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MARITAL STATUS AND SEXUAL ORIENTATION DISCRIMINATION IN INFERTILITY CARE

By Richard F. Storrow *

Introduction

During a visit to her dentist in 1994 for a routine cleaning, Sidney Abbott disclosed on her patient information form that she was a carrier of the human immunodeficiency virus (HIV). 1 Her dentist, Randon Bragdon, examined her teeth and found a cavity, but he refused to fill it outside a hospital setting. 2 In her subsequent lawsuit against Bragdon for violating the Americans with Disabilities Act, Abbott testified that her HIV had influenced her decision not to have children. 3 In 1998, the Supreme Court ruled in Abbott’s case that the Americans with Disabilities Act (ADA), enacted in 1990, protects those living with HIV and AIDS from discrimination because those conditions substantially limit the major life activity of reproduction. 4

Bragdon v. Abbott was a watershed for people living with HIV and AIDS and remains a landmark in the landscape of ADA jurisprudence. It has significance, too, for the infertile, who see in the language of the Supreme Court an acknowledgment that infertility itself may be considered a disability. 5 Whether one is infertile, however, is not as easy to determine as whether one is a carrier of HIV. Infertility requires a more contextualized diagnosis than does HIV and has been variously defined and understood. Does infertility exist only where a heterosexual couple cannot conceive a child after engaging in sexual intercourse for a certain period of time? 6 Can gay and lesbian couples and single individuals also be infertile even if they do not engage in reproductive sexual activity? The lack of fixed agreement about what constitutes infertility raises questions about who is a deserving recipient of assisted reproductive treatment. The answers to those questions have important implications for those who need to employ assisted reproduction to have children and are hopeful of finding a medical professional willing to help them.

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1 Professor of Law, City University of New York. J.D., Columbia University; M.A., Columbia University; B.A., Miami University. I thank Mindy Mitchell for her excellent research assistance.


3 Id.


This article addresses, in particular, the obstacles gay and lesbian couples and single individuals face when attempting to have children using assisted reproduction. As Marla Hollandsworth sees it, “parenthood for gay men and lesbians has always been an issue of societal condemnation, social discomfort, and repudiation.” Single individuals, too, especially women, elicit opprobrium and bias when they choose to have children on their own. In the United States, where few laws exist that define who may and who may not have access to assisted reproduction, these groups will face discrimination primarily from unwilling physicians and laws that mandate insurance coverage only for those who meet a narrow and heterocentric definition of infertility. In other countries, laws may explicitly exclude gays, lesbians, and singles from eligibility for treatment. In still others, the differential application of the law may stymie the efforts of same-sex couples to use medical technology to have children. Individually, these laws may appear to have little impact on the reproductive desires of nontraditional families. Collectively, however, they are a reflection of the perspective that medical technology is most appropriately employed to enable heterosexual couples to have children.

This article unfolds in the following manner: Part I discusses statutory and other legal barriers that prevent gays, lesbians, and single persons from building their families with the use of assisted reproduction. This part is divided into two subsections, one that addresses laws that explicitly limit access to assisted reproduction to heterosexual couples and another that examines laws and policies that are not on their face discriminatory but, in their application, limit access by gays, lesbians, and singles. Part II explores the bias that some infertility clinics may display toward gays, lesbians, and singles who seek treatment. This part focuses on the United States, where laws prohibiting such discrimination are uncommon. It asks specifically whether either laws forbidding discrimination in public accommodations or medical ethics principles can effectively combat private discrimination against gays, lesbians, and singles seeking access to assisted reproduction.

Statutory and Other Legal Barriers

Statutory and other legal barriers to assisted reproduction tend to reify what scholars have identified as a heteronormative bias in the delivery of assisted reproduction. The

7 For the purposes of this paper, the term “single individuals” encompasses single persons of all sexual orientations and gender identities.


manifestation of this bias takes several forms, ranging from laws that limit the use of assisted reproduction to heterosexual couples, to policies that deny legal recognition of families that have already been created.¹¹

Most developed countries have comprehensive legislative regimes that regulate access to assisted reproduction. These legislative schemes can be categorized in the following manner: (1) permissive; (2) cautious; and (3) prohibitive.¹² Permissive jurisdictions allow most procedures and typically do not limit access to assisted reproductive technology based on marital status or sexual orientation.¹³ Cautious jurisdictions occupy a middle ground between permissive jurisdictions and prohibitive jurisdictions in terms of the types of procedures they will allow; however, they may permit only stable heterosexual couples to have access to assisted reproduction.¹⁴ Assistance to single women is not permitted.¹⁵ Lastly, the prohibitive approach is characterized by bans on techniques that are elsewhere embraced as mainstream procedures and by limitations on access to stable heterosexual couples. In these jurisdictions, oocyte donation is banned outright,¹⁶ and there may be similar restrictions on using donor sperm for in vitro fertilization (IVF).¹⁷

Facially Discriminatory Regulation

Facially discriminatory regulation of assisted reproduction either gives married couples exclusive access or limits access to heterosexual couples. Other provisions are so readily identifiable as excluding gays, lesbians, and singles that they cannot with any seriousness be labeled neutral. For example, one of the most exclusionary statutory mandates, albeit rare, heteronormative assumptions underlie objections to reproductive cloning).


is one that bars access to assisted reproduction unless the patients are able to demonstrate their “medical infertility.”

Although the Muslim world is relatively uniform in limiting access to assisted reproduction to heterosexual married couples, mandated exclusion of unmarried persons from access to assisted reproduction is unusual in developed countries. Oklahoma limits artificial insemination to use by heterosexual married couples, and some jurisdictions that allow surrogacy impose a similar requirement. Other developed countries, however, if they place any restrictions on who may have access to assisted reproduction, tend to draw the line at “stable” heterosexual couples. Even countries that ban egg and sperm donation, insisting on the importance of genetic links between parents and children, do not always require the couple seeking treatment to be married. Italy, for example, passed laws barring all but heterosexual couples who employ their own gametes from having access to assisted reproduction. This legal regime is recognized as the most restrictive in Europe. In passing the restrictions, the fashioning of which was of particular interest to the Roman Catholic Church, the legislature was expressing its belief that its formerly permissive stance caused harm to the reputation of the country and its physicians, harm to future children who would not be raised by their biological progenitors, and harm to donors from unsafe procedures or conditions that exploit their poverty or vulnerability.

In the early days of IVF, the Warnock Commission in Great Britain considered how reproductive technology should be regulated. Its ultimate recommendation was to limit access to assisted reproduction unless the patients are able to demonstrate


20Richard F. Storrow, Marginalizing Adoption Through the Regulation of Assisted Reproduction, 35 CAP. U. L. REV. 479 (2006). This is not to say there have been no efforts to enact such restrictions. See, e.g., Elizabeth Weil, Breeder Reaction, MOTHER JONES (Jul.-Aug. 2006), http://www.motherjones.com/politics/2006/07/breeder-reaction, (mentioning bills that failed in Indiana and Virginia).


raised in a heterosexual-couple-headed household. The legislation that was passed in 1990 based on these recommendations required the licensure of assisted reproductive treatment. Among the criteria necessary to consider in each case was the need of the child for a father. During the years that this factor was a required consideration, the Human Fertilisation and Embryology Authority (HFEA) permitted clinics to engage in a wide range of screening practices, including best-interests screening. The clinical application of the standard came under sustained attack by infertile couples and individuals, scholars, and even members of Parliament as varying widely across clinics and resulting in discriminatory and arbitrary screening within individual clinics. In response, the Human Fertilisation and Embryology Authority (HFEA) conducted a study on clinical screening practices in the United Kingdom. In a remarkable turnaround said to be motivated to “provide greater clarity and give clinics more confidence about deciding whether or not treatment is appropriate,” the HFEA has quite pointedly embraced the avoidance-of-harm principle in gatekeeping and has revised its code of practice with appropriate language. A new guidance issued by the HFEA in November of 2005 permits nothing beyond fitness screening. Henceforth, clinics in the United Kingdom must entertain a presumption in favor of providing treatment and may not refuse treatment unless there is evidence that the child is likely to suffer serious physical or psychological harm. The new approach has been fully implemented as of January 2006. In further development in 2008, Parliament

33 See id. at 6 (“The involvement of a medical team in assisted conception means that certain third parties have some responsibility towards the child to be born. However, the importance of patient autonomy means that clinics should only refuse to provide treatment where there is evidence that the child is likely to suffer serious physical or psychological harm.”).
35 See id.
36 See id. at § 3.1.
altered the mandate to consider the child’s need for a father to read “the need for supportive parenting.”

This change was celebrated as a victory for same-sex couples and single women alike. A similar inclusive spirit was behind the enactment of New Zealand’s regulation of assisted reproduction in 2004 and recently concluded reform efforts in Victoria, Australia.

Some jurisdictions that have placed heterosexual marriage restrictions on access to assisted reproduction have been forced to dismantle their restrictions based on prevailing human rights norms. For example, two Australian states, Victoria and South Australia, originally enacted laws that excluded all but married heterosexual couples and heterosexual couples in “de facto” relationships from access to assisted reproduction. These laws spurred interstate travel by single women and lesbian couples wishing to obtain treatment. In subsequent lawsuits against these states, infertility physicians who wished to accept single women as patients claimed that these restrictions ran afoul of the prohibition on marital status discrimination in Australia’s federal Sex Discrimination Act. The courts in both cases found restraints on access based on marital status to be inconsistent with the Sex Discrimination Act. The ruling did not open up infertility treatment to single women and same-sex couples, however, as both jurisdictions’ statutes contained the requirement that the patient presenting for treatment be medically infertile, a requirement that single women and lesbian couples seeking treatment rarely fulfill.

After many years of struggling for equal treatment in Australia’s states and provinces, single women and lesbians celebrated the repeal, in December of 2008, of Victoria’s Infertility Treatment Act of 1995. Instead of requiring patients to be medically infertile, the new Assisted Reproductive Treatment Act gives access to assisted reproduction procedures to single women and lesbian couples whose “circumstances” satisfy the doctor

[...]

that the patient is unlikely to have a child without medical assistance.\textsuperscript{47} Medically assisting a single woman or a woman in a same-sex couple to become pregnant creates a presumption, via an amendment to the Status of Children Act of 1974, that the patient’s female partner is also a parent of the child if she consents to a procedure, excluding self-insemination,\textsuperscript{48} by which her female partner becomes pregnant.\textsuperscript{49} The semen donor and/or egg donor is not a parent, whether or not he is known to the couple, or to a single woman undergoing the procedure.\textsuperscript{50} The most controversial amendment of the new law is the requirement that patients presenting for treatment provide a “national criminal records check” to their infertility physician, give permission to providers to perform child protection order checks on patients presenting for treatment,\textsuperscript{51} and submit to two sessions of face-to-face counseling.\textsuperscript{52} These requirements were for the purpose of ascertaining that:

No charges under clause 1 or clause 2 of the Sentencing Act 1991 have been proven against the patient and her partner and that a child protection check is provided which specifies that no child protection order has been made removing a child from the custody or guardianship of the woman or her partner.\textsuperscript{53}

The medical infertility requirement, where it is still the law, remains a significant barrier to treatment.\textsuperscript{54} The requirement continues to plague denizens of South Australia, making it necessary that applicants for treatment be “classified as infertile,”\textsuperscript{55} and forces lesbian couples to travel interstate to more permissive jurisdictions like New South Wales, Victoria, and the Australian Capital Territory.\textsuperscript{56} Moreover, there is no presumption under state law “of parentage for same-sex co-parents.”\textsuperscript{57} This can lead to problems between the co-parent and the child’s school and medical providers.\textsuperscript{58} The good news is that the South Australia legislature is close to dismantling the medical infertility requirement.\textsuperscript{59} Even so, Medicare does not reimburse women who are not medically infertile.\textsuperscript{60} This disparity of

\begin{itemize}
\item\textsuperscript{47} Assisted Reproductive Treatment Act 2008, supra note 46, at s 10. This includes problems achieving pregnancy, carrying a pregnancy to term, or the possibility that without treatment the woman might give birth to a child with a genetic disease or abnormality.
\item\textsuperscript{48} Id. at s 3 (defining “treatment procedure”).
\item\textsuperscript{49} Id. at s 147.
\item\textsuperscript{50} Id.
\item\textsuperscript{51} Id. at s 42.
\item\textsuperscript{52} Porter, supra note 42, at 10.
\item\textsuperscript{55} Id. at 181.
\item\textsuperscript{57} Id.
\item\textsuperscript{58} Id.
\item\textsuperscript{60} Porter, supra note 42, at 10; Soren Holm, Infertility, Childlessness and the Need for Treatment: Is Childlessness a Social or a Medical Problem?, in CREATING THE CHILD: THE ETHICS, LAW, AND PRACTICE OF ASSISTED PROCREATION 65, 70 (Donald Evans ed., 1996).
\end{itemize}
approximately $10,000 between the cost that medically infertile women must pay versus what socially infertile women must pay will remain an effective bar keeping some from pursuing treatment.  

South Australian legislators are right to call into question the view that there is a medical bright line separating those who may obtain treatment from those who may not.  Medical infertility could result from conditions such as endometriosis, fibroids, blocked fallopian tubes or azoospermia, but it also has a social dimension. A purely medical definition of infertility would hold that a woman capable of becoming pregnant with someone other than her current male partner is not medically infertile:

Let us imagine a couple in which the wife has developed antibodies against specific antigens on her husband’s spermatozoa. This couple is infertile when seen as a couple, but taken separately they are in perfect health. With a change of partner each of them would be as fertile as anybody else.

The South Australian approach, however, appears to allow treatment in cases not so much of medical infertility but of reproductive incompatibility, introducing a social factor into the definition. Indeed, the statute itself speaks not only of infertility but of the appearance of infertility of the woman or her partner after they have engaged in the requisite twelve months of unprotected sexual intercourse. Reproductive incompatibility among heterosexual couples, not medical infertility, is thus the primary key to accessing infertility treatment in South Australia.

In order to bring single women into this discussion, as Stuhmcke does in her analysis and to further underscore the inescapable social dimension of infertility, I would go further and, borrowing a line from the insurance industry, argue that infertility is not a medical condition at all, because the condition itself cannot be cured through assisted reproduction.

I am not here defending insurance companies that try to refuse coverage for infertility treatment but simply wish to point out how unmoored the notion of medical infertility is from any fixed, non-contextual reality. Commentators have noted that there is no fixed definition of infertility, but that it is more than anything a social construct. Individuals are not themselves infertile but are infertile only in relation to those with whom they seek to reproduce. Infertility has meaning, then, only when we consider these particular pairings. If only heterosexual couples can be infertile, then it is indisputably the same-sex feature of the lesbian couple that lies behind the refusal to provide in J.M. and behind the restrictive medical definition of infertility itself.

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61 Porter, supra note 42, at 10.
62 Id.
63 Id.
64 Holm, supra note 60, at 70.
65 The analogy in the United States is to insurance companies that recognize infertility as existing only within heterosexual couples who turn out to be reproductively incompatible.
67 Id.
Courts have routinely refused to recognize this more rarefied understanding of infertility. If we resort to the case law, we find that the courts that deem infertility a disorder invariably do so with the use of the arbitrary medical definition, entrenching even further the misguided view that only heterosexual couples can be infertile. 71

I think infertility is better understood as a disability of which the effect on normal life activities can be diminished by medical intervention. This understanding would include not only heterosexual couples who wish to reproduce but cannot, but also gay and lesbian couples and singles who have similar goals. Whether medical intervention is required at all, therefore, would depend not upon marital status or sexual orientation but upon whether there is volition to reproduce in the first instance. Just as heterosexual couples who do not want to reproduce are not infertile, single women who wish to employ assisted reproduction are.

This approach to infertility may have the disadvantage of lacking the physiological and copulative bright lines of the traditional medical definition, but it has the advantage of making transparent the otherwise hidden social dimension of any diagnosis of infertility. It has the further advantage of emphasizing that not all disabilities are medical conditions. Infertility is one of these. It is a social condition that interferes with a major life activity, as the Supreme Court recognized in Bragdon. 72

The distinction between medical and social infertility does not have much influence in the United States, where regulations defining who may have access to assisted reproduction are virtually nonexistent. 73 Instead, in the few states with statutes mandating that health plans include coverage to help the medically infertile pay for reproduction-assisting technologies, gays, lesbians, and singles will have to find other sources of financial support to pay for the treatments they need. These mandates take two different forms: one group requires insurers to offer infertility treatment to group plan sponsors; the other requires insurers to provide coverage. 74 For example, Hawaii, Arkansas, and Maryland mandate insurance coverage for legally married couples. 75 This may be meant to express societal disapproval of reproductive technology for any but married couples, or it may be a statement about the responsibility of the insurance industry to assist only those with a medical condition. Either way, lesbian and gay couples and unmarried heterosexuals are excluded.

The legal definition of infertility in insurance legislation is informed by the medical definition of infertility, the inability of an opposite-sex couple to achieve a pregnancy after a year of engaging in regular and unprotected sexual intercourse. 76 Insurance laws in New Jersey, Hawaii, Maryland, California, Massachusetts, Connecticut, and Rhode Island, for example, all define infertility as arising from some medical condition that prevents pregnancy and is tied to some abnormality in the physiology of either the man or the woman.
who wishes to have a child with someone of the opposite sex. These definitions, if
determinative of who is infertile, suggest that infertility refers to those whose gametes or
gestational capacities render them unable to have a healthy child with their opposite-sex
partner. This definition does not include those who wish to have and raise children with
someone of the same sex or by themselves. As in South Australia, then, medical infertility
in the United States is a dividing line between heterosexual couples who cannot achieve
pregnancy and same-sex couples and singles who would also benefit from insurance
coverage.

**Facially Neutral Regulation**

Many legal policies that impede gays, lesbians, and singles from having access to
assisted reproduction are facially neutral. These include bans on reproductive tourism, laws
that ban self-insemination and sperm donation by gay men, parentage laws that make it
difficult to achieve legal recognition of a social parent, and immigration policies that restrict

Some countries ban third-party gamete donation, thus limiting access to heterosexual
couples. Such regimes may be accompanied by bans on reproduction tourism, as in
Turkey’s ban on leaving the country for artificial insemination and New South Wales’ ban
on international commercial surrogacy. Although the European Court of Human Rights
recently declared that the availability of fertility tourism was a factor weighing against a
finding that restrictions on human-assisted reproduction violate human rights, many people
have no access to the means to pursue such travel, and most of the world lies outside of a
free-trade zone that allows Europeans to escape restrictive reproductive laws by traveling to
friendlier European countries. A gamete donation or surrogacy ban, coupled with a fertility
tourism ban, is the strongest prohibition yet devised on the creation of families headed by
gay and lesbian or single parents.

Related to bans on reproductive tourism are immigration policies geared toward
deterring international commercial surrogacy. Such policies may exist in countries that
either outlaw surrogacy or forbid its being the subject of a commercial transaction, leading
citizens of such countries to travel to jurisdictions like India, the United States, or the
Ukraine, where surrogacy is legal. Either way, such policies have a disparate impact on
gay male couples or singles whose sole reproductive option is to engage a surrogate to
contribute the gestational component to the creation of their children. Upon bringing a
child back to the country that prohibits commercial surrogacy, numerous families have
encountered serious problems. Not only will some governments refuse to recognize the
parent-child relationships in such situations, but France recently refused to recognize the

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77 Charles P. Kindregan, Jr. & Maureen McBrien, Assisted Reproductive Technology: A
Lawyer’s Guide to Emerging Law and Science 221-23 (2d ed. 2011).
78 Id. at 15-16.
79 Richard F. Storrow, Assisted Reproduction on Treacherous Terrain: The Legal Hazards of Cross-
Border Reproductive Travel, 23 Reproductive Biomedicine Online 538, 539 (2011).
81 Storrow, supra note 79, at 539-40 & 543.
82 Emilio de Benito, Justicia Abre la Puerta a la Inscriptión de los Hijos de ‘Vientre de Alquiler’, El País
twins born to a heterosexual married couple with the help of a surrogate in California as French citizens. The Spanish press has reported that Spain’s similar response to international commercial surrogacy has fallen disparately on the shoulders of gay men who cannot “hide” the fact that they have pursued surrogacy abroad.  Although England, which permits uncompensated surrogacy, has dealt with such cases by applying the best-interests of the child standard embodied in its parenting order legislation, the problems plaguing those who seek to evade bans on surrogacy will not be resolved at any time in the near future. Even India’s proposal to pass legislation that would require potential parents to prove that surrogacy is permitted in their home country, that their sexual relationship is legal in India, and that the child to be born will be permitted entry on the same terms as would a biological child of the parents, would only likely induce potential parents faced with restrictive surrogacy laws at home to pursue surrogacy elsewhere. The worldwide problem has induced the Hague Conference on Private International Law to commence a study on the possibility for some form of broader response to the problems arising in the context of international commercial surrogacy.

Immigration laws that inhibit surrogacy, by refusing to recognize the parent-child relationships they create or denying children citizenship, bear a striking relationship to regulation that makes it difficult for a social parent to achieve legal parenthood status, whether by adopting their partner’s children or by petitioning for recognition as a functional parent. Although it is analogous to step-parent adoption, second-parent adoption, where it is available, does not require the legally recognized parent to be married to the party seeking to adopt the child. Where it is forbidden, such regulation clearly targets the formation of unmarried-couple families. Even where it is allowed, second-parent adoption requirements are more onerous than step-parent adoption requirements. Adoption as a second-parent provides a measure of protection to the non-biological parent of a couple whose relationship is not entitled to any legal recognition under state law or who choose not to seek it. It is a mechanism that has often been used by lesbian couples who have employed artificial insemination to have children. Without recognition as a second-parent, the non-biological parent risks having no right to a continuing relationship with the child if the legally recognized parent later wishes to exclude her and the court refuses to give any weight to her


85 de Benito, supra note 82.

86 Storrow, supra note 83, at 607-08.


90 Id. at 336-47.
functional parenthood. Second-parent adoption is not explicitly permitted in many states, however, and not all states recognize functional parenthood, forcing couples whose family formation efforts could benefit from legal recognition to consider whether they should relocate to a friendlier jurisdiction, run the risks that lack of recognition entails, or forego having children altogether. As a practical matter, prohibition on second-parent adoption and a refusal to recognize functional parenthood may be as ineffectual in inhibiting unmarried couples from pursuing assisted reproduction as are immigration laws aimed at combating international surrogacy, but these are nonetheless potential barriers to the formation of gay, lesbian, and single-parent-headed families via assisted reproduction.

Finally, several little-known attempts have been made to interfere with the ability of gays, lesbians, and singles to gain access to assisted reproduction. Judith Daar mentions a Virginia bill to require “all unrelated gamete donors [to] be identified in a woman’s medical chart.” She explains that although the bill is facially neutral, it would have a “dramatic impact” on single and lesbian women who are dependent upon anonymous sperm donation. Additionally, an FDA-recommended rule would establish a “ban on gay men as sperm donors unless they have been completely celibate for the preceding five years.” Obviously, this proposed rule is neither neutral nor free of stereotypes regarding who should be allowed to donate sperm, but it nonetheless does not specifically target who may have access to it. Moreover, the rule may not pose practical problems for most infertility patients, since it applies only to anonymous donors and does not disallow one’s choosing a gay man to be a known donor. Even so, the proposed rule is insidious in that it has been used as a makeweight argument by doctors who would prefer not to serve gay and lesbian patients. Finally, bans on self-insemination impact access by lesbians and single women to a common and relatively easy technique that assists them in conceiving children. One reason why self-insemination may be so common among lesbians and single women is that

93 Id.
95 Id.
“[m]any women may prefer the comfort of home and appreciate a more familiar surrounding, as the insemination process, while not complicated, is quite personal and invasive.”

Barriers in the Clinical Setting

Where law is not the primary barrier to access, physicians, in their gatekeeping function, may effectively bar gays, lesbians, and singles from gaining access to infertility care. The medical infertility requirement was at the root of the sexual orientation discrimination case J.M. v. Q.F.G. In this case, a lesbian was refused treatment by a Queensland clinic whose semen donor program was restricted to heterosexual couples where the male partner proved unable to produce semen of sufficient quality to achieve pregnancy. J.M. sued under the Anti-Discrimination Act prohibiting discrimination on the basis of lawful sexual activity or partnership. The Court of Appeal of the Supreme Court of Queensland concluded that the refusal was not due to her lesbianism, but that she did not comply with the medical definition of infertility. Here we find full judicial deference to a convention of the infertility industry to define infertility as “the inability to conceive after engaging in unprotected heterosexual intercourse over a period of 12 months.” Thus, it turns out that J.M. had not been rejected for her sexual activity but for her sexual inactivity, her refusal to engage in heterosexual intercourse for twelve months.

In the United States, the American Medical Association’s Code of Medical Ethics, promulgated by doctors to self-regulate their profession, speaks in terms of helping patients who present with a “medical problem” or a “medical condition.” The ability to distinguish medical conditions from other disorders may tempt infertility physicians to judge that single women and lesbians who wish to reproduce do not present with a “medical” problem, but a social one. An infertility physician may thus conclude, as did Q.F.G., that medical ethics principles do not forbid her from refusing to treat gay or unmarried patients, since the refusal to assist arises from a benign choice to help only those who present with

102 Stuhmcke, supra note 70, at 249 n.19.
103 Id. at 246.
105 Hwang, supra note 6.
108 In a recent European example of such thinking, it was found that “[m]any clinics refuse to exchange oocytes between lesbians when the woman who will become pregnant is fertile because they judge this as a social indication not worth the medical investment.” Katrien Wierckx et al., Reproductive Wish in Transsexual Men, 27 HUM. REPROD. 483, 486 (2012) (citing W.J. Dondorp et al., Shared Lesbian Motherhood: A Challenge of Established Concepts and Frameworks, 25 HUM. REPROD. 812 (2010)).
medical issues. This justification for a refusal to treat has arisen in the past in connection with contraception\textsuperscript{109} and voluntary sterilization.\textsuperscript{110}

Today, there is admittedly very little evidence to suggest that infertility patients in the United States are turned away by clinics based on whether they meet the test of medical infertility as was J.M. by the clinic in Queensland. But medical infertility may be a reason given to mask other forms of discrimination, some of which may be outlawed.\textsuperscript{111} This raises the possibility that physicians may be faced with a choice between violating anti-discrimination laws and expressing their objection by refusing to treat gay, lesbian, or single patients. Physician John Pearn has expressed his distaste for requiring doctors to treat problems of social infertility.\textsuperscript{112} Patrick O’Connell and Jacques Mistrot have gone even further in stating that doctors should not have to conform to anti-discrimination laws that force them to perform procedures that are an affront to human dignity.\textsuperscript{113} These are not simply extreme views but can arguably be found in the Code of Medical Ethics itself: a religious physician might be tempted to invest the medical ethics principle that physicians must act in the best interests of their patients\textsuperscript{14} with an admonition not to “assist [patients] in harming themselves.”\textsuperscript{115} Consider as well that the wording of both Opinions 10.01 and 10.015 speak in terms of “medical problems,” “medical condition,” and “alleviate suffering.”\textsuperscript{116} Such terms do not disable physicians from concluding that those presenting with “social” infertility do not have a “medical” problem. Under this reasoning, even a referral to another physician would not be necessary.

As noted above, there have been legislative reforms in some Australian jurisdictions to do away with the exclusionary medical-infertility requirement, but a single mother who desires artificial insemination to have a child and raise him alone, or a gay or lesbian couple seeking egg donation or IVF with a surrogate, may be subjected to discrimination for reasons having nothing to do with their inability to have children without assisted reproduction.\textsuperscript{117} Clinicians may turn away single women, or lesbian couples not for failing

\textsuperscript{109} In the landmark family privacy case \emph{Griswold v. Connecticut}, the State of Connecticut argued in response to the physicians’ position that their practice was hindered by a statute barring the dissemination of information about contraceptives that counseling about and “issuing prescriptions . . . for contraceptives [have] nothing to do with the practice of medicine.” \textit{John W. Johnson, Griswold v. Connecticut: Birth Control and the Constitutional Right of Privacy} 119 (2005). The state’s attorneys characterized contraceptive advice as “social philosophy [that] must fall before the police power of the state.” \textit{Id.} at 118.


\textsuperscript{111} See N.Y. STATE TASK FORCE ON LIFE \\& THE LAW, supra note 15, at 186; see, e.g., Farr A. Curlin et al., The Author’s Reply, \textit{Religion, Conscience, and Controversial Clinical Practices}, 356 NEW ENGL. J. MED. 1889, 1891-92 (2007) (taking the position that where the physician concludes the condition is not a true sickness, the physician has no duty to refer the patient elsewhere for treatment).


\textsuperscript{114} AM. MED. ASS’N, supra note 106, at Op. 10.015.

\textsuperscript{115} O’Connell \\& Mistrot, supra note 113, at 1891.

\textsuperscript{116} AM. MED. ASS’N, supra note 106, at Ops. 10.01 \\& 10.015.

\textsuperscript{117} \textsc{Pauline Irit Erera}, \textit{Family Diversity: Continuity and Change in the Contemporary Family} 111 (2002); M.M. Peterson, \textit{Assisted Reproductive Technologies and Equity of Access Issues}, 31 J. MED. ETHICS 280, 281-82 (2005).
to present with a true medical problem or a problem of “medical futility,” but for being capable only of irresponsible or socially inappropriate parenthood. Individual physicians may object to assisting patients who request help in building families that will not be headed by married heterosexual couples. Although many physicians feel inadequate to the task of making such an assessment, others may feel bound by a set of values to do so and may believe such a decision falls comfortably within the ambit of their professional responsibility. Laws banning discrimination based on family status, marital status, or sexual orientation may help combat discriminatory decision making, but, sadly, in the United States at least, almost half the states have no statewide prohibition of either marital status or sexual orientation discrimination.

The United States infertility industry on the whole is not known for turning away patients. With no law regulating who an infertility clinic may accept for treatment, and a medical establishment actively opposed to regulation, it is more likely that clinics will be more committed to doing what is necessary to improve their success rates than with turning away patients on matters of philosophical or religious principle. This effort to boost success rates may cause clinics to “cherry-pick” patients in order to guarantee high success rates, misrepresent their success rates in order to attract more business, or even perform unsafe practices in the hope of increasing the likelihood of pregnancy. There is a law that requires clinics to report their statistics, but there is little oversight of this mandate and no mechanism to enforce it. These realities of infertility practice in the United States might suggest that discrimination against gays and lesbians by infertility clinics is not a significant problem.

The fact that infertility clinics have little incentive to discriminate against gays and lesbians does not mean that such discrimination does not exist, just that it is largely hidden. A few cases are worth mentioning. In Minnesota, a court granted summary

\[\text{118}\] Peterson, supra note 117, at 281-82 (noting that some clinicians purport to use “common sense” to judge what reproduction is “appropriate” and who has adequate parenting ability).

\[\text{119}\] Storrow, supra note 29, at 2292.

\[\text{120}\] Within states with no statewide prohibition, municipalities may choose to provide such protection. See, e.g., TUCSON CODE § 17-12(a) (outlawing sexual orientation and marital status discrimination in public accommodations), available at http://cms3.tucsonaz.gov/sites/default/files/oep/Chapter%2017.htm.

\[\text{121}\] A rare exception is an Oklahoma statute permitting only married couples to receive infertility treatment. OKLA. STAT. tit. 10, § 553 (2012).


\[\text{123}\] Elizabeth Weil, Breeder Reaction, MOTHER JONES (Jul. 2006), http://motherjones.com/politics/2006/07/breeder-reaction.


\[\text{125}\] REPRODUCTION AND RESPONSIBILITY, supra note 124, at 36.


\[\text{127}\] REPRODUCTION AND RESPONSIBILITY, supra note 124, at 48-49.

\[\text{128}\] R. Alta Charo, And Baby Makes Three—or Four, or Five, or Six: Redefining the Family after the Reprotech Revolution, 15 WIS. WOMEN’S L.J. 231, 240 (2000); DeLair, supra note 104, at 150-51; Holly J. Harlow, Paternalism Without Paternity: Discrimination Against Single Women Seeking Artificial Insemination by Donor, 6 S. CAL. REV. L. & WOMEN’S STUD. 173, 175 (1996); Audra Elizabeth Laabs, Lesbian ART, 19 L. & INEQ. J. 65, 82 (2001); Justyn Levin, Mis/Conceptions: Unjust Limitations on Legally Unmarried Women’s
judgment to a clinic accused of refusing to artificially inseminate a lesbian because of her sexual orientation. In Massachusetts, the parties settled a similar lawsuit before trial. Other cases have involved single women and lesbians who were denied treatment because of their marital status or sexual orientation or where their lack of a partner was of concern to physicians. There is a body of empirical evidence suggesting that many clinics would be likely to turn away single women and lesbian couples. Stories of clinics that reject single women, gays, and lesbians are simply part of a larger culture clash between those who wish to bring religiously motivated discrimination into the public marketplace and protected classes seeking access to certain services. The lack of litigation over this form of discrimination in infertility clinics is evidence that, as a practical matter, if refused treatment at one clinic, applicants merely proceed to another.

Whether infertility physicians should be permitted to refuse to perform procedures for those of whom they disapprove has been the subject of an ethics report produced by the

Access to Reproductive Technology and Their Use of Known Donors, 14 HASTINGS WOMEN’S L.J. 185, 199-200 (2003).

See Harlow, supra note 126, at 207-12.

See supra note 98. The clinic claimed it was applying a Food and Drug Administration guideline against using the sperm of sexually active gay men in infertility treatment. Littrell, supra note 97.

See N.Y. STATE TASK FORCE ON LIFE & THE LAW, supra note 15, at 185-86; Carol M. Ostrom & Warren King, Infertility Clinic Accused of Past Bias—Women Say Lesbians, Singles Turned Away by UW Facility, SEATTLE TIMES (Nov. 21, 1993), http://community.seattletimes.nwsource.com/archive/?date=19931121&slug=1733101; Press Ass’n, MPs Challenge Fertility Clinic Ban on Lesbians, THE GUARDIAN (U.K.), July 2, 2006, at 7, available at http://www.guardian.co.uk/uk/2006/jul/03/politics.gayrights (highlighting the political response to fertility clinics’ refusal to treat single women and lesbians).

John A. Robertson, Procreative Liberty and Harm to Offspring in Assisted Reproduction, 30 AM. J.L. & MED. 7, 30 (2004); Lesbian Denied Fertility Treatment Wins Complaint, CTV NEWS (Oct. 1, 2005), http://www.ctv.ca/CTVNews/Canada/20050930/invitro lawsuit 050930/ (reporting on a ruling of the Quebec Human Rights Commission that ordered a fertility clinic to pay thousands of dollars of compensation to a woman who was refused fertility treatment because she was not accompanied by a man).


American Society for Reproductive Medicine (ASRM). ASRM issued a report related specifically to the provision of services to gays and lesbians. ASRM identified three important values at play in the ethical debate whether clinics may or must assist single individuals and gay and lesbian couples: reproductive autonomy, child welfare, and professional responsibility. The society concluded that the balance was best struck in favor of equal treatment of heterosexual couples, single persons, and gay and lesbian couples by infertility clinics.

The society believes that in the absence of other factors, being single, gay, or lesbian is not an ethical basis for the denial of treatment.

Although discrimination against gays, lesbians, and singles may be ethically suspect, the stark reality is that there are, as noted above, very few laws that prohibit such discrimination. The following map illustrates the problem:

![Sexual Orientation and Marital Status Discrimination Prohibitions Map](image)

Where such laws do exist, it has been ruled that physicians’ offices are covered by the prohibition. This is no guarantee, however, that a physician will not make a decision to

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138 Id. at 1191.

139 Id. at 1192.

140 Id.

141 N.Y. STATE TASK FORCE ON LIFE & THE LAW, *supra* note 15, at 186 (citing Cahill v. Rosa, 89 N.Y.2d 14, 21 (N.Y. 1996)). Infertility clinics may fall outside the ambit of such legislation, however, if they are not considered places of public accommodation. Courts have reached different conclusions on whether medical clinics are places of public accommodation. Compare Duffy v. Ill. Dep’t of Human Rights, 820 N.E.2d 1186,
refuse or terminate treatment based on a patient’s sexual orientation or marital status. Compounding the problem of combating discrimination even where prohibitions exist are cases where physicians base their refusal to treat on a religious belief. The argument in such cases is not that the religious nature of the refusal renders it nondiscriminatory but that, as O’Connell and Mistrot point out, in matters of conscience, physicians should be exempt from anti-discrimination laws. Some physicians even urge that the Code of Medical Ethics provides cover for such refusals, as long as the refusal is a matter of conscience and a referral to another physician is made in good faith.

The best known case of this type is North Coast Women's Health Care Group v. Superior Court. The case presented the classic dilemma of a nontraditional family seeking help from a conservative medical establishment in order to have children. North Coast Women’s Care Medical Group contracts with insurers to provide infertility treatment to their subscribers. Guadalupe Benitez, a lesbian, received basic infertility treatment from North Coast under the terms of her employer-provided health insurance plan until it became clear she would require intra-uterine insemination. At that point, North Coast raised religious objections to helping her become pregnant, referred Benitez to a clinic not covered by her insurance, and reimbursed her for the cost of treatment at the new location.

Although the treatment at the new clinic was successful, Benitez brought suit under the Unruh Act, a California law specifically prohibiting sexual orientation discrimination in public accommodations. The California Supreme Court granted review after summary judgment for Benitez was overturned. The Court framed the issue as whether a physician is constitutionally insulated from the Unruh Act when the discrimination arises out of sincerely held religious beliefs.

Although the doctors claimed to have discriminatory motives only toward unmarried women, a group unprotected by the Unruh Act at the time the relevant incidents took place,
it was never definitively established whether they objected to treating unmarried women, lesbian couples, or both. The Supreme Court did not have to resolve this issue to rule that discrimination grounded in religious belief is not exempted from the Act’s ambit.\textsuperscript{151} In the wake of the Court’s decision that doctors with religious scruples are not exempt from the Act, North Coast and Benitez settled the lawsuit for an unspecified sum.\textsuperscript{152}

One of the oddest aspects of \textit{North Coast} was that the doctors Benitez and Clark consulted had no objection to helping Benitez become pregnant at first.\textsuperscript{153} It was not until she required the technique of intrauterine insemination that their religious scruples were triggered.\textsuperscript{154} Even more peculiar was the obvious lack of agreement among physicians groups weighing in on the matter about whether the actions of North Coast’s physicians were permissible under the Code of Medical Ethics.\textsuperscript{155} The physician defendants, of course, argued that the Code of Medical Ethics permits doctors to refuse to treat a patient for religious reasons as long as they provide an immediate and effective referral to another physician who will perform the service.\textsuperscript{156} Just as in \textit{Bragdon}, where the American Dental Association submitted an \textit{amicus curiae} brief asking the court to rule in Bragdon’s favor,\textsuperscript{157} several medical societies believed that North Coast should prevail.\textsuperscript{158} But amid the flurry of filings of \textit{amicus} briefs discussing the medical ethics aspects of the case was an equal number taking Benitez’s side.\textsuperscript{159} The California Medical Association changed its mind in the middle of the lawsuit.\textsuperscript{160} The briefs of the various medical society amici exhibited striking disagreement about what the ethics rules governing their profession require.

It is generally accepted that a doctor may refuse the initial treatment of a patient for a nondiscriminatory reason,\textsuperscript{161} but once a doctor has agreed to treat a patient, she has a duty

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\item \textsuperscript{151} Richard F. Storrow, \textit{Medical Conscience and the Policing of Parenthood}, 16 WM. & MARY J. WOMEN & L. 369, 372-76 (2010) (describing the court’s reasoning on this free exercise question).
\item \textsuperscript{153} \textit{N. Coast Women’s Care Med. Grp.}, 189 P.3d at 963 (indicating Benitez had been in North Coast’s care for almost a year before she was refused care).
\item \textsuperscript{154} \textit{Id.} at 963-64.
\item \textsuperscript{155} Storrow, \textit{supra} note 151, at 382-87.
\item \textsuperscript{156} Petitioners’ Answer to Brief, \textit{supra} note 143, at 3-4.
\item \textsuperscript{157} O’BRIEN, \textit{supra} note 3, at 272 n.133.
\item \textsuperscript{159} \textit{See, e.g.,} Brief for Anti-Defamation League et al. as Amici Curiae Supporting Real Party in Interest, \textit{N. Coast Women's Care Med. Grp.}, 40 Cal. Rptr. 3d 636 (No. D045438); Brief for Gay and Lesbian Med. Ass'n et al. as Amici Curiae Supporting Real Party in Interest, \textit{N. Coast Women's Care Med. Grp.}, 189 P.3d 959 (No. S142892).
\item \textsuperscript{160} \textit{Notice of Errata Regarding Amicus Brief of Cal. Med. Ass'n at 2, N. Coast Women's Care Med. Grp.}, 40 Cal. Rptr. 3d 636 (No. D045438) (on file with author).
\item \textsuperscript{161} \textit{See AM. MED. ASS’N, \textit{supra} note 106, at Op. 9.12 (prohibiting physician’s discrimination against potential patients on the basis of “race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination.”)}; \textit{see also AM. MED. ASS’N, \textit{supra} note 106, at
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not to neglect or abandon that patient. The debate in the amici briefs, then, was whether North Coast’s physicians had breached any medical ethics rules in refusing to treat her but sending her to another physician from whom she received successful treatment.\(^{162}\) It is thus odd that none of the parties to, or amici in this case, considered the applicability of the Code of Medical Ethics provisions concerning the neglect of patients and when a physician may ethically refuse to treat a patient but must refer her elsewhere.

Opinion 8.11 of the Code of Medical Ethics reads, “[p]hysicians are free to choose whom they will serve. The physician should, however, respond to the best of his or her ability in cases of emergency where first aid treatment is essential. Once having undertaken a case, the physician should not neglect the patient.”\(^{163}\) Opinion 10.01 describes the fundamental character of a physician-patient relationship as a “collaborative effort” and a “mutually respectful alliance” in which the parties share the responsibility for making health care decisions.\(^{164}\) Within this framework, patients have the right to be treated with courtesy and dignity and have the right to continuity of health care. “The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.”\(^{165}\) Added to this is the understanding from Opinion 10.015 that a physician-patient relationship is a fiduciary relationship in which the physician’s self-interest is subordinate to his duty to promote the patient’s best interests and advocate for her welfare.\(^{166}\) It may be possible to read into these provisions the anti-discrimination language of Opinions 9.12 and 10.05, the Opinions that captured the attention of the various players in North Coast, but one cannot do so directly, since those provisions apply to the acceptance or denial of potential patients by their own explicit terms. It may be a good idea to assume from the specific language of the Code of Medical Ethics Principles that a physician who decides to discriminate in the course of an ongoing physician-patient relationship is not respectful of the law, respectful of human rights and dignity, or even supportive of access to medical care for all people.\(^{167}\) Perhaps the Principles’ Preamble can be read together with Opinions 10.01 and 10.015 to conclude that it is simply not honorable or respectful for a physician to discriminate, because it is of no benefit to a patient, does not promote her best interests and welfare, and arguably exacerbates rather than alleviates her suffering.\(^{168}\)

Unfortunately, the vague and general language of these provisions, when contrasted with the forceful nondiscrimination language embodied in the provisions applicable to potential patients raises doubt, as North Coast noted,\(^{169}\) about whether any provisions of the Code are suited to assist a court, or an American Medical Association disciplinary board for that matter,\(^{170}\) in resolving a case like North Coast.

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\(^{162}\) Storrow, supra note 151, at 382-87.

\(^{163}\) Id. at Op. 10.01.

\(^{164}\) Id. at Op. 10.01(5).

\(^{165}\) Id. at Op. 10.01(15).

\(^{166}\) Id. at Op. 10.015.

\(^{167}\) Id. at prins. I, III, and IX.

\(^{168}\) Id. at pmb., Op. 10.01, Op. 10.015.

\(^{169}\) Petitioners’ Answer to Brief, supra note 143, at 6-7.

\(^{170}\) The AMA’s Council on Ethical and Judicial Affairs is vested with the power to “censure, or place on probation the accused physician or suspend or expel him or her from AMA membership as the facts may justify.” AM. MED. ASS’N COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, RULES IN CASES OF ORIGINAL
At first blush, the resolution to the questions raised here about medical ethics principles might appear straightforward. As a practical matter, Benitez did eventually receive what she was seeking without any additional expense. Or did she? Anti-discrimination statutes are meant to advance several compelling public interests beyond averting economic harm, among these, combating “humiliation, embarrassment, inconvenience to residents and non-residents alike, . . . breaches of the peace, inter-group tensions and conflicts and similar evils.”¹⁷¹ The scholarly literature on discrimination strongly indicates that discrimination incurs a deep psychic cost, no matter what the other more material damages might be.¹⁷² Indeed Joann Clark, Benitez’s partner, eloquently captured the effect that discrimination has, whether the aim of acquiring medical treatment is achieved or not: “[Clark] commented, ‘I had no idea the depths that [discrimination] reaches. Personally and psychologically, it destroys you.’”¹⁷³

Conclusion

Gays, lesbians, and singles commonly encounter barriers when they seek assistance to have children. Some will choose to bypass the medical establishment entirely and will self-inseminate; others will choose to employ an infertility physician in their quest to have children. Because the practice of infertility medicine opens new and unfamiliar avenues to family formation, it also raises fierce anxieties in society about who should be allowed to become a parent and who should not. In this debate, entrenched attitudes about marriage and procreation have been repackaged to express antipathy toward nontraditional families and functional parenthood unbuttressed by genetic or gestational connections. Unsurprisingly, then, many of the same battles about parentage and legitimacy that used to arise from concerns about the place of marriage in society continue to be fought against the backdrop of those who use reproductive technologies. Equally unsurprising is the prominent role of marital status and sexual orientation discrimination in this struggle. Legislatures have passed laws mandating the delivery of infertility care only to heterosexual couples. Administrative agencies have enforced laws, otherwise facially neutral, in ways that exclude gays, lesbians, and singles from pursuing parenthood. Finally, physicians, because they are the purveyors of the technology, may perceive that they are entitled to exclude certain individuals from having access to it based on the perception that certain classes of individuals lack the capacity to provide minimally adequate care.

¹⁷² See Pittsburgh, Pa., Code § 651.01(e) (2006) (“Discrimination in . . . public accommodations . . . [creates] humiliation, embarrassment and inconvenience to residents and [non-residents alike and] tends to create breaches of the peace, inter-group tensions and conflicts and similar evils.”); available at http://library.municode.com/index.aspx?clientId=11163.

Several of the legal developments detailed in this article indicate a slight trend in the direction of relaxing restrictions on access to assisted reproduction by those not in heterosexual relationships. It is a given that the science of assisted reproduction will continue to evolve. In the future, it may even be possible for gay and lesbian couples to have children genetically related to both of them, without the necessity of donor gametes and surrogates. Such technology may not develop until far into the future. If that day ever arrives, it is to be hoped that discriminatory animus against gays, lesbians, and single individuals who wish to become parents will be a dim memory from a distant past.

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