Assisted reproduction not only offers a variety of services for treating infertility but also includes some services useful for fertile women. One method of conception, physician-assisted insemination, can be helpful to fertile women who wish to use insemination as their preferred method of conception. Single women, lesbians, and lesbian couples are among those who rely on this method. A few years ago, my partner and I began using assisted reproduction to conceive our first child, and it occurred to me as I wondered about lesbians’ access to reproductive services, insurance coverage, and parenting rights for nonbirthing partners that there was little difference between us and the many infertile heterosexual couples for whom reproductive services were designed. While we lacked a medical reason for infertility diagnosis, the similarities in the treatment plan and goal suggested that perhaps lesbian couples might be regarded as having a sort of “relational infertility” that could be said to accompany lesbian relationships. Armed with a medical diagnosis, our reproductive concerns would be seen as legitimate. Our access to services would increase, they would be covered by insurance, and we would be granted the crown jewel of benefits afforded married heterosexual couples using donor insemination—parental rights for the nonbirthing partner. Despite similarities between our situation and that of those who are routinely diagnosed as infertile, infertility specialists do not regard as infertile lesbian couples who use physician-assisted insemination. But why not? Is it due to antilebian discrimination in assisted reproduction? I began reading the medical and philosophical literature with this question in mind: Should lesbians pursuing assisted reproduction count as infertile couples? It is a question of strategy with complex theoretical implications.

It may seem foolish to want a diagnosis of infertility, since medical diagnoses are rarely coveted. The fact is that accompanying an infertility diagnosis are some desirable privileges that lesbians currently lack. If lesbians want these privileges, perhaps we should be demanding the same diagnosis and trying to convince the medical establishment that lesbian couples seeking assisted reproduction are as infertile as male-female couples using assisted reproduction. As a result, we might have a good chance of obtaining the same privileges, and we would advance lesbian reproductive rights and increase the legitimacy of lesbian (and gay) families. Many lesbians using assisted reproduction are from the middle class. Their class privilege could be used to garner equity in reproductive services (e.g., from private physicians and insurance providers), with the hope that any hard-won gains could be extended to all women irrespective of economic class.

In this essay I focus on physician-assisted insemination. In order to evaluate the benefits of applying an infertility diagnosis to lesbian couples with no known fertility impairment who are pursuing physician-assisted insemination, I will describe this reproductive method within a lesbian and feminist context. Next, I identify three benefits of an infertility diagnosis accompanying assisted insemination for heterosexual couples, benefits that lesbians lack and that constitute forms of antilebian discrimination. A review of arguments on physician-assisted insemination in the medical literature reveals common assumptions about lesbians and reproduction that reinforce all three forms of discrimination. Finally, I evaluate parity arguments in favor of applying an infertility diagnosis to lesbian couples. I argue that it is wise to be wary of certain tempting diagnostic strategies when searching for ways to address antilebian discrimination in assisted reproduction.
many as ten thousand children have been born to lesbians this way (Cohn 1992:39). Insemination is popular for many reasons. It can be significantly easier, quicker, and less costly than adopting a child (not to mention that many adoption services discriminate against lesbian and gay clients). The most popular insemination is unassisted or self-insemination, whereby a woman is not aided by a healthcare professional. There are no obvious class barriers to alternative insemination. Sperm can be donated by a friend, acquaintance, or relative of the nonbirthing partner, and vaginal insemination requires no technical expertise or expensive equipment. In the late 1970s the feminist self-help movement promoted self-insemination for women wishing to reproduce on their own, and formal and informal sperm banks were established, some specifically for lesbians (Klein 1984). In engaging in self-insemination, usually at home, women directly seized control over conception, enhancing independence from men and a personal sense of freedom from heterosexual relationships and the medical establishment.

While unassisted reproduction represents an advance in reproductive freedom for lesbians and single women and is open to women from all economic classes, the trend in the 1990s is to seek out fertility experts when self-insemination fails to achieve pregnancy. Increasingly, lesbians who can afford to are pursuing assisted-reproductive options (Hornstein 1984). Fertility clinics offer a range of reproductive techniques to increase the chances of pregnancy. They include vaginal as well as intrauterine insemination, hormone injections, ovarian hyperstimulation, egg harvesting for in vitro fertilization and embryo transfer, gamete intrafallopian tube transfer, and other techniques; eventually, human cloning may be possible. I wish to explore antilebian discrimination in an early intervention, physician-assisted (vaginal or intrauterine) insemination.

**ANTILESBIAN DISCRIMINATION**

Antilebian discrimination in assisted reproduction occurs in at least three ways. The first is access. Fertility services are expensive and commonly not covered by insurance plans, excluding women who are insured or cannot afford these services. In addition, some fertility clinics and physicians refuse to extend services to single women and lesbians (Robinson 1997). Restricted access to infertility services is not unique to the United States. It is common for fertility centers throughout Western countries to restrict physician-assisted inseminations to heterosexual couples, although there are exceptions (Arnup 1994; Daniels and Taylor 1991; Knoppers and LeBrison 1991). Physicians regulate lesbian access not only to infertility techniques but also to sperm banks (both physician-operated and others requiring physician authorization). Insurance plans that cover fertility services only if there is a diagnosis of infertility also regulate and discriminate against lesbians. Even after one gains access to reproductive services, discrimination can still occur from nurse-clinicians, midwives, and other healthcare providers, who may withhold information and support for lesbian patients or in other ways create a hostile atmosphere for lesbians.

The second form of discrimination already alluded to occurs in the use of infertility diagnosis and perceptions about the value and meaning of lesbians' requests for reproductive services. A lesbian couple in a committed relationship who seek out a physician for insemination services is not regarded as "infertile," unlike a married couple experiencing male infertility problems that require insemination by donor. The diagnosis of infertility legitimizes the heterosexual couple as a "reproductive couple." In the minds of many, the diagnosis declares that the couple's desire to reproduce is not frivolous or optional (as might be thought of a single woman who wishes to reproduce on her own) but, rather, is a necessity for the couple that is central to their very being. Rare is the physician who regards a lesbian couple's desire to reproduce as similarly "necessary" to their life together. It is commonly assumed that lesbians will not reproduce and are not reproductive couples. This creates a vicious circle.

The diagnosis of infertility not only alters perceptions about couples' reproductive interests, it also provides heterosexuals with certain important benefits. Among them is the important benefit of paternity. In the case of a married heterosexual couple, if the sperm donor terminates paternity claims in advance, the husband of a woman having insemination is permitted to adopt any offspring that result from donor insemination. Many states have statutes that grant the husband automatic parental rights, provided that the insemination occurred in a doctor's office and that he has acknowledged in writing that he accepts the child as his own. Such statutory rules deem the consenting husband the legal father for all purposes. No adoption procedures, not even stepparent-adoption procedures to examine his suitability to parent, are required (Andrews 1988; Chambers 1996). This is the third form of antilebian discrimination associated with physician-assisted insemination. The nonbirthing partner in a lesbian couple does not have any automatic parental rights and commonly lacks any parental rights whatsoever. Even in places where adoption is permitted, it can be expensive, and social
workers and judges can, and occasionally do, insist on longer procedures or additional steps for gay men and lesbians.  

Antilegal discrimination practices in access, perception, and adoption are intimately linked. A review of the scholarly literature on the topic reveals that the main reason for refusing access to lesbians for assisted-reproductive services is a failure to recognize lesbians as reproductive, hence as capable of having treatable fertility problems. It is assumed that lesbians are incapable of having families. Insurance companies, even in states mandating infertility coverage, do not cover sperm bank charges and can refuse to cover lesbians by claiming that fertility procedures are not “medically necessary” (Millsap 1996). Hence conservative judges refuse to legitimize lesbian families by failing to grant adoption requests of nonbirthing partners. The standard assumption is that only heterosexuals can reproduce, which comes to mean that only heterosexuals should reproduce. If lesbians requested medical assistance in reproductive technology, such requests are deemed special requests. These assumptions and their allegedly “special” status are borne out by the medical literature, albeit scanty and with very little discussion of physician-assisted insemination for lesbians.  

Physician-assisted insemination for lesbians was first discussed and sharply condemned in 1979 in letters to a British medical journal in response to an ethics committee report for the British Medical Association (Thomas 1979). Opponents argued that physicians would be unable to foresee possible trauma to the child from being raised in a nontraditional family (Cosgrove 1979), or from not knowing his or her father (Hatfield 1979), or that the procedure itself was unwarranted lacking a clear medical condition (Wilson 1979) (emphasis added). How we regard the reproductive interests of lesbians is, at the very least, a philosophical matter. Perceptions about lesbians’ reproductive possibilities are often linked with assumptions about lesbian parenting, as well as about lesbians and infertility. Do lesbians “lack a clear medical condition” for infertility? There are striking similarities between lesbians choosing insemination and heterosexuals suffering from some form of male or female infertility that is treatable by donor sperm and insemination. The same treatment yields the same result, a pregnancy. Does that suggest that the “condition” is essentially the same? If so, then lesbians possess “a clear medical condition.”