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1 International social science perspectives on donor insemination: an introduction

Erica Haimes and Ken Daniels

In this book we aim to present the first systematic social science analysis of donor insemination (DI): the process through which a (usually anonymous) fertile man provides semen (most often with the assistance of medical personnel) to a fertile women in order to help her try to conceive a child. The major indication for the use of DI is that the female does not have a fully fertile male partner. We also aim to locate this practice in its global setting. In pursuing these aims we shall be both documenting, and contributing to, the debates on practice and policy around DI that have emerged in the latter half of the twentieth century and that promise to shape the social identity of DI in the first part of the next century.

It is especially appropriate to tackle this task now since donor insemination has been practised for just over 100 years (the first successful case occurred in 1884) and is the oldest technique in 'the new technologies of reproduction'. DI has remained hidden from public view and scrutiny for much of that time, only emerging fully on to the public agenda with the development, in the 1970s and 1980s, of other related technologies of reproduction, such as *in vitro* fertilisation and egg donation. There are numerous strands to the historical development, and current social context of DI, both as a medical technique and as a solution to the problem of infertility: these require identification and disentangling. In this book we make a start on that task by presenting an analysis that focuses on the perspectives on DI from a range of social groups involved: the users of DI; the semen providers; the clinicians; the policy makers; the wider community. The major theme that recurs throughout these different perspectives is the analysis of why DI has been hidden from such scrutiny for so long and what impact that secrecy has had on all parties involved, as well as on DI as a social practice. Clearly these perspectives overlap with and inform each other. In documenting the nature of these overlapping influences we, as social scientists, can begin to gain analytical purchase on the complex web of social relationships that DI both reflects and constitutes as part of a wider social order.

For the sake of clarity we shall briefly outline here what the practice of DI can involve but, in so doing, we note that any such description itself

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constructs the practice of DI in a particular, perspectival way. Thus, we shall merely sketch out the possible outlines that give it some shape: some of the following chapters will colour those in, whilst others will provide alternative sketches which render DI a rather different shape and colouring. It is the claim of this collection that such variations are, paradoxically, the essence of DI and, of course, of social life as a whole.

Donor insemination emerged from the medical problem of infertility. The first account of a successful insemination using donated semen was published in 1909, but described events in 1884, when the sperm from 'the best looking member' of a doctor's class was used to inseminate a merchant's wife, who successfully conceived. Neither she nor her husband knew what had taken place though the doctor did tell the husband when he heard of the pregnancy. At the husband's request the wife was never told. The author of this article reports shaking the hand of the twenty five year old, in 1909; the reader is left to assume that the author was also the sperm provider (Achilles 1992: 15–16).

Donor insemination does not cure male infertility but rather provides a way of circumventing the associated difficulties. Uses of DI have expanded in the late twentieth century to situations where a male partner carries a genetic disorder and thus where the use of donor semen can avoid the onward transmission of that disorder, or where a male partner has had a vasectomy, or where a woman wishes for a child but has no male partner or wishes to avoid intercourse with a man.

Thus, from a clinical point of view, the issues around DI concern questions of diagnosis, treatment, how and when to suggest DI, success rates, how to recruit semen donors and how to mediate the relationship between recipients of DI and the providers of donated semen. The only accurate figures available regarding the use of DI emanate from Britain and France. While other countries, most notably Australia, New Zealand, the United States, collect data on assisted human reproduction (AHR) technologies, DI is not included. In 1994 in the United Kingdom a total of 8,096 women received 21,180 cycles of treatment and this resulted in the birth of 1,805 children (HFEA 1996). Alnot (1993) says that 20,525 cycles of DI were carried out in France in 1991 resulting in the birth of 1,777 children. A United States Report (OTA 1988) estimated that 86,000 cycles of treatment were provided resulting in the birth of 33,000 children.

However, since the purpose of DI is to create a baby, another way of looking at the practice (as evidenced by the 1909 report mentioned above) is to describe it in terms of making and becoming parents, of having children and forming families. Such a reformulation makes it explicit that DI is about social relationships and social processes that incorporate, but also go beyond, the medical perspective. This raises additional questions. Who is making the decisions about the use of DI? Who is actually making these parents? What types of children are being conceived? What types of families are being made? What types of donors are being used? It is not that clinicians are unaware of these other questions, it is just that they are confronted on a day to day basis with other, more immediate questions of practice and practicality. It is the social scientist's task to ask these other questions and to analyse their significance to the wider socio-cultural context. That is what the authors in this collection are doing: asking about, documenting and analysing the social relationships that shape and change both the development and deployment of DI as a social as well as a clinical practice.

In claiming that this book presents a social science perspective we have the following points in mind. First, we follow Giddens in the view that the social science endeavour is multidisciplinary, involving the combination of the 'sociological imagination', with 'historical sensibility' and 'anthropological insight' (1982: 22). We would also add social psychology to that list as a means of addressing the language of individual behaviour and motivation. Secondly, such an approach enables us to address questions concerning DI at the level of the conceptual, the empirical, the cultural, the political and the practical (Stacey 1992). The purpose of such a multi-layered approach is that it enables the contributors to this volume to address issues surrounding, and the reactions to, donor insemination. Thirdly, the social science approach has itself to be reflective: to acknowledge, that is, the provisional basis of its own claims. Far from being a weakness this allows the possibility of dialogue and inter-connections between our social science approach and that of other disciplines (e.g. medicine and science) and between the apparently narrow issues of donor insemination and the wider field of social life.

This also explains why it is so important to take a global perspective on these issues. Since the practice of, and market for, DI is worldwide, it is only by knowing about what is going on in a range of countries that one can begin to participate in a fully informed dialogue. One needs to be able to document the similarities and differences in practice between different countries in order to break free from familiar patterns of thought and to be able to place these comparisons in their cultural, conceptual, empirical, political and practical contexts. Thus, this collection has authors from the United States, the United Kingdom, France and New Zealand, who each draw upon their extensive research knowledge of Canada, Australia, Scandinavia, eastern and southern Europe and Latin America.

Thus the notion of dialogue comes to the fore again. We hope that this book will contribute to and provoke further dialogues around the world on DI from a number of different perspectives, since this collection represents the thinking of leading social scientists who are working in and writing about this area. In chapter 2, Judith Lasker explores the issues that arise for the users of DI, as they go through the process of considering, and then deciding to use, DI. She describes their assessment of the costs, the risks and the alternatives to DI use. She also analyses how they perceive the man who provides the semen and their concerns for the child who is conceived from this donated semen. In her analysis she draws out the similarities and differences between the various user groups, including heterosexual couples, single women and lesbian couples.

In chapter 3, Robert and Elizabeth Snowden build upon their pioneering work in the field of DI in the 1970s to explore the issues that arise for the families that are created through the use of DI. Using data taken primarily from their own interviews with parents, the Snowdens analyse the nature of biological and nurturing family relationships and of how their, and our, understanding and experience of these has been shaped by DI. One theme around which other aspects of these relationships turn is the question of how much information about the child's conception is shared within the family. The Snowdens demonstrate, through rich and detailed data, that, whether they decide to tell their child or not, this is an aspect that no DI parents can ignore.

In chapter 4, Erica Haimes suggests that one of the legacies of not telling children about their DI conception is that we have very little data on how people who have been conceived in this way view that fact. What we have instead is very full data on how others have claimed the authority to speak on their behalf. Haimes explores the historical and social processes through which those claims have been established and the ways in which these claims have led to certain characterisations of the people conceived as having particular needs and interests. The emerging body of data that directly presents the views of the people conceived, although still thin, provides a potential challenge to these characterisations and thus to policy and practice.

In chapter 5 Ken Daniels uses a historical perspective to show how the position of the semen provider has moved from one of obscurity to one of acknowledgment. He argues that the next stage needs to be one of valuing the semen provider for the contribution he makes, especially when that contribution is analysed in terms of gift dynamics and when efforts are made to reduce the marginalisation of providers. Daniels' worldwide review of research also indicates that semen providers have rather more complex motivations and views than they have commonly been attributed with by the clinicians who have usually spoken on their behalf. This research also indicates that semen providers are more open to the possibility of future contact with offspring than had previously been assumed.

The chapter by Simone Novaes highlights how DI came to be constructed as a medical treatment for male infertility, through the focus on DI as merely a technical act under clinical management. Thus the doctor came to fulfil a mediating role between the infertile couple and the semen provider which, in turn, allowed for the establishment and maintenance of secrecy between recipients and providers. The advent of semen banks moved DI from its quasi-clandestine position to one of greater social acceptance. Novaes concludes her chapter by asking questions about the extent to which the specific domain of competence that clinicians inhabit legitimises their role in making wider decisions about reproduction.

Robert Blank shifts the focus to the public policy context and asks what role, if any, governments ought to play in regulating fertility services, and reproduction more generally. He explores the regulatory options that are available to cover the DI field and cautions against 'excessive public control'. He provides a worldwide overview of the current regulation covering DI in different countries, highlighting the diversity of approaches adopted but also highlighting the number of areas in which no regulation exists. He suggests the UK Human Fertilisation and Embryology Authority provides one regulatory model that has 'promise' and argues that an approach is needed that provides a form of public accountability.

In the final substantive chapter, Jeanette Edwards, an anthropologist, examines the question of whether we can usefully talk about 'public opinion' in relation to DI. In exploring the views held by people not directly involved in DI she notes that most made sense of this procedure in terms of its potential for creating and affecting social relationships. The people with whom Edwards discussed these issues drew upon their own experiences of kinship to make sense of DI and were able to turn the issues around and see them from a range of different perspectives: at one point from the child's perspective, at another point from the recipients' perspective. This not only alerts us to the dangers of assuming that any one individual can only speak from one perspective, it also alerts us to the dangers of assuming that there is only one 'public' and only one 'opinion'.

In the concluding chapter we return to the theme of the multiplicity of perspectives in order to reflect on those which have been most influential in directing our thinking about DI and those which have, until recently, been relatively neglected. We consider a range of debates that have yet to be conducted around DI whilst, at the same time, noting just how much the authors in this collection have helped to broaden the existing analysis of donor insemination.

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2 The users of donor insemination

Judith N. Lasker

Introduction

Donor insemination (DI) is the oldest, most widely used, and probably most effective alternative method of conception in use today. Yet its use continues to be fraught with anxieties, controversies, and a deep cloak of secrecy. Those who consider donor insemination often do so at first with great reluctance and with fears about the ramifications and the results. The focus of this chapter is on the concerns and experiences of those who are potential or actual users of DI. Donor insemination has two very distinct types of users, and these two groups have almost entirely different needs and priorities, different experiences and different dilemmas. Although most fertility programmes are geared exclusively or primarily to married couples, and in some countries they are limited by law to married couples, donor insemination is increasingly being used in many parts of the world by single women, both heterosexual and lesbian. Two important changes are pushing this trend: alternative treatments have become increasingly available that allow men with severe fertility impairments to father children, eliminating the need for a donor, and the idea of single motherhood through insemination has become more widely accepted. In addition, the possibility of finding ones own donor and carrying out the insemination at home eliminates for many single women the necessity of having to get past the barriers that exist to their using medical services (Stephenson and Wagner 1991). Thus, there is reason to believe that single women are gaining rapidly in their representation among insemination clients (Leiblum *et al.* 1995).

Many single women, both lesbian and heterosexual, consider it to be an important advantage that they can conceive a wanted child without concern about sexual and emotional involvement with a man and without the stigma which may be associated with becoming pregnant accidentally. Donor insemination allows them to explain to the children, and to others, that this was a planned and desired conception, and it allows them to select desired characteristics of the genetic father and to have some confidence that he has been screened for genetic and other illness.

For heterosexual couples in which the man is infertile, donor insemination offers the possibility of having an apparently ‘normal’ pregnancy and birth with the man present at both the conception and birth. Both partners can share the experience of pregnancy just like any fertile couple, without ever having to reveal the man’s infertility. In contrast to adoption, the child will have a genetic tie to one member of the couple, and there will not be the uncertainty about the physical and social conditions in which the birth mother carried the pregnancy.

Donor insemination is also the simplest and least expensive form of alternative conception. Because of the apparent disadvantages and the growing difficulties and higher costs associated with adoption, insemination has become increasingly popular among many couples in which the man is infertile as well as among lesbians and single heterosexual women. Occasionally, donor insemination is chosen by couples in which the man carries a genetic trait which they do not want to pass along to the child, or where both members carry a recessive gene which may result in a child having a serious illness. It is also used in cases where the male partner had a vasectomy or has undergone chemotherapy. There have been a few cases of widows using the sperm of their deceased husbands; in one case a woman asked for sperm to be withdrawn shortly after her husband’s sudden and violent death (Caplan 1995).

Although technically quite simple and in use for many years (it is therefore inaccurate on at least two counts to call donor insemination a ‘new reproductive technology’), there are serious social and psychological issues which emerge from the use of DI. This chapter will focus on the experiences of men and women who consider and try DI and on the types of issues and dilemmas which they face. In particular, I will consider what is known about: first, the decision to try DI; second, the effects of going through the procedure; and third, the looming issue of secrecy. Many of these issues affect the two client groups quite differently. Therefore, in discussing each of the three subjects, I will first address the common concerns of both groups and then consider the concerns which are particular to each group separately.

Much of the information and all of the quotations used in this chapter come from a study of people who considered or tried various methods of achieving pregnancy (Lasker and Borg 1994). Respondents were recruited by word of mouth, through infertility clinics, and by notices in the newsletters of the RESOLVE infertility support group. Approximately two dozen subjects were interviewed by phone, and the interviews were taped (with permission) and transcribed. An additional ninety-four people completed questionnaires sent out to those who responded to the request in RESOLVE newsletters. Thus, as in most studies, they do not represent all infertile people or all people using artificial means of conception, but rather they reflect many of the concerns and opinions of people who are able to consider using these methods and are willing to talk about their experiences. Findings from this study are combined in this chapter with results from the work of others who have studied programmes of donor insemination and the people who use them.

Considering donor insemination

The possibility of donor insemination begins for the majority of heterosexual couples when they recognize that the man is unable to produce sufficient numbers of healthy sperm to fertilise the woman's eggs *in vivo*. Thus the first and most important issue to be faced is the reality of his infertility. For single women, infertility is rarely the reason for choosing DI. For them, it is a very different recognition, that they are not going to have a male partner with whom to conceive a child. This may be by choice in the case of lesbians, who often have committed women partners, or by 'default' in the case of heterosexual women who have not found a suitable partner or do not want one and do not want to wait any longer to become mothers.

Issues for both groups. Both groups have to consider the costs in time, money, and stress of going through the procedure, the chances of success and the physical risks, as well as their feelings about using a donor. Both may also have concerns about the effects of using DI on their relationships and on any future children, but these will be addressed separately for the two groups.

1. *Cost*. The costs of the procedure are part of the challenge. Although artificial insemination usually costs far less than *in vitro* fertilisation or hiring a surrogate mother, the monthly expenses mount up quickly. Each time a woman is inseminated, there is the charge for the office visit and the fee for the sperm sample. In addition, she may be taking expensive fertility drugs to stimulate her ovulation. The American Office of Technology Assessment's 1987 survey of practitioners of artificial insemination concluded that the average patient cost for four cycles was about $1,000, with physicians who carry out the most inseminations reporting considerably higher charges. Approximately three-fourths of the total costs in the United States are paid by the patients themselves (Office of Technology Assessment 1988). A recent report gave much higher estimates: that an initial work-up costs between $400 and $500, and each cycle can cost anywhere from $500 to $2,500 depending on the technology used ('Sperm Banks and Clinics' 1994).

There is also a non-monetary cost, such as the pressures of checking daily temperatures and being available for insemination at the time of ovulation.

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There is often a great deal of inconvenience, compounded by the anxiety and stress of the procedure. Women who have been through DI often complain about the difficulty of coordinating their ovulation with the physician's schedule. The increased use of frozen sperm has alleviated the logistics problems somewhat, as it is no longer necessary in these cases to coordinate with the donor as well.

2. *Risks*. Donor insemination increasingly involves treatment of the woman with powerful drugs. In the last few years, many fertility centres have introduced the use of superovulation through hormonal treatment of the woman before insemination because of the greater likelihood of pregnancy after hormone injections. Nevertheless, these drugs are inconvenient to administer, expensive, and often have side effects (Stephenson and Wagner 1993).

Another risk of donor insemination is the possibility of transmitting infections or genetic disorders. A study of 316 Danish and Swedish couples who had been through DI revealed that 85 per cent of them had worried about contracting a sexually transmitted disease as a result of donor insemination (Nielsen *et al*. 1995). A recent study identified seven cases of women in five fertility clinics in the United States and Canada who were infected with HIV through DI prior to 1986; while the availability of screening has greatly reduced this risk, it remains a concern for many women (Araneta *et al.* 1995).

3. *Success rates*. Studies of donor insemination report widely varying success rates, dependent in part on the woman's age and the treatment strategy. Generally DI is much more likely than IVF to result in pregnancy, but many couples are surprised that it may take six months or longer of inseminations before this may be accomplished, and some drop out after one or more attempts.

4. *The donor*. Perhaps the greatest concern of those who are deciding whether or not to try DI is over the identity, the health, and the characteristics of the donor. Usually the donor is not known to the couple at all unless they seek him out themselves. In most cases, the physician finds a donor, either through personal contacts or through a sperm bank, and the identity is carefully guarded. Baran and Pannor (1989) found that many couples fantasise about the donor and have considerable anxiety about him.

Many people who use DI express uncertainty about the real identity and characteristics of the donor. One woman commented: ‘They asked what characteristics we wanted from the donor but warned that special requests might mean a delay since there were so few donors. We often joked that it was probably one guy who went behind a screen and put on a different wig each time depending upon the request’.