reasonable inquiry that he does, and yet he failed to mention it when filling out his donor questionnaire, a court would likely find him liable for the foreseeable consequences of his negligent nondisclosure.[27] Furthermore, if the AID practitioner failed to detect the disease or to warn the recipient that it might exist, he would likely be held liable for negligent breach of his professional duties if (1) it was foreseeable that the donor would carry such a condition, and (2) a reasonable practitioner would have detected the condition or given warnings to the recipient.[28]

*1. Liability of the Sperm Donor.*—Suppliers of products can be held liable for negligence in the sale or manufacture of the product or

26. In a study of AID screening practices, 90% of sperm donors with non-medical backgrounds failed to identify genetic disorders in their familial histories. M. Chrystie Timmons et al., *Genetic Screening of Donors for Artificial Insemination*, 35 FERTILITY & STERILITY 451, 453, 455 (1981). Donors in the medical field did somewhat better, but still missed over two-thirds of the disorders in their families. *Id.*

27. Conversely, if a donor has no notice, either actual or constructive, of the potential presence of a defect, he would not be negligent in failing to disclose it. *See* Hubbell v. South Nassau Communities Hosp., 260 N.Y.S.2d 539, 540-41 (1965) (holding blood donor free from liability where he had no reason to know his blood was contaminated with serum hepatitis).

28. *See infra* Part III(A)(2).

for a failure to provide adequate warnings as to the product's dangers.[29] A sperm donor might be negligent in "selling"[30] semen which he reasonable should know to be unfit for use in inseminations due to some genetic defect or transmissible disease. Also, he might be negligent in failing to warn the practitioner to whom he delivers the semen about all known or reasonably knowable defects in his semen. Since privity is no longer a prerequisite to products liability claims sounding in negligence,[31] the donor could conceivably be held liable to the semen recipient for either type of negligent conduct, even though he may have had no direct contact with her. Therefore, since a sperm donor knows that his semen will be used by someone other than the person to whom he delivers it and because the donor's negligence in failing to reasonably identify his genetic risk factors could cause foreseeable harm to that person, he may be liable for his negligence without privity.[32]

Sperm donors generally remain anonymous to the birth parents in AID, a fact which may present obstacles to recovery from the donor in some instances. However, in several states a donor's identity can be disclosed upon a showing of good cause.[33] Evidence that a sperm donor may have intentionally or negligently withheld pertinent medical information may be sufficient to persuade a judge to require that his identity be made known, not only to make him amenable to suit, but

29. *See generally* W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 96 (5th ed. 1984).

30. For a discussion of whether a semen donation constitutes a "sale," see *infra* Part III(B)(2).

31. MacPherson v. Buick Motor Co., 111 N.E. 1050 (N.Y. 1916).

32. *See id.*

33. The sperm donor consent form used by the Department of Obstetrics and Gynecology of the University of Washington School of Medicine, reprinted in the 1990 edition of AFS GUIDELINES, states: "I understand that my . . . identity will be kept in strictest confidence unless a court orders disclosure for good cause shown pursuant to state law (RCW 26.26.050)." AMERICAN FERTILITY SOCIETY, NEW GUIDELINES FOR THE USE OF SEMEN DONOR INSEMINATION: 1990 at 12S [hereinafter 1990 AFS GUIDELINES]. Several other states statutorily provide for disclosure of a sperm donor's identity upon a showing of good cause, as well. *See* ALA. CODE § 26-17-21(a) (1993); CAL. FAM. CODE § 7613 (West 1994); COLO. REV. STAT. § 19-4-106 (1993); 750 ILL. COMP. STAT. ANN. 40/3 (Michie 1993); MINN. STAT. § 257.56 (1993); MO. REV. STAT. § 210.824 (1992); MONT. CODE ANN. § 40-6-106 (1993); NEV. REV. STAT. ANN. § 126.061 (Michie 1993); N.M. STAT. ANN. § 40-11-6 (Michie 1993); WIS. STAT. § 891.40 (1992); WYO. STAT. § 14-2-103(a) (1992). Disclosure for good cause is also used with respect to discovering the identities of an adoptee's biological parents in states with "closed" adoption statutes. *See* ALASKA STAT. § 25.23.150 (1993); FLA. STAT. ANN. § 63.162(1)(d) (West 1992); N.J. STAT. ANN. § 9:3-52(a) (West 1992); N.Y. DOM. REL. LAW § 114 (McKinney 1993); S.C. CODE ANN. § 20-7-1780(B) (Law. Co-op. 1992); VA. CODE ANN. § 63.1-236 (Michie 1993).

also to enable the birth parents to gain a fuller understanding of the nature of their child's genetic condition.[34]

*2. Liability of the Artificial Insemination Practitioner.*—A physician or sperm bank could be held liable for negligently failing to properly screen donors[35] or to warn recipients of any foreseeable risks inherent in insemination with an anonymous donor's semen.[36] More specifically, if a physician relies blindly upon what a donor has voluntarily disclosed about his medical history without taking any tests or checking any medical records,[37] the physician has probably breached a duty of care to that patient and should be held liable in negligence. This result is especially desirable when one considers that the recipient patient, having no reasonable means or opportunity to inspect the semen for defects herself, must rely on the practitioner's professional judgment that the semen is acceptable for use in inseminations. Largely for this reason, one court has found artificial insemination practitioners in the context of surrogacy contracts to owe a special duty of care — an affirmative duty of protection — to the woman being inseminated and her resulting child.[38]

As a defense, physicians might assert that their actions comported with the prevailing medical practice, and therefore, that they satisfied the required duty of care.[39] The applicable standard of care in the

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34. In deciding what constitutes good cause, courts must weigh the interests of all parties involved. *See generally* Golan v. Louise Wise Serv., 507 N.E.2d 275, 277 (N.Y. 1987). For disclosure to be warranted in the adoption context, for example, the adoptee must prove that her need to discover the information outweighs the biological parents' interest in protecting their privacy, the adoptive parents' interest in freedom from interference by the biological parents, and society's interest in maintaining the integrity of its adoption process by avoiding unnecessary breaches of confidence. *Id.* The child's need for medical diagnosis and treatment is likely to be sufficient to override the competing interests in the artificial insemination context, just as it has in adoption cases. *Cf.* Burr v. Board of County Comm'rs of Stark County, 491 N.E.2d 1101, 1103 (Ohio 1986) (allowing the opening of adoption records to facilitate medical treatment of child with Huntington's Disease).

35. *See* Stiver v. Parker, 975 F.2d 261 (6th Cir. 1992) (holding persons who performed artificial insemination in the context of a surrogacy contract liable for negligent donor screening). In an analogous context, blood banks have been held liable for negligently failing to detect contaminants in donated blood through donor screening. *See, e.g.*, Heirs of Fruge v. Blood Servs., 506 F.2d 841 (5th Cir. 1975) (interpreting Louisiana state law); Klaus v. Alameda-Contra Costa Medical Ass'n Blood Bank, Inc., 133 Cal. Rptr. 92 (Ct. App. 1976).

36. *See, e.g.*, Boyl v. California Chem. Co., 221 F. Supp. 669 (D. Or. 1963) (holding manufacturer of pesticide liable for failure to warn consumer of inherent dangers in product which were foreseeable to the manufacturer but not to the ordinary consumer).

37. Unfortunately, this appears to be a prevalent practice in the United States. *See supra* note 23 and accompanying text.

38. Stiver v. Parker, 975 F.2d 261, 272 (6th Cir. 1992).

39. Wilson v. Irwin Memorial Blood Bank, 18 Cal. Rptr. 2d 517 (Ct. App. 1993) (accepting

medical field, established by expert testimony, is that to which a reasonably prudent medical professional in the same field would adhere in the same or similar circumstances.[40] It is possible, however, that the entire profession may be acting unreasonably and that mere compliance with common practice is not enough.[41] This may be the case with the screening of sperm donors. With complex genetic testing procedures currently available,[42] mere reliance on donor questionnaires is an unreasonable and inadequate screening method. Of course, many genetic conditions exist which are so rare and difficult or expensive to detect that requiring physicians to perform such tests would be thoroughly impracticable.[43] In the alternative, when a condition is common and relatively inexpensive to detect or when a donor is a member of a particularly high-risk group,[44] failure to conduct such tests may properly be viewed as negligence. Although additional testing would raise the costs of artificial insemination, most prospective recipients would be willing to pay for the increased likelihood, albeit not certainty, of giving birth to a normal, healthy child.[45]

Ideally, rather than leaving it to physicians to weigh the costs and benefits of testing for each and every conceivable genetic disorder, mandatory national standards should be drawn up to guide them.[46]

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the defendant's argument that failure to perform a particular AIDS test on donated blood was not negligent when no other blood bank in the country was using the test at that time); *see also* Osborn v. Irwin Memorial Blood Bank, 7 Cal. Rptr. 2d 101 (Ct. App. 1992).

40. *See* Strain v. Ferroni, 592 A.2d 698, 701 (Pa. Super. Ct. 1991); Douglas v. United States, 626 F. Supp. 86, 90 (W.D. Mo. 1985); Plutshack v. University of Minnesota Hosps., 316 N.W.2d 1, 5 n.7 (Minn. 1982); Landeros v. Flood, 551 P.2d 389, 392-93 (Cal. 1976).

41. *See* Promen v. Ward, 591 N.E.2d 813, 817 (Ohio Ct. App. 1990) (finding that compliance with customary practice alone was not conclusive as to the defendant's non-negligence).

42. *See generally* GENETIC SCREENING: FROM NEWBORNS TO DNA TYPING (Bartha Maria Knoppers & Claude M. Laberge eds., 1990).

43. Biochemical testing, while inexpensive, is capable of detecting less than 100 of the nearly 2,000 medically recognized genetic defects. Beyond taking familial medical histories, the only way to detect many genetic disorders is through karyotyping, a relatively costly and at times imprecise procedure. *See generally* Ellen E. Wright, Note, *Father and Mother Know Best: Defining the Liability of Physicians for Inadequate Genetic Counseling*, 87 YALE L.J. 1488, 1490-94 n.16 (1978) [hereinafter *Genetic Counseling*].

44. In particular, four ethnically linked disorders exist for which reliable testing methods are available — infantile Tay-Sachs disease among Ashkenazi Jews, juvenile Tay-Sachs disease among the Lebanese, sickle-cell anemia among persons of African descent, and thalassemia among Mediterranean peoples. William G. Johnson, M.D., et al., *Artificial Insemination by Donors: The Need for Genetic Screening*, 304 NEW ENG. J. MED. 755, 756 (1981).

45. *See* Ziporyn, *supra* note 12, at 14.

46. From a plaintiff's perspective, the need for standards becomes especially clear in light of two recent California state court decisions in which a blood bank was held not negligent in limiting its donor screening practices to a certain series of questions when there were no published standards detailing the types of questions that should be asked of prospective blood donors with

Not only would this enable doctors to determine with some certainty what actions they should take to protect themselves from liability for negligence, but such standards would also reduce the probability of children being born with birth defects.

### *B. Implied Warranty of Merchantability*

*1. U.C.C. "Goods" Requirement.*—The Uniform Commercial Code (U.C.C.) imposes an implied warranty of merchantability upon all sales of goods by merchants.[47] This warranty requires that the goods be fit for the ordinary purpose for which they are intended, but stops short of requiring absolute perfection.[48] In trying to imply that such warranties exist with respect to artificial insemination, the most obvious question to be answered is whether or not the transfer of semen from the donor to the recipient, through the various intermediaries, can be categorized as a sale within the purview of the U.C.C. The U.C.C. does not apply to the rendering of services, but only to the sale of goods.[49] However, the goods versus services distinction is sometimes hard to draw, especially when a contract calls for the use of products during the performance of a service.[50]

*(a) The goods versus services distinction in the context of blood.*—To determine how to classify artificial insemination, it is helpful to look at an analogous type of transaction, the blood transfusion. Under the common law, many courts held medical personnel liable for breach of an implied warranty of merchantability when contaminated blood was introduced into a patient's body.[51] This

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regard to their likelihood of being infected with the HIV virus. Wilson v. Irwin Memorial Blood Bank, 18 Cal. Rptr. 2d 517 (Ct. App. 1993); Osborn v. Irwin Memorial Blood Bank, 7 Cal. Rptr. 2d 101, 123, 128-29 (Ct. App. 1992).

47. U.C.C. § 2-314 (1993).

48. *Id.* § 2-314(2).

49. *Id.* § 2-102 (1993).

50. *See, e.g.*, Newmark v. Gimbel's, 258 A.2d 697 (N.J. 1969) (discussing the existence of an implied warranty in a hybrid sale/service transaction involving the application of a permanent wave solution by a beautician).

51. *See* Hekeler v. St. Margaret Memorial Hosp., 74 Pa. D. & C.2d 568 (1976); Rostocki v. Southwest Fla. Blood Bank, 276 So. 2d 475 (Fla. 1973); Hoder v. Sayet, 196 So. 2d 205 (Fla. 1967). Several courts have similarly held blood transfusions to constitute sales for purposes of *strict* products liability. *See, e.g.*, Weber v. Charity Hosp., 487 So. 2d 148 (La. 1986); Cunningham v. MacNeal Memorial Hosp., 266 N.E.2d 897 (Ill. 1970). Many courts appear willing to hold a commercial entity such as a blood bank liable for breach of warranty while refusing to subject hospitals to the same liability. *See, e.g.*, Carter v. Interfaith Hosp. of Queens, 304 N.Y.S.2d 97 (N.Y. Sup. Ct. 1969) (dismissing warranty claim against hospital but upholding claim against blood bank).

rule of liability applied even when the defect in the blood was undiscoverable, because in the warranty context the quality of a product was the sole determinant of whether there had been a breach, and any precautions taken by the seller were irrelevant.[52]

Other courts have characterized blood transfusions as services such that no warranties attach.[53] Among this line of cases is *Perlmutter v. Beth David Hospital*[54] in which the court refused to define blood as a product, largely because imposing liability on medical personnel for undetectable defects would make them virtual insurers of the purity of donated blood.[55] Undoubtedly, imposing liability on medical personnel would cause medical malpractice insurance rates to rise, making some physicians unwilling to perform blood transfusions at all. To ensure the continued availability of blood transfusions, an extremely beneficial medical procedure, those courts following the *Perlmutter* rationale have declined to impose warranty liability in that context.[56] As the concern over liability for supplying contaminated blood has grown during the recent AIDS crisis, many states have statutorily adopted the *Perlmutter* approach. These so-called "blood shield statutes" expressly provide that the supply of blood for transfusions is a medical service and not a sale, thus removing this type of transaction from the U.C.C. umbrella.[57]

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52. *See, e.g.*, Vlases v. Montgomery Ward, 377 F.2d 846 (3d Cir. 1967) (holding that the delivery of diseased animals pursuant to a sales contract constituted a breach of warranty even though the disease was undetectable by the seller); City of Greenville v. W.R. Grace & Co., 640 F. Supp. 559, 565 (D. S.C. 1986).

53. *See* Jennings v. Roosevelt Hosp., 372 N.Y.S.2d 277 (N.Y. Sup. Ct. 1975) (hospital); Balkowitsch v. Minneapolis War Memorial Blood Bank, Inc., 132 N.W.2d 805 (Minn. 1965) (blood bank); Sloneker v. St. Joseph's Hosp., 233 F. Supp. 105 (D.C. Colo. 1964) (hospital); Koenig v. Milwaukee Blood Ctr., Inc., 127 N.W.2d 50 (Wis. 1964) (blood bank); Dibblee v. Dr. W.H. Groves Latter-Day Saints Hosp., 364 P.2d 1085 (Utah 1961) (hospital).

54. 123 N.E.2d 792 (N.Y. 1954).

55. *Id.* at 795.

56. *See supra* note 53 and cases cited therein.

57. *See* ALA. CODE § 7-2-314(4) (1993); CAL. HEALTH & SAFETY CODE § 1606 (West 1993); COLO. REV. STAT. § 13-22-104(2) (1993); CONN. GEN. STAT. §§ 19a-280 (West 1992); FLA. STAT. ANN. § 672.316(5)-(6) (West 1992); GA. CODE ANN. §§ 11-2-316(5), 51-1-28(a) (1993); IDAHO CODE § 39-3702 (1993); IND. CODE ANN. § 16-41-12-11(a) (Burns 1993); KY. REV. STAT. ANN. § 139.125 (Michie 1993); LA. REV. STAT. ANN. § 9:2797 (West 1992); MISS. CODE ANN. § 41-41-1 (1993); MO. ANN. STAT. § 431.069 (Vernon 1992); NEV. REV. STAT. ANN. § 460.010 (Michie 1993); N.M. STAT. ANN. § 24-10-5 (Michie 1993); OKLA. STAT. ANN. tit. 63, § 2151 (1993); R.I. GEN. LAWS § 23-17-30 (1993); S.C. CODE ANN. § 44-43-10 (Law. Co-op. 1992); UTAH CODE ANN. § 26-31-1 (1993); WASH. REV. CODE ANN. § 70.54.120 (West 1992); W. VA. CODE § 16-23-1 (1993).

*(b) The goods versus services distinction as applied to AID.*—As for artificial insemination by donor, the question regarding whether or not courts would consider semen to be "goods" remains open. Although many blood shield statutes are not restricted to blood alone, none specifically mentions semen as being within its contemplation. Arguably, semen could be included in the catch-all phrase "human tissue" which many such statutes contain,[58] but none of the acts' legislative histories indicates that such an inclusion was intended. Further, the underlying intent behind most blood shield statutes was to ensure that the blood supply did not suffer due to donors' fears of being held accountable if their blood proved to be contaminated.[59] This policy decision was made in view of the essential role that donated blood plays in our health care system.[60] Donor semen, by contrast, does not enjoy a comparable status in our society. Although it may be deemed essential by those persons for whom other methods of conception are impracticable, unavailability of donor semen would not create a national crisis as would occur with a depletion of our blood supply. Artificial insemination is therefore distinguishable from blood transfusions, and it cannot be assumed that semen will be afforded protection under the ambit of blood shield statutes in their current forms.

*2. U.C.C. Sale by Merchant Requirement.*—While there appears to be a substantial possibility that the semen provided in artificial

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58. The language of the Illinois blood shield legislation is typical of this type of statute:

> The procuring, furnishing, donating, processing, distributing or using human whole blood, plasma, blood products, blood derivatives and products, corneas, bones, or organs or other human tissue for the purpose of injecting, transfusing or transplanting any of them in the human body is declared for purposes of liability in tort or contract to be the rendition of a service by every person, firm or corporation participating therein, whether or not any remuneration is paid therefor, and is declared not to be a sale of any such items and no warranties of any kind . . . nor strict tort liability shall be applicable thereto . . . .

745 ILL. COMP. STAT. ANN. 40/2 (Michie 1993).

59. *See, e.g.*, McDonald v. Sacramento Medical Found. Blood Bank, 133 Cal. Rptr. 444, 447 (Ct. App. 1976) (stating that the purpose of California's statute was to promote the constant availability of an adequate blood supply). The historical notes accompanying the Idaho blood shield statute contain an explicit statement of legislative intent: "[With] the availability of . . . blood products . . . being important to the health and welfare of the people of the state of Idaho, it is . . . the public policy of the state that the health and welfare . . . will be promoted by limiting the legal liability arising out of . . . blood services . . . ." IDAHO CODE § 39-3702 (1993) (quoting 1987 Idaho Sess. Laws § 1, ch. 148).

60. *See, e.g.*, Hill v. Jackson Park Hosp., 349 N.E.2d 541 (Ill. App. Ct. 1976) (finding that the legislature had decided to treat blood differently from other articles because of the special and indispensable place that blood occupies in the practice of medicine).

insemination may be deemed to be "goods" under the U.C.C., this alone does not create an implied warranty. It also must be determined that a sale has occurred and that the seller is a merchant.[61] The U.C.C. defines a sale as "the passing of title from the seller to the buyer for a price."[62] When a donor delivers his semen to a sperm bank or hospital, he is usually paid for his donation.[63] Thus, assuming *arguendo* that it is possible to obtain "title" in semen, this exchange surely fits the definition of a "sale." If a sperm bank is involved, it then transfers the semen to the artificial insemination practitioner in exchange for payment. The recipient, in turn, pays the practitioner an average of $953.00 per insemination.[64] Each of these transactions might also qualify as a sale, although it is arguable that the insemination itself is not a sale if the recipient is not billed separately for the semen.[65]

The sperm bank and practitioner would also fit the U.C.C. definition of "merchant" since both "hold themselves out as having knowledge or skill peculiar to the practices or goods involved."[66] The donor, on the other hand, most likely would not be considered to be a merchant unless he donates his semen frequently, in which case a plaintiff might assert that he "deals in goods of the kind."[67]

*3. Problems with Treating Sperm as a Commodity.*—A potentially difficult issue which might arise in the warranty context is that the sale of sperm conjures up images of baby selling, an illegal practice in every

61. *See* U.C.C. § 2-314 (1993).

62. U.C.C. § 2-106(1) (1993).

63. Curie-Cohen et al., *supra* note 22, at 587.

64. OTA REPORT, *supra* note 18.

65. *See* Whitehurst v. American Nat'l Red Cross, 402 P.2d 584 (Ariz. Ct. App. 1965) (holding that a blood bank was not a seller of blood because the recipient was not charged separately for the blood); *see also* Koenig v. Milwaukee Blood Ctr., 127 N.W.2d 50, 53 (Wis. 1964).

66. U.C.C. § 2-104(1) (1993).

67. *Id.* Whether or not a party is a merchant "is of necessity highly dependent on the factual setting of the transaction in question." Ferragamo v. Massachusetts Bay Transp. Auth., 481 N.E.2d 477, 480 (Mass. 1985) (quoting 1 R.A. ANDERSON, U.C.C. § 2-104:25 (3d ed. 1981)). *See also* Touch of Class Leasing v. Mercedes-Benz Credit of Canada, 591 A.2d 661, 668 (N.J. Super. Ct. 1991). Some courts have found non-professional sellers to be merchants if they engage in a regular pattern of sales. *See, e.g.*, Colorado-Kansas Grain Co. v. Reifschneider, 817 P.2d 637 (Colo. Ct. App. 1991). The more prevalent rule, however, is that a seller is not a merchant unless he has more specialized knowledge with regard to the product than the ultimate consumer. *See, e.g.*, Bennett v. Jansma, 329 N.W.2d 134 (S.D. 1983). Under this approach, most sperm donors would not be considered merchants.

state.[68] *In re Matter of Baby M*[69] involved a surrogacy contract providing that a "surrogate" mother who was to be artificially inseminated with another man's sperm be paid for carrying the resulting child after she relinquished the child to the sperm donor after its birth. The New Jersey Supreme Court declared this contract to be violative of a state statute prohibiting the payment of money for private adoptions[70] and further suggested that such contracts may even be criminal.[71] This decision hinged, in part, on the fact that the surrogate mother would receive $10,000 if the child was born and delivered to the "adoptive" parents, only $1,000 if the child was stillborn, and nothing if the fetus died during the first trimester of her pregnancy.[72] Under these facts, the surrogate was found to be receiving payment for the child itself, not for her expenses or services in carrying and delivering it since those costs would have been the same whether or not the child had been born healthy.[73]

Artificial insemination obviously differs from surrogacy in that payment is made not for a child and not for a fetus, but merely for semen which has not yet and may never successfully fertilize an egg. In that sense, sperm donation cannot truly be considered baby selling. Sperm donations in exchange for the payment of money may, however, be sufficiently similar to baby selling to warrant being declared contrary to public policy; the process also tends to treat children as commodities.[74] The result of such analysis is a "catch-22" situation for plaintiffs. To recover under a warranty theory requires proving that the insemination was a sale, but in so doing, a plaintiff exposes herself to the possibility that courts will refuse to grant relief because the sale violated public policy. In addition, the plaintiff could theoretically end up as the target of a criminal prosecution.

Overall, the implied warranty of merchantability offers a plausible theory under which plaintiffs may recover damages for genetic defects resulting from artificial insemination. It is fraught with obstacles,

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68. *See* William L. Pierce, *Survey of State Activity Regarding Surrogate Motherhood*, 11 FAM. L. REP. 3001 (1985).

69. 537 A.2d 1227 (N.J. 1988).

70. *Id.* at 1240-42.

71. *Id.* at 1234.

72. *Id.* at 1241.

73. *Id.*

74. The American Fertility Society appears to have foreseen the possibility of legal and/or ethical problems with paying donors for their semen. The guidelines promulgated by that association provide that "[p]ayment to donors will vary from area to area but should not be such that the monetary incentive is the primary factor in donating sperm. However, the donor should be compensated for his time and expenses." AFS GUIDELINES: 1993, *supra* note 10, at 4S.

however, and predicting how a court might come out on such a claim would be sheer speculation given the law in its current state.

### C. *Strict Liability in Tort*

Parents of a genetically impaired child conceived through artificial insemination by donor may also seek recovery under a strict products liability theory in tort. The Restatement (Second) of Torts § 402A allows recovery for physical harm from a merchant who sells a product "in a defective condition unreasonably dangerous to the user or consumer."[75] Privity between the defendant and the plaintiff consumer does not have to be established for liability to attach.[76] Accordingly, under this approach, a semen recipient could recover from anyone along the supply chain who was "in the business of selling"[77] the semen. As in negligence, strict liability can attach for the manufacture and sale of the product, as well as for failure to warn of knowable defects.[78]

Obviously, this theory involves some of the same questions discussed with regard to the warranty theory, namely, whether semen is a "product"[79] and whether artificial insemination constitutes a "sale."[80] Strict liability gives rise to additional issues as well. Specifically, strict liability requires an analysis of when semen is considered "defective" and when such a defect renders it "unreasonably dangerous."

*1. Tests for Product Defect.*—Two tests have been developed to determine whether a product is defective under § 402A. The first, a consumer expectation of safety test, looks to the level of safety a prudent consumer would anticipate for a reasonably foreseeable use of the product.[81] In the case of artificial insemination, reasonable recipients of donor semen would probably expect that the semen has been screened and found to be free of sexually transmissible diseases and obvious genetic defects. However, a reasonable person would most likely also recognize that no amount of testing can guarantee that a child will be born perfect. As with conception through sexual

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75. RESTATEMENT (SECOND) OF TORTS § 402A(1) (1965) [hereinafter RESTATEMENT].

76. *See generally* Greenman v. Yuba Power Prods., Inc., 377 P.2d 897 (Cal. 1962).

77. RESTATEMENT, *supra* note 75, § 402A(1)(a).

78. *See, e.g.*, Ross Lab. v. Thies, 725 P.2d 1076 (Alaska 1986); Collins v. Sunnyside Corp., 496 N.E.2d 1155 (Ill. App. Ct. 1986).

79. *See supra* Part III(B)(1).

80. *See supra* Part III(B)(2).

81. *See, e.g.*, Keogh v. Grasle, Inc., 816 P.2d 1343 (Alaska 1991); Baughn v. Honda Motor Co., 727 P.2d 655 (Wash. 1986).

intercourse, mutations are bound to occur on occasion, and scientists cannot predict with accuracy what will happen when two individuals' gene pools are combined.[82] Under the consumer expectation of safety standard, then, semen probably will be considered "defective" only when the abnormality is reasonably foreseeable and readily detectable.

The second test for defectiveness involves a risk-utility balance in which a product's inherent dangers are weighed against its societal benefits.[83] Here, a defendant would likely assert that the benefits of making donor semen available for use in artificial insemination outweigh the inherent risks of genetic defects. In support of this position, a defendant would assert that (1) the number of normal children born through AID greatly exceeds the number born with genetic deficiencies, and (2) imposition of strict liability would drive many sperm banks and practitioners out of business by making them virtual insurers of a child's health. Blood banks successfully made similar arguments in several states prior to the passage of blood shield statutes,[84] but as discussed earlier, donor sperm may not be deemed to have as much social utility as donor blood.[85] Also, the social utility argument is weakened by the fact that many AID practitioners are not taking adequate precautions to minimize the risks associated with the procedure.[86] It is difficult to predict how a court would resolve a balancing test in these circumstances. However, lawmakers' actions in passing blood shield statutes and their inaction in addressing artificial insemination might suggest to courts that lawmakers consider artificial insemination by an anonymous donor to have less social utility than blood transfusions. Such a determination may tip the scales in favor of the sperm recipient, reinforcing the argument that semen should be considered a defective product under the risk-utility test.

*2. Unreasonable Danger Requirement.*—Even if a product defect is proven, it usually must be shown to have been unreasonably

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82. *See generally* EDWARD NOVITSKI, HUMAN GENETICS (2d ed. 1982).

83. *See* Crispin v. Volkswagenwerk AG, 591 A.2d 966 (N.J. Super. Ct. App. Div. 1991); Haran v. Union Carbide Co., 497 N.E.2d 678 (N.Y. 1986); Halphen v. Johns-Manville Sales Corp., 484 So. 2d 110, 114 (La. 1986); Aller v. Rodgers Machinery Mfg. Co., 268 N.W.2d 830, 835 (Iowa 1978). *But see* Dauphin Deposit Bank & Trust Co. v. Toyota Motor Co., 596 A.2d 845 (Pa. Super. Ct. 1991) (holding that the risk-utility balance is not to be used in Pennsylvania cases involving § 402A).

84. Most blood shield statutes protect blood suppliers from strict liability as well as from the imposition of implied warranties. *See supra* note 57.

85. *See supra* Part III(B)(1)(b).

86. *See supra* notes 20-26 and accompanying text.

dangerous in order for strict liability to be imposed.[87] Some courts, however, have found that the unreasonable danger requirement of § 402A is too similar to a negligence standard, which has no place in strict liability, and have refused to require anything beyond defectiveness.[88] Of those states that recognize the unreasonable danger requirement, most follow the definition in Comment i of the Restatement[89] which establishes that, "the article sold must be dangerous to an extent beyond that which would be contemplated by the ordinary consumer who purchases it, with the ordinary knowledge common to the community as to its characteristics."[90]

In some cases, practitioners attempt to guard against a finding of an "unreasonably dangerous" product by informing the recipient of the dangers involved in AID. In so doing, many artificial insemination practitioners require their patients to sign consent forms stating that they understand that the occurrence of a certain percentage of physical and mental defects is beyond the practitioner's control.[91] Arguably, after signing such a consent form, a recipient may appear to have notice that some dangers exist. However, it is not necessarily true that the *degree* of danger would be obvious to the recipient, as she might reasonable expect more thorough donor screening than is actually performed.[92] Thus, even if a recipient is aware of the general risks of AID due to a consent form, donor semen is likely to meet the unreasonable danger requirement of Comment i.

*3. Semen as an Unavoidably Unsafe Product.*—A plaintiff seeking recovery for strict products liability will also run into the obstacle created by Comment k to § 402A, dealing with unavoidably unsafe products. Comment k states the following:

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87. RESTATEMENT, *supra* note 75, § 402A(1). *But see* Balido v. Improved Mach., Inc., 105 Cal. Rptr. 890, 895 (Ct. App. 1973) (holding that negligence and strict liability claims merge); Jones v. Hutchinson Mfg., 502 S.W.2d 66, 69-70 (Ky. 1973).

88. *See, e.g.*, Azzarello v. Black Bros. Co., 391 A.2d 1020 (Pa. 1978); Bradford v. Bendiz-Westinghouse Automotive Air Brake Co., 517 P.2d 406 (Colo. Ct. App. 1973); Cronin v. J.B.E. Olson Corp., 501 P.2d 1153 (Cal. 1972).

89. *See, e.g.*, Rigby v. Beech Aircraft Co., 548 F.2d 288, 290 (10th Cir. 1977) (federal court predicting that a Utah state court would follow Comment i); Menard v. Newhall, 373 A.2d 505 (Vt. 1977); Kirkland v. General Motors Corp., 521 P.2d 1353 (Okla. 1974).

90. RESTATEMENT, *supra* note 75, § 402A cmt. i.

91. Sample recipient consent forms, courtesy of the Division of Reproductive Endocrinology and Infertility at Wayne State University/Detroit Medical Center, can be found in the 1990 AFS GUIDELINES, *supra* note 33.

92. *See infra* Part V(A).

> There are some products which, in the present state of human knowledge, are quite incapable of being made safe for their intended and ordinary use. . . . The seller of such products . . . is not to be held to strict liability for unfortunate consequences attending their use, merely because he has undertaken to supply the public with an apparently useful and desirable product, attended with a known but apparently reasonable risk.[93]

In the context of blood transfusions, prior to the enactment of blood shield statutes courts were split as to whether contaminated blood constituted an "unavoidably unsafe product." Some held that blood was "unavoidably unsafe" because the contamination was not discoverable with the technology at the time, because the benefits of a strong blood supply greatly outweighed the dangers of contaminating some donees, and because these benefits were not achievable by any other means.[94] It is difficult to predict whether or not a court using this analysis would categorize donor semen as "unavoidably unsafe." Any decision would necessarily depend upon the level of social utility accorded to artificial insemination as compared to blood transfusions, an issue which has never been addressed by the courts.

Other courts have declared that contaminated blood is *not* "unavoidably unsafe." For example, the court in *Cunningham v. MacNeal Memorial Hosp.*[95] held that Comment k does not apply to impure products, such as contaminated blood, but only to pure products that carry inherent risks, such as the Pasteur rabies vaccine.[96] Semen would fall into the latter category of products since a genetic defect is not the result of some outside force contaminating the semen, but rather is inherent in cells which are still in their pure, natural state. Under this approach, then, Comment k might apply to donor semen. However, before such a determination can be made, one must find that the danger of a genetic defect is *unavoidable*. If accurate methods of discovering the defect are available, the danger of its being transmitted is clearly avoidable, and Comment k would not protect the AID practitioner from liability. Absent a technologically feasible means of detecting the defect, though, a court might be persuaded to categorize the semen as an unavoidably unsafe product, especially if it feels that artificial

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93. RESTATEMENT, *supra* note 75, § 402A cmt. k.

94. *See* Belle Bonfils Memorial Blood Bank v. Hansen, 665 P.2d 118 (Colo. 1983); McMichael v. American Red Cross, 532 S.W.2d 7 (Ky. 1975); Brody v. Overlook Hosp., 332 A.2d 596 (N.J. 1975); Hines v. St. Joseph's Hosp., 527 P.2d 1075 (N.M. 1974).

95. 266 N.E.2d 897 (Ill. 1970).

96. *Id.* at 903-04.

insemination has high social utility similar to blood transfusions. In that case, after a finding that semen is an "unavoidably unsafe product," a plaintiff would be unable to recover if she was adequately warned of the dangers.[97]

## IV. Obstacles to Making Out a Prima Facie Case

Although all three products liability theories are to some extent applicable in the artificial insemination context, proving a prima facie case might be difficult for several reasons. First, in the uncertain area of genetics, a plaintiff may have difficulty proving that a particular defect was caused by the sperm donor's genes. In addition, while most states would permit a cause of action to be brought by the mother of a child born with a genetic defect, many would find that the child lacks standing to assert a claim for injuries.

### *A. Difficulties in Establishing Causation*

To make out a claim against the sperm donor under any theory of liability, a plaintiff must be able to show a direct causal link between the donor's semen and the child's condition.[98] This could be quite difficult to establish with any degree of certainty. The majority of genetic and nongenetic birth defects occur as the result of spontaneous mutations such that causation cannot be attributed to either biological parent.[99] Also, birth defects are often caused by nongenetic factors, such as toxic exposure, smoking, alcohol consumption, and drug use by the mother during her pregnancy.[100] Finally, it is always possible that a defect exists in the genes of the recipient mother. Thus, it may be difficult to show that the donor's semen was a cause-in-fact, let alone a legal cause, of the child's condition.

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97. Although all members of the supply chain have a duty to warn of unavoidably unsafe characteristics of the products, the "learned intermediary" doctrine might excuse a sperm bank from liability if it adequately warns the AID practitioner, a professional intermediary, of the dangers inherent in donor semen. *See* Swayze v. McNeil Labs., Inc., 807 F.2d 464 (5th Cir. 1987), *reh'g denied*, 812 F.2d 1405 (5th Cir. 1987) (finding drug manufacturer's warning to physicians was adequate and did not require the manufacturer to provide warnings to consumer). *But see* Odgers v. Ortho Pharmaceutical Corp., 609 F. Supp. 867 (D. Mich. 1985) (finding that the manufacturer's duty to warn the ultimate consumer of the dangers of oral contraceptive use was not discharged by warnings given to physician intermediaries).

98. *See generally* KEETON ET AL., *supra* note 29, § 41.

99. Colin D. Matthews, M.D., et al., *Screening of Karyotype and Semen Quality in an Artificial Insemination Program: Acceptance and Rejection Criteria*, 40 FERTILITY & STERILITY 648, 653 (1983).

100. *See generally* David F. Chavkin, *"For Their Own Good": Civil Commitment of Alcohol and Drug Dependent Pregnant Women*, 37 S.D. L. REV. 224 (1992).

Causation presents less of a problem with respect to AID practitioners, since they might be held liable even if the donor's semen did not cause the birth defect. For example, an AID practitioner might be found liable for failing to warn a recipient of the possibility that her own genes might be defective or that a spontaneous birth defect might arise.[101] However, given the current practice of inadequate donor screening, plaintiffs will frequently allege that the birth defect arose due to the practitioner's failure to detect a genetic defect in the donor's semen. In such cases, she must be prepared to show a causal connection between the semen and the child's condition.

*B. Establishing Standing to State a Claim*

*1. The Child as Plaintiff.*—It is well established that children can recover for torts committed against them during the time between conception and birth,[102] but some courts are reluctant to allow recovery for preconception torts.[103] On the other hand, those decisions that rejected claims based on preconception conduct have not involved conduct that was aimed specifically at achieving the conception itself.[104] Even though a physician who negligently performs an abortion has been held not to owe any duty to any subsequent children the patient may conceive,[105] it is hard to accept that an artificial insemination practitioner, sperm bank, and sperm donor owe no duty of care whatsoever to the child whose conception they are actively seeking. Unlike the reported preconception cases, the child resulting from an AID procedure is a foreseeable plaintiff. Therefore, because of the nature of artificial insemination, courts might be inclined to find a duty to the unconceived child and thus might theoretically entertain claims brought on that child's behalf after its birth.[106]

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101. *See supra* Part III(A)(2).

102. *See, e.g.*, Rodriguez v. Patti, 114 N.E.2d 721 (Ill. 1953); Sinkler v. Kneale, 164 A.2d 93, 96 (Pa. 1960).

103. *See generally* Hegyes v. Unjian Enters., 286 Cal. Rptr. 85 (Ct. App. 1991) (holding that a driver owes no duty of care to the yet unconceived child of a female driver with whom he negligently collides). *See also* Albala v. City of New York, 429 N.E.2d 786 (N.Y. 1981) (denying recovery by child for harm committed against his mother prior to his conception because he was not within the immediate zone of danger).

104. The majority of preconception tort cases have involved the daughters and grandchildren of women who were given the drug DES prior to their pregnancies. *See, e.g.*, Grover v. Eli Lilly & Co., 591 N.E.2d 696, 700-01 (Ohio 1992) (holding that the son of a "DES daughter" was not a foreseeable plaintiff for recovery in products liability for the administration of a harmful drug to his grandmother prior to the birth of his mother).

105. *See* Albala v. City of New York, 429 N.E.2d 786 (N.Y. 1981).

106. If the child is not born alive, other legal issues arise as to whether an action can be

Even in states which would permit a child to sue for preconception torts, however, it is unlikely that the child would recover for defects arising out of the AID procedures. Any action the child could bring would necessarily be based on a claim for wrongful life. These claims do not involve situations where a fetus *in utero* has been injured by the defendant's conduct and has suffered injury as a result. Instead, the conception, the creation of the child's life itself, is alleged to be the "harm." Courts have consistently refused to recognize claims for wrongful life because of the deep-seated ethical dilemma involved.[107] Few courts have been willing to say that children, no matter how severely impaired, would have been better off had they never been born. "One of the most deeply held beliefs of our society is that life — whether experienced with or without a major physical handicap — is more precious than non-life."[108]

*2. The Mother as Plaintiff.*[109]—The child's mother would have a better chance of recovering if she brings a products liability claim in her own right, seeking damages based on a wrongful birth[110] theory. The wrongful birth claim enjoys far greater judicial acceptance than wrongful life[111] because it does not define the wrong as the child being given life, but rather as the denial of the mother's right to choose to abort or to never even initiate the pregnancy.[112] Thus, if the

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brought on its behalf. The decision is likely to turn on whether or not the fetus ever achieved viability. Some courts have been willing to treat stillborn full-term children the same in terms of their capacity to bring suit for wrongful death as children who are born alive but die within a few seconds. *See* Johnson v. Levin, 501 A.2d 1085 (Pa. 1985). But, if the fetus never achieved viability, it is unlikely that a tort action could be filed on its behalf in any state. *See, e.g.*, Miccolis v. Amica Mutual Ins. Co., 587 A.2d 67 (R.I. 1991); Humes v. Clinton, 792 P.2d 1032 (Kan. 1990); Rambo v. Lawson, 799 S.W.2d 62 (Mo. 1990); Hudak v. Georgy, 567 A.2d 1095 (Pa. Super. Ct. 1989).

107. *See, e.g.*, Berman v. Allan, 404 A.2d 8, 12 (N.J. 1979); Becker v. Schwartz, 386 N.E.2d 807 (N.Y. 1978). *But see* Curlender v. Bio-science Laboratories, 165 Cal. Rptr. 477 (Ct. App. 1980) (permitting recovery under wrongful life theory by child who was born with Tay-Sachs disease as a result of negligent genetic testing).

108. *Berman*, 404 A.2d at 12.

109. *See supra* note 14.

110. A wrongful birth claim is a claim brought by the parents of a child born with severe defects against a physician who negligently fails to inform them . . . of an increased possibility that the mother will give birth to such a child, thereby precluding an informed decision as to whether to have the child.

Smith v. Cote, 513 A.2d 341 (N.H. 1986).

111. A few states have, however, statutorily prohibited both wrongful life and wrongful birth claims. *See, e.g.*, MINN. STAT. ANN. § 145.424(2) (1993); 42 PA. CONS. STAT. ANN. § 8305 (1988).

112. A third related type of claim is known as wrongful conception, but this generally applies when a negligently performed sterilization procedure fails to prevent a pregnancy and where the

mother can show that she would not have carried the child to term or that she would not have consented to the insemination if she had known the truth about the sperm donor's medical history,[113] many courts may award her compensation for wrongful birth.[114]

The forms and amounts of damages that courts award for wrongful birth vary. The most common measure of damages in wrongful birth cases is the extraordinary medical and educational expenses which the parents will incur due to the child's mental or physical handicaps.[115] The ordinary costs of the pregnancy and of childrearing are not awarded by most courts because, unlike wrongful conception cases in which the parents never intended to bear a child in the first place, wrongful birth plaintiffs planned to support a child and would have incurred certain expenses anyway.[116] Emotional distress awards are frequently denied in wrongful birth cases as well, either because no physical manifestation of distress is evident,[117] because the joys of having a child are considered to outweigh any distress due to the defect,[118] because the

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child is born healthy. *See generally* Philip Braverman, Note, *Wrongful Conception: Who Pays for Bringing Up Baby?*, 47 FORDHAM L. REV. 418 (1978).

113. Courts may look with suspicion upon mothers who, in hindsight, assert that they would have aborted their pregnancies if they had known of any reason to do so, but it is generally believed that most parents will be able to meet the burden of persuasion on this issue. *See Genetic Counseling, supra* note 43, at 1510.

114. *See, e.g.*, Lininger v. Eisenbaum, 764 P.2d 1202 (Colo. 1988); Garrison v. Medical Ctr. of Del., 571 A.2d 786 (Del. 1989); Berman v. Allan, 404 A.2d 8 (N.J. 1979).

115. *See* Schroeder v. Perkel, 432 A.2d 834 (N.J. 1981) (allowing recovery of extraordinary medical expenses associated with raising a child with cystic fibrosis when the parents were deprived of their right to abort the pregnancy by the physician's negligent failure to diagnose the disease).

116. *See* Arche v. United States Dept. of the Army, 798 P.2d 477 (Kan. 1990). The underlying rationale for this approach to damage measurement is that the mother's rightful position in a case involving the negligent misrepresentation that her fetus is free of genetic defects should be defined according to the position she would have been in had the circumstances been as the defendant represented them to be — a position in which she would be responsible for the financial upbringing of a normal child. Michael B. Kelly, *The Rightful Position in "Wrongful Life" Actions*, 42 HASTINGS L.J. 505 (1991).

117. *See* M.H. v. Caritas Family Services, 488 N.W.2d 282 (Minn. 1992) (holding an adoption agency liable for negligently misleading adoptive parents as to a child's genetic and medical background but refusing to award damages for emotional distress in the absence of a physical manifestation of such distress). Although the case was founded on misrepresentation rather than wrongful birth, it is similar to this Comment's hypothetical artificial insemination cases in that the defendant's wrongful conduct caused the plaintiffs to become the legal parents of a genetically impaired child without being given the opportunity to avoid their situations by abortion or by refusing to adopt. *But see* Branch v. Homefed Bank, 8 Cal. Rptr. 2d 182 (Ct. App. 1992) (stating that damages for emotional distress are recoverable in cases of negligent misrepresentation when the plaintiff has sustained other non-economic injuries as a result of the misrepresentation).

118. "The benefit rule requires that any special benefits to the plaintiffs from having a child should be offset against the damages caused by the defendant's negligence." *Arche*, 798 P.2d at

parents did not witness the actual injury to the child,[119] or because the placement of a dollar value on this type of harm would be too arbitrary.[120]

## V. Defenses

Even assuming that a plaintiff can establish causation, sperm donors, physicians, and sperm banks are likely to raise at least one of several defenses if faced with a prima facie products liability case against them. These defenses include assumption of the risk, the use of consent forms and disclaimers, lack of privity, and the state-of-the-art defense, among others.

### *A. Assumption of the Risk and Exculpatory Clauses*

For assumption of the risk to bar recovery, a plaintiff must manifest consent to accept that risk, either expressly or implicitly through conduct.[121] This defense is probably best examined in conjunction with consent forms and disclaimers, because such documents often contain exculpatory clauses with language resembling express assumptions of the risks inherent in artificial insemination.[122]

Although these waivers might appear to bar any legal action by a sperm recipient, they are not effective unless knowingly signed. Also, some courts require more than a general awareness of danger, rejecting

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482. *See also* Harbeson v. Parke-Davis, Inc., 656 P.2d 483, 493 (Wash. 1993). Although generally applied against damages for emotional distress, those courts which allow recovery of ordinary childrearing expenses will often apply the benefit rule to reduce the damage award. *See* Hartke v. McKelway, 707 F.2d 1544 (D.C. Cir. 1983).

119. *See, e.g., Arche*, 798 P.2d at 482 (stating that the "visibility of results as opposed to visibility of the tortious act does not give rise to a claim for emotional damages"). *But see* Naccash v. Burger, 290 S.E.2d 825 (Va. 1982) (allowing parents to recover for emotional distress because their pain was caused directly by the deprivation of their right to abort the fetus, regardless of whether they "witnessed" the tortious conduct).

120. *See, e.g.*, Howard v. Lecher, 366 N.E.2d 64 (N.Y. 1977). *But see* Berman v. Allan, 404 A.2d 8, 15 (N.J. 1979) (allowing recovery for emotional distress despite its inherent valuation problems because emotional distress is considered just as real an injury as physical harm).

121. RESTATEMENT, *supra* note 75, § 496C cmt. h.

122. The sample AID recipient consent form provided in the 1990 AFS GUIDELINES, *supra* note 33, at 13S states:

> I . . . understand that within the normal human population a certain percentage (approximately 4%) of children are born with physical or mental defects, and that the occurrence of such defects is beyond the control of physicians. I therefore understand that [the practitioner] do[es] not assume any responsibility for the physical or mental characteristics of any child . . . born as a result of artificial insemination . . . I do hereby absolve, release, indemnify, protect, and hold [the practitioner] harmless from any and all liability for the mental and physical nature or character of any child . . . so conceived or born . . . .

the assumption of the risk defense unless the plaintiff knew of the specific risk that eventually caused her harm.[123] Arguably, women who decide to undergo artificial insemination expect that an adequate amount of genetic testing will be performed, and therefore, they sign the consent forms. Unfortunately, as previously discussed, such testing is not always performed,[124] and the risk of genetic defects is higher than most recipients would probably expect. Presumably, many women would refuse to consent to the procedure if they had full knowledge of the inadequacy of the testing that actually takes place.[125] This, together with the inequality of bargaining power between physicians and patients,[126] the lack of a suitable alternative to AID,[127] and the public policy against physicians contracting away liability for their own negligence,[128] would in all likelihood convince a court to disregard these consent forms as express risk assumptions.

Defendants would have an equally tenuous argument that a recipient has *implicitly* assumed the risk of bearing a genetically

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123. *See* Garcia v. City of Tucson, 640 P.2d 1117 (Ariz. Ct. App. 1981).

124. *See supra* notes 20-26 and accompanying text.

125. Where the language of a release "alerted the plaintiff to the dangers inherent in [an activity] . . . it does not follow that [s]he was aware of, much less intended to accept, any *enhanced* exposure to injury occasioned by the carelessness of the very persons on which [s]he depended for [her] safety." Gross v. Sweet, 400 N.E.2d 306, 310-11 (N.Y. 1979) (emphasis added).

126. When two parties have significantly unequal bargaining power, exculpatory clauses benefitting the party with the bargaining advantage are generally held to be void as against public policy. *See* Ash v. N.Y. Univ. Dental Ctr., 564 N.Y.S.2d 308, 311-12 (1990) (striking down exculpatory clause where "one party must either accept what is offered or be deprived of the advantages of the relation"); Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 445-46 (Cal. 1963).

127. The alternatives to artificial insemination include adoption, in vitro fertilization, and surrogacy. The rates of contraceptive use and elective abortion have risen over the past several decades, resulting in a dramatic reduction in the number of adoptable children. ANDREA L. BONNICKSEN, IN VITRO FERTILIZATION: BUILDING POLICY FROM LABORATORIES TO LEGISLATURES 24 (1989). Also, adoption is not fully comparable to artificial insemination in that it involves a child who is not biologically related to either parent. Undoubtedly, many couples would prefer to raise a child that is genetically linked to at least one of them, if not both. In vitro fertilization is not a viable option for many couples either, especially if they are seeking artificial insemination out of fear that a particular trait of the husband will be passed along to his offspring, since in vitro fertilization uses the husband's semen to fertilize an egg which has been removed from the mother's body. Surrogacy contracts have obvious disadvantages as well, including the possibility that the surrogate mother will change her mind or that the contract will be declared invalid. *See supra* notes 68-73 and accompanying text. *See also* BONNICKESEN, *supra*, at 84, 118-19. In addition, trying to find different AID practitioners to perform the procedure would probably not be a real option either, since they are all likely to use consent forms containing similar language.

128. *See, e.g.*, Smith v. Hospital Auth., 287 S.E.2d 99 (Ga. Ct. App. 1981); Olson v. Molzen, 558 S.W.2d 429, 430 (Tenn. 1977); Meiman v. Rehabilitation Ctr., 444 S.W.2d 78 (Ky. 1968); Belshaw v. Feinstein, 65 Cal. Rptr. 788 (Ct. App. 1968).

impaired child by undergoing artificial insemination. Reproduction, by its very nature, involves an inherent risk of untoward results, but at least with sexual reproduction the mother has some opportunity to research the father's genetic history, so that she may self-screen to some extent.[129] In artificial insemination, she must rely on others to conduct this screening process for her. Surely, she has a reasonable expectation that some degree of testing will be performed. The extent of testing which can be legitimately expected is debatable,[130] but given the current state of affairs in this field[131] it is unlikely that what is presently being done will meet the recipient's expectations. While a recipient of donor semen must implicitly assume a certain degree of risk due to the unpredictability of the human reproductive process, she does not necessarily assume the risk that the screening and testing process will fall below her own standards of acceptability.[132]

### *B. Lack of Privity*

Although the defense of lack of privity has been heavily eroded in products liability law, it still enjoys limited application under the warranty theory.[133] The Uniform Commercial Code provides three alternative approaches from which states may choose in determining who may recover for breach of an implied warranty.[134] Alternative A extends the warranty to "any natural person who is in the family or household of the buyer or who is a guest in his home if it is reasonable to expect that such person may use, consume, or be affected by the goods."[135] Under this approach, the actual donor could use lack of privity as a defense because even if the donor was considered a merchant, the recipient is not closely enough related to the entity to whom the donor sold his sperm. The recipient would, however, be able to maintain a claim against the party who inseminated her because, in

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129. Interestingly, it is because of self-screening that many women seek artificial insemination by donors in the first place. Curie-Cohen et al., *supra* note 22, at 585. In a 1979 survey, at least one-third of physicians who had performed artificial inseminations using donor semen had inseminated women whose decision to undergo AID was due to a fear of transmitting genetic conditions which they knew their partners to possess. *Id.*

130. *See supra* notes 42-45.

131. *See supra* Part II.

132. *See* KEETON ET AL., *supra* note 29, § 68, at 485 (asserting that "it is not true that in any case where the plaintiff voluntarily encounters a known danger he necessarily consents to any future negligence of the defendant.").

133. The status of the privity requirement in warranty actions in each state is summarized in 2 L. FRUMER & M. FRIEDMAN, PRODUCTS LIABILITY, Ch. 3, at 3-7 to 3-24 (1977).

134. U.C.C. § 2-318 (1993).

135. *Id.*

that case, she is the buyer, and the practitioner who inseminated her would not be able to employ the lack of privity defense.

Alternatives B and C permit recovery by any person whom the seller could foresee might be affected by the goods.[136] Here, a recipient could probably recover from either the donor or the practitioner if they were considered to be merchants, because both know that the sperm they are selling will ultimately be used to inseminate a woman in the recipient's position. Therefore, because the recipient is reasonably expected to "use, consume, or be affected" by the donor's sperm, the recipient is a foreseeable plaintiff if the sperm is shown to be defective. In states which have adopted Alternative B or C, then, lack of privity would not be a valid defense for any of the potential defendants.

### *C. State-of-the-Art Defense*

Physicians or sperm banks might assert a state-of-the-art defense in response to a products liability claim, arguing that it was not technologically feasible for them to discover the defect in the donated sperm given the leading edge of medical practice at the time. This defense has never been available under warranty theory and many courts have followed the Restatement view[137] that strict liability in tort will attach even when a product defect is undetectable.[138] In the negligence context, the state-of-the-art defense should be distinguished from cases in which the technology exists to test products for a particular defect but it is not customary practice to run such tests. In the latter situation, the issue becomes whether or not the customary practice was sufficiently non-negligent that compliance therewith would satisfy one's duty of care.[139] The state-of-the-art defense is properly invoked only if there was *no technologically feasible way* of discovering the defect in the semen. In these particular cases, the state-of-the-art defense acts as an absolute bar to negligence.[140]

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136. *Id.* The only difference between the second and third alternatives is that Alternative B extends the warranty to "any natural person who may reasonably be expected to use, consume or be affected by the goods . . ." while Alternative C contains the same wording except that the word *natural* is omitted.

137. According to the RESTATEMENT, *supra* note 75, § 402A(2)(a), strict products liability may attach although "the seller has exercised all possible care in the preparation and sale of his product."

138. *See, e.g.*, Majdic v. Cincinnati Mach. Co., 537 A.2d 334 (Pa. Super. Ct. 1988); Cunningham v. MacNeal Memorial Hosp., 266 N.E.2d 897, 902 (Ill. 1970).

139. *See supra* notes 40-45 and accompanying text.

140. *See* Caterpillar Tractor Co. v. Beck, 593 P.2d 871, 875 (Alaska 1979); Belle Bonfils Memorial Blood Bank v. Hansen, 665 P.2d 118 (Colo. 1983); Rucker v. Norfolk & Western Ry.,

## VI. Recommendations

Conception through artificial insemination by donor has gained increasing acceptance in the United States over the last several decades, and it now provides many couples and single women with a viable alternative to adoption, in vitro fertilization, and surrogacy contracts. Because of the important role which artificial insemination now plays in our society, we must ensure that it remains both safe and available.

### *A. Steps Must Be Taken to Eliminate the Potential for Liability for Non-Negligent Conduct in Artificial Insemination*

No matter how extensively sperm donors are screened for compatibility with recipients, the nature of human reproduction is such that some children are bound to be born with genetic defects.[141] If products liability suits are permitted against artificial insemination practitioners regardless of fault, the practitioners would become insurers of the health of the children they help conceive. Ultimately, this would result in increased costs being passed on to the recipients, effectively placing AID out of the reach of many prospective mothers.

*1. Sperm Donor Liability Should Be Limited in Order to Encourage Donation.*—A man's willingness to donate semen is crucial to the continued availability of AID as an alternative means of conception. Therefore, the liability of the sperm donor should be limited to situations in which he intentionally or recklessly fails to inform the physician or sperm bank that he carries a genetic defect. Exposing donors to liability for mere negligence, or especially for strict liability or warranty liability without any fault, would dissuade many men from participating in the AID procedure. In turn, this would eliminate AID as an option altogether or drive the costs of AID so high that only the wealthy could afford it. Furthermore, it is more practical to place the burden of detecting genetic defects on the AID practitioner than on donors who are likely to be unfamiliar with the intricacies of genetics.

*2. Legislative Limits Should Be Placed on AID Practitioner Liability.*—While AID practitioners are more appropriate targets for liability, society should also limit the availability of products liability actions against physicians and sperm banks so that the AID procedure

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396 N.E.2d 534 (Ill. 1979).

141. *See supra* note 82 and accompanying text.

remains widely available. At the same time, society should take proactive measures to improve genetic screening practices and reduce the chances of undiscovered defects being passed to children. Given the nature and importance of AID today, it deserves legal treatment similar to that afforded blood transfusions.

Blood shield statutes should be amended to cover artificial insemination explicitly, and states that have no such legislation should take steps to enact similar provisions. So far, the only state that has dealt with this issue is Georgia, already having passed a law that protects AID practitioners from liability unless they are negligent.[142] The Georgia approach is sensible because those practitioners who negligently fail to detect a genetic defect should be held accountable for the foreseeable consequences of their negligence, but those who fail to detect a defect that would be technologically or economically impracticable to discover should not be found similarly responsible.

### *B. Mandatory National Donor Screening Standards Should Be Promulgated*

To more clearly define whether the failure to test a sperm donor for a particular genetic trait constitutes negligence, our system needs a more comprehensive set of standards than those that presently exist. Also, unlike the two sets of voluntary standards now in place,[143] the new standards must be mandatory for all practitioners. This idea is not without support. In fact, several United States Congressmen have suggested that uniform regulation of artificial insemination is necessary.[144] Many medical[145] and legal[146] commentators have made such recommendations as well. Despite any practical problems

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142. GA. CODE ANN. § 43-34-42(b) (1993).

143. *See supra* note 19 and accompanying text.

144. *See* 37 Cong. Rec. E4145-02 at E4146 (1991) (introducing legislation to develop mandatory regulations in the artificial insemination industry by Rep. Ron Wyden of Oregon); 135 Cong. Rec. S396 (1989) (suggestion by Senator Jesse Helms that genetic history and, when appropriate, genetic screening be required of sperm donors in conjunction with AIDS Control Act). During his tenure as a United States Senator, Vice President Albert Gore also indicated an intent to use the federal government's authority to develop a mandatory sperm donor screening system, suggesting that practitioners get together with government agencies such as the Food and Drug Administration to establish national standards. Charles Marwick, *Artificial Insemination Faces Regulation, Testing of Donor Semen, Other Measures*, 260 JAMA 1339, 1339-40 (1988); Gregory Byrne, *Artificial Insemination Report Prompts Call for Regulation*, 241 SCIENCE 895 (1988).

145. *See* Mascola & Guinan, *The Saga Unfolds*, *supra* note 11.

146. *See* Kathleen M. Peterson, Comment, *Federal Regulation of Artificial Insemination Donor Screening Practices: An Opportunity for Law to Co-Evolve with Medicine*, 96 DICK. L. REV. 59 (1991); L. Thomas Styron, Comment, *Artificial Insemination: A New Frontier for Medical Malpractice and Medical Products Liability*, 32 LOY. L. REV. 411, 445 (1986).

inherent in promulgating a comprehensive system of standards,[147] we must at least establish a minimum acceptable standard of care in donor screening that exceeds the level of care currently being provided by some AID practitioners. Not only will these standards help physicians (and, if necessary, the courts) determine what should be done when screening donors, promulgating such provisions will ultimately reduce the risks of conceiving genetically impaired children through artificial insemination.

## VII. Conclusion

Artificial insemination by donor is clearly an area in need of legal oversight. Self-regulation has become dangerously lax. Further, under the current state of the law, if a child is born with genetic defects, there is a substantial likelihood that any of the three products liability theories might succeed against some, if not all, of the potential defendants. To preserve the option of artificial insemination and to protect the health and welfare of the children the procedure is aimed at conceiving, the availability of legal action should be restricted in concurrence with a promulgation of mandatory national donor screening standards.

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147. Each human genome consists of at least 30,000 structural genes, approximately three to five of which are lethal recessive genes capable of causing genetic defects. *See* Newton E. Morton et al., *An Estimate of Mutational Damage in Man from Data on Consanguineous Marriages*, 42 PROC. NAT'L ACAD. SCI. 855 (1956). Since testing all semen donors for all 2,000 medically recognized genetic diseases would be thoroughly impracticable, Peterson, *supra* note 146, at 90, any guidelines would necessarily have to leave room for practitioners' professional judgment when it comes to screening for the rarer conditions.