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Against Seminal Principles: Ethics, Hubris, and Lessons to Learn from Illicit Inseminations

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So I never conceptualized this kind of deception and betrayal. I expected the doctors to be truthful and honest… If he had told me that he didn't have enough donors and he had said, "Hey, I have more women on the list for insemination, I don't have enough donors," … I would not like hearing that, but I can handle it… Had he told me it was going to be him using his own semen I would have been absolutely creeped out.

—Judith, research interview

Recently, international headlines have announced that several OB-GYNs allegedly inseminated unsuspecting patients with their own sperm in the 1970s through the early 1990s, conduct discovered when commercially available genetic testing revealed their transgressions decades later. These physicians were not the first such offenders. In the mid-1990s, another physician, Cecil Jacobson, was found guilty of federal mail and wire fraud, travel fraud, and perjury as a result of charges for the very same misconduct. Europe, too, has had its malefactors; a Netherlands physician (now deceased) allegedly used his own sperm to father at least 12 children (now 8–36 years old).

Not surprisingly, this conduct has landed these physicians in legal hot water. After genetic testing revealed that Donald Cline of Indianapolis had deceived the Indiana Attorney General about using his own sperm to inseminate two former patients, he pled guilty to two counts of felonious obstruction of justice and was recently given a suspended sentence and fined $500. Unfortunately, an attempt to pass a "fertility fraud" bill in the state of Indiana failed after the bill was not heard in a senate committee meeting. In Canada, a physician faces a civil class action lawsuit from as many as 150 plaintiffs, including his alleged donor offspring, their mothers and fathers, and men whose sperm samples were allegedly lost or contaminated in his lab. A third physician faces a civil suit from one child and her parents; he allegedly conceived the child using his own sperm in donor insemination. Each lawsuit includes diverse claims, including breach of contract and express and implied warranties; negligence (failure to use selected sperm, keep proper records, prevent contamination of sperm samples, etc.); battery; failure to obtain informed consent; fraud; negligent misrepresentation; intentional and negligent infliction of emotional distress; breach of fiduciary duties; and Consumer Protection Act violations.

Although their motivations are unclear, some of these physicians have argued their patients' "desperation" to conceive justified their gross misconduct. Cecil Jacobson's defense attorney claimed that "if he made any mistakes, it was in losing his objectivity and trying so hard to get patients pregnant." Donald Cline stated he "felt that he was helping women because they really wanted a baby" (1). News media has unfortunately circulated and reinforced these "desperate patient" rationales.

There is no law that makes it illegal for a male physician to use his sperm to impregnate his own patients. However, the physician-patient relationship is a fiduciary relationship, one characterized by "confidence" or "trust." The parties in a fiduciary relationship have an expectation of trustworthiness, a power disparity, and interactions that "occur under conditions of privacy" (2). A patient's confidence in her physician, the bond of trust between them, and the therapeutic space in which patients can feel safe are all fundamental building blocks for treatment compliance, communication, and efficacy. Traditional models of care were paternalistic and required patients to depend on physicians' professional authority, even if their own values, preferences, and needs dictated otherwise—a far cry from today's patient-centered care ethos, based on shared decision-making. Ensuing decades have wrought profound changes in the physician-patient relationship. Over the last several decades, respect for patient autonomy has refocused medicine on the need to involve patients in most aspects of their care, and treatment relationships have grown less cold and clinical and more warm and empathic. Nonetheless, defining physical and emotional boundaries is inherent within—and essential to—the success and efficacy of professional relationships.

Perhaps the closest ethical parallel to these illicit inseminations is sexual relations between physician and patient. Here, ethical and professional barriers are breached when "the physician uses or exploits trust, knowledge, emotions, or influence derived from the professional relationship" (3). With the authority that comes from healing knowledge, prescriptive power, and surgical skills, doctors can wield tremendous control over patients—their bodies, psyches, emotions, and even social relationships. Serving others in the healing arts is a tremendous privilege, which also carries grave responsibilities. But the power imbalances between physician and patient imply that the physician cannot legitimately obtain a patient's consent to sexual conduct. Such relationships actually harm patients. Patients who have been sexually involved with their doctors compare the experience to rape or incest, suggesting that such conduct has ubiquitously negative outcomes. Finally, such behavior violates doctors' vocational duties, prompting others—including patients and colleagues—to distrust and lose respect for medicine. Only a handful of states criminalize sex between doctors and patients; to date, prohibitions against such relationships largely come from ethical standards and state medical licensure board guidelines. Thus, the physician who has intimate relations with a patient can be liable for compensation and subject to disciplinary action.

While sexual relations between physicians and patients is an ethical violation, physicians' inseminations of nonconsenting (and unaware) patients represent a gross trespass against all standards of modern practice. In the 1970s and 1980s when these deceitful acts were committed, it was standard practice to use fresh semen—often procured from medical house staff who were conveniently local and who were paid for the specimen(s). Donors and patients were assured that the anonymity of the involved parties would be preserved. But in cases in which a physician produces a sample in one

clinic room, and then immediately goes into another to use that same sample to inseminate the patient, the professional boundaries are blurred between clinical biologic sample procurement and the sexual touchings of masturbation, orgasm, and ejaculation.

Such conduct introduces the gravest of conflicts of interest into the physician-patient relationship. The physician engaging in illicit insemination exploits his patients' ignorance of circumstance, trust, intense desire to conceive, and vulnerability, essentially interposing himself in the relationship in lieu of a sperm donor who is supposed to resemble the intended parents or represent a specific phenotypic likeness chosen by patients themselves. In committing illicit inseminations, physicians also breach 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. In the deepest sense, these physicians have breached a fundamental tenet of the Hippocratic Oath: "first, do no harm." Impregnating a patient without properly obtained consent is *categorically* forbidden, irrespective of perpetrators' self-serving rationalizations.

It is particularly disturbing that unscrupulous physicians and their attorneys use patients' "desperation" as an excuse for performing illicit inseminations. In fact, it is the accused physicians who are desperate and now facing prosecution or civil liability. These are the same defenses used by misogynists to justify sexual harassment ("She needed the attention!"), or when abusers blame victims and present themselves as the injured parties. These assertions hijack vulnerability and commonly reinjure those who are already suffering. We're quick to recognize and reject these excuses for abuse when committed by the likes of Larry Nassar. But for some reason the public is slower to acknowledge the gross trespass when these acts involve reproductive care. This "desperation" label reinforces damaging and inaccurate stereotypes of people struggling with infertility (3). When we assume that patients who desperately want children would "do anything" to conceive, we tend to doubt and devalue their agency and regard them as paralyzed or pathological broken souls who can be healed only by a baby.

This desperation stereotype is based on deeply flawed understandings of how emotions actually affect individuals' family-building experiences. Instead of a smothering, paralyzing gloom, people trying to conceive usually find desperation to be a spark, an impulse motivating them to seek answers and treatment. These emotions actually spur *healthy* coping behaviors. Thus, what we define as desperation could actually be better described as "determination." Desperation is a political label, used to justify restrictions on reproductive decision-making. Victims of these physicians now bear the brunt of these misperceptions. Former patients are confronted with a series of callous remarks from others. "What does it matter? You got what you wanted, a baby, right?" "Hey, it turned out great; your kid had a doctor for a father!" Their adult children—who often compare this experience to learning that one was born from rape—deal with crass statements like, "If it weren't for that doctor, you wouldn't even be here!" These comments are irrelevant—it's impossible to justify the past through the present. But they're also hurtful and imply that what these doctors did wasn't really problematic.

To leave the "desperate" excuses of alleged OB-GYNs unchallenged is to become complicit in these harms. Fertility fraud cases will continue to make the headlines. In these cases, new half-siblings are appearing with increasing frequency. Desperation should *never* be an excuse to deprive others of the respect, autonomy, and opportunity to make such fundamental life decisions. These lawsuits are also sobering reminders of what can happen when physicians focus on their own desires to the detriment of—and with disrespect for—their patients' needs.

What's also astonishing about these stories is the role played by direct-to-consumer genetic testing, which ultimately exposed these alleged illicit inseminations. In the 1970s and 1980s, the idea that patients or their children could one day uncover a donor's identity—and gain access to a new unknown family tree through a fairly inexpensive test—was science fiction. Most individuals using or participating in gamete donor services probably haven't paid that much attention to privacy concerns in their search for new genealogic information or health information. Recent news stories about Cambridge Analytica and the use of DNA-matching services to identify the Golden State Killer, however, might raise concerns for those consumers who prefer anonymity (4). In catching the Golden State Killer, after all, investigators uploaded the killer's crime-scene DNA evidence onto the genealogy website GEDmatch and found a match through a close relative.

Contemporary standards of medical practices surrounding IUI make it very unlikely that physicians will engage in illicit insemination of their patients (although Netherlands media reported that a physician allegedly engaged in such conduct as recently as 2010 or 2011). A sperm donor's identity is increasingly known or discoverable, and infectious disease testing and technological advances have ushered in new practice guidelines and regulations, as well as new market players, including sperm banks who distribute tested frozen sperm through the mail. But genetic testing could still reveal other unethical negligent or intentional conduct, such as the use of nonconsenting patients' gametes or embryos to impregnate others. This misconduct occurred in 1995 at the Center for Reproductive Health at the University of California, Irvine, costing the university tens of millions of dollars in settlements and legal fees (5). For that reason, the sagas surrounding these alleged OB-GYNS—which are far from over—serve as a sobering reminder of where hubris can lead.

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REFERENCES

1. Indiana fertility doctor used own sperm to impregnate patients, court docs say. CBS News. Available at: https://www.cbsnews.com/news/indiana-fertility-doctor-used-own-sperm-to-impregnate-women-court-docs-say/. Accessed June 28, 2018.
2. Searight HR, Campbell DC. Physician-patient sexual contact: ethical and legal issues and clinical guidelines. J Fam Pract 1993;36:647–53.
3. Madeira JL. Taking baby steps: how patients and fertility clinics collaborate in conception. Berkeley: University of California Press; 2018.
4. Kolata G, Murphy H. The Golden State Killer is tracked through a thicket of DNA, and experts shudder. New York Times, April 28, 2018:A1. Available at: https://www.nytimes.com/2018/04/27/health/dna-privacy-golden-state-killer-genealogy.html. Accessed June 28, 2018.
5. Mydans S. Fertility clinic told to close amid complaints. New York Times, May 29,1995:1001007. Available at: https://www.nytimes.com/1995/05/29/us/fertility-clinic-told-to-close-amid-complaints.html. Accessed June 28, 2018.