AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Legislative and Regulatory Efforts Against Fertility Fraud

Referred to: Reference Committee B

Whereas, Illicit insemination, or fertility fraud, is defined as the failure on the part of a fertility doctor to obtain consent from a patient before inseminating her with his own sperm normally in the context of patients using assisted reproductive technology[1]; and

Whereas, The results of a 1987 survey conducted showed that as many of 2% of fertility doctors polled had used their own sperm to inseminate their patients[2]; and

Whereas, Over the past several years, more than 50 fertility doctors in the United States have been accused of fertility fraud and nearly all of the physicians who have been accused were discovered as a result of DNA tests taken by their offspring[3]; and

Whereas, Physicians' inseminations of nonconsenting and unaware patients represent a gross trespass against all standards of modern practice[4]; and

Whereas, Engaging in illicit insemination exploits patients' ignorance of circumstance, trust, intense desire to conceive, and vulnerability and breaches other ethical obligations, including the duty to disclose all relevant medical information to patients and to deal honestly with them, robbing them of their decision-making autonomy[4]; and

Whereas, Former patients of these physicians speak of feeling violated and assaulted, their personal dignity and bodily integrity trampled, their family plans routed, and their trust broken[5]; and

Whereas, Illicit insemination is a violation of the ethical principle of respecting individual autonomy to make an informed decision regarding the nature of one's health[5]; and

Whereas, Illicit insemination is a violation of the ethical principle and physicians' responsibility to truth-telling[5,6]; and

Whereas, These ethical, medical, and psychological issues patients and their children face as a result of physician actions directly contradicts the medical ethics principle of nonmaleficence[7]; and

Whereas, Only four states specifically penalize physicians for inseminating their own sperm into patients without express consent and there are no federal penalties[2,8]; and

Whereas, In Texas, Senate Bill 1259 classified illicit insemination as a form of sexual assault[9]; and

DRAFT

Whereas, Indiana lawmakers introduced Senate Bill 174, making it legal for victims of fertility fraud to pursue legal action against physicians who commit acts of fertility fraud[10]; and

Whereas, Arizona lawmakers approved Senate Bill 1237 in 2021, giving victims and children conceived from illicit insemination the opportunity to pursue civil damages against the physician committing fertility fraud[11]; and

Whereas, Utah House Bill 192 states that healthcare providers may not knowingly use their own gametes during assisted reproductive treatment without the patient's written consent, otherwise punishable as a third degree felony[12]; and

Whereas, A lack of laws regarding illicit insemination in the majority of states requires people and families affected to seek legal action through application of existing criminal laws, such as those written for criminal deception, sexual battery, or rape, which do not fully apply to or encompass the actions conducted[5,13]; and

Whereas, The use of applicable criminal laws that were written without consideration for illicit insemination may result in relevant cases being a poor fit for existing law, expiring past the statutes of limitation, or lacking evidence due to temporal constraints[5,13]; and

Whereas, The rise of consumer genetic testing is growing in popularity with estimates of 26 million testing kits bought in 2019 and an annual growth rate of 12.25%[14,15]; and

Whereas, Hundreds of people who have been fathered by non-consensual insemination have discovered this information through consumer genetic testing[16,17]; and

Whereas, A number of countries already have legislation that restrict the number of conceptions by an individual sperm donor in order to prevent unintentional consanguinity[7]; and

Whereas, The American Society of Reproductive Medicine recommends restricting conceptions by individual donors to 25 births per population of 800,000 to avoid unintentional consanguinity[7]; and

Whereas, Without measures to prevent illicit insemination by physicians, increased risk of consanguinity in communities can pose a significant threat to public health and lead to medical, psychological and ethical issues patients and their children must face[18]; therefore be it

RESOLVED, That our American Medical Association oppose physicians using their own sperm to artificially inseminate patients without proper explicit and informed patient consent, otherwise known as illicit insemination or fertility fraud (New HOD Policy); and be it further

RESOLVED, That our AMA support legislative and regulatory efforts to protect patients from physicians and healthcare practitioners who inseminate their own sperm into patients without their consent. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 4/3/23

DRAFT

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RELEVANT AMA POLICY

E-4.2.1 Assisted Reproductive Technology

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

(a) Value the well-being of the patient and potential offspring as paramount.

(b) Ensure that all advertising for services and promotional materials are accurate and not misleading.

(c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.

DRAFT

(d) Provide patients with psychological assessment, support and counseling or a referral to such services.
(e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
(f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
(g) Participate in the development of peer-established guidelines and self-regulation.
Issued: 2016

E-4.2.3 Therapeutic Donor Insemination
Therapeutic donor insemination using sperm from a woman's partner or a third-party donor can enable a woman or couple who might not otherwise be able to do so to fulfill the important life choice of becoming a parent (or parents).
However, the procedure also raises ethical considerations about safety for the woman and potential offspring, donor privacy, and the disposition of frozen semen, as well as the use of screening to select the sex of a resulting embryo.
Physicians who choose to provide artificial insemination should:
(a) Provide therapeutic donor insemination in a nondiscriminatory manner. Physicians should not withhold or refuse services on the basis of nonclinical considerations, such as a patient's marital status.
(b) Obtain informed consent for therapeutic donor insemination, after informing the patient (and partner, if appropriate):
(i) about the risks, benefits, likelihood of success, and costs of the intervention;
(ii) about the need to screen donated semen for infectious disease agents and genetic disorders when an individual proposes to donate sperm specifically for the patient's use in therapeutic donor insemination;
(iii) about the need to address in advance what will be done with frozen sperm (if any) from a known donor in the event the donor dies;
(iv) that state law will govern the status, obligations, and rights of the sperm donor, known or anonymous, in relation to a resulting child.
(c) When sperm is collected specifically for use by an identified patient, obtain informed consent from the prospective donor, after informing the individual:
(i) about the need to test donated semen for infectious disease agents and genetic disorders;
(ii) whether and how the donor will be informed in the event the semen tests positive for infectious disease or genetic disorder;
(iii) that state law will govern the status, obligations, and rights of the donor in relation to a resulting child.
(d) Counsel patients who choose to be inseminated with sperm from an anonymous donor to involve their partner (if any) in the decision.
(e) Provide sex selection of sperm only for purposes of avoiding a sex-linked inheritable disorder. Physicians should not participate in sex selection of sperm for reasons of gender preference.
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DRAFT