

**SECRETLY CONNECTED? ANONYMOUS SEMEN DONATION,  
GENETICS AND MEANINGS OF KINSHIP**

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**Doctor of Philosophy**

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**2007**

*Dedicated to the memory of*

*Izzy Speirs*

*a beloved wife, mother and sister,  
a much loved and respected friend, kinswoman and  
colleague,  
and a stotter of a sister-in-law.*

Stotter, stoater: excellent, admirable, exactly what is required (Scots, esp. Glasgow).

## Acknowledgments

I am overawed by the number of people who have supported, exhorted, pushed, pulled and accompanied me on the journey of producing this thesis. Many of them will never have the occasion to read it, such as library staff across the length and breadth of the UK who facilitated internet access whilst I was doing fieldwork, the staff in the ticket centre of Edinburgh's Waverley station who helped to plan my travel, and the staff in the David Hume Tower Senses Cafe, particularly Joan who made it her job to ensure that students eat cheaply but well.

For perseverance and (almost) unremitting cheerfulness the reward goes to my principal supervisor Professor Janet Carsten and second supervisor Professor Lynn Jamieson. Their encouragement to believe that I could write a PhD thesis, their attention to detail, their kind but astute and prompt feedback, and their sharing of practice wisdom and intellectual knowledge, were crucial to the achievement of the project. I take this opportunity to thank also my thesis examiners, Professor Anthony Good (Edinburgh) and Dr Bob Simpson (Durham) for their careful analysis of my thesis and their interesting and thought-provoking comments and questions during my *viva*. Over the years I have benefited from help and encouragement from many other social anthropologists and I thank Soraya Tremayne (Oxford) and Monica Konrad (Cambridge) for their invitations to present my work in progress, and Jeanette Edwards who gifted me a copy of 'Born and Bred'. Conversations with the late Dr Jonathan Telfer in Adelaide about social anthropology, social work, Janet Carsten's research, and adoption, are a very precious memory.

It has been a privilege to be encouraged by members of the Department of Social Anthropology in Edinburgh, and particularly by the late Dr Charles Jedrej, by Professor Jonathan Spencer, course co-ordinator of the Scottish Training in Anthropological Research (STAR) Advanced (post fieldwork) Course in 2007 and, I suspect, of much else besides which was to my benefit, and by Dr Iris Jean-Klein whose observation that Winnie the Pooh was not stupid, he just had a differently constituted knowledge, has been a constant source of reassurance. I thank also the patient university library staff and the admirable administrative staff of the Graduate School office, especially Sue Grant, who all dealt with problems and queries with a cheerful efficiency, and Ian McNeil, School Computing Officer, for whom no query from me about computer problems was ever too stupid.

Funding for most of my fieldwork and writing-up costs came from an Economic and Social Research Council (ESRC) studentship tenable at the ESRC Innogen Centre, for which I am most grateful. Members of Innogen's academic and administrative staff were all unfailingly encouraging about my research and my small contribution to the programme of the centre. The ESRC funds the Post Graduate Forum on Genetics and Society (PFGS), a multidisciplinary network of new researchers working in and around areas of genetics and society, and my participation in several PFGS workshops and conferences in the UK provided ideal opportunities for presentation of work in progress. I heartily thank my fellow PFGS students for their interest, conviviality, and robust discussions on these occasions. Postgraduate students at Edinburgh University who also had study space in the inspirational 18<sup>th</sup> century flats at 10 and 12 Buccleuch Place were a constant source of intellectual and emotional support, especially Weining Cheng and Kelly Davis (Social Anthropology), Ruth Lewis (CRFR), and additionally for I.T. lessons and

chocolate exchange, Lucia (“Comrade”) Siu (Sociology) and Michael (“Mr”) Ofori-Mensah (African Studies).

Support from family and many friends both near and far were crucial by way of providing hospitality during my fieldwork, and by showing that life continued outside of my PhD project. In particular I thank my cousins Alison, Hilary, Rosemary and Angus and their families, friends Arthur, Libby (and Marouf), Elizabeth S, Elizabeth W, Lorna, Barry, Frances, Linn and family, Ruth and John, Ann and Donald and also Dave and Brenda in Siabost bho Dheas, and ‘the ladies who breakfast’ after the 9 a.m. service at St Andrews and St Georges Church. For practical kinship, memorable food and wine, love, laughter and companionship in sorrow, I thank my dear brothers John and Alasdair, my savvy sister-in-law Susan, and my admirable nephews and nieces-in-law Andrew and Rachel, David and Catherine, Sandy and Julie, and Tom and Kirsten. To the elders of the youngest generation, Tasha and Magnus, thank you for making me feel special.

Many people working in the field of infertility, and many others keeping an eye on what they are doing, were generous with the attention which they gave to my research questions, and with advice, ideas, sharing of memories and access to documents. I thank members of the British Fertility Society (BFS) and especially members of its Executive Committee, other members of the medical, scientific and nursing professions in the UK and Scandinavia, Gwen Skinner at the Department of Health in London, and Peter Mills at the Human Fertilisation and Embryology Authority. BFS conferences were sponsored and supported by pharmaceutical and other commercial businesses whose representatives were always happy to discuss my project and to keep me supplied with free ball point pens. Many thanks also to the National Gamete Donation Trust Advisory Council, to colleagues in post-adoption agencies, the British Infertility Counselling Association and the Scottish Infertility Counselling Group, and to staff of Doctors.net.uk. For engaging discussions on professional, personal, ethical and political aspects of donor-assisted conception I am grateful to current and recent members of the British Association of Social Workers’ Project Group on Assisted Reproduction: Amanda, Ann, David, Elizabeth, Jennie, Julia, Marilyn, Olivia, and especially Eric Blyth who demonstrated his faith in me by providing a reference for my PhD application.

I am profoundly grateful for the information, personal stories, comments and exasperations shared by people with a personal involvement in donor-assisted conception as donors, donor-conceived individuals, family members of donors, parents of donor-conceived children and young people, members of DC Network, UK Donorlink and the Donor Conception Support Group of Australia. Finally I acknowledge my great indebtedness to the semen donors who agreed to be interviewed by me and to share their views, feelings, and memories, especially because, having been socially obliterated, they were not supposed to exist as *persons* at all. I hope that they will feel that their trust in me was worth their while.

University of Edinburgh  
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December 2007

## ABSTRACT

The use of donated human semen in the UK was developed by medical practitioners as a means of circumventing male infertility and helping childless women to achieve a pregnancy. Uncertainty about the legal status of donor-conceived children and moral concerns about the possible effects on the marital relationship of the recipients worked to maintain donor insemination (DI) as a largely hidden practice in which the donors remained anonymous to the recipients and unrevealed to any resulting donor offspring. Donors were not expected or encouraged to take any interest in what became of their donations even after the practice became subject to regulation by the Human Fertilisation and Embryology Act 1990.

This thesis is based on a set of unstructured interviews with medical practitioners and other health professionals currently or formerly working in clinics providing DI services in the UK, and with men who donated semen between the 1960s and early 1980s mostly when they were medical students. Participant observation was carried out at conferences and other meetings of organisations and individuals with professional or personal involvement in donor-assisted conception, and a survey was made of infertility clinics' policies concerning the use of semen from donors known personally to recipients.

Discussions with donors revealed ambivalent and mixed feelings about their involvement in providing semen, often for payment, and about their lack of information regarding the outcome of their donations. The idea of possible contact with donor offspring is influenced for these semen donors by their perceptions and experiences of what it means to be a parent and by the significance attributed to physical resemblances between genetically related people. In this situation of ambiguity and uncertain obligation, there is no existing script for managing possible new kinds of kinship relation.

The historical tension in DI services between opportunity and risk because of possible defects or disease in donated semen is now echoed in professional uncertainties about whether to allow semen donation where the donor and recipient are known personally to each other. I show that for some people, including donors, this brings the practice into a kinship frame, whilst for others it confuses family boundaries because of the possible fantasies between donor and recipient, and the involvement of the genetic father with the donor-conceived child's upbringing. Finally I show that disagreements in the UK over whether to remove the legal provisions for anonymity turn on whether it is necessary to protect donors from emotional and financial claims from their donor offspring, and on perceptions about what constitutes a parent.

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## **Chapter One: Introduction**

The use of anonymously-donated semen as a strategy for circumventing human male infertility has been practised in the UK for over sixty years. Donated semen has also been used to help couples to avoid passing on a genetic problem from the otherwise fertile male partner, and more recently it has been used to enable a woman without a male partner to conceive and bear a child. It has been estimated that approximately 12,000 babies were born from donated semen and ova before the practice became regulated by the Human Fertilization and Embryology Act which came into force in 1991 (Department of Health 2003b). There were an estimated 1,800 births after donation of semen up to 1978 and a further 4,369 births up to 1981 (Newton 1985). Despite the extent of the practice, however, little is known about what effect there is in the long term for men who donated semen, and 'in this vacuum, it is simply assumed that the act of donation has little or no significance for them' (Crawshaw 2000:17). Scant information has been available about whether semen donors held, or developed, any sense of connection to their donor offspring, nor whether they were aware of a difference in their perception and perspectives between the time of their donation and the present. A stereotypical donor was a young medical student who donated in return for cash, without any apparent interest in the implications for himself and for any donor-conceived children resulting from his donations (Snowden and Mitchell 1983). The possibility was seldom acknowledged that there might be long term physical problems in donor-conceived children and psychological problems in the parents. No mention was made of possible long term outcomes for donors although after the Human Fertilization and Embryology Act was implemented they were supposed to be encouraged to think of the implications of donating (Royal College of Obstetricians and Gynaecologists 1992:39).

With a few exceptions, the social aspects of semen donation have not been specifically researched within social anthropology and other social sciences. The contrast with ova donation is striking and remarkable. The association of semen donation with human male infertility may be a significant reason, given the more serious stigma attached to male infertility in comparison to female infertility (Lasker 1998:25), and the 'elision between potency and genetic reproduction for men' (Thompson 2005:121). Another reason may be the requirement for the use of

complex drug regimes and technological systems in the process of ova donation, and these 'new reproductive technologies' elicited interest and concern in social anthropology about the possible risks to and exploitation of, the women who donated ova. As Lasker points out, however, the use of anonymously donated semen long predates the use of technology (Lasker 1998), yet the possibility that the young men who donated semen might be in a similar situation of risk and exploitation as ova donors was overlooked in the presumption that donating semen involved no inconvenience and no physical or emotional difficulties for the donors. Good (1996:312) suggests that social anthropology has been concerned in the past with emic views about physical relationships and not with genetic relationships in themselves, but this has changed with the development of academic debate about genetic knowledge as kinship knowledge (Finkler 2001; Strathern 1999). Yet semen donation both as a bodily practice and as a means to help to achieve a pregnancy raises issues which are highly relevant to social anthropology, including public policy making, gendered attitudes about procreation, concerns about commodification of gifts, and indigenous UK notions about social and genetic parenthood.

### **Origins of research project**

The idea of investigating the field of anonymous semen donation developed out of my previous professional experience in social work, and a coincidence of several events involving the topic. Although the Human Fertilization and Embryology Act 1990 provided for the identity of semen and ova donors to remain anonymous to the recipients and donor offspring, there was an increasing amount of questioning throughout the 1990s about whether the law should be amended. Particularly from the late 1990s, there was discussion about the sharing and exchange of personal and identifying information between donors, donor offspring and their parents, and also about whether there should or could be contact between the parties. Discussions included contested views about similarities to adoption, about the right to have access to information about one's genetic origins, and about the commodification of semen and ova donation (Haines 1992; Blyth et al 2001). As a founding member of a special interest project group of the British Association of Social Workers known as PROGAR (Project Group on Assisted Reproduction), I was involved in many of

these discussions as well as in media briefings. PROGAR was set up originally at the time of the Warnock Inquiry in the 1980s, taking forward work carried out by a predecessor group which had submitted evidence to that Inquiry on behalf of the Association. I also was privileged to be able to network with donor conceived adults and with the parents of donor conceived children and young people living in the UK, America, Australia, Canada and New Zealand.

In 2001 the UK government consulted publicly as to what information about people who had donated semen, ova or embryos should be given to people born as a result of their donations (Department of Health 2001). At the time, the Human Fertilization and Embryology Act did not permit identifying information about donors to be provided to donor offspring unless the donor was being sued for liability for genetically inherited medical problems. A consultation on the matter had been promised in 1995 during the parliamentary debate in the House of Lords on the Children (Scotland) Bill (Hansard 1995) but was postponed due to a change of government shortly afterwards and the perceived controversial nature of the consultation. In 1998 the Human Fertilisation and Embryology Authority (HFEA) carried out a public consultation on how to implement a new policy concerning payment to gamete donors. Some of the responses, which I studied as part of research for an MSc dissertation (Speirs 1999), touched on issues to do with the broader matter of anonymous donation as a practice. For example, the response on behalf of the Medical Research Council Reproductive Biology Unit expressed opposition to unpaid donation by friends or relatives of patients, which would not be anonymous, suggesting that that kind of arrangement might be coercive.

Increasingly, the topic of the anonymity of gamete donors became central to a number of conferences organised by pro-life groups and by professional social work, medical and legal groups in the UK. The British Infertility Counselling Association produced a report, to which I contributed, on the likely future counselling needs of donor conceived people and their family members. The report was produced (British Infertility Counselling Association 2003) with the participation of, and consultation with, people with a personal and/or professional involvement in donor-assisted conception, adoption, reconstituted families and genetic counselling.

On a personal level, I had become interested in the phenomenon of the suppression of information about genetic parents to donor conceived people through my previous professional location in social work with its interest in human rights, identity formation and family functioning. I became one of a growing number of social workers both surprised and concerned to learn about the deceit and secrecy which appeared to be embedded in the practice of anonymous semen donation. The concern did not derive from personal and professional views that genetic parenthood was superior to social parenthood. Social workers are used to promoting the values of and acknowledging the problems in both, and to recognising that the one word 'parent' is inadequate for encompassing the various roles encompassed by the term 'parent' in our society (see Goody 1982). My own experience as a social worker involved daily negotiations about the rights, responsibilities and affective ties of parenthood as claimed and disclaimed by biological family members, the state, and non-family carers such as friends and neighbours. What required explanation, and what encouraged me towards doctoral research, was the need to understand how semen donors themselves were experiencing the culture of secrecy surrounding donation, and the fact that they were consigned to obscurity by others after donating. Despite the long period of time in which anonymous semen donation has been practised in the UK, when I embarked upon my project the only completed research with semen donors in the UK had been initiated by a social work academic from New Zealand (Daniels et al 1997).

I became interested also in the way in which the voices of donors were seldom heard. Their views were represented by others, as if the views were being reported. One example from the time when there was increasing speculation in the media about the possibility of a change to the donor anonymity provision in the Human Fertilisation and Embryology Act, came from the then President of the National Union of Students Scotland. He was quoted as saying about anonymous semen donation:

A lot of students do this because they are so desperate for cash. They have the choice of doing something like this or dropping out because of debt. Students will do anything for money. But they certainly don't expect to be traced later by a child with whom they had no intention of having any contact at all  
(Daily Record 1999)

This claim on behalf of donors struck me as being too clear cut, and I wondered whether ambivalences, hopes and anxieties of donors were being suppressed or simply ignored. The statement suggested that donors were in a vulnerable position (Daniels 1999) but took no account of the possibility that donors' views might change over their lifetime, especially if their youthful donations had been made out of financial need. I considered that this might be particularly true of men who donated when they were medical students and who now might be dealing with genetic factors in their work with patients.

### **Methodology**

Starting out on my ethnographic path (Sanjek 1990:398), I had the doubtful advantage of realising that it would probably be difficult to find semen donors, and so it proved, and more than once I ruefully recalled the enthusiastic suggestion from several members of the Donor Conception Network of Australia that I should carry out my research in their country. My reasons for deciding to focus on the UK were not only because of the potential academic support in my subject area, but also because of the paucity of social science research on social aspects of semen donation in the UK at that time. It seemed to be a cultural phenomenon over-long neglected, and I was simultaneously vexed and curious about the ethnographic silence.

The probable difficulty of locating research informants was succinctly put by a retired female doctor of my acquaintance who expressed encouragement for my project but then added that my potential interviewees 'are not likely to have a sign up outside their gate, are they?' Her observation implies that semen donors' identities as donors remained as hidden as they had been when the donors were originally recruited to make donations. It might be suggested that the most effective way to contact donors would be through the managers of extant infertility clinics. However, that would have require me to seek approval from National Health Service research ethics committees for the research, without actually knowing whether or not the necessary records about the donors still existed. I knew already, from contact with donor conceived adults and with parents of donor conceived children who were seeking information about donors, that many donors' records in National Health Service hospitals had been destroyed deliberately after the births of the donor conceived babies to which the records related. Records from some private clinics had

been destroyed, or were in the personal possession of retired clinic doctors. Consequently, I decided to recruit using strategies of convenience, opportunistic methods and 'snowballing' (Atkinson and Flint 2001).

In addition to interviews with individual semen donors and where possible their family members, I also planned to carry out a social network analysis (Phillipson et al 2001) with contemporary medical students at Edinburgh University, with the intention of obtaining interesting comparative material. This plan was put aside when the opportunity arose to conduct a telephone survey of policies in UK infertility clinics about own known donors. The purpose of this survey, whose results are described in Chapter Seven, fitted better with the original aims of my research project and with the data which was beginning to emerge from my fieldwork. The survey was carried out for the National Gamete Donation Trust (NGDT) into the current provision of treatment to patients using semen donors known personally to the patients. The NGDT and its advisory council decided that such a survey might shed light on perceived variations in the provision of such a service at a time when clinics were reporting contradictory effects on levels of gamete donor recruitment following the UK Department of Health consultation on donor anonymity. At the time I was a member of the NGDT advisory council, representing the British Association of Social Workers. Twenty nine clinics were contacted by telephone and a short questionnaire completed with a member of staff identified in the past to the NGDT as a contact person for that clinic. Respondents were advised that the researcher was a doctoral student carrying out the survey as part of her own research as well as on behalf of the NGDT. Respondents were assured that their responses and their identities would be non-attributed and would remain confidential to the researcher. Responses were obtained from clinics located in all four UK nations and included both National Health Service and private clinics. Due to resource and time constraints, the survey focussed only on semen donation and therefore a comparison with egg donation was not possible. One clinic declined to participate, on the grounds that it was not currently providing any DI treatment due to shortage of staff.

### **From site to site**

I chose multi-sited ethnography (Marcus 1995) for my research, a qualitative method exemplified in work by Franklin (1997) and Rapp (1999). The method is associated

by Marcus especially with enquiry into the type of complexity inherent in the new cultural products of globalising societies, such as reproductive technology, and it involves a variety of methods employed in a variety of sites, tracing or following a cultural phenomenon in different settings. The sites and how they are connected are chosen by the researcher. Multi-sited ethnography represents the ‘endeavor to break the connection of space, place and culture’ (Rapp 1999: 12).

Early on in my research it became apparent that my search for donors was itself an ethnographic site. I spent much time telephoning, talking with, emailing and writing to doctors who were working in infertility clinics, assuming that they might have friends or colleagues who had donated semen in the past. In the course of these contacts, I gleaned information about their views and beliefs regarding the social aspects of semen donation. In some of the senior doctors aged in their 50s and 60s I sensed for a while an ambivalence about my project: on the one hand there was approval that I was trying to carry out research into an area where doctors had been complaining about the dearth of research, but on the other hand there was a wariness, as though my attempt to find and to meet with donors of the past might resemble the unwelcome contact attempts that some doctors said would be made by donor offspring. There was also the problem that my asking for advice about how to find donors was occasionally mistaken for advice as to how to carry out the research. One senior doctor listened with a guarded expression as I outlined my project and then said firmly, ‘You need to speak to Sarah Franklin’.<sup>1</sup>

Some of the ethnographic sites were infertility clinics where I participated in inspections carried out by the HFEA. I had been appointed in 1992 as one of a number of lay inspectors for the HFEA with a particular remit for ‘social and ethical’ matters, and I continued to take part in up to four inspections annually during my research, always however declaring at the outset that I was a social anthropology doctoral student carrying out research on the social aspects of donor insemination. Inspections took place in the clinics themselves: a room would be made available to the inspection team to meet together and also to meet with clinic staff and to examine a sample of patients’ records in order to check compliance with the Human Fertilisation and Embryology Act 1990. Inspectors also examined the clinic’s

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<sup>1</sup> Sarah Franklin’s ethnographic research on Pre-implantation Genetic Diagnosis was known to some infertility specialists whom I met during my fieldwork.

premises and facilities including laboratories, operating rooms and the storage containers for cryopreserved gametes, and they carried out separate interviews with receptionists, counsellors, embryologists, nurses, scientists and medical staff.

There were also research sites which called to mind the ‘instant place’ of the fire fighters’ camp described by Altork (1995:108). Such camps are erected in a day to become a self-sustaining base for fire fighters and support workers. After a fire has been extinguished or brought under control, the camp is dismantled and no trace of it remains. In my project the instant places were the places of participant observation, places where I endeavoured to be both detached and involved (Atkinson 2001) as a member of several groups with an interest in social aspects of donor insemination. These included the advisory council of the National Gamete Donation Trust whose purpose is to raise awareness about gamete donation, the British Infertility Counselling Association (BICA), and PROGAR. I had involvement with these groups prior to the start of my fieldwork and my continued involvement provided me with encouragement, useful advice and information about the field of infertility treatment, as well as a window to the dynamics of discussions about the law and practice concerning anonymous gamete donation in the UK and other European countries. None of these groups were associated with a special place. In contrast to the grand buildings of the medical profession’s elite Royal Colleges, these three groups had no permanent accommodation, and their meetings usually took place in London at the Department of Health, in rented rooms in community centres, or in cramped infertility clinic offices. A further contrast was the instant place of conferences organised by the British Fertility Society (BFS), the HFEA, the Royal College of Obstetrician and Gynaecologists (RCOG), and the Progress Educational Trust whose aims are to promote scientific research in reproductive medicine. The Nordic Fertility Society’s annual conference which I attended as the representative of the BFS was held in a ski resort. These conferences were time-limited places of semi-public performance and of discussions shared, observed, and sometimes overheard.

### **The failure and success of snowballing**

This particular method of recruiting informants worked successfully in enabling me to meet doctors and others involved in the development and contemporary provision

of donor insemination services in infertility clinics. It worked only once in finding semen donors to interview. The snowball sampling method can be used when the desired sample characteristic, such as that of having donated semen anonymously, is rare and where it may be difficult and/or expensive to find people with the sought-for characteristic. The method involves referrals from initial informants to produce further informants. It is therefore also known as 'chain referral sampling' (Atkinson and Flint 2001). As applied to research, snowballing means one informant introducing the researcher to one or more of his or her contacts, who in turn introduce further potential informants. The sample of the researcher thereby grows larger with each introduction. However, in my fieldwork it was not the sample of self-defined donor informants which increased through the snowball method, but the number of non-donor doctors and scientists who agreed to meet with me. They provided significant personal views and historical information about the development of anonymous semen donation services in the UK.

As part of the search for donors of the past who might agree to help with my research, I wrote to several nursing journals and to the *Hospital Doctor* newspaper, asking if anyone could help me to find donors. I received no response to any of these letters but at a BFS conference, several young infertility doctors recalled that they had seen my letter in *Hospital Doctor* and had found it interesting. They advised me to ask for an advertisement to be placed on the website of Doctors.net, and gave me the name of the manager, to whom I wrote. A meeting was arranged with one of his staff so that the manager could be reassured about the integrity of my project and it was agreed that I would compose an open letter which would be targeted at doctors who had been medical students at certain universities at which, I had been told, semen donors had been recruited from the medical student population. The website is sophisticated such that when those doctors logged on to the website, the letter would appear on their screens, and only theirs. Unfortunately the whole process from the suggestion from the young doctors to actual display on the website took almost a year, and the letter was displayed for only three weeks due to other priorities of doctors.net., but within two weeks, four doctors telephoned or emailed me to express interest in being interviewed. According to doctors.net, 700 doctors logged on and saw my letter but it is impossible to know whether any of them were also donors.

My fieldwork involved considerable travel in order to meet with non-donor informants and, eventually, with 14 donors. Another donor who was very keen to be interviewed could not make a definite appointment to meet me in the foreseeable future and so I spoke with him at length by telephone. Three of the 15 donors lived in country areas in England and Scotland, and the others lived in ten different cities in England and Scotland of which I visited nine. Three donors chose, for reasons of convenience, they said, to be interviewed away from their homes. Meetings took place in donors' offices or homes, in relatives' homes, in café corners and clubs, and discussions continued on walks and in donors' cars as I was chivalrously collected from and returned to the nearest railway station.

The table below shows how I met the 15 donors

Number	Means of Introduction	Number who were former medical students
4	Doctors.net website advertisement	4
2	Friends of infertility clinic doctors	2
2	Friends of another donor	-
4	Identified themselves personally to researcher	2
1	Friend of a doctor friend of researcher	1
1	Contacted by researcher after the donor revealed information on public radio	1
1	Infertility specialist was dealing with enquiry from donor about donating again	1
Total 15		Total 11

Introductions to other donors were abandoned before personal contact was made: one donor did not reply to my letter, one was repeatedly unavailable even by telephone due to work commitments, and one donor became ill before the go-between contacted him. Go-betweens for two other donors never contacted them, although they frequently apologised to me for not doing so.

### **Gatekeepers, go-betweens and the matter of complicity**

As can be observed from the table above, I could not have met the majority of the donors without the help of go-betweens, all of them doctors who knew me personally or professionally and who agreed to contact someone whom they knew to have donated as a medical student. The term 'go-between' fits better than gatekeeper because it implies support for the researcher. It is also more accurate than 'broker', which Murphy describes as a person not simply linking two domains but as 'presenting an image of transactions with one side that cannot be easily identified by the other' (Murphy 1981:680). This brokerage role is evident in the work of clinicians in the DI services of the past and in how they recommended themselves in debates about access to medical information on donors by donor offspring. Some people, both doctors and non-doctors, ended up as gatekeepers for my research not by blocking off access, but by not contacting donors known to them, for various reasons. Some were too busy; others were clearly not comfortable about contacting a colleague about the matter.

The go-betweens tended to prepare for the contact by asking perceptive questions about my research and then gauging how to approach the donor in order to reduce the chance of the donor being offended or refusing to help. It was clear that they trusted me and believed that my project was important. This helped to encourage the go-betweens in what was a potentially risky undertaking for them. Only one donor, now in the legal profession, refused to be interviewed and he clearly made the go-between feel very uncomfortable indeed. As noted by Saunders (1979) in his analysis of the sociology of urban politics, research with powerful groups must 'overcome hurdles not often faced in studies of lower status and less privileged groups in society' (1979:325). Access to 'society's underdogs' generally proves relatively simple, he asserts, partly because the researcher is intruding upon people who are less prestigious and powerful than himself (p.326). The implication is that such people would find it difficult to block access to the researcher. By contrast, Saunders suggests that with dominant groups, 'their privacy cannot easily be violated, their secrecy cannot simply be penetrated, and their support is unlikely to be forthcoming' (p.326).

I had anticipated dealing with issues of secrecy and confidentiality in my fieldwork, such as have been well described by Rayna Rapp in her research work with genetic counsellors and patients considering amniocentesis (Rapp 1999:17). What I had not anticipated was the impact which the secrecy inherent in the field would have upon me. The following description of a small ethnographic incident serves as one example of many which occurred during my fieldwork: I am standing in a small, private, exclusive art gallery in London, deep in conversation with a doctor. The event is a drinks reception on the evening before a conference and the wine is being poured liberally. Occasionally I remind myself that whilst this may be a fun way of doing participant observation, it will not do to get drunk on the job. A fieldworker always has to be on the lookout, 'to be constantly on the *qui vive*, to ask yourself not only what people are doing but how they came to be doing it' (Toren 1996:103). The doctor and I are talking about infertility treatment policies. He has recently agreed to be interviewed for my research project having confided to me that he had donated semen when he was a young medical student. A woman known to us both comes to greet us. I do not know what she knows about the doctor who turns to her with a beaming smile and announces to her with evident pride, 'Jennifer is going to interview me!' I am aware of a fixed smile on my face as I feign nonchalance at this piece of information. Inwardly I panic that the situation is potentially out of control and that I am unable to protect the doctor from a challenge as to whether or not he is to be interviewed because he donated semen as a student. His hidden identity as a donor which I had previously guaranteed to him is about to be made overt. However the woman just smiles graciously, makes no comment and the conversation turns to another matter.

It is possible to suggest, without being cynical, that in the art gallery the doctor revealed his status of former semen donor accidentally, in the context of 'in vino veritas'<sup>1</sup>. This did not seem very likely, however, because doctors are used to playing roles and masking their feelings, and as a non-donor doctor had put it to me previously in a discussion, 'There is an actor in most doctors'. Indeed one of the doctor donors had pointed out to me that operating theatres are not called theatres for nothing. Most likely the donor status of the doctor in the art gallery was known to

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<sup>1</sup> A saying from the Latin meaning that it may be hard to be discreet under the influence of alcohol.

quite a number of people present (although not to people conceived as the result of his donations). What I had been treating as an ‘inside secret’ which had been entrusted to me was really a ‘free secret’ (Goffman 1971:143). Such a secret was one which any member of the doctor’s social network could reveal without imperilling trust. As a piece of social interaction the situation was dramatic in the sense that Goffman would recognise.

In line with normal research practice, I promised all informants that they would not be identified. Given the topic of my research, it was important to allay possible anxieties about the protection of the privacy of the donors and their families. Yet the work of protecting privacy places stresses on the researcher. Care has to be taken not to carry messages from one informant to another nor to reveal that an informant’s story has already been conveyed, or at least a version of it, by another colleague or friend. One remembers to be constantly impressed as though hearing a story for the first time. On occasions, others not involved with the research have to be trusted to collude with protecting confidentiality. I felt that I became complicit in the business of the longstanding secrecy paradigm of the donor insemination service in the UK. Marcus would perhaps describe this as a result of the ‘here and there’ – ness of contemporary multi-sited ethnography which he viewed as having ‘begun to wreak havoc on the “being there” of classic ethnographic authority’ (1998: 117). Carrying out anthropology at home adds to the possibility of ‘havoc’ precisely because what the ethnographer wants from research informants

is not so much local knowledge as an articulation of the forms of anxiety that are generated by the awareness of being affected by what is elsewhere without knowing what the particular connections to that elsewhere might be.  
(Marcus 1998:119)

Sensitive topics can be a threat to research interviewees due to the psychic costs of guilt, shame or embarrassment associated with the topic and they can also be threatening for the interviewer as well, due to the risk to personal security and of being stigmatised (Lee and Renzetti 1993:4). However, I suggest that it was being drawn in to a world of keeping secrets which were not secrets, of being complicit in actions to protect other action of moral ambiguity, which I found threatening to my personal values and challenging to my identity as a researcher seeking after knowledge. The fact that my research informants sometimes reacted differently is

obviously an ethnographic fact which requires and will receive description and analysis.

In contrast to the secrecy which I had to uphold in public, most of the meetings with donors took place ‘backstage’, and I was awed by the trust which they showed by confiding in me. Most meetings lasted up to two hours. I always advised the donors that that would be the limit because they would be likely to lose concentration after that time. Prior to the meetings I described my research questions in a telephone call, and then emailed them when possible. I invited donors to check my webpage on the ESRC Innogen website, so that at least they might know what I looked like, but apparently none of them did so. All of the donors gave permission, when asked, for me to record all or part of our discussion, but the recording equipment failed to work on several occasions, and I resorted to taking notes which I then clarified for myself as soon as possible thereafter. I transcribed only the discussions which I had taped, since I discovered that typing up my handwritten notes immediately began to transform them. Meetings with some donors were followed up by later telephone calls, emails, or impromptu meetings at conferences.

### **Terminology**

The use of donated semen to achieve a pregnancy is now called, in the UK, ‘Donor Insemination’, abbreviated to DI. In America the practice is still sometimes referred to as Artificial Insemination by Donor, abbreviated to AID. This terminology was dropped in many countries from the 1980s onwards in order to avoid confusion with AIDS, the acronym for Acquired Immunity Deficiency Syndrome. Donor Insemination involves the use of semen from a man who is known to the recipient woman, or from a man who is not known to her but is known to the infertility clinic and whose donation thereby is *anonymised*, or from a man unknown to the recipient woman and whose donation is *anonymous* because there is no record kept of whose sperm was used to inseminate her.

People with a personal involvement in donor-assisted conception have had a number of name descriptions assigned to them. I use the term ‘semen donor’ for a man who has provided one or more samples of his semen, whether for financial reward or otherwise, with the understanding that it will be used for research or to inseminate a woman to make her pregnant. Some researchers have used the term

‘semen provider’ (Daniels 1998) or ‘sperm donor’ (Almeling 2007). ‘Sperm donor’ tends to be the term used by infertility clinic staff in the UK and by the media. I use the term ‘parents’ to indicate the nurturing or social mothers and fathers who are also the legal mothers and fathers of people conceived as the result of donor insemination.

Haimes describes a ‘proliferation of labels’ for people conceived as the result of the use of donated sperm, each one signifying different perspectives. She opts for ‘people conceived by DI’ because it emphasizes the practice of donor insemination rather than the parties involved in the practice (Haimes 1998:54). In the UK the print media has tended to use ‘children’, as in the headline ‘Donor Children Demand to Know Genetic Parents’ (The Times: 2002). In the UK, and frequently in America, the term ‘donor offspring’ is acceptable; in Australia it is not and the term ‘donor conceived people’ is preferred. A recent article by an infertility counsellor in England refers to ‘the New Age Adoptees’ for children created from donor(s) (known or unknown) and from surrogacy (Rennert 2002). Bill Cordray, an American who was conceived with donor sperm, uses the term ‘DI adoptee’ (Cordray 2000:11). Donor offspring is the term used in the government consultation on providing information about gamete donors (Department of Health 2001), and technically it encompasses both children and adults. I use the term ‘donor offspring’ when I am implying a perceived or possible connection between a donor and the people conceived as a result of his donation of semen. I use the term ‘donor conceived people’, or ‘donor conceived adult’ when referring to such people in general.

### **Concepts of kinship and the person**

Franklin and Ragoné suggest that ‘an important genealogy of modern anthropology can readily be traced through its relationship to a core set of ideas related to reproduction’ (1998:2). As a significant area of anthropological enquiry, the concept of kinship has come to encompass not only the analysis of ideas about how people are reproduced but also about how they perceive and demonstrate their connections to each other and how these ideas reflect how people view their world. Central to the anthropological analysis of kinship has been a focus on ‘the social organisation and regulation of so-called biological facts such as procreation and genetic relatedness of “consanguinity”’ (Franklin 1997:21). Franklin describes the process of a lengthy

controversy, which came to be known as the Virgin Birth debate, about the constitution of these facts as representing knowledge of how conception occurs. She suggests that the debate shows the attachment of anthropologists to biological models of reproduction (1997: 1).

Early anthropologists (e.g. Westermarck 1891; Rivers 1910) were interested in emic descriptions of genealogical relatedness and the connections derived from marriage patterns. The image of kinship which was conveyed was of a static, closed social system. Most research was conducted in non-EuroAmerican societies, but in 1968 a description and analysis of American kinship was published by David Schneider (Schneider 1980). He described the kinship system of Americans as being a symbolic one in which cultural objects 'stand for' something else. It is a system of symbols within which a person is a cultural unit. By this he means something which can be culturally defined and distinguished as an entity. Kinship can be described but the words used to describe it are not necessarily the same as the meaning of the unit. Some cultural units do not have names: this is not to imply that people do not have names but rather that in some of the roles they occupy, people cannot be easily categorised. They can be identified and described but do not necessarily have a name. Schneider states that this is one characteristic of American kinship. Further, the system is not rigid, timeless, given. The rules about cultural units 'are not, contrary to mythology, handed down from the sky to remain in the same state until they are taken back by the gods who invented them. They arise, they grow, they change' (1980:7). The system is also a highly personalised one, with the decision as to who is and who is not a relative being made 'by and about a *person*' (1980:57; italics in the original). The person is a cultural unit with agency and a primary identity which defines 'what kind of person he is; that is, it defines the relevant cultural domain in terms of which he acts' (1980:57).

Paradoxically, Schneider describes kinship in such a way that it could be considered as just such a timeless, remote structure against which he seemed to be arguing. It is 'a self-contained system of symbols and concepts defined and differentiated without reference to person, place, or time' (1980:59). This system is distinct from the persons who are subsumed into the category of being kin. 'The relative as a person is quite different from the distinctive features which define the

person as a relative' (ibid). Whilst Schneider asserts that Americans define a relative as a person who is related by blood or by marriage (substance, or code for conduct), it is clear that in most cases persons can and do decide for themselves whether to count people in or out as relatives. Some of his informants excluded some relatives from being relatives because they never or seldom saw them, highlighting the significance of physical and socio-economic, as well as genealogical, distance. The point that shared substance is not all that there is to kinship is made also by Jeanette Edwards and Marilyn Strathern who note, from Edwards' research in the town of Bacup in England, that connections, or links, between people can be broken by lack of attention as well as becoming attenuated through genealogical distance or from a perception that the links were not secure in the first place (Edwards and Strathern 2000).

Marilyn Strathern's ethnography of the village of Elmdon in Essex, also provides insight into aspects of English kinship and the significance of locality as well as of connections derived from family of origin and created through marriage ties. She describes 'kinship in practice' in the context of help and dependency, and how care-giving 'expresses some of the obligations relatives feel towards one another' (1981:134). Strathern identifies three types of 'non-kin' help: caring and befriending characterised by non-reciprocity, such as the help given by a young couple to an old person without relatives; metaphorical siblingship created through the transformation of friendship between neighbours; and residential proximity, in which neighbours help each other out but do not become friends. In all of these situations, people do what is expected of blood relatives and they are clear that that is what they are doing. Strathern contrasts this with the kinds of contact which Elmdon people have outside of the village. Where these contacts are with kinspeople in neighbouring villages, they are more like personal networks, whereas contacts amongst Elmdoners themselves take on a concretising role, 'contributing to some kind of structure', the solidarity of the village (1981:157). The matter of outside contact is complicated by the degree of access to transport, with relatives distanced geographically also being distanced socially. As with Schneider's material, kinship in Elmdon is not totally discrete from other areas of social life such as economics.

Nevertheless, personal affection enters into the matter too, 'both within and beyond the village certain kin are ignored, others claimed' (p.158).

Various ways are found by Elmdoners to reduce the potentially infinite number of kin links to a manageable number: firstly by excluding close relatives of a spouse if the spouse was in-coming to the village, and also relatives created through second marriages; secondly by creating a smaller category of 'family' from the larger one of 'relatives'. The category of family would exclude cousins but might include parents' siblings and grandparents' siblings, one purpose being to avoid costly social celebrations or care obligations. Thirdly, there was variation in the extent to which people connected through marriage in senior generations considered each other to be relatives. However, whichever strategy is employed, personal characteristics are assumed to be significant. This strategy of exclusion I can contrast with my own brief experience of fieldwork in 1998 in the Isle of Lewis where connections made through marriage were known and called up, often as a way of placing people and sometimes, it seemed obvious, as a device for social control (Speirs 1999).

Strathern suggests that classification of kinsfolk can be done by contrasting 'open' with 'closed' elements, and with 'friendship and non-kin contacts' and 'all one's relatives through birth or marriage' (1981:166). In her fieldwork in Bacup, Jeanette Edwards found that people were experts in the kind of classifying identified by Strathern, and noted that 'the English are adept at conceptualising boundaries, and where they locate them, and what and whom they enclose within them' (2000:3). Her informants identified various 'strands of connectedness' which they traced through things which make up kinship, such as blood, genes, care, and love (2000:248). Edwards notes how kinship had been relegated to the domestic sphere, without significance in the wider world. It no longer appeared to have relevance in England particularly for the white English middle classes, but that is only if kinship is defined as an area of social life which is separated off from all others. Edwards asserts that notions of shared substance 'be it blood, genes, flesh or bone' are one way of tracing connections; at the same time, kinship emphasises social relationships created and maintained 'through intimacies of care and effort' (p.27). Her interest is in a society which distinguishes the social from the biological but which uses both in its defining of relatedness. That kind of kinship requires not only the social and the biological but

also the interplay between those two understandings. Kinship defined as shared (natural) substance and the affective ties derived from the fact of the substance must include also 'connection'. However, this connection may not necessarily include blood ties. Kinship is mobilised 'in all kinds of contexts which do not 'look like' kinship' (p.34). Kinship-thinking is used to analyse and discover notions of persons, belonging, translocation, and relatedness to other people, to places and to the past.

In contrast to the kinship created through consanguinity and marriage, it has been suggested, is that created through friendship, which is held to operate regardless of status or kin relationships: 'Friendship, as a continuous creation of personal will and choice, is ungoverned by the structural definitions that bear on family and kinship' (Silver 1996: 46). Lynn Jamieson (1998) notes that research shows this to be a widely held view of friendship, but that the ideal does not differ so much from what we expect from kin and community relationships, for example reciprocity and confinement within predefined boundaries. Citing Willmott (1987:94) she notes that respondents to a survey described the key characteristic of friends as 'their reliability as sources of help, their trustworthiness, their respect for privacy and readiness to act as confidantes, and the pleasure they gave as companions' (Jamieson 1998:88). Jamieson points out that this list of characteristics might equally well be found in good kin or neighbours, and that friendship contains uncertainty, in contrast to the known obligations of kinship, although the sense of obligation to others has always been contingent on economic circumstances and the quality of relationships; kinship ties contain an element of selectivity. Janet Finch notes that there is often uncertainty about obligations towards relatives, and about what is 'the proper thing to do' (Finch 1989:177). She suggests that evidence shows how people use moral rules not as an absolute, but rather as guidelines or principles which help them to decide what they should do. She offers a description of normative guidelines which take into account the genealogical and emotional relationship between people, the history of the relationship, the effect on others and whether the timing is appropriate. Finch and Mason (1991), in another piece of sociological research, also point up the selectivity surrounding the obligations themselves. Their survey respondents demonstrated that there was no normative consensus on many issues surrounding the obligations which adult kin might have towards each other, and that obligations were not easily

recognised nor agreed upon. These perceptions suggest that kinship obligations are not a set of rules but more like a set of general principles. Michael Peletz notes that social anthropologists have often discovered ambivalence about kinship practices amongst their fieldwork informants, and he suggests that it originates in the constraining effects of moral claims, made in the name of kinship, on personal autonomy and affection (Peletz 2001).

Schneider (1984) points out that early writers on kinship, such as Morgan (1870) and Maine (1861), treated kinship 'as primarily a biological relationship' and that they looked on those arrangements which are not a true biological relationship, such as adoption, as a legal fiction. Arrangements which are not included in the relatedness of friendship, marriage and consanguinity, are often 'lumped together' (Lambert 2000) as 'fictive kinship', although as Janet Carsten notes, it is not always clear where are the boundaries between biological and social domains and they may be 'more permeable in people's discourses than might be assumed' (Carsten 2000:21). Lambert's analysis of her ethnographic field in North India leads her to suggest that relatedness there is more extensive than kinship and includes a form of adult adoption, *jholi*, which serves to give support through a substitute family of origin for incoming brides. She found, unexpectedly, a system of relatedness highly significant to social life but which took its model and metaphors from the sphere of consanguinity. Lambert notes that relatedness 'is broader than the domain of "kinship" as the latter is both locally and analytically understood' (2000:75). Her ethnography suggested to her that there might be different reasons for becoming related and different ways of being related, which were not necessarily equivalent nor interchangeable. Research amongst adopted people in Scotland (Carsten 2000) highlighted the importance of the time and effort of sustained nurturing in the production of kinship. There is no automatic bond between adopted people and their birth mothers because the making and sustaining of kinship involves a process of working at relationships. Carsten also describes elsewhere the establishment of 'natural' links over time in Langkawi, Malaysia, between people previously unrelated, through processes of shared meals and cohabitation (Carsten 1997).

This brief review of literature on kinship suggests that semen donors may perceive and define connections with donor offspring in a variety of ways. The ways

in which kinship is theorized and lived out in the UK will allow donors to deny any kind of connection at all, or to evaluate it against the amount of work which has been put into creating and maintaining a connection. There will be a ‘cultural repertoire’ (Edwards 2000:248) from which to select, and which may guide donors in deciding what the consequences of donor insemination have been for them and whether they involve any kinship implications. However, the kinship repertoire for anonymous semen donors may have a partial scope given not just that their identity was obscured but that their very existence after donating was denied. As Daniels describes, quoting from a research article by Glezerman (1981: 185), the donor’s semen ‘was to be regarded as a ‘material from an anonymous testis’, the donor being actually a ‘non-person’ (Daniels 1998:78).

### **Reproductive technology and ‘new’ reproductive technology**

As I show in Chapter Two, there was much concern in the UK about the practice of DI when it came to public attention but Strathern suggests (1992b) that in the 1980s the public concern about the threat to of DI to the institution of marriage was overtaken by the ‘intrusion of technology into biological process’ (p.41). The terms of the debates in the 1980s about human fertilisation and embryology was about ‘the fit between genetic make-up, the recognition of real parenthood and the fact of birth’ (p.61). Franklin and McKinnon (2001) point out that the development of reproductive technologies was a challenge also to social anthropology and to kinship studies as an appropriate analytical framework with which to discover and interpret their social effects. Rather than being rendered irrelevant, however, kinship study ‘has been steadily reinventing itself and in the process, has undergone a substantial make-over’ (2001:6). Part of the process has involved both a repatriation of ethnographic enquiry to EuroAmerican societies and an exploration of new kinds of spatial and temporal sites such as laboratories and international adoption.

The development of reproductive technology elicited an increasing amount of social science enquiry but Strathern suggests that, in one sense, social anthropologists initially were not ready to respond (Edwards 1993:ix) and there needed to be a catch-up in the investigation of the social implications of the ‘new’ reproductive technologies. Meanwhile, the relatively untechnical but longstanding reproductive practice of DI continued to be overlooked. The donation of semen has

never been the focus of the same kind of attention from social scientists as given to ovum donation. The development of *In Vitro* Fertilisation (IVF) which was followed by the birth in 1978 of the first baby conceived by means of the practice, made it possible for ova to be extracted from a live woman's ovary and fertilised outside of the body. As Monica Konrad points out, in contrast to the 'non-technical and relatively straightforward affair' of semen donation, the practice of ova donation 'is nothing less than a technological feat' (Konrad 2005:7). Unlike the older and technically simpler practice of donor insemination, it was the possibilities offered by the new IVF technology for women to help other women which drew the attention of social anthropologists. Surrogacy in particular was seen to 'defamiliarize what was once understood to be the 'natural' basis of human procreation and relatedness' (Ragoné 1998:118). Reproduction using surrogacy meant that sexual intercourse, pregnancy and motherhood became separated parts of what had previously been inseparable, in Euro-American perceptions. Gestational (IVF) surrogacy fragmented reproduction further, in that the surrogate mother does not contribute her own ovum to the creation of the child but is the birth mother of the child conceived with the ovum of another woman and semen from a man other than her own partner, if she has one.

Konrad suggests that semen donation remained non-technical until the development of intracytoplasmic sperm injection (ICSI) in the early 1990s (Konrad 2005:7). Certainly, the process of inserting a single sperm into an ovum demands the considerable skill of a trained embryologist as well as the use of highly specialised laboratory instruments and facilities. To watch the process on a training video made me marvel. Yet ICSI was preceded by many decades of research on human sperm, and on the technical procedures involved in preparing sperm for the process of insemination. In social anthropology and other social sciences the impression is of an abrupt move from no technology to high technology. The 'old' reproductive technology involved in the practice of donor insemination was either of insufficient interest or was the result of a 'motivated inattention, an uneasiness about the message' as Carrier describes for gifts in Western societies (Carrier 1995:145). Yet the technology is surely remarkable: as well as being screened for a number of viruses and bacteria, the semen is centrifuged in the laboratory in order to separate

out the sperm, chemicals are added to the sperm and they are then cryopreserved (deep frozen) within 'straws' in containers of liquid nitrogen where they are stored at minus 196 degrees centigrade. After being thawed at a later date, from six months upwards, some sperm will have suffered cryoinjury. Those that survive must be able to ascend the female reproductive tract and one will recognise and fuse with a human ovum in order to create a pregnancy and the subsequent birth of a healthy baby. It was the 'old' technique of cryopreservation which meant that semen could be stored and transported, thus removing the previous boundaries of time and geography, yet sociology researchers in the 1980s pointed out: 'The social implications of the changes introduced by the possibility of freeze storage have hardly been considered' (Snowden et al 1983:24).

My emphasis in this section has been to draw attention to the technology involved in DI long before IVF, and not to praise the plucky little sperm, but Emily Martin warns us that it is vital for metaphors to be made explicit so that we become aware 'of when we are projecting cultural imagery onto what we study' (Martin 1997:95). She analyzes how stereotypical gender roles and characteristics are used in the description of the functions of human gametes. The medical texts which she cites emphasize the marvel of the daily 'production' of millions of sperm by the male in comparison to the relentless aging of the 'stockpiled' oocytes in the female (1997:86). Moreover, the gender stereotypes about the action of the sperm and the egg, reframed as behaviour of a typically masculine or feminine kind, survived after biological research showed that conception is the result of joint activity. I did not witness such obvious stereotyping in biological terms during my fieldwork but gender assumptions were apparent in the taken for granted differences between the willingness and motivations of male and female donors. For example, information from infertility clinic staff in Aotearoa New Zealand (Speirs 1998) and from my fieldwork in the UK indicates that infertility clinic staff believe that women find egg donation more difficult to contemplate not because of the inherent risks of the process but because, they suggest, it is psychologically contrary to women's reproductive psyche. In the normal process of conception, they pointed out, the male gives and the female receives and therefore in being givers of their eggs, women might have no cultural metaphors with which to frame the actual process of donation.

## Concepts of giving things

Concern is often expressed by the public and by some of the professional groups with an interest in gamete donation that what should be a gift, the object of donation, has been turning into a commercial object, thus dispelling an almost romantic notion that the 'gift' of gametes was morally superior to the 'provision' of them (Ahuja et al 1998; Frow 1997:102). An interesting legal perspective on this is provided by Graeme Laurie (2002) in the context of genetic research. He suggests that the use of 'the gift model' has brought confusion into the consideration of what is meant by informed consent, and that 'the notion of the gift has a strong, normative appeal in lay terms, not least because it is seen to be a laudable act, demonstrating the virtues of altruism and beneficence, and untainted by the twin evils of self-interest or exploitation' (2002:312). Laurie points out that this is useful for recipients in that the gift can then be treated as having been given unconditionally.

However there is a lack of consensus as to what is meant by the word gift, and if something is a gift, whether it should be, or whether it should be described instead as a commodity. These issues are also apparent in the social science literature. Titmuss' work *The Gift Relationship* (1997) provoked considerable interest and concern after it was first published: in the introduction to the new edition of the book the editors note the suggestion that the publication of the original book explains why the UK's then Conservative Government did not try to alter the National Blood Transfusion Service into one of using paid donors after the American model. Titmuss describes blood donation systems as an example of how different kinds of giving not only affect the system itself but also serve to exemplify the values of the society in which the system is located. Taking the substance of human blood as the object of the giving, he identifies, describes and analyses different types of donors on a continuum from 'the paid donor' (Type A) to the 'Voluntary Community donor' (Type H). Placing on the continuum depends on a number of factors to do with the form and the amount of non-material and material gain (including financial). Titmuss' exegesis highlights characteristics of various kinds of giving, and the emphasis given to blood in societies across time and space as a unique, priceless, sometimes mystique-imbued substance. He also draws out the impact of altruism on society through the comparison of different blood donation systems. The new edition

of the book includes a chapter on milk donation (Weaver and Williams 1997) in which the authors note the lack of attention given to milk banking statistics and research. Their account of the development of the milk bank service nevertheless shows the similarities to blood donation. The editors, Oakley and Ashton, suggest that it was significant that Titmuss ignored the parallels between these two substances but, tantalisingly, omit to tell us why. Several possibilities occur: firstly, in the social climate of his time, there might have been a perceived impropriety in a male researcher's interest in breast milk unless he were socially sanctioned to have an interest for example as an obstetrician, and secondly, the practice of milk donation, unlike blood donation, is a gendered matter. Further, Titmuss did not have the benefit of later anthropological analysis of human milk as a substance with much broader and deeper connotations than just as a source of nourishment for a baby (e.g. Carsten 1997:112).

There is a variation by different authors in the descriptions of transacted body substances. The giving of body substances and parts is termed 'donation' by Titmuss as it is in UK legislation about the treatment of infertility with donated gametes. Carsten's ethnography of a Malay fishing village emphatically uses the word 'sharing'. This distinction is absent in Weaver and William's account of human milk banks, where milk is a 'gift' that is 'supplied' by a 'donor'. Carsten's use of the word sharing implies that that which is given is divisible. Milk from a mother's breast may be shared by children who thereby become kin. In Euro-American society, milk is also, like blood, reproduceable and so is human sperm. Depending on factors such as health, age and hormonal status, blood, milk and sperm can be reproduced over a long period of time and given away to others. Body parts such as limbs and internal organs cannot be reproduced (at least, in the current state of biotechnology), and neither can human ova. Human ova are present in the female baby at birth - the baby as a woman does not produce more.

The reproduceability of blood is described by Titmuss as one of the 'unique attributes which distinguish it from other forms of gift' (1997:127). Blood is replaced in the giver's body in a short time. It is in a sense then not permanently lost. Had Titmuss been writing today, when sperm donation is finally being discussed in public, he might have qualified his description to include sperm as well as milk as

substances which are given through being shared. Daniels (1998:96), following his psychosocial studies on semen donors, is clear that they give a part of themselves, perhaps even themselves, and that this differentiates them from blood and organ donors. The quality of reproducibility may affect whether a gift may be made at all. According to Titmuss, giving something away which is necessary to the giver is what we call sacrifice (1997:167).

In contrast to the sharing of sperm and milk, the complicated concept and practice of ova donation and sharing described by Monica Konrad was made possible only after the development of IVF, but the opportunity to make a gift has brought potential dangers to the donors. IVF has permitted women to make 'gifts of life' to other women but only through the work of externalising their reproductive substance in order that their gift may be transferred to another woman (Konrad 1998). Donors have to participate in a complex and highly interventionary medical regime 'of corporeal preparation, regulation and bodily change' (1998:649), with all the physical risks that that entails. A way of helping another woman to have a child thus becomes a situation of potential danger due to the 'unnatural' body changes brought about by the hyperstimulation of the ovaries with prescribed drugs. Titmuss refers to this aspect of giving when he highlights the need for blood donors to give informed consent, because of the concern that they might be putting their health and lives at risk by donating (1997:169). With proper information given to them about the risks of donation, the potential blood donors might have decided not to proceed with donating, in order to avoid harm to themselves.

Konrad examines whether the notion of 'partible persons' (Strathern 1988) might be used to analyse her material in a cross-cultural comparison. She concludes that this is not theoretically possible and that the extracted ova of the donors cannot have any meaning if they are treated as abstractions. If a human ovum is to be a 'part' then that can only be in the context of it being related to persons. To think otherwise is 'genetic fetishism'. The substance itself, the egg that is to be donated, has not changed in its nature, it is what the transaction involves, the dangers in the methods of extraction, which give other meanings to the gift of human ova. It has been noted that ova donors in the UK give far more information about themselves on the consent forms which they complete at the infertility clinics than sperm donors do,

and this information will be available to donor conceived adults if they apply to the HFEA for non-identifying information about their donors. If the egg is detached from women through the clinic's egg recovery procedure but is still a 'part' of them, then giving sometimes considerable personal information might indicate that they want to follow eggs on their 'ova pathways' (Konrad 1996:60). I have seen consent forms in patients' medical records where the supposedly non-identifying information would be enough for a determined and imaginative donor offspring to trace the donor. Clinic staff and clinic inspectors have suspected that that may have been the intention of the women..

For Konrad's informants, separation has created the possibility of a different kind of reproduceability, but the egg cannot return to its previous owner. However, there is still an attachment between the giver and the gift, for under current legislation, the giver can withdraw consent for it to be used as a 'gift of life' at any time up to its transfer to another woman, even although the thing itself, the egg, is not in the possession of the giver but stored at the clinic or already mixed with an anonymous donor's sperm to form an embryo. If the giver, the previous owner, withdraws consent for the egg to be used, it is not so that the egg will be returned for use by the giver, but so that it will be destroyed (allowed to perish) and not be used by anyone. This characteristic of the donation, which applies also to donated semen, suggests two possibilities: either that it should not be considered as a gift at all, but as a commodity, or that the power retained by the giver to order its destruction actually emphasises its gift qualities. If gifts set up connections between giver and receiver, then the destruction of them is a way of preventing connection.

Are gifts given for the greater good? Social psychologists would suggest that gamete donation has many motives, depending on whether the donor and recipient are known to each other (Schwarz 1967). Marcel Mauss in his analysis of gift-giving in different cultures can be read as saying that gift giving should be for the greater good. This moral slant in 'The Gift' has been expanded upon by Parry (1986) who suggests that Mauss' interpretation of the gift giving practices of many societies does not square with his conclusion: 'So while Mauss is generally represented as telling us how *in fact* the gift is *never* free, what I think he is really telling us is how *we* have acquired a *theory* that it should be' (p.458; italics in original). Mauss, he suggests,

was looking back in his review of anthropological material to a time and place when interest and disinterest were combined. In modern societies, these aspects of gift giving have become separated. For example in the case of classical Hinduism, Mauss (1990) describes a system in which ‘presents are still obligatory, things have special powers and form part of human persons (1990:56). They produce rewards which are of the same kind, both in this life and the after-life. Not only are they parts of humans, but also they are personified, ‘they are living creatures with whom one enters into a dialogue and who share in the contract’ (p.56). Brahminism identifies property with the person, Mauss asserts. So a thing irrevocably links its donor and a recipient. Consequently a person may wish to refuse a gift in order to avoid the creation of a bond with the intentional donor. Becoming a recipient implies being dependent in respect to the donor. In contrast to the market place, there is a considerable etiquette governing the nature of the bond, what Mauss terms a ‘form of economic morality’ (p.59).

Mauss assigned an ‘atmosphere’ to the gift, a mixture of obligation and liberty, which he claimed still permeated a considerable part of our morality. When someone accepts a gift with no thought of reciprocating it, that makes the person inferior. We must give back more than we have received. Developing his analyses of ethnographic examples, especially in relation to Melanesian societies, Mauss describes things which are sold as having a spirit. The things are ‘followed around by their former owner and they follow him also’, so that rituals may have to be carried out to ensure separation. A thing that has been abandoned by its owner still possesses something of him and continues to do so even if passed on to another person. It is this, Mauss states, that underlies the obligatory circulation of gifts in New Zealand. In her forward to the latest edition of Mauss’ treatise, Mary Douglas notes that ‘increasingly we are finding that the idea of the gift economy compromises all the associations – symbolic, interpersonal and economic – that we need for comparison with the market economy (Douglas 1990: xiv). She continues that it is not just that there are no free gifts, but that ‘the whole idea of a free gift is based on a misunderstanding. There should not be any free gifts. What is wrong with the so-called free gift is the donor’s intention to be exempt from return gifts coming from the recipient’ (1990: vii).

Laidlaw (2000) describes the practice of giving alms to Shvetamber Jain renunciators in India as an example of unreciprocated gift-giving, and notes Derrida's assertion that the gift cannot ever be free. To be so there must be non-reciprocation, non-recognition of it by both donor and recipient, and non-definition as a gift.

Paradoxically therefore, 'as soon as it appears 'as gift', it becomes part of a cycle and ceases to be a gift' (2000:621). Laidlaw suggests that the way in which alms are given to the renunciators is an attempt to remove or disguise any gift-giving characteristic. 'A renouncer may not give, and a donor family may not receive, anything in return for the food donated' and that includes expressions of thanks and feelings of self-congratulation (p.624). Nevertheless the donor family is making a sacrifice, since the food is taken from what has already been prepared for the family's own consumption. Laidlaw suggests that this form of gift-giving, *supatra dan*, avoids the creation of new social relations between donors (lay Jains) and renunciators. This free gift is in contrast to 'the Maussian gift, the one that creates social relations' (p. 626), and which relies on our idea 'that a real gift is free, beneficent and unconstrained' (p.627).

Sociologists have suggested that in modern Western-type societies, gifts are redundant but are still given great social importance because they can create certain kinds of voluntary social relationships. David Cheal (1988) in his study of 'The Gift Economy' carried out in Winnipeg, Canada, suggests that 'studying gift behavior gives us a window through which we can look into people's lives' (1988: ix). Cheal suggests that gift exchanges are not between groups in modern Western-type societies, where moral individualism influences culture and there is an ideology of personal love. Gifts are not given to just anyone, but 'to individuals with whom the donor has personal ties, or who occupy social positions within a community to which the donor also belongs' (p.173). This is a precondition for gift-giving. Gifts also are exchanges between people who have personal knowledge of each other and they are a means of maintaining bonds between co-members of communities. Cheal found that the majority of gift-giving was carried out by women; they transformed 'men's income and family ties' within marriage into 'the means for constructing extended female networks of love' (p.178). He concludes that 'the dominant social definitions in the gift economy today are derived from a feminized ideology of love' (p.183).

Part of the difficulty about gift theory is that it is not certain that we are all talking about the same concept. Derrida goes so far as to suggest that the gift is not a social phenomenon but simply a word. The same word is made to represent very different social practices and forms of sociality (Derrida 1994). This rings true for the use of the word in the field of infertility treatment in the UK, where reciprocity in private infertility clinics means free or reduced price IVF treatment in exchange for donated ova, or access to treatment in exchange for the male partner's donation of semen to an unknown other couple, systems which are more akin to barter. The difficulty about gifts in the context of semen donation is whether the motivation of the donors affects the extent to which the donation is a gift, and whether the kind of reward which donors receive will be a return of gratitude, esteem, regret or shame. If donors were discouraged from treating their donation as a gift to a known person, and if the activity of donation was rewarded with payment, rather like a wage, then the practice of donor insemination could be perceived as a commercial transaction. The act of donation would not create any social relations, either with the recipients or with the person born as a result of the donation. Nevertheless it leaves as problematic the inclination noted by gift theorists for people to want to reciprocate in some way, if they are unable to make a return gift to the donor.

### **Outline of thesis**

I set the scene in Chapter Two for the context in which semen donation has occurred in the UK. I describe the development of DI services from the publication of an article in the influential British Medical Journal in 1945 to the passage of the Human Fertilisation and Embryology Act in 1990. My sources are a number of significant reports from government and other committees set up to enquire into donor insemination services. These reports yield documentary evidence of the many problems associated with DI in the eyes of contemporary publics, particularly the need, as perceived by the doctors providing DI services, to keep the practice secret and the donors anonymous. Issues such as the presumed illegitimate status of the donor conceived children, the possibly adulterous status of the donors and the stigma attached to male infertility were thought by infertility clinic practitioners to necessitate the donors remaining unidentifiable to the recipient and especially to the donor conceived children. The debates leading up to the introduction of regulation by

the Human Fertilisation and Embryology Act make it clear that the driving force for regulation was not a concern about the psycho-social issues implicated in anonymous semen donation but rather the public disquiet about the new scientific and technological practices involved in IVF. Although DI was developed as a medical strategy for circumventing male infertility, it is also a social practice intended to enable women to achieve a pregnancy and has been used increasingly to enable women without male partners to have children. In the period during which my fieldwork informants donated semen, the service was intended to meet the need of heterosexual married couples, and therefore I concentrate on this characteristic in my thesis.

Chapters Three to Six focus primarily on the data from interviews with donors but also include information from doctors who told me that they had not donated semen (non-donor doctors) and from individual workers in the infertility treatment field. In these and later chapters, in order to maintain confidentiality, I do not use personal names. I do not use pseudonyms either, partly to avoid the reader drawing misleading comparisons between particular informants and partly because the allocation of a pseudonym, like the allocation of a personal name (see vom Bruck and Bodenhorn 2006) may reveal something of the characteristics or personality attributed to a person by others.<sup>1</sup> Chapter Three relates the stories of semen donors about how they were recruited and why they became donors. In many cases, the motivation for donating was to earn money because at the time the donors were students who needed to supplement their grants. However, money is shown to be not the only motivation. Although some of the donors had donated up to approximately 40 years previously, their stories contained significant details which give an immediacy and atmosphere of veracity to their narratives. The circumstances of the donating placed an emphasis on the instrumental production of the semen as a sexualised act and avoided the social implication that the donor was the creative, surrogate provider of sperm to another man whose fertility was impaired, and that the intended outcome was a baby of which the donor would be the genetic father. Looking back to the time of their donating, donors revealed mixed feelings about

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<sup>1</sup> I am grateful to Alastair Brown for pointing out that choosing an appropriate name for a fictitious character is a crucial decision for a novelist precisely because of the associations which it will carry.

their involvement in the practice and what it had come to mean to them by the time I interviewed them.

Chapter Four is about genes and eugenics, particularly the extent to which these concepts played a part in donors' motivation for donating semen, and appeared in donors' views about the long term implications of having donated semen. Although the recruiting doctors had concerns about what might be passed on in the semen of some donors, donors themselves were more likely to hope secretly that they were passing on something positive of themselves to unknown future offspring. Passing on genes is associated also with potential resemblance between a donor and his offspring, and also with the possibility of unwitting incest between a donor's grown up children and his adult donor offspring. Donors' views about genes were shared with me during a period of intensified public interest in genetics and genealogy, and public and professional debates about the relative influence of heredity and environment in the development of ill health during the life course. In contrast to the early practice of some clinics of inseminating a woman with a mixture of semen from several donors at the same time, so that genetic paternity would not be identifiable, infertility clinics in the UK must now comply with the EU Tissues and Cells Directive which introduced strict requirements about the traceability of human tissues, including donated semen. The Directive governs the donation, procurement, testing, processing, storage and distribution of gametes and embryos (H.F.E.A. 2006).

In Chapter Five I describe more of how donors recalled the activity of donating, and I illustrate what I suggest is a lack of respect shown to donors through failing to provide them with appropriate space in which to produce their semen samples. The chapter also illustrates donors' views about the outcome of their donating and I address the phenomenon of uncertain paternity, which is a core characteristic of anonymous semen donation. Lack of knowledge about whether or not children had been resulted from their donations was used by some donors as a strategy for supporting a view that there were none. Concurrent with the period of my fieldwork there were debates about whether donor conceived people should have the right of access to identifying information about their genetic parent(s) and whether there were analogies with the situation of adoption in which birth parents

have been unable to discover what became of the babies which they gave up to adoption. Associated with the issue of knowledge about whether donor offspring existed or not, there is the matter of naming. The evident difficulty for donors in giving a category description such as donor offspring, donor conceived person etc was more obvious for donors who said that they wished to remain anonymous. Perhaps surprisingly, despite the donations all having been anonymised by the infertility clinics, so that the donors' identities were never revealed to the female recipient and her husband, the fact of a man's donation was usually known to several people in his social circle.

Chapter Six explores views of donors about connections between themselves and their adult donor offspring. I describe also the views and reported views of donors' wives and grown up children. For the donors, the situation of being connected genetically to unknown, possible people is one of ambiguity, ambivalence and uncertain obligation, similar to the situation of birth fathers in the UK with respect to adoption. In the absence of legislative clarity about the matter, several donors were concerned about the kinds of claims which their donor offspring might want, or be able to make upon them, and about how such claims could be managed, especially if they materialized as a 'knock on the door'. Nevertheless, several donors expressed curiosity about their donor offspring, and some had a desire or willingness to meet them. Views about connection were generally influenced by the extent of knowledge and experience of adoption reunions and about the work required to develop new kinship relationships. Ideas about kinds of kinship are reflected in a section about donors' views on whether they could ever have been a personal semen donor that is, a donor who is known personally to the recipient.

The concept of risk has been part of the thinking about anonymous semen donation in the UK since knowledge of the practice first came to public notice in the 1940s. Whether used to mean 'danger' 'uncertainty' or 'likelihood', the concept has covered the risks of donors passing on defective genes or venereal disease in their sperm, as well as the safety of drugs, laboratory practices and clinical procedures used in the diagnosis and treatment of infertility. In Chapter Seven I explore risk as it is applied in the context of semen donation where the donor and the recipient are known personally to each other. Such a practice was not acceptable to infertility

clinicians from the start although explanations, when available, demonstrate concern that the practice might confuse the donor conceived child, encourage adulterous sexual feelings between donor and recipient and encourage interference by the donor in the upbringing of the child. These concerns were evident in discussion with several donor informants and also in the responses to a survey which I carried out of clinics' policies on the provision of a service using a known, or personal, donor. Conversely, risk can be seen as having positive outcomes and this association with the concept of opportunity was noted by other donors, parents and clinic workers. Ultimately, what is at risk for some people is the boundedness of the nuclear family, for others the opposite: the need to bring semen donation into a frame of kinship.

In Chapter Eight I follow the concerns about connections between donors and recipients as revealed in the responses to the UK Government's consultation on whether or not to remove the provisions in the Human Fertilisation and Embryology Act which allowed donor anonymity. Whereas the use of personal donors has been seen as posing a threat to the donor conceived child and the donee parents, the removal of anonymity is claimed by some clinicians to pose a threat to the donors. Normalizing secrecy and keeping the donor hidden from donor offspring is thought to be necessary to protect the donor from emotional and financial claims, as though the genetic link to donors will have more meaning to donor conceived people than the longstanding affective tie to their social fathers. I describe some of the heated public disagreements about this view, and how they provided opportunities for people with a personal involvement in donor assisted conception to have their voices heard and to share their perceptions about what that personal involvement means. What appears to be in dispute are very different views about what constitutes a parent in the UK of today.

Finally I conclude by revisiting the questions about how semen donation might be perceived now by men who donated between the late 1960s and early 1980s, and what it would mean to them to experience a sense of connection with unknown donor offspring. I compare the context in which they donated in the past with the situation today in which the legal provisions for anonymous donation in the UK have been removed, and I find surprising similarities in the ambivalence shown

towards semen donors, the belief in secrecy as a protective strategy, and the differing views about what constitutes a parent in the UK.



## **Chapter Two: The development of donor insemination**

The Human Fertilisation and Embryology Act 1990, which came into force in the UK in August 1991, introduced the first legislation in any State in the world for the purpose of regulating reproductive technology. The Act provided for a system of licensing for clinics and for carrying out certain medical and scientific procedures, and introduced a definition of who was to be considered the mother and the father of a child conceived with the use of donated gametes. The practice of anonymous semen donation undertaken by the donors interviewed for this research project was not subject to legal regulation. The practice was not considered to be unlawful but to be legally ambiguous. For many people it was immoral because of the implications which it was presumed to have for the status of marriage and for the legal status of children born following donor insemination. Others were concerned about the problems inherent in a practice whose efficacy was supposed to rely upon secrecy. The attribution of ethically dubious characteristics to semen donation is fundamental to the descriptions of how services developed and debates whether they should have been developed. The historical perspective helps to frame the social context of the circumstances in which donations were made by the semen donors who informed my research. In this chapter I show how semen donation was described in the past and how this affected the way in which donation was organized, by referring to several key documents. I show also some of the problems which were acknowledged to be implicated in the practice even by those who were in support of it, such as doctors working as infertility specialists. Finally I note some explanations as to why, despite these problems, the provision of services continued.

### **Definition of semen donation**

As I noted in the introduction, semen donation for many years was known as Artificial Insemination by Donor, or A.I.D. The practice of Artificial Insemination by Husband was, and still is, described as A.I.H. (AIH). In the 1980s, the term A.I.D was changed to DI, for Donor Insemination, in order to distinguish it from the then growing health problem of Artificial Immune Deficiency Syndrome, which was abbreviated to AIDS. The acronym A.I is generally used in the UK now only in the context of animal breeding, particularly the artificial insemination of cattle, but I use

A.I.D when referring to historical documents. The Report of the Departmental Committee on Human Artificial Insemination (Feversham Report 1960) noted that:

the technique of artificial insemination is comparatively simple. Within three or four hours of collection a small quantity of semen is placed in or near the cervix, usually by means of a syringe. This takes only a few minutes.... Insemination is carried out at the point in the menstrual cycle when ovulation is believed to take place....One or at the most two inseminations are carried out each month until conception occurs or until it is decided to cease treatment

(Feversham Report 1960:10)

These medical descriptions exclude the social definitions of semen donation, which include ‘treatment’ of male infertility and ‘circumvention’ of male infertility.

Kleegman as cited (n.d.) by Bartholomew (1958:193) suggested that the practice ‘should be referred to as therapeutic rather than artificial insemination’.

Bartholomew notes that that is what the practice of semen donation appeared to be: ‘It is no more artificial than blood transfusion, plastic surgery or corneal transplantation’ (p.193). This opinion discounts the perceived distinctions held then and later by others, between technical practices used in medicine for different purposes. It also undervalues the significance of what has been described as the ‘resistance many of us intuitively feel to ‘interfering with nature’: to the substitution of artificial processes for natural ones’ (Glover 1989:18). Bartholomew (1958:188) cites a book review as far back as 1866 in the *Medical Times and Gazette* which criticized the reporting of AIH cases by American gynaecologist Dr James Marion Sims ‘with the pronouncement that “this dabbling in that canal with a speculum and syringe” was not compatible with decency and self-respect’. Sims later abandoned the practice of AIH for ethical reasons (Finegold 1976: 6, cited in Bateman-Novaes 1998: 110).

### **The beginnings of semen donation**

There is no comprehensive history of the origin and development of the practice of semen donation in the UK, but such records as do exist reveal that ambivalence and contradiction about the practice was expressed whenever there was publicity about it. Two particular sources of written information have been used by social scientists (e.g. Haimes 1998, Daniels 1998) and by religious organizations in the UK such as

the Church of England (1996:57) and quoted by them in their explorations of views about the status of donor conceived children and the matter of their access to identifying information about the donor whose gametes were used to assist in their conception. The first source is the report of a Commission appointed by the Archbishop of Canterbury in 1945, entitled Artificial Human Insemination (Church of England 1948). It was chaired by the Bishop of London, the Right Reverend and Right Honourable J.W.C.Wand. For ease of description and because it has been referenced in various publications and library catalogues in the UK by several very different titles, I shall follow the convention currently used in the description of government reports and refer to this report as the Wand Report. The second significant source is a UK government report produced by a departmental committee, known as the Feversham Report, which was published in July 1960. I shall also refer to publications of the British Medical Association and of the Voluntary Licensing Authority, and to the Warnock Report which led ultimately to the Human Fertilisation and Embryology Act 1990.

The Wand report began its section on the ‘History of Artificial Insemination’ by describing what it calls the ‘legend’ that artificial insemination had been used with horses by the Arabs in the fourteenth century. Speed and stamina were essential for animals used in their battles and therefore according to Cusine (1988:12) citing Rohleder, the legend has it that the Arabs would try to impregnate their enemies’ mares with semen from poorer quality stallions of their own in order to weaken their enemies’ stock. The Wand Report describes later successes in the use of artificial insemination with other animals in Europe, and notes the ‘spectacular results’ of the practice in animal husbandry (1948:11). The report observes that ‘it was perhaps not to be expected that, while such remarkable results were being obtained from the application of artificial breeding methods to livestock, so novel and potent an instrument would not be directed to the solution of some of the most grievous human problems’ (1948:12).

The phenomenon of artificial insemination of livestock was also noted later by the Feversham Committee, with about two million cattle reportedly being artificially inseminated in England and Wales annually by 1960. The purpose of this method of breeding was *inter alia* to allow for greater ease of veterinary supervision

and for the use of bulls ‘of higher than average breeding potential’ (Feversham Report 1960:5). However, apart from what might be learned from animal artificial insemination regarding methods of freezing semen, the committee argued that

the purpose of the artificial insemination of livestock, being largely to improve productivity by the maximum use of superior sires, is so different from that of human artificial insemination that no useful comparison can be made between the two (1960: 6).

Both the Wand and Feversham Reports refer to articles on artificial insemination published in medical journals, mostly in America, which describe the use of donors in the practice of artificial insemination. A particularly significant article in the British Medical Journal (BMJ) by three medical practitioners in London (Barton, M., Walker, K. and Wiesner, B. 1945) described practice in the UK. Dr Mary Barton at the fertility clinic of the Royal Free Hospital, Mr Kenneth Walker a genito-urinary surgeon and Dr B.P. Wiesner, a biologist, both at the Royal Northern Hospital, wrote of their findings from a number of cases in which they had used the technique of artificial insemination by husband. The reasons for using the technique included impotence in a woman’s husband, other physiological factors such as female dyspareunia (painful sexual intercourse), and failure by the husband to ejaculate during sexual intercourse. The authors reported that they had also used donated semen for artificial insemination in a limited number of cases of ‘male sterility’ or cases of ‘severe subfecundity’ which had failed to respond to treatment ‘so that chances of conception were remote’ (1945: 40). They had also used the practice of A.I.D. in order to prevent cases of hereditary disease. The authors note that artificial insemination has some accompanying dangers: infection carried in the semen, miscarriage from dysgenic conception when subfertile semen has been used, damage to semen if preservatives are used to prolong its viability before being used, and possible psychological trauma to the patients involved, either at the time or after the birth of a child (ibid: 42).

### **The Wand Report**

The Commission which produced the Wand Report was set up in December 1945 by the then Archbishop of Canterbury and its terms of reference were ‘To consider the practice of human artificial insemination with special reference to its theological,

moral, social, psychological, and legal implications' (Church of England 1948:5). It was composed of 'experts' and its report was intended to assist professionals for whose work the practice of artificial insemination had implications. Members of the Commission represented a range of professions: medical specialists (psychiatry, child health, and surgery), psychology, voluntary social service, theology, philosophy and law. According to Haimes (1998:56), the Commission had been set up due to the concern of the then Archbishop of Canterbury about the practice of A.I.D. as described in the BMJ article by Dr Barton and her colleagues already noted. Pfeiffer suggests that the Archbishop was prompted by dismay that the government 'stubbornly refused to appoint a Royal Commission which might clarify the uncertain legal position of AID' (Pfeiffer 1993:117).

The assumption prompting the enquiry by the Commission was that the practice of artificial human insemination, whether by husband or by donor, raised a broad range of problems, and that the practice should be investigated even though it was believed to be happening only on a small scale. The reasons understood by the Commission for doctors to use artificial insemination were as had been described by Dr Barton and her colleagues in their article (Barton et al 1945), but in addition, the Wand Report noted that Artificial Insemination by Donor could be used in cases where 'the paternity of a man endowed with outstanding qualities is desired' (Church of England 1948: 7). The Report quotes at length from *The Uniqueness of Man*, a collection of essays written between 1927 and 1939 by Dr Julian Huxley. He was quoted as proposing that the human race would benefit 'if married couples of average or sub-average endowment were prepared, after having one or two children of "their own," to admit into their families a third and fourth child conceived as a result of A.I.D.' (Church of England 1948:8). The success of such a venture was thought by the Commission to be unlikely, because the proposal relied on evidence of its efficacy from its practice in animal breeding. Furthermore, the report notes that 'Some of those who are most expert in the science of eugenics deprecate the exaggerated claims made for A.I.D. and the supposed benefits it could confer on humankind' (1948:32). However, it was accepted that artificial insemination could lead to the capability of differentiating between male and female sex-determining sperms (spermatozoa), and thus eventually to an imbalance in the sex ratio of society,

which the report deploras: 'In a single generation the balance of the sexes, only slightly affected by two world wars, might be completely overthrown. The impact of such a disturbance upon traditional patterns of behaviour and especially upon the institution of marriage may be easily imagined' (p.33). In conclusion, the Wand Report doubted what benefit Julian Huxley's proposal would bring to society, but pointed out that 'the prospect of wholesale adoption of A.I.D. especially by totalitarian states cannot be lightly dismissed. The effect upon human society if one donor were used for hundreds or even thousands of inseminations cannot be estimated' (p.56). The Report also queries 'whether any one human being is entitled to reproduction on this scale' and whether there might be possible intermarriage of people conceived, unknown to themselves, from the same donor (p.56).

It is interesting to note that the Wand Report does not attack the eugenic proposal directly on ideological grounds. This may be because it was deemed unnecessary to do so: the proposal, if implemented, obviously would have a social consequence on marriage and on the status of children, and it was these matters which the commissioners saw as insuperable difficulties about the practice of A.I.D. With one abstention, by the Dean of St Paul's Cathedral in London, the commissioners recommended that the practice should be made illegal. The Report concluded that the 'evils necessarily involved in artificial insemination (donor) are so grave' that the practice should be made a criminal offence (p.58). The summary findings of the commissioners did not include comment upon the role of the various parties to donor insemination, namely the donor, the recipient woman and her husband, and the doctors who arranged the service. It was the practice of A.I.D. as an institution, and its effects on those involved, which the commissioners condemned. In their perception it involved 'a breach of the marriage. It violates the exclusive union set up between husband and wife. It defrauds the child begotten, and deceives both his putative kinsmen and society at large' (p.58). The effects of A.I.D. on the family are perceived to be damaging, involving an attack on the marital relationship, a cheating of the donor offspring about who his genetic father is, and the deception of the wider family and beyond through the pretence that the husband of the child's mother is the genetic father. The commissioners stated that A.I.D. objectified the intimate sexual act by making it 'a mere transaction' (p.58). Finally the

commissioners stated that there were dangers in the secrecy inherent in the practice of A.I.D.: ‘For the child there must always be the risk of disclosure, deliberate or unintended, of the circumstances of his conception’ (p.58).

The dissenting view of the Dean of St Paul’s, the Very Reverend W. R. Matthews has a prescience still of relevance to current debates about the practice of donor insemination. He describes his reaction of ‘repugnance to the whole idea of A.I.’ (p.60), meaning A.I.H. as well as A.I.D., and attributes this to a concern about human dignity and about the separation of the ‘mechanical factor in procreation, not only from the personal, but from the organic life of the individual’ (p.60). He acknowledges that there may be psychological harms to donors and donor offspring but there is no evidence, only conjecture, to support the concern, and perhaps the difficulties would be no more ‘than those observed in adopted children’ (p.60).<sup>1</sup> As regards adultery, Dr Matthews strongly criticized the legal interpretation that A.I.D. was an adulterous act. In his view, the ‘spiritual elements which constitute the sin of adultery are absent’ (p.61), that is, there was no intention to commit adultery on the part of the donor nor the woman who would be inseminated with his sperm, and there was no intention by the donor to replace her husband in a sexual relationship. Dr Matthews pointed out also that whilst a theological interpretation of marriage might deem A.I.D. as being against ‘the law of nature’, the Christian ethic of love equally could justify the right, even the duty, of a married woman to have a child by another man if her husband was infertile (p.61).

### **The role of eugenics**

Dr Barton and her colleagues described their principles for the selection of donors as being governed by the need ‘to reduce obvious biological dangers’ (1945: 41). This meant that there should be no history of transmissible disease, no adverse family history of ‘characteristics of possible genetic significance, such as alcoholism, criminality, or tuberculosis’ (p.41). Eugenic quality of donors depended on scientific views but also the preference of the doctor and of the prospective parents. It was pointed out that ‘the legal father may hope for a donated child with whose

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<sup>1</sup> At that time, adopted people in England, Wales and Northern Ireland had no right of access to their original birth certificate giving the name of their birth parents.

personality he might be in accord' (p.41), but that the difficulty in recruiting donors made it more difficult to match a donor with the prospective parents' preferences.

The word 'eugenics' itself is often associated with the practice of compulsory birth control (Nuffield Council on Bioethics 2002:14), but the Wand Report noted the interest which the supporters of eugenics were taking in the practice of A.I.H and A.I.D. According to the journal of The Eugenics Society the society's objects were

To study the influences, social and genetical, that may modify inborn human qualities; to formulate and support policies for developing these qualities to the utmost advantage; to promote research upon eugenic problems; and to foster a responsible attitude to parenthood

(*The Eugenics Review* 1957)

Pronouncements on the topic of artificial insemination in *Eugenics Review* were generally supportive of the practice. An unattributed commentary on the Wand Report (*The Eugenics Review* 1949: 119) noted the concerns of the Archbishop's Commission about whether A.I.D. amounted to adultery, and the risks of unwitting incest between adults conceived by donor semen. The author of the commentary disagreed with the Commission's recommendation that the practice of A.I.D. should be banned, but did agree that there was a problem about the issue of secrecy, although the perspective was somewhat different from that of the Commission. The commentary pointed out that if A.I.D. was kept secret, then it 'cannot but multiply the eugenic risks of A.I.D' (1949:123) and that would be of no help to the geneticists. Secrecy in A.I.D. caused 'confounding of pedigrees' (p.123), and the commentary concludes with a reference to Lord David Cecil's biography 'The Young Melbourne' as an example of 'the genetical chaos of a promiscuous society' (p.123). Lord Melbourne, a future Prime Minister of the UK, had at least one sibling fathered by the Prince of Wales, and his wife ran away for a time with the poet Lord Byron (Scotland Office 2007). The events described in the biography took place in the 19<sup>th</sup> century, but the book was first published in 1939, and clearly made a long-lasting impression.

In an article in the *Eugenics Review* which was written to raise awareness of the unresolved legal issues surrounding A.I.D., Bartholomew (1958) noted that 'there are not wanting those who urge that artificial insemination should not be merely a therapeutic technique...but should be actively encouraged...for eugenic purposes as

conceived by Julian Huxley' (1958:193). Julian Huxley's reasons for promoting the necessity for A.I.D. as laid out in the forward and first two chapters of *The Uniqueness of Man* (Huxley 1941). At that time the UK was fully engaged in World War II, and Huxley asserts that even if the war was not won by Nazi Germany, 'civilization is not necessarily safe' (1941:viii). It was necessary for civilization to find a new basis for its belief in itself, and the belief 'must be a social one, based on the concept of society as an organic whole, in which rights and duties are balanced deliberately' (ibid). Economic ideals, he argued, had to be replaced by human ones. Huxley claims that 'man is by far the most variable wild species known' (p.5) and that in addition to the biological variability 'is the even greater amount of variability due to differences of upbringing, profession and personal tastes' (p.8). Variability is but one of many attributes which Huxley describes and explains as underpinning his view that man is unique. He calls for this uniqueness, the 'human superiority to the impersonality and irrationality of the rest of the universe' (p.3) to be acknowledged and to underpin man's duty to guide the progress of his own evolution. In line with his self description as a humanist (p.x), Huxley concludes that in the perspective of biology, 'our business in the world is seen to be the imposition of the best and most enduring of our human standards upon ourselves and our planet' (p.33).

The second chapter of *The Uniqueness of Man* is an essay on 'Eugenics and Society'. Huxley suggests that variability between humans may be caused by differences not just of genetics, of inherited differences, but also of nutrition. Citing Hogben (1933:95), he points to the 'basic relativity of nature and nurture' (p.48) and asserts that attributing difference to genetics alone is pseudo-scientific and political; the Nazis' racial theory 'is a mere rationalization of Germanic nationalism on the one hand and anti-Semitism on the other' (p.50). Nevertheless, Huxley suggested that artificial insemination, by separating sexual intercourse from reproduction, provided an opportunity for implementing the eugenic idea. Together with birth control, this separation 'has opened up new horizons, by making it possible to provide different objects for the two functions' (p.78). It would now be possible to have sexual intercourse with the person you love, and to reproduce through someone else who is admired for other reasons. Huxley did not explore the legal or social status of the offspring of such unions. However, this opportunity could not be fulfilled, he

claimed, unless religious objections to birth control and to the splitting of personal love from procreation within the institution of marriage had been overridden. As the Wand Report shows, the separation of the procreative and affective characteristics of sex within marriage was a fundamental concern.

Huxley's vision for eugenics was still intact in 1962 when *New Scientist* reported his delivery of the annual Galton Lecture to the Eugenics Society (*New Scientist* 2006). He is reported to have stated that advances in medicine, public health and social welfare had made the need for negative eugenics urgent because of 'the survival and reproduction of many types who would have died young in earlier periods'. These 'types' were persons affected by

undesirable genes or gene combinations' and therefore suffering from conditions such as haemophilia, schizophrenia, susceptibility to diabetes, various types of mental defect including very low IQ, certain temperamental deficiencies and, of course, the great majority of radiation-induced mutational defects. (*New Scientist* 2006)

Positive eugenics were more inspiring, the *New Scientist* reported Huxley as saying, but they were more difficult because of opposition springing 'from tradition and prejudice'. The techniques of positive eugenics included conception control, artificial insemination by donor, and the long term freezing of sperm. What the human race needed was the encouragement of 'the differential reproduction of human beings exhibiting generally desirable characteristics such as health, physical beauty, manual dexterity, longevity, athletic ability, intelligence' and other aptitudes (*ibid*).

Huxley had written (1941:76) that religious objection to birth control was an obstacle to population control and to eugenics. The term eugenics literally means 'well born' (Nuffield Council on Bioethics 2002:13) and 'refers to the doctrine that humanity can be improved by selective breeding, that is, by encouraging those with desirable traits to reproduce or discouraging those with undesirable traits from doing so' (2002:13). Many eugenicists, including the Eugenics Society, did not favour coercion and involuntary sterilization (2002:17). Nevertheless, eugenics is not the term which one of my fieldwork informants, a retired clinician, would associate with the history of gynaecology and fertility treatment as he knew it from his long career in obstetrics and gynaecology. He suggested that in the UK 'we were led by the likes of Sir Dugald Baird, who talked about the fifth freedom, and it is the freedom from unwanted fertility'. Sir Dugald Baird was an obstetrician and gynaecologist in

Aberdeen who offered abortion to women before the Abortion Act 1968 made the practice legal in the UK. My informant recalled that women in Aberdeen would be offered an abortion after their third or fourth pregnancy, and added:

Still all of these you may feel are slightly eugenic approaches but they were also a response by doctors to a tyranny of unwanted pregnancy and unwanted fertility, where there was inadequate contraception and where men behaved terribly badly about their wives' fertility and doctors appallingly.

This perspective acknowledges the tension in the medical profession about women's right to freedom of choice in reproductive matters, which this informant and others suggested might often be based on the religious values of individual doctors. In this clinician's view, offering to terminate the pregnancies of poor women struggling to feed and clothe a growing family was not based on eugenic values, but on respect for the women. A similar point was made by a former colleague of Dr Margaret Jackson, a member of the Eugenics Society who started the donor insemination service in Exeter. The colleague told me that Dr Jackson had also started a family planning service because she thought that women's health in the 1930s was 'shocking: 22 year olds with six children, TB, prolapsed wombs, etc'. Dr Jackson's response to the physical needs of vulnerable women can be seen as a compassionate and proper response of a doctor to the 'eugenic' characteristic of the social and economic circumstances of her time, which affected the well-being of pregnant women and young mothers (see Nuffield Council on Bioethics 2002:17).

### **The Feversham Report**

The Government-appointed committee which produced the Feversham Report was set up in 1958 with the following terms of reference:

To enquire into the existing practice of human artificial insemination and its legal consequences and to consider whether, taking account of the interests of individuals involved and of society as a whole, any change in the law is necessary or desirable (Feversham Report 1960:1).

The circumstances leading to the setting up of the committee was a court case in Scotland, *Maclennan v. Maclennan* [1958] S.L.T.7., in which a married woman alleged in a divorce case that a child who appeared to have been born to her as a result of an extra-marital affair had actually been conceived by A.I.D. (Cusine

1988:49). The woman and her husband had separated in early 1954 and the child was born in July 1955 in America. The presiding judge, Lord Wheatley, decided that artificial insemination by donor did not amount to adultery according to the law of Scotland, but that the wife must provide information to establish that the child was conceived as the result of A.I.D. and that 'her failure to do so would result in an inference of adultery'. The wife did not provide the evidence and so the divorce was granted (1988:49). Cusine suggests that the inference to be drawn from Lord Wheatley's approach to the problem as to whether non-consensual A.I.D. amounts to adultery, is that the existing legal framework was unable to deal with the problem of the status of child born as a result of A.I.D., even if the husband has consented. The Feversham committee noted that this court case had been the subject of a speech by the Archbishop of Canterbury, much public discussion had ensued, and 'there was considerable public anxiety' (Feversham Report 1960:1).

The Feversham committee met in private and took oral and written evidence. It published a report with recommendations but no report of its proceedings. A verbatim record was made during sessions where oral evidence was received 'but this was purely for the convenience of members of the committee. We made it clear to those who gave evidence that the record would never be published, and in this way we found that our witnesses readily agreed to discuss with us fully and freely the intimate details of the practice into which we were enquiring' (1960:1). Most of the doctors involved at that time in providing a semen donation service reportedly agreed to provide the committee with information. Views were also sought from religious, medical and legal groups as well as from organizations with a special interest in marriage, family life and the welfare of children. Members of the public were invited to submit written evidence, and information was sought from overseas countries where semen donation was known to have been practised. The Feversham Report noted (1960:6) that the possibility of semen donation had been discussed in the UK in the decade before the Second World War, and quoted from *The Eugenics Review* of July 1935, p.121, that the discussion had been 'as much from the point of view of improving the race as of dealing with sterile marriages'. In addition, the report noted that

we have heard evidence from one practitioner who carried out A.I.D in cases of infertility between 1934 and 1939, though without much success. Two of

the present practitioners of A.I.D. began in 1940, and others in 1942, 1943 and subsequently. Advances in medical science had made it more and more clear that in a considerable proportion of childless marriages the husband was the cause of the infertility, rather than the wife as had hitherto been supposed. (Feversham Report 1960:6)

Thus, according to the report, there was a climate of opinion to support the concept of studying male infertility, and experiments encouraged certain doctors to begin using donors' semen to achieve pregnancies. These doctors were infertility specialists who turned to A.I.D. 'because it appeared to be the only solution in a small number of cases where prolonged investigation had proved the wife fertile and the husband sterile. Often A.I.D. was tried after A.I.H. had proved unsuccessful' (1960:6.). The Feversham Report noted that, apparently, artificial insemination had been practised in the United States on a considerable scale for over thirty years, and that according to estimate perhaps over 10,000 children had been born there since the practice began. It was also practised in Australia, South Africa, France, Germany, Scandinavia, Belgium and the Netherlands. In proportion to population, the country with the second most frequent use of A.I.D. was thought to be Israel. In several of these countries government committees had recommended that A.I.D. should be regulated or criminalized but in no country had legislation been introduced. A.I.D. had also been practised in New Zealand: in one case described by Daniels (1998:77), the clinic doctor had used his own semen because he had forgotten to make arrangements to obtain the donation from a willing friend in sufficient time before the arrival of the prospective recipient at the clinic.

According to the Feversham Report, the number of requests for A.I.D. increased whenever there was publicity about the practice, such as the publication of the article in the British Medical Journal by Dr Mary Barton and colleagues (Barton et al 1945), and after the 1958 court case in Scotland referred to above. It was thought that the practice would be more widespread were it not that many members of the medical profession, and the public, strongly disapproved of it on religious and ethical grounds. In addition, the committee believed that if the practice were to be recognized in law, then there would be an increase in the number of potential donors, of requests from couples, and of doctors prepared to use the technique.

The role of potential semen donors and their wives was considered by the committee members and it is clear that they were troubled by what they heard. They reported having heard from witnesses that men who had donated had done so for financial gain. They might have wanted to help the medical practitioner either out of gratitude for infertility treatment given to their wives, or 'if he is also in the medical profession he may donate because he wants to help a colleague' (p.58). The report continues: 'It would, however, be clearly undesirable for use to be made in this way of medical students' because 'they are of an age when they might be too easily persuaded of the desirability of A.I.D.' (p.58). The committee had also received views that a semen donor was 'in a sense, serving the community, by helping to bring a child into the world, just as the blood donor serves the community by helping to save a life' (p.58). The committee members were not convinced, and were sceptical that the selection of semen donors was made by medical practitioners, and doubtful about whether a man who could be a donor without ever meeting the mother of the potential child could be described as responsible. They also noted that semen donation improperly separated sex from marriage: even though masturbation was sometimes done in order to produce a specimen of semen for medical analysis, masturbation itself 'is accompanied by emotional activity' (p.58). The committee were concerned therefore that the role of donor 'is of such a kind that it is liable to appeal to the abnormal and unbalanced. As a leading psychiatrist put it to us, it is an activity which might be expected to attract more than the usual proportion of psychopaths' (p.59). Yet the question remained as to whether such characteristics would be passed on to the A.I.D. children.

The effect of donation on a donor's marriage was also a concern to the committee. They heard reports of wives having objected to their husbands acting as semen donors, and were not surprised: 'We can well understand that many wives would object to their husbands being responsible for the conception by other women of children who would be the half-brothers of half-sisters of the children of the donor's own marriage' (p.59). The committee also heard suggestions that it was unnecessary for a man to obtain his wife's consent before donating semen, but pointed out that a wife might feel that by becoming a donor, her husband was taking something away from the marriage relationship. The committee did not elaborate on

what was being taken away: perhaps it would not have been acceptable in a public report at that time to note that by being a donor, a man would have to abstain from sexual relations with his wife for some days before making the donation.

The report concluded that, in the view of the committee members, artificial insemination by donor was undesirable. It caused a 'grave injustice' to the child (p.79) and was likely to cause conflict between the desire of the parents for a child and the interests of the child. It was like 'fornication and adultery' (p.80) because it was immoral but not criminal. It was not an offence, but neither was it good for 'the harmony of society' (p.81). However, the committee was not in favour of regulating the practice, believing that that would not be practicable nor enforceable, and indeed that it was not desirable to give the practice official recognition. Moreover, the number of births following donor insemination was about one hundred each year, which was considered a small number of cases for which to introduce legislation. Perhaps if there were to be an increasing number then the state might decide to intervene, but in the meantime, the committee recommended that matters should remain as they were.

### **The Peel Report**

A panel was set up by the Annual Representative Meeting of the British Medical Association in 1971, to enquire into 'the place of A.I.D. (artificial insemination by donor) in our modern society' (British Medical Journal 1973:3), following an increasing number of requests to the BMA headquarters for information about A.I.D. It was noted that 'A.I.D. is a subject which generates considerable interest, emotion and often prejudice among both the profession and the lay public' (p.3). The panel's report is referred to as the Peel report after its chairman by Sir John Peel. One member of the panel represented the Medical Defence Union; others included a General Practitioner, three professors of obstetrics and gynaecology and a medical observer from the Association of British Adoption Agencies.

The panel's report noted that since the publication of the Feversham Report, there had been no changes to the legal status of the children born as a result of A.I.D. The children remained illegitimate whether or not the mother's husband had given consent to the procedure. The panel members thought that, nevertheless, public and judicial thinking in the UK on this matter was changing, and that it was likely that

any such children would be presumed to be legitimate, that is, the child of the marriage, unless evidence was produced to the contrary. The panel endorsed the view of the dissenting members of the Feversham committee who had recommended that the legal status of the children should be changed to one of legitimacy, and that for the purpose of birth registration, a husband should be deemed to be the father.

The content of the report focussed particularly on issues of protection and negligence for medical practitioners of A.I.D. For example, practitioners should take adequate care to ensure that couples fully understood what A.I.D. involves and what emotional repercussions they might later experience, and care should be taken to ensure that donors did not transmit disease in their sperm. The report referred to the possibility of A.I.D. practitioners being sued, in line with what had recently occurred after pregnant women treated with the drug Thalidomide had given birth to children with physical malformations. The report stated that the apparent increase in the practice of A.I.D. made it even more important for the medical profession to have proper standards and safeguards in place. The increase in enquiries about A.I.D. and its use was thought to be associated with a decline in the number of children being placed for adoption. The panel foresaw an increase in enquiries if the facilities for A.I.D. were to become more widely available.

The panel had taken advice from colleagues in the USA as well as the UK, and reported that the prevalent practice in the USA was to recruit donors from the medical profession, including medical students. The reasons were that 'the men and their background are known to the profession locally, a minimal intelligence quotient is guaranteed, they are readily accessible and they form a rotating section of the population so that it is possible to avoid the over-use of any one donor' (p.5). The panel recommended that in the UK, donors could be recruited from amongst students generally, as well as from fertile husbands of women receiving investigation for infertility. Whatever the source of the potential donors, it was important for practitioners 'to establish their medical and, as far as present knowledge allows, their genetic history' (p.5). The report noted that the practice of A.I.D. would increase in the USA since frozen semen was now being used there. The pregnancy rate was lower but frozen sperm was more accessible than fresh sperm.

The matter of follow-up of children was addressed by the panel, noting that the members had been urged by a number of people that there should be no follow up, in order to protect the feelings of those involved. The panel members sympathised with the concern but did not entirely agree with them: 'Information must be obtained on the genetic effects, especially where frozen semen has been used, and it is important to learn the effects, in human terms, on the development of personal relationships in families resulting from the use of A.I.D.' (p.5). The panel recommended that there should be long-term follow up of the families. The panel noted that A.I.D. was still considered controversial by the medical profession and the public but recommended that it should be available on the NHS at a number of accredited centres, that semen donors must be thoroughly examined and perhaps financially reimbursed for the time spent undergoing the examinations, that frozen semen banks should be set up, and that patient records should be treated as confidential in the same way as other medical records.

### **The development of services**

Despite the negative attitudes to donor insemination, ranging from outright disapproval to anxiety and concern about its effects on individuals and society, the practice continued to increase. Two reports of proceedings from study groups of the Royal College of Obstetrics and Gynaecology (RCOG) (Brudenell, McLaren, Short and Symonds 1976; Thompson, Joyce and Newton 1985) demonstrate views about how the practice could best develop, and how the practical and ethical problems could be addressed and overcome. Some of the medical practitioners taking part in these study days, especially in 1985, are still involved in the provision of donor insemination services, and I shall refer again to the reports of the proceedings later in my thesis. The discussions at the study days were about concerns about how to make services more widely available, how to recruit enough donors to meet the increasing demand, and how to ensure that donors' semen would not pass on diseases to the recipients. There were difficulties about legal issues and insistence about the necessity of keeping the practice as secret as possible, and discussions about whether donors should be paid, and how to ensure that they had a responsible attitude.

An important characteristic of the development of new services was that they would start as a result of the connections which doctors had with each other across

the country. These served to facilitate the diffusion of information about clinical, scientific and administrative matters. Doctors, embryologists and scientists who had worked in the field of infertility since before 1990 were able to tell me who had introduced them to the knowledge about semen donation, who had introduced it to the place where they were working at the time, and where that person had moved on to. They often remembered where the person had come from and from whom they had gained their knowledge and ideas about DI. Some of my informants described the system as being like kinship, with knowledge transfer being traceable through the movement of doctors as they progressed from one hospital to another, from their clinical student training through junior house jobs and on to research fellow and registrar.

One clinician who I interviewed told me that donor insemination services were not, in his experience, ever part of a formal, planned, service development:

None of these developments in infertility ever had an official starting point, no one said, as of 1<sup>st</sup> January next year we will have a service. It starts with the first patient who captures the heart of a doctor who finds a donor and says 'I'll try and help you with it'.

He went on to describe the development of the service as being opportunistic, as circumstances allowed. In the hospital where he was working, he told me, 'we stole a machine and borrowed a microscope and begged a bit of a room and gradually did things...gradually got things going'. At that time there had been no cryopreservation and therefore the service had been technologically simple. He described a clinician in another city as having had a similar approach: 'a sympathetic man, responded with the heart, and let word get out that he could do with some donors, and donors came'.

### **Perceived problems about A.I.D**

All of the reports about donor insemination noted the problem about the legal status of the practice. Donor conceived children were illegitimate, and the semen donor and recipient were at risk of being accused of adultery. The donors were thought to be financially liable for children, if the fact of the matter were to be revealed. As a consequence, the recipient's husband was potentially guilty of perjury when declaring himself to be the father of the child when registering the child's birth. One way of avoiding these risks was for the medical practitioner to mix sperm, so that it

might be assumed that the husband was indeed the biological father of the child. According to the Feversham report, the reason for the practice was that not all of the husbands were completely infertile, and if a man's semen was used as part of the insemination material, then he and his wife could assume that there was a chance that a subsequent pregnancy might be due to the husband's sperm. This practice was termed A.I.H.D., meaning artificial insemination by husband and donor.

(Feversham:ii). By the early 1980s this practice was said to be on the decrease. In a report 'Choices by Childlessness' a working party of the Free Church Federal Council and the British Council of Churches recommended that 'the mixing of semen should be made illegal, so that genetic records can be kept and genetic abnormalities traced' (Free Church Federal Council 1982:54). The working party noted that the practice

which is now generally rejected, is unacceptable on both medical and moral grounds. It prevents the keeping of accurate genetic records. It encourages wishful thinking and untruthfulness – hardly a proper basis for a sound human relationship (1982: 44).

The working party agreed that there was a view that no one need ever know that a person had been 'an A.I.D. child', but they pointed out that 'what begins as the concealment of the truth may end as a distortion of the truth' especially if people began to ask about their origins, which the working party anticipated to be the case (p. 44).

Douglas Cusine notes that the mixing of a husband's and a donor's semen together before insemination was sometimes called AIM - 'mixed artificial insemination' (1988:125). Another term was CAI – 'confused artificial insemination'. He reports that some doctors were against the practice because it reduced the chances of conception, but others disagreed. The main reason for using the method was to make it more difficult to prove that the woman's husband was not also the genetic father, or to help the father to believe that he was the genetic father too. Some practitioners mixed the semen of several donors, again to make it difficult to establish the identity of the genetic father. Witnesses to the Feversham committee who provided an A.I.D. service advised that they kept some kind of confidential record of the practice. Some contained the link between the donor and a pregnancy, but that was impossible with sperm mixing. Some records were kept in code known

only to the doctor and the clinic nurse or private secretary, but as I noted in Chapter One, many records were destroyed.

A number of reports noted the worry about unwitting incest because of the anonymity of A.I.D. and the related problem of how many donor offspring should be permitted for each donor. The Feversham committee decided that the danger of genetic half siblings unwittingly meeting and marrying each other was minimal at the time (Feversham Report 1960:12), and would remain a remote possibility even if the practice of A.I.D. increased substantially, and in any case would be much smaller ‘than that resulting from fornication and adultery’ (ibid). Most doctors limited the number of donor-assisted conceptions to ten per donor and few had even reached that number. This was partly because donors did not want to continue donating over a long period of time and partly because most pregnancies were not achieved until after several inseminations. During my fieldwork a clinical scientist told me that he recalled going to a meeting in 1981 about the ethics of sperm freezing, and realizing for the first time from what he heard that semen donation had been going on for some years in the UK. He learned that the number of offspring was limited to 10 live births by UK doctors because of the potential hazard of siblings committing unwitting incest. He recalled that the Eugenics Society was concerned about siblings being connected in that way.

From the beginning there was lay concern about who would want to donate semen. The Wand report expressed grave doubts about the personal qualities of some of the semen donors, assuming that not all of them were motivated purely by the best of reasons: ‘A man who secretly cherishes absurd and inflated opinions of his own worth and ability may see in A.I.D. a unique opportunity to propagate these talents through a much wider circle of offspring than he could normally hope to father. He may thus – though unwittingly – feed his pride and indulge his desire for power while escaping responsibility for the care of his progeny’ (1948:54). The Feversham committee members were told that it was extremely difficult to find men suitable as donors. Young married men with children were preferred, and were often husbands of patients or former patients of the doctors. Other donors were personal friends of the doctors or known to them through friends or acquaintances. Recruitment was through the potential donor being approached by the doctor, and ‘strangers who offer

themselves as donors are not accepted' (1960:11). The personal responsibility of the doctor for recruiting donors, although time-consuming and embarrassing, ensured that the donor was suitable for donating to a particular couple. The donors had to have a semen analysis and medical examination and to be free of any hereditary disease or disability which might be transmitted to the future child. The men produced the semen by masturbation up to four hours before required for insemination and delivered it to the doctor. Payment was seldom made other than in some instances to cover expenses such as travelling costs. The committee was given to understand from witnesses that the absence of payment to donors for their services had had the effect 'of excluding from the field undesirable persons' (ibid).

### **Known donors**

Concern about the use of donors known personally to recipients was noted from early on. Barton et al in their article in the British Medical Journal stated that

Certain facile assumptions suggested by purely biological considerations must be refuted. Thus the husband's brother might be regarded as the first choice because of genotypical resemblance; but experience shows that this choice is usually incompatible with secrecy, and that it is conducive to emotional disturbance involving both husband and wife (Barton et al 1945:41).

Barton and her colleagues elaborated that they had observed cases where the donor and the woman inseminated with his semen had not been sufficiently emotionally detached in their relationship, and therefore they advised that the donor's identity should never be known to the recipients, the prospective parents. Other commentators concurred with this: a working party on childlessness was set up in 1979 because of concern in the churches in England, Wales and Scotland about the ethical implications of artificial insemination, and its report stated:

It is a generally accepted principle in the practice of A.I.D. – a principle which we feel bound to support – that the prospective parents should not know who has donated the semen and that the donor should not know to whom his semen has been given (Free Church Federal Council 1982: 43).

By way of reassurance, the report notes that usually a confidential record was kept by the clinics providing a DI service 'in order to preserve a genetic history and to prevent undesirable conceptions in the future' (p.44). The report does not elaborate

the reason for needing to maintain anonymity between donors and recipient couples, although as in reports over the years from other Christian faith groups in the UK on the subject of infertility, there is an insistence that the fundamental principle of marriage involves an exclusive relationship between husband and wife, not only in sexual intercourse but also in the procreation of children. The Church of Scotland claimed that donation of gametes 'involves the intrusion of a third party into the marriage' and might not square with 'the unqualified acceptance of husband and wife of each other in the totality of their being, fertile or infertile' (Brown and Gibbs 1996:72). The Free Church of Scotland (1990) also was of the view that the donation of gametes entailed the intrusion of a third party into the marriage at the intimate point of the procreation on children, which would cause confusion and heartbreak in the future.

The Free Church Federal Council's report insisted that the 'covenant-relationship' of marriage 'does not of course, rule out adoption, but it rules out A.I.D. as much as it rules out adultery' (p. 43). A Working Party of The Church of England (1996) described donor insemination as introducing 'a third party into the intimacies of married life in the form of donated sperm' (p.57), but admitted that there were divided views on what that meant: for some members of the working party it meant an actual breach of the marriage, whilst for others, 'the semen of a third party imports nothing alien into the marriage relationship and does not adulterate is as a physical union would' (p.57).

### **Concern about lack of follow-up**

The Wand report expressed frustration about the sparse data available about the practice of A.I.D.: 'We shall hardly be expected to furnish what so many experts cannot - the detailed information apart from which no final sociological judgments on this matter can be made' (1948:30). They noted that the element of secrecy in the practice prevented proper research and publication of findings and that 'like all to whom we have addressed enquiries, we are dependent partly upon conjecture as to what the principal effects of A.I.D. (we are not concerned here with A.I.H.) are likely to be' (p.30). Such information as the Commission found consisted of informal evidence from two doctors in America who had practiced A.I.D. for a number of

years and who reported that they had not encountered any difficulties. One doctor had advised that ten couples had returned to ask for help in having a second child by A.I.D. and that 'in all the cases he has observed, the father has accepted the child as his own' (p.29). Another doctor had pointed out that follow up studies were impossible because there was no information about who the families were. No information was available about the long term consequences to the children nor to the donors, from their perspectives.

The Feversham report noted that little was known about the development of the children conceived following DI, nor about the welfare of the family. Apparently some patients, more particularly the wives, kept in touch with the doctors for a few years, and couples with one child might return to ask for assistance to have another, but no doctor apart from just one had any knowledge of the family beyond the children's early years. Intrusion into the privacy of the family and a perceived unwelcome focus on the child's origin status were seen as obstacles. One unnamed exception amongst the doctors had sent annual letters to the wives of donor-conceived children, had also interviewed many of them, and had reported that the children had developed well and that the mothers had no regrets about having used A.I.D.

The need for research, which had been stated by the Feversham report (1960:64) and also by the Peel Report, was repeated in the recommendations of the Warnock Report (1984: para 13.9). Although respondents who were against the idea of research suggested that it was likely to be intrusive, the Warnock report pointed out that it was not possible without follow-up studies to know what the long term effect was, if any, on children conceived through AID and other new techniques. No mention was made in the Warnock report about research into the long term implications of donation for donors. There was sociological research undertaken in the late 1970s into donor insemination and the parents of children conceived at an infertility clinic in Exeter (Snowden, Mitchell and Snowden 1983), and many of the recommendations from the study were adopted in the Human Fertilisation and Embryology Act 1990. However the researchers state that donor insemination holds implications for family relationships, and that 'couples should be assisted to examine these implications openly and honestly rather than burying them' (1983:143) and that

the parents needed help to do this, which a skilled counselling service could provide. One of these implications is the lack of separate words in the English language for the terms ‘pater’ and ‘genitor’, that is for the terms denoting legal father and genetic father, and the researchers note many instances of the fathers of donor-conceived children expressing uncertainty about whether, and in what way, they are the father of their children (1983:141).

### **The move towards legislation and regulation**

Although concern about the legal situation of semen donation had been expressed in the reports which I have quoted, it was the advent of *in vitro* fertilisation (IVF) and the proposals for research on human embryos which finally led to the introduction of legislation. The birth of the first child born as a result of the IVF technique had occurred in 1978, and seemed to pave the way for developments in embryology and in ways of circumventing female and unexplained infertility. Against this background a Government Inquiry was set up in 1982 chaired by Dame Mary Warnock (later Baroness Warnock) which reported in 1984. It had the following terms of reference:

To consider recent and potential developments in medicine and science related to human fertilisation and embryology; to consider what policies and safeguards should be applied, including consideration of the social, ethical and legal implications of these developments; and to make recommendations (Warnock 1984:4).

The report was clear that it was science and technology which had prompted the inquiry, given the ‘public excitement and concern’ which the developments had engendered, and therefore the committee had decided to examine

the new processes of assisted reproduction, including surrogacy, which can cause public concern. We have also considered artificial insemination which, though practiced in this country for many years, is not universally accepted ethically (ibid).

Two significant recommendations were made in the report regarding these scientific and technological developments: firstly that a statutory licensing authority should be set up whose purpose would be to regulate research and the provision of certain infertility treatment services which would be subject to a license; and secondly that

research on live human embryos could be carried out but only up to fourteen days after fertilisation. This recommendation was the subject of fierce public and Parliamentary debate when the government finally introduced draft legislation in 1990 (Franklin 1993). The Progress Educational Trust was set up in order to lobby for the legalisation of the research, and there was controversy about the status of the human embryo and whether and to what extent it required special protection in law.

The Warnock report received evidence from a wide spectrum of organisations with an interest in the legal, social, medical, scientific and ethical aspects of infertility and embryology, as well as many individuals. The Committee members ‘were agreed that there is a need to maintain the absolute anonymity of the donor’ but it is not clear ultimately as to what reason prevailed. The report notes that it had been put to the committee that men would be less likely to offer to donate ‘in view of the risk that they might subsequently be identified and forced to accept parental responsibility for an AID child, by payment of maintenance or otherwise’ (Warnock 1984:25). The committee recommended that the law be changed ‘so that the semen donor will have no parental rights or duties in relation to the child’ that is, a child born to a woman as a result of her being inseminated with sperm from the donor. What the report does not indicate is whether any of the donor respondents agreed that they would donate if the law were thus to change, or even whether the question was put to them. What the report does indicate is a view of the donor in relation to the recipient couple which has a familiar ring: ‘anonymity would give legal protection to the donor but it would also have the effect of minimizing the invasion of the third party into the family’.

Rather than ignore DI or express moral disapproval and hope that the practice would not continue, the Warnock committee decided that the practice ‘should no longer be left in a legal vacuum’ (Warnock 1984:23). They recommended that semen donation should only be provided in licensed clinics, that donors and recipients should be and remain unknown to each other, that there should be a limit of ten children conceived from any one donor, a central register of donors should be maintained, and donors should be paid no more than their expenses (pp.80 – 82). With regard to the status of the donor-conceived child, the committee recommended that the child should be treated in law as the legitimate child of the recipient couple.

No mention was made in the report about making that proposal retrospective so that any person who had donated before the introduction of legislation would benefit from the same freedom from parental rights and duties.

By the time I commenced my research, Baroness Warnock had told PROGAR members that she had changed her mind about the necessity for donor anonymity, and indeed was now not supportive of it. Writing on the matter of reproduction, she notes that ‘the main argument against identifying the donor is the fear that in future donors will not come forward, anxious that they will have to take some responsibility for those children they have fathered by AID’ (Warnock 2002:65). She adds that she herself was persuaded by that argument at the time of the report of the Committee of Inquiry which she chaired, but no longer. She also states her belief that deceiving children about their genetic origins ‘is an evil’ and that such deception ‘arises largely out of conventional and timid attitudes’ (2002:66). She implies that these attitudes are associated with societal attitudes about the institution of marriage and about different forms of family.

### **Voluntary regulation**

The proposed establishment of a statutory regulatory authority was not greeted enthusiastically by all members of the medical profession. Prior to the legislation the profession had decided that it was essential for public confidence for the activities of infertility clinics to be regulated. However the Government was moving too slowly for those doctors who were concerned that the public needed and deserved reassurance, without which trust (and therefore investment) in IVF might be withheld. In response to this concern a Voluntary Licensing Authority for Human Fertilisation and Embryology (VLA) was set up in 1985, sponsored jointly by the Medical Research Council and the Royal College of Obstetricians and Gynaecologists. The foreword to the first annual report of the VLA in April 1986 noted that there had been ‘much public anxiety and misunderstanding over *in vitro* fertilisation’ (1986:1), but pointed out that infertility was affecting one in every ten couples who wished to have a child and that one in every hundred children was born with a congenital defect and that IVF was being used to address these problems. The terms of reference of the VLA were:

1. To approve a Code of Practice on research related to human fertilisation and embryology.
2. To invite all centres, clinicians and scientists engaged in research on *in vitro* fertilisation to submit their work for approval and licensing.
3. To visit each centre prior to its being granted a licence.
4. To report to the Medical Research Council and the Royal College of Obstetricians and Gynaecologists.
5. To make known publicly the details of both approved and unapproved work.

In 1988 another term of reference was added:

6. To contribute as expedient to the relevant public debate and legislative process.

The first report makes it clear that the primary focus of the VLA was, and would be, on clinical and research processes involving IVF, since that was the remit from the sponsoring bodies. ‘Only when donated eggs or sperm have been used for IVF has the Authority considered it necessary to satisfy itself that due and proper consideration has been given to the ethical issues caused by their use’ (VLA 1986:8). When the VLA responded to the Government consultation paper ‘Legislation on Human Infertility Services and Embryo Research’ (Department of Health and Social Security 1986) it noted that ‘Donor Insemination does not come within the terms of reference of the present Authority’ (VLA 1987:43). According to a clinical scientist who discussed the issue of anonymous donation with me, many infertility clinicians were so determined that a licensing system for clinics should be introduced that they were concerned that encouraging a debate in Parliament about anonymous donor insemination, which was being pressed by social work organizations who were against donor anonymity, would be a distraction from the urgent matter of regulating IVF practice and research. This perception is supported by Cusine (1988) who notes that after the publication of the Warnock report, surrogacy and research on human embryos ‘continued to occupy most of the post-Warnock discussion, almost to the exclusion of other topics’ (p.193).

The VLA did give attention to the recruitment of egg donors. In its second report it clarified that the Authority had no clinical objection to women donating eggs except that ‘egg donors should remain anonymous and for this reason alone,

donation from any close relative should be avoided, as this may not be in the best interests of the child' (1987:43). This view was not universally supported: in its fourth report the authority gives a summary of a meeting in 1988 on egg donation held jointly with the King's Fund Centre. The report noted that Dr Virginia Bolton (an embryologist currently still in practice) who had presented the findings of a study into the attitudes of IVF patients into egg donation, had argued 'for flexibility in allowing relatives as egg donors' but also that two professors of social science, Janet Finch and Jean La Fontaine 'addressed the social and anthropological aspects of donation involving related donors. Both cautioned against it' (1989:15). Their reasons reportedly included the perception that

Donation between sisters is not the simple gift it might appear initially because it cannot be reciprocated. It is a gift of such magnitude that it goes beyond the natural run of reciprocity in family obligations and cannot be returned. Another point to be considered was the relationship of the husband to his wife's sister and the child's perception of it. The position of a husband in relation to his wife's sister is of particular significance in human relationships.

(Voluntary Licensing Authority 1989:15)

The VLA's report describes the views of participants at the meeting as having varied widely, especially on the question of the child's right to know its genetic identity. The authority concluded that this was an 'ethical' issue, and that 'the weight of the argument lay on the side of caution' (1989:16). Therefore the Authority would continue to advise that donors should remain anonymous.

Following a hunch that I had attended that meeting in 1989 as a social worker, I recently searched for and found my notes of it amongst my personal papers. Of interest are some points which I recorded from the speakers but which the VLA report omitted: Virginia Bolton noted that rules about who should be allowed to donate were being drawn up by people who were not affected, that is, the professionals, and that the research study had revealed that many respondents were worried that the mothers of children conceived from donated eggs would not be treated by them as the real parent. According to my notes, Jean La Fontaine had pointed out the importance of cultural differences, and how in some societies, donation by a relative would be expected. Her observation had been confirmed by comments from some audience members from ethnic minority groups. Altogether, it appears that the VLA decided that donation from relatives should be discouraged,

and donor anonymity supported, because of the attitudes of the members about family formation. What is clearly a cultural matter is framed by the VLA as an ethical one.

### **Rationale for service development**

Given the many problems with anonymous donor insemination, why did the provision of the service not only continue, but increase? One clinician told me that there was an inconsistency in the practice of anonymous semen donation: it meant that donor-conceived people would have very little access to information about their ‘genetic pedigree’, as he put it. He added:

By and large up until recently, it’s been a wee sort of voice in the back of one’s mind saying, heh, this isn’t quite right, but the voice is sort of suppressed, you are focussed so much on the couple in front of you and their needs, and welfare of the child is assumed, in the context that it is born and it is healthy, and its welfare is being attended to really. But I think now people aren’t quite so sure about that.

This inconsistency was not even in the minds of some medical practitioners: a retired NHS clinician who was responsible for an infertility clinic in the 1970s and 1980s, explained to me that it was because of the medical response to the needs of patients that doctors like himself had provided DI services:

Clinician: Couples are desperate. If you work in infertility you see that desperation. People are prepared to do almost anything.

Jennifer: Why are they desperate?

Clinician: It’s a basic human need to reproduce. Also, it means that you are the same as others.

Jennifer: Is there social pressure?

Clinician: There’s both social pressure and a biological urge. And parents put pressure on couples. The desperation is almost like an illness.

For this clinician, providing a donor insemination service was the result of what he called ‘a pragmatic approach’ to the problem of male infertility, although his view of the necessity of it being anonymous had changed over the years. It had been necessary to maintain anonymity in the past, he said, because it was thought that otherwise, men would not offer to donate. When I told him that Baroness Warnock

had changed her mind and was now not in support of anonymity, he replied 'Quite right too!' He also thought that, with hindsight, he should have had a social worker involved with the work of the donor insemination clinic, and perhaps a sociologist as well. At the time, however, confidentiality was a priority.

The sense of 'desperation' is summed up by an infertility specialist, a clinician who has been working in the field since 1984 and who was one of my (non-donor) informants:

The despair felt by some disappointed patients is unbelievable until you are touched by its potency. The hopelessness, the sense of failure, of biological rejection, often turns the infertility clinic into a minefield of emotion and distress. (Cowan 2003:16)

The desperation has been commented upon by social anthropologists from research in the UK (Franklin 1997; Konrad 2005). In her analysis of anonymous ova donation, in a description with Biblical and therefore ancient connotations, Konrad notes 'the lamentations', the emotional phenomena in the background of commercial IVF services (2005:239). The particular distress of male infertility is described by another specialist, a clinical scientist specialising in male infertility whom I had met before my fieldwork started: 'A diagnosis of male infertility is shocking, not only because of its social stigma but also because those who seek a second and third opinion find themselves becoming confused, isolated and frustrated.' (Lee 2003:73). He adds, in stark terms:

In recent years I have become the harbinger of doom. They [the patients] sometimes tell me that they do not wish to hear my information, which may have the ring of a death sentence, but some do thank me for taking off their rose-tinted spectacles (2003:74).

Given the distress caused for many people by infertility, Baroness Warnock explains how the Committee which she chaired decided that it would be wrong for doctors 'on compassionate grounds, not to offer assisted conception to those who sought to overcome their infertility, in other words that the medical profession had a duty...to continue to provide assistance' (Warnock 2002:42). Such assistance refers to medical intervention, not to the alternative of helping the involuntary childless to find ways of adjusting their lives to infertility. An infertility counsellor noted that historically, there was an emphasis on a clinical perspective in dealing with infertility, and that 'it is possible that in the rush to find ways to assist reproduction, little opportunity was

provided for people to acknowledge their feelings, far less help to cope with them' (McGhee 1993:2).

However, the continued involvement in the provision of DI services was not only a way of doing something to help childless couples: it was also a way of satisfying the wish to be involved with reproduction. A doctor who has been responsible for many years for a private sperm bank told me of the great pleasure which he had derived from the work of helping to produce new life. It was so rewarding to be involved with helping to create babies, but he added, with a little embarrassment, 'Easier than helping to deliver them'. A clinician currently working in an infertility clinic recalled that the service there had probably been started by a professor who was a 'big name' in the field of research into ovulation and when the professor had retired, the local newspaper had printed an article celebrating his life and work together with a photograph of him, 'surrounded by hundreds of babies and it said something like "father to thousands" which alarms one a little bit'. It was interesting that my informant recalled this headline which was probably conjured up by a sub-editor with an instinct for the double meaning which readers would attribute to the word 'father' in this context. The professor was not the genetic father of all of these hundreds of babies, we assume, and had he been so then indeed it would have been alarming, an excess of masculinity perhaps. He was given the epithet 'father' because he had been essential to the production of the babies. His work as a doctor had helped the conception and birth of many children.

I asked my informant to expand on the implications of the newspaper article's headline 'father to thousands':

Jennifer: Is there something about helping to bring babies into the world that you think maybe just appeals to a part of the

Clinician (interrupting): Well, I suppose so. There's photographs there....it just happens to be here, but eh, I get a Christmas card from this couple.

Jennifer (with a gasp): Quads!

Clinician: I think that's the best photograph I've, quads, yes.

Jennifer: Good Lord! They look very healthy.

Clinician: Yes, they are....so I am thrilled to be part and parcel of that, it's

terrific.

Like many infertility specialists working in the NHS, in contrast to the private sector, this clinician worked also as a specialist in obstetrics and gynaecology. He was aware that he obtained emotional reward from the work of helping women to reproduce, the ‘thrill of managing childbirth’, the use of his skills to ensure that childbirth had no life-threatening nor long-term health consequences for the mother and the baby, and of course, ‘the immediate result is clear to see’. Unlike in other medical specialities, there are ‘immediate results’ although these might not always be good ones. A ‘catastrophe’ might occur because of something which the doctor did or did not do, ‘and you have to deal with that’, he said. The clinician went on to suggest that he and many of his colleagues were in the medical field because they liked the idea of helping people, and people responding with thanks. He said that it was nice to be thanked and that ‘There’s an insecurity amongst us all.....bolstered up by people saying yeah, you’re doing a good job, thanks very much, thank you’.

### **Conclusion**

This summary of some historical aspects of donor insemination in the UK, and especially of the controversies surrounding the practice, show that it was a cause for concern for many people. The involvement of a semen donor, even if the man was anonymous to the recipient, was believed by many to be adultery, and if not legally so, then certainly in the imagination of the parties concerned. The article by Dr Barton and her colleagues in 1945, the Peel Report in 1973 and the proceedings of the RCOG study group conferences in 1974 and 1985 reveal consistent concern that donors should never meet with recipients in case adulterous feelings developed. Daniels has suggested that it was only in the 1970s that semen donors began to be recognised as ‘a person with feelings, thoughts and actions, rather than a “non-person”’ (1998:79). My exploration of the Wand and Feversham Reports and the views of some faith groups, has shown that donors were very much viewed as persons, although not always as responsible ones. Donors as men with human feelings needed to be kept apart from the people they were supposed to be helping by means of donating their semen. Certainly in the long term the donors were supposed to absent themselves, whether they wished to or not.

The influence of eugenics in the development of DI is apparent in the way in which concerns were expressed about it. Medical practitioners did not show enthusiasm for eugenics in the sense of selecting out ‘unfit’ people and preventing them from reproducing, but they were concerned to recruit young men with positive attributes such as good health and high intelligence. Indeed the practice of semen mixing in A.I.H.D. was a deliberate ‘blurring of the issue’ of the source of the genetic substance (Snowden, Mitchell and Snowden 1983:15). Paradoxically, whilst certain characteristics were sought after by the infertility specialists, the fact that young men would be willing to donate their semen at all was perceived as problematic by those who opposed the practice of DI, and who suggested that donors did not have a right attitude. The method of producing the semen, by masturbation, added to the difficulty in accepting DI as a proper way to help couples. Indeed it was suggested, particularly by some faith groups, that it would be better to remain childless than to use artificial human insemination as a way to achieve a pregnancy.

Medical practitioners insisted that DI must be kept secret, partly as a protection for themselves against legal liability if anything went wrong, but also in order to protect the marriage of childless couples from the stigma attached to male infertility, and to protect the donor-conceived child from the stigma of illegitimacy. It was believed that the implications of not keeping DI a secret would have adverse implications for the marriage and for the child, and concealing the fact that a child was donor-conceived was thought to be best for the protection of the family. It was also believed to be necessary for the protection of the semen donor from accusations of adultery and from claims for financial support of the child. The legal status of donor-conceived children in the UK was not clear, and the morally and legally precarious position of the practice in the medical endeavour to help childless couples to have children led the early practitioners to encourage, even insist upon, a climate of secrecy. Couples were advised not to tell their donor-conceived children about the nature of their conception, clinic records were not always retained, and above all, identifying information about donors was kept from the recipients and sometimes from the clinic staff too.

A reluctance to legislate on the part of successive UK governments is clearly evident: forty five years elapsed between the publication of the article about

anonymous semen donation in the British Medical Journal by Dr Barton and her colleagues, and the passage of the Human Fertilisation and Embryology Act in the UK parliament in 1990. Only in the late 1960s was legislation passed which ensured that in cases of divorce, separation or nullity of marriage, a donor-conceived child was eligible for maintenance (Cusine 1988:56). The 1990 Act introduced provisions for regulating donor insemination services and defined who was to be considered as the parents of a donor-conceived child, but did not deal comprehensively with the issues which reproductive technology was raising for the existing structure of the family in the UK (Douglas 1991:138). Meg Stacey suggests that the lack of action on the part of the government was only to be expected, given the 'libertarian traditions of the country', and 'the conflicting interest groups in the electorate' (Stacey 1992: 171). She notes also that the matter has tended to be defined as a health problem, and then given low priority in the National Health Service. Thus it operated outwith the usual sphere of influence of social researchers and policy makers.

The medical profession itself appears not to have taken steps to lobby for a change in the law, possibly because the practice of anonymous donor insemination reveals a fundamental contradiction between the perceived need for secrecy and possible long term genetic issues for donor-conceived people. The infertility specialists were preoccupied with immediate service provision. They were concerned about the safety aspects of semen donation, and about what they thought was in the best interests of the recipients, but these were focussed on the short term. Donor Insemination only became subject to regulation as a result of the introduction of legislation primarily addressed to the concerns about the technologically more complex and risky practice of *In Vitro* Fertilisation. Little or no attention was paid to the possible long-term implications of encouraging patients to introduce deceit into their family life, perhaps because there were thought to be no such implications. Semen donors themselves were an essential but apparently temporary resource for helping infertility specialists to gain the reward of helping childless couples to become a family, and therefore just like everyone else.

### **Chapter Three: Semen donors: the business of recruitment and donating**

In the previous chapter I described and analysed the ways in which semen donation developed as a response by the medical profession, particularly those specialising in obstetrics and gynaecology, to the problem of male infertility. The voices of donors themselves have been noticeable by their absence. In this chapter I shall describe how the donors who agreed to be interviewed by me narrated how they were recruited, and what they recalled of their motivation for donation and their intentions in donating. Further aspects of donor self-perception and of lay and professional attitudes to donors will emerge from exploring why other doctors did not donate, and how the action of donating is talked about by the donors.

The use of donor insemination to enable a woman to achieve a pregnancy requires that a fertile man provides semen which contains healthy sperm. In so doing he is termed in the UK a sperm donor, or in general terms a ‘gamete donor’ (Department of Health 2005), ‘gamete’ meaning either sperm, or ovum (egg) or both. As I noted in Chapter One when discussing terminology, the term ‘donor’ has not been accepted universally by those working in or researching the field of infertility, and has been given different meanings. Daniels (1998:76) recommends that ‘provider’ is a more accurate description, since the word ‘donor’ implies gift qualities in the intention and transaction. The difference between the two terms points to the actual or perceived differences in the role of the man and in the meaning given to the semen by him and the others involved, namely, the donor insemination service organisers, the semen recipients and the person conceived as a result of the donation. Daniels notes that the term ‘vendor’ has been used (Annas 1980) and also ‘consignor’ (Blank 1980). Diane Tober (2002) suggests that the concept of ‘reproductive work’ is useful for analysing the practice of semen donation. Her fieldwork in America involved interviews with the staff of commercial sperm banks, with single women and lesbian couples using DI in order to achieve a pregnancy, and with paid semen donors. She points out that although semen donors do not refer to themselves as ‘reproductive workers in the way that prostitutes might refer to themselves as ‘sex workers’, nevertheless, reproductive work in being a semen donor and sex work both involve the commodification of bodies and bodily practices

(Tober 2002:154). Tober also found connections between sex work and semen donation in the way in which sperm bank websites advertised for semen donors and the higher rate of payment to sperm donors in comparison to egg donors (2002:156).

The term 'donor' usually implies a person who gives something for the benefit of others or another, without financial reward or inducement. Any reward comes from enhanced self esteem, feelings of altruism, and if the giving is not secret, then also the approval of others. There may also be gratitude from the recipient. In contrast the term 'provider' acknowledges the possibility of a commercial or other type of economic transaction, in which the provider receives financial or other material benefit in return for the thing provided. The term 'donor' is in general use in the UK and I shall continue to use it here without suggesting that it carries a particular emphasis.

Whichever meaning is used, does the term fix a particular status for the donor? Can one ask 'what it means now to have been a semen donor' as though the status belongs to the past? Certainly, that is how it is portrayed by a number of people professionally involved in the field of infertility treatment. The status of semen donor is associated with an action, or more correctly a series of actions, in the past. It is not considered to be a part of current identity. The donors that I interviewed usually described themselves in that way. It was 'I once gave sperm', 'I donated sperm when I was a student', seldom 'I was a sperm donor' and never 'I am a sperm donor'. It was a young medical student currently in training and who has not donated semen, who suggested to me that there is a concept of 'donorhood', drawing a particular meaning of permanent status from the action of the past. One doctor donor, who responded by telephone to my request for help with my research on the Doctors.net website, told me, 'I was an ex sperm donor'. One donor told me that being a donor stops when the donations stop: after that, a man becomes an ex-donor because he is no longer giving and has no connection to the recipient. These answers seemed to depend on the meaning of the donation as defined by each individual and their social circle, and there was no difference between men whose original motives to donate might make them 'providers' rather than 'donors' in the perception of others.

## **Remembering and retelling**

At an international conference on adoption in 1997 which I attended, one of the speakers began his address with the significant information: 'I am a birth father'. He then added, with a mischievous expression on his face, 'That is the truth for today. Tomorrow it may be different, depending how much I trust you'. This addendum is not included in the published version of the presentation in the conference proceedings (Walker 1997). It was offered to conference participants to explain that we would not be hearing the whole story about how Walker came to be a birth father and what implications the information had for his presentation. Information provided about the past clearly may not represent the truth of what actually was the case twenty or more years ago when my informants donated or decided not to donate. I cannot know what that truth is, and have to accept what was said as 'the truth for today'. Donors were aware of this and frequently apologised for absence of detail, reminding me that for some of them the time when they donated was up to forty or more years ago. The stories which they told are a part of how they view themselves now.

The stories raise questions about the accuracy of memory and also about the ability to recall. I was surprised by the extent of this: after several decades some donors remembered the names of the doctors who had recruited them to be donors or who had assessed them at infertility clinics, and other information about the context of the donating. Equally interesting was the information which they said that they could not recall, such as the name of the medical practitioner who owned or managed the clinic. In her essay about Javanese people who are former servants of Dutch colonial households in Indonesia, Ann Laura Stoler and her associate Karen Strassler describe the way in which information about the employment and the relationships with former employers was recalled (Stoler 2002). Stoler and Strassler note that memories which were 'rooted firmly in the senses' were the ones which were 'recounted with the most energy and engagement' (2002:198) and that the people whom they interviewed were able to remember 'the detailed menus of meals eaten more than fifty years ago' (ibid). Stoler and Strassler suggest that the prevalence of memories about food reflects its symbolic importance in the lives of the employees.

David Rubin (1996) notes the paradox that our autobiographical memories are not always accurate, but we believe that they are, even in the face of conflicting evidence. One reason for this may be that these memories are accompanied by images which provide details of events, and which convince us that we are dealing with a memory of an event and not simply thinking about it (1996:4). Another explanation is given by John Robinson (1996) who suggests that 'remembering, like perceiving, is guided by present ways of understanding. Memory will be most stable when we construe events in the same way as we did originally' (p.214)

### **How donors were recruited**

The means by which donors were recruited was usually brought up early on in interviews by the donors themselves. In some cases I had some knowledge of this beforehand because I had been told by the go-between who had made the introduction between us. Most donors, whether doctors or otherwise, were recruited as undergraduate students. They were mostly aged between 19 and 23 at that time. Donating semen involved visiting a clinic either to hand over a sample of semen produced by masturbation elsewhere, or to produce the sample there. The number of donations varied, as did the period of time over which the donations took place. The clinics were either privately run or part of National Health Service hospitals.

Students who donated in clinics within National Health Service hospitals were recruited mainly through the efforts of clinical teaching staff in medical schools. Male students in their pre-clinical years of medical training might be invited to stay behind at the end of a lecture about human reproduction. Alternatively they might be told about the need for semen donors to help childless couples and then invited to put their names forward as possible donors. Students doing their Obstetrics and Gynaecology department placement in the fifth year of medical school would be approached personally and individually by a senior doctor who knew them. Several donors told me that it was made convenient, or even easy, for students to donate, if they were donating at their medical school hospital. There was little travel time involved and no time nor energy had to be put into attending a counselling session with a psychosocial expert such as a psychologist or medical social worker.

An exception to the donors who donated as students was a doctor who donated after the birth of his third child, his wife having been asked by her obstetrician if her husband would be willing to donate semen. This donor told me that he had been flattered to be asked. He understood that he was assumed to have proven fertility since there was no questioning as to whether the three children were his genetic children or not. Neither the donor nor apparently his wife had had objections to this method of recruitment. The go-between who introduced this donor to me, a female health professional of the same age as him, told me that she viewed the method as ethically 'dubious', since it involved giving consent to an action with long-term implications at a time of emotional vulnerability. After the safe delivery of their third child, it was suggested, a husband and wife would feel such gratitude towards the obstetrician that the request could not be refused. I learned from senior medical practitioners that the practice of recruiting from maternity wards had never been a universal one in the UK and that obstetricians at other hospitals disapproved of it.

One donor who told me that when he was a medical student he had recruited three friends to donate at the same clinic as himself, heard about a need for sperm donors at a meeting organised by the Eugenics Society which took place in the hospital where he was a student. He was not a member of the society but went along with a female friend, another medical student, out of interest in the topic of the meeting:

I mean the context is... the Eugenics society were having an evening meeting about artificial insemination at (name of) hospital and we rolled along there.

The donor remembered two speakers addressing the meeting.

One was a woman who really had used AI as a means of supporting people who couldn't have children, on a very non-commercial....she was a woman from Exeter....She had inherited a sperm bank from various people, she had a very, she saw it as a sort of, it was obviously nothing to do with money the reason she was doing it, she thought it was a very good way to help people to have children which they could have very natural relationships with, complete themselves, complete their families and eh, very decent woman I remember thinking back she was sort of member of the old fashioned Whig establishment, I thought. You know, I liked her and ..... she came along with... .respect...

Jennifer: She was a doctor?

Donor: I presume she was – I can't remember, it was a long time ago, I think she was a doctor, I think they were both doctors.

The donor here is recalling that he was impressed by what the doctor at the Eugenics Society meeting said, and how she said it. Her attitude towards people with fertility problems and the use of donor insemination as a way of helping them to become a complete family, was respectful. She had come across in a reassuring way.

In the recounting about recruitment, the influence of senior doctors in the medical profession was clear. None of the donors recalled being given the opportunity to discuss whether semen donation was an appropriate thing for them to do. Medical social workers who were employed in hospitals at that time and who would normally have been called upon to provide counselling to people in complex areas of decision making were deliberately not involved by clinicians who so appreciated their services in other areas of patient care that they tended to speak of 'my' medical social worker. Although a few infertility specialists involved medical social workers in the counselling of the semen recipients, and reported that this was very beneficial for the couples concerned (Thompson et al 1985:302), I was told by some retired doctors that social workers were deliberately excluded from the work of the DI service, partly because there appeared to be no need for counselling of donors but also in order to maintain secrecy as much as possible. Students who donated did not discuss amongst themselves beforehand the possible long term implications of donating.

Amongst the non-donor doctors who I met during my fieldwork there was always respect and deference shown to their seniors. Both they and the doctors who had donated as students or later, often described how their career pathways as newly qualified or junior doctors were mapped out for them by senior doctors in whose teams they had worked as students or junior housemen. In addition to the recognition of the influence of senior doctors on their job opportunities there was the injunction of the Hippocratic Oath which requires graduating medical students to show respect for their seniors. There might be public scraps between doctors of the same generation, and I witnessed these on several occasions acted out at conferences, during infertility clinic inspections or through the medium of newspapers, and

relayed to me in private conversations. One example of this, which was the focus of much dispute during the time of my research, was the practice of multiple embryo transfer in IVF treatment. Some infertility clinicians strongly believed that only they, in conjunction with female patients and their partners, should decide how many embryos should be transferred to the patient, and not the medical profession nor any regulatory authority such as the HFEA. Respect for the older generation of doctors was portrayed as a traditional value and I noticed how often a doctor would say something kind about an older colleague who had been a teacher or a member of staff senior to them in the past. This perhaps explained why the doctors who recruited student donors were thought by the donors 'to know best'. This applied particularly to the donors who were recruited by doctors working in the National Health Service. Two of the doctor donors whom I met had donated at a clinic which did not pay donors although travelling expenses were reimbursed. One had been a young married man at the time and as noted, the mutual friend who introduced us wondered whether in the circumstances the donor's consent had been fully informed. The other donor had donated as a fifth year medical student during his Obstetrics and Gynaecology placement and the approach from the recruiting doctor had been personal in his case too. The donor recalled that the doctor had asked him if he would donate, and had added that he was sure that the student would understand the need.

The doctors who ran the private clinics did not always receive the same respect from the other donors who I met. One of the non-doctor donors made overt criticism of them and their recruitment practices. He described the private clinic where he had donated as having presented the need for donors 'mechanistically': there was no counselling, donors' sperm would be mixed with that of the recipient woman's husband before insemination, and 'things were glossed over'. He believed that this was due in part to the 'culture of pretence' in society at that time, the late 1960s, whereby the husband of the mother of a donor-conceived baby was passed off as being the genetic father of the baby as well as the legal father. This man was one of several donors who I met who had subsequent family experience of adoption, and he contrasted what he described as the reflective support and discussion there with the 'conspiracy' in donor insemination to keep discussion 'shut down'. This donor,

who had been recruited by a friend who also donated, had donated for financial reasons.

There was also criticism of the private clinic doctors from two of the donor donors. One of the donors noted the extent to which the fees paid to these clinic doctors by patients with fertility problems would pay for ‘another wheel on the Ferrari’. Another donor described how it was clear to him at the time that the doctor in charge of the clinic where he donated was running a lucrative business. According to the donor, he had showed no care at all towards the young donors, and, as the donor recalled, only a superficial medical history was taken from them. By this the donor was suggesting that the clinic doctor was also showing no care towards his patients, the semen recipients, nor the future donor offspring. Although the system of relationships in hospitals at that time was described as ‘very hierarchical’ and this particular clinic doctor ‘ruled the roost’, the donor said to me, ‘I felt superior to him because he was not a special doctor’; what he was doing, that is providing a donor insemination service, was ‘not like other medics’. In other words he was not working in a way that required use of complex knowledge and skills, but was using the work of others, the young donors who produced the semen for him, and thereby earning a lot of money for himself. The donor recalled how he and his fellow students at one time had asked for more money for their donations. The clinic doctor had become upset and angry but gave in to the students’ demand because, the donor told me, ‘it wasn’t so easy to recruit donors after all’.

### **Motivation**

The reasons for donating included the wish for various kinds of reward, the result of social pressure and wanting to have fertility confirmed. For each donor there was seldom just one reason for donating, and the reason which propelled the would-be donors to the clinics was not always the same one which kept them motivated to donate over a period of, in some cases, up to two years.

The event of the first donation was accompanied by some anxiety, not about the physiological process of producing the semen sample but rather whether the semen would be inadequate in some way. In order to be useful it had to contain sperm of sufficient number, motility and appropriate morphology. This was

especially important after cryopreservation was introduced in the 1970s because sperm had to be robust enough to withstand the process of being frozen, stored and then later thawed just before insemination. After quarantining of sperm was introduced in the 1980s due mainly to the spread of HIV/AIDS, and the risk of donors passing on the virus through their sperm, the period of storage became a minimum of 6 months. One would-be donor now aged in his 60s had had his donation rejected because 'it was not good enough'. He told me that he had not been upset however, because he and his wife already had children, and he knew that sperm quality tends to decline with a man's increasing age.

For donors who were young students, the prospect of their sperm being assessed as inadequate, or worse, that they might be infertile, was a worry. I heard several stories of a temporary misdiagnosis of infertility because a sample had not been delivered in time to the clinic. One donor had passed a sample to a friend to give to the clinic for him and the friend had got delayed on the way. Fresh semen, if it is to be used for insemination must be used within 3-4 hours of emission from the body. Another donor recalled that he had received a telephone call after giving his first donation telling him that he might be infertile. He had taken the sample to the clinic with him on his motorbike and it had cooled. The next time the donor made a donation, he wrapped the pot containing his semen sample in cotton wool, and travelled to the clinic on the underground. He was not infertile after all. Nevertheless there appears to have been no possibility that the private clinic would provide a comfortable and private room for the use of the donors to produce their sample, in order to avoid such a situation occurring in the first place.

Donors seem to have devised ways of finding an appropriate place to produce their semen donation, and one of them remembered rather enjoying the routine of cycling across the city where he lived in order to give his sample in to the clinic, but finding privacy and dignity was not always easy. In order to avoid interruption from flatmates or family or the risk of delay in getting the sample to the clinic, if it was produced at home, some donors went to public lavatories near to the clinic. This too was not without problems, as one donor told me:

I used to get a train up to Waterloo and masturbating in Waterloo station lavatory and I remember having a note pushed through... obviously this homosexual next door and I really didn't like that.

To the embarrassment of the donor, the physical act of masturbation had been overheard by another man who might have assumed that he, the donor, would be interested in sexual activity with him. The donor admitted that ‘the whole business about masturbating in time to deliver’ the sample to the clinic caused him bother. At first it had not been a problem but then he got married, and he said to me, after a pause and a resigned sigh, ‘I didn’t like masturbating in the same house as my wife’.

One donor’s wife who joined her husband for our meeting commented that producing the sample in a lavatory was ‘sordid’. Her husband, who is a doctor, disagreed: it did not feel that way to him, but he admitted that jokes about semen donation helped to deal with any potential embarrassment. Also in his case there had been what he described as ‘a club attitude’ because fellow students were donating too. He also pointed out that medical students tended to be unshocked by nudity.

The lack of adequate provision by clinics of a suitable place for semen donors to produce their sample is commented upon by Daniels (1998:98). He argues that

For men to have to use a toilet cubicle to masturbate and produce their semen sample is not according them a status or recognition that is in keeping with them making a gift of life.

Daniels goes on to suggest that this practice is depersonalising and in keeping with a view of donors as ‘semen producing machines’ (1998:98). Views from donors themselves have been recorded by Daniels and other colleagues in Sweden, where donors donated mainly from altruistic motives and in the knowledge that under Swedish law they would be identifiable in future to donor offspring (Lalos, Daniels, Gottlieb and Lalos 2003). In answer to the question about what were the least satisfactory aspects of being a semen donor, most replies ‘focused on dissatisfaction with the facilities provided for the collection of the semen. Often this had to do with difficulties producing a semen sample or where they have to masturbate and feelings of embarrassment’ (2003:214). The impression given by these accounts from semen donors is that the sexual, perhaps noisy, act of masturbation and ejaculation must not take place within the pseudo-domestic setting of private clinics some of which are still located at prestigious London addresses, or that the clinics perceive donors as able and willing to perform whatever the setting.

## **Financial payment**

This was the commonest reason given for deciding to donate and to continue donating. Most donors were paid, and the amount was variable, ranging from £4 per donation in the late 1960s to £15 in the 1970s and 1980s. Another donor thought that £4 was about the equivalent of £40 in today's prices. One donor recalled that he was paid £5 per sample, at a time when his nurse girlfriend's weekly salary was £47. Donors and non-donor doctors told me, with mixed admiration and disapproval, stories of some students earning considerable sums of money by donating sperm. A non-donor doctor told me that a former fellow medical student in his year had earned enough money from donating semen 'to support a mistress [a married girlfriend] on the proceeds – which was quite something for a student then'. Regrettably for my research project this donor refused to be interviewed. The story and the reaction to it by other donors when I told them about it, indicated that although the donor's enterprise was admired, his use of the money and the fact that he earned so much was not. Some kind of boundary had been crossed, it was suggested, between the financial payment helpful to a student on a minimum grant, and selfish hedonism.

For most donors, the money had been considered a welcome addition to their income from student grants. One said that it was 'enough to buy two cinema tickets and a box of chocolates for the girlfriend'. Another remembered that 'we were paid £10 a go' and that 'it was a significant amount of money. It bought 40 pints in the medical school bar'. This donor did not mean to imply that he had used the money for that purpose, rather he wanted to describe to me the value of the payment in financial terms at that time. For some donors the financial reward was significant. Although, as medical students, they would be able to anticipate considerable future earning power, as students without long holidays in which to take temporary employment or as young husbands with a baby and stay-at-home wife, they were, at least in the short term, socially disadvantaged (Scheper-Hughes 2002:2). Like the anonymised organ givers described by Scheper-Hughes as 'invisible and discredited', semen donors stood in contrast to the recipients, 'cherished patients, treated as moral subjects and as suffering individuals' (ibid:4).

In discussing reasons for donating, one donor specifically suggested that there was something wrong about having done so for money. He said that it was the fact

that donating for money might be seen as shameful by his children that had so far prevented him from telling them that he had donated semen as a student. For him, the donating had been 'a financial transaction'. By contrast, another donor was reassured that he had been given a financial reward: 'I'm happy that I donated for money. Makes it clear that you could draw a line under it'. Being paid meant that there was no need for further thought about the donating and its long term implications. It was a short term transaction.

A different perspective was given by a retired clinician who worked with infertility patients during the 1970s. He told me that semen donors had not been paid because payment would have attracted unsuitable donors. Treating donors as if they were volunteers helped to ensure, as much as possible, that donors would not be drug addicts, alcoholics, or 'thieves, brigands and bad hats in general'. He had wanted donors to be altruistic and to have no regrets, which he thought might happen if donors were 'coerced' with financial reward.

### **Non financial motives**

I did not gain any impression that donors were justifying having donated when they described non-monetary reasons as having been significant too. They did not seem to be trying to put a different spin on a long ago event. Often a variety of reasons were given by individual donors. Several recalled having gone along with others, not necessarily with the definite intention of donating semen. One donor told me: 'Someone mentioned at university that donors were needed. A bunch of us went up [to the clinic] for a laugh'. The implication is that the activity of going to a clinic and offering to donate semen, without considering that it might not be some sort of entertainment, was the kind of thing that young male students might do. An embryologist who has worked in an infertility treatment centre for many years told me that she recalled when the male students of an entire geography class at the nearby university turned up offering to donate semen.

Several donors mentioned that they had had a curiosity to know whether or not they were fertile. They remembered when young men with whom they had visited a clinic had been 'rejected' because their sperm count was not good enough.

Only one donor was told specifically that pregnancies had been achieved as a result of his donation and he remembers having felt very pleased that he had been told.

One donor had been a member of a university rugby team which needed a new set of shirts and the set was promised by the recruiting doctor in the hospital as a reward to the students in exchange for donating semen. The students were asked to donate on five occasions. If they returned for another session of five donations then they would be paid £50 each. The donor told me that he believed that he would not have donated had he not been a member of the rugby team. He remembered the recruiting doctor, a senior lecturer, as having been 'persuasive'. There had been no serious discussion with the doctor nor amongst the students themselves, about any long term implications of donating semen, just joking in the pub after playing rugby that they would 'shoot it out for those without'. Although this joking acknowledged the existence of another person as the potential recipient of the donation, namely an infertile man, it shows an almost slogan-like quality which worked as part of the social pressure to participate in the activity of donating.

Few donors had come across people with fertility problems by the time they donated. Most of them heard about childlessness from the recruiting doctors. The donors recalled the recruiting doctors who worked in the NHS explaining about the plight of childless couples and how the students could help by donating semen. Several donors viewed themselves as being like blood donors in responding to this request for help. They were assisting people in need of a substance which they, the donors, could supply. Like blood donors they were making a contribution to society. They felt good about donating because they believed that they were helping people in need. Even if they had no experience of infertility themselves, they were sometimes touched, as they called it, by feelings of compassion. Even as students they had compared their own family of origin experience of being one of several children, with the childless prospect of the infertile couple with male fertility problems.

One UK-born non-Caucasian donor had heard from his doctor father of how badly childless women were treated in the father's country of origin. Knowing that donors from his ethnic group were rare in the UK, this donor hoped that his donation would help childless women in the UK who were of the same race. This donor and others mentioned that their donating was partly out of altruistic motivation, although

this was with the benefit of hindsight. One donor was very clear: ‘I was not altruistic in my youth. My donation was for money’. The wife of another donor suggested that young people were not altruistic in that way, and that money was a significant inducement to donate. I asked another donor whether he would donate again:

Donor: Well I can’t because I’ve had a vasectomy but I guess that is not what you mean. Yes I might, but at the time I did it for money.

Jennifer: No altruism?

Donor: Not really.

Some donors who donated in the 1960s were recruited by doctors working in private clinics who were members of the Eugenics Society. The donors recall being told by these doctors that it is important for people with good intelligence and good health to reproduce. Even if they were recruited by NHS doctors who were not Eugenics Society members, donors mentioned that there was an aspect of ‘spreading the genes’ or ‘contributing to the gene pool’ which had appealed to them. This spontaneously offered information was usually accompanied by a wry smile, as though that reason for donating was not entirely wholesome and might shock me, or as though a grey-haired 60-something man could never have entertained such a self-flattering idea.

None of the donors said that they had questioned, at the time of being recruited, the rightness of donating semen anonymously to help childless couples. All of the donors except one, who is unmarried, and all but one of the non-donor doctors whom I interviewed, have had children and some have grandchildren. They referred in passing to the wonder of parenthood, and the rewards of family life, and the hopes that their adult children would find satisfying jobs and partners. I would notice the pride and delight on their faces at the prospect of a visit to the grandchildren. One non-donor doctor said that children were ‘a reason for getting out of bed in the morning’. My observation of donors’ interaction with their children, although limited, was of warm and involved relationships. Many donors did not think that they knew any childless married doctors. Helping people to have a family seemed the right thing to do. Only two, now senior, infertility doctors who were involved in running DI clinics told me that they remembered thinking at the time that the practice was problematic. ‘There was a small voice, but we ignored it’, one told me,

indicating that there had been no stopping to review what the long term consequences might be, if indeed there were any, and whether the practice was free from harm.

### **The meaning of the donation**

The purpose of donation to a clinic is to help a woman to conceive a child through the assistance of donor insemination. However, the meaning of donation is complex. It was so at the time when my informants donated, a time spanning approximately twenty years from the late 1960s to 1987, and it has remained so during the debates in recent years about removing donor anonymity for future donors.

The medical practitioners who recruited donors gave a mixed message to would-be donors: donors were required in order to help unfortunate childless couples but donations would be paid for. There was no contact between donor and recipient. The clinics were brokers, buying from one party and selling or providing the product to another. The brokers were rewarded financially if the clinic was a private one, and in any case with feelings of pride in successful pregnancies and the gratitude of patients. Their involvement with patients ended with the establishment of the pregnancy or the delivery of the baby. Considered in this way, the donation was a service and the semen a commodity. For the donor, involvement would cease after the semen had been transferred to the clinic. However, the appeal to the donors to respond to the neediness of the infertile couple meant that some donors felt a sense of compassion, even towards people who they had never met and would never be allowed to meet. Knowing that they were doing something to help, produced a feeling of altruism in donors. Like blood donors, they were helping unknown others and as a result felt a sense of self-esteem. Those donors who compared blood with semen and themselves with blood donors could refer to a duty to donate in order to help alleviate the plight of childless couples as described to them by the recruiting doctors. The making of the analogy of semen donation with blood donation was frequently attributed to donors by others, but not always positively. A non-donor scientist who worked in an assisted conception unit believed that semen donors considered sperm to be like blood: ‘deed done, hand over your sample, that’s all it is. Sometimes you wonder if they know what they are doing.’ The scientist was

implying that in contrast to the donation of blood, the donation of semen has long term implications of which the donors were not aware.

### **Instrumentality versus creativity**

For most of my informants, their donations' generative potential was downplayed by the recruiting doctors in the past. As well as the various motivations for donating, an important aspect of being a semen donor was the way in which the semen was produced, not on helping to create a pregnancy. Donating was a sexual act, not a procreative one. One doctor donor told me that 'donor insemination is a sexual act to provide semen' and that that is why it causes difficulties for people: it is difficult to separate the way in which the clinics obtain the sperm from consideration of the purpose of the act, which is part of a process to create a baby. As described by my informants, donors became instrumental in helping to achieve a pregnancy for a couple with fertility problems. Indeed one non-doctor donor who was overtly critical of the recruiting doctors, described doctors in general as 'mechanics' although he emphasised, affectionately, that the medical friend who had encouraged him to be recruited as a semen donor when they were students was 'a mechanic with soul'. A doctor donor now working as a General Practitioner commented that the clinicians who earned the most money tended to be surgeons such as gynaecologists and infertility specialists: 'They want a technical thing that they can do fast...surgeons tend to be very rich on the whole'. He recalled that at the time when he was donating he had viewed himself as 'the technical agent' who had 'made the sperm'. What the recruiting doctors aimed to do and what they succeeded in doing through their practice of keeping the donors in ignorance of the result of their donating was to avoid the attribution of a creative quality to the donations. The donors were not to view themselves as creative through contributing 50% of the resulting baby's genetic make-up.

### **Talking about being a donor**

There was a marked variation in the style and content of how donors talked with me. Donors who stated that they would not ever want to be identified were all much less talkative than those who said that they would accept being identified or even would want to be contacted by donor offspring. This contrast applied whether the donor was

a doctor or otherwise. The exception was a media professional who spoke with great eloquence about why he would accept being identified but not being contacted, at least in the near future, by any offspring. This difference in communication at first seemed counter intuitive. During the period of my fieldwork there was considerable public argument and discussion about whether gamete donors in future should be allowed to remain anonymous. Infertility clinic doctors, the British Fertility Society and the British Medical Association were mostly either fiercely opposed to ending anonymity or were lukewarm in support. Yet during my research, the donors in favour of ending anonymity seemed the most eager to justify their views about this to me. Those who were opposed or ambivalent seemed to find it harder to explain and to share their ideas. There may have been a personality factor at work, with these donors tending to be reserved, but it was also obvious that those who did not want to be identified were less likely to have discussed being a donor with anyone else. In one way there was no reason for discussion: donating semen was not supposed to have long-term implications nor significance. It was not supposed to be something which affected the time after donation. It was now a remembered action in the past of no relevance to the present. These donors spoke in a truncated way which served to close off discussion. I found these meetings very hard work and had to use a different interviewing technique, one which encouraged reflection and elaboration but without crossing the boundary into counselling. The meetings also tended to be rather solemn.

Interviews with donors who were in favour of identifiability were expansive, longer and more reflective. Discussions with these donors were often punctuated with humour, with the donors describing events about their donating which amused them. This often involved a play upon words which I, too, found funny and this served to establish a more engaged relationship between researcher and informant. Humour about the donating also indicated an understanding by the donor of the young student that they had once been, before the mantle of professional respectability had descended upon them. A donor who donated as a medical student recalled:

There was another friend of mine who got involved really because he wanted some money... and he was quite amusing, he said that we were all members of the Semen's Union....and we actually held out for a pay rise, I remember

that um, we felt it was about time we got a pay rise. I remember we actually... threatening to withdraw our services.

The humour here is in the play on the word 'semen' which sounds the same in English as 'seamen'. Another donor who may have donated at the same clinic, but several years later, also used humour in describing the demand of the students for a 'pay rise' from the clinic: 'We went on strike once. We threatened that we would lay down our tools'. The word 'tool' is a slang word for the human penis.

Talking about donating by infertility clinic workers during my fieldwork included humour also. Jokes made at conferences by clinicians were often despised of by infertility counsellors, who considered the content disrespectful to donors and to infertility patients. Since the jokes usually involved reference to male genitalia, counsellors considered them puerile as well. However humour has many functions, one of which is to deal with something feared or which is a source of embarrassment. Infertility clinic workers, in a backstage manner, would refer to objects and procedures using different words with sexual overtones. Thus in referring to the Institute of Population Studies, the word 'Copulation' was substituted for 'Population', sperm banks were widely referred to as 'wank banks', and some clinics had cartoons about infertility, masturbation, and oral sex on display in staff rooms. One clinic that I visited as an HFEA inspector had such cartoons in the patient waiting area, and I shared my concern about how patients, especially men, might feel about them, but the staff assured me and my co-inspectors that no one had complained and indeed that some of the male patients had mentioned that they appreciated the effort of the staff to make them smile, even if it was a rueful smile.

There were also examples of humour at the expense of the traditional image of medical students as wild, sexually active young people. Most doctor donors knew of a book written in the 1970s by a young doctor under a pseudonym, about life in an unidentified (but recognisable) public hospital and what the medical students got up to (Douglas 1975). One donor protested to me that he had not behaved at all like the students portrayed in the book, others smiled at the mention of the book, and another admitted that when he was a student, young men had been more concerned lest they get a girl pregnant, than they were about the implications of donating semen. None of the donors mentioned the fact that cryopreservation of semen had been introduced

not simply to enable the development of sperm banks but also to avoid passing on HIV/AIDS in the semen. It was a non-doctor donor who asked me why the use of fresh semen had stopped, and who looked shocked when I told him. The behaviour of some young donors added considerably to the economic costs of providing a DI service because of the necessity for testing and quarantining the sperm.

### **Not donating**

I interviewed doctors and scientists who had played or continued to play an important part in the development and operation of donor insemination clinics and I spoke to many others in my search for donors. After two doctors had volunteered the information to me that they themselves had been donors I began to ask others not simply if they knew of donors but whether they themselves had been. None of them said that they had, and they gave a variety of reasons for not having donated. One doctor, pretending to be offended, said that no one had asked him to donate. Some doctors said that they had been asked individually by recruiting doctors to donate, but had refused. Those of them who had not obviously supported or who had openly opposed the proposed change in regulations about donor anonymity, always looked guilty when they said this to me. Their position was paradoxical: they had professional investment in donor insemination services as a way of helping childless couples, but had chosen not to donate even under an anonymous system. The explanations for not having donated were given as one-liners. Some of them emphasised the practical problems and outcomes which were perceived to be part of semen donation:

‘Too much work involved. Easier ways to earn money’.

‘I think I was worried that I might be infertile’.

Other explanations suggested more complexity:

‘There was a family history of a medical condition’.

‘My wife said no. I don’t know why’.

‘I didn’t know where the genes would end up’

‘DI is a complicated thing’

‘I didn’t want kids out there’.

These reasons were supposed to be self-explanatory but they suggest that these informants thought that semen donation has definite or potential long term social or medical implications, for donors, their families, and the potential donor offspring. This awareness had not always been encouraged in their own recruiting of would be donors in recent years.

### **Conclusion**

Being a semen donor at the time when my informants were donating had masculine characteristics quite apart from the sexual nature of producing the ejaculates. For many of my informants, donating semen was an activity undertaken in the context of other things that young male students of their time would do, either as a motivation for donation or as a reward for doing so. Money earned from the donation helped the young men with courtship rituals such as taking the girlfriend to the cinema, with meeting sexual needs by 'running a mistress', and with some of the financial costs of being a medical student. Several donors explained the restriction on earning through taking on the holiday jobs available to non-medical students, and the low wages earned by their wives as nurses.

A point made by Simon Sinclair (1997) in his account of traditional medical training in London is the importance of sex as one of the features of medical life (1997:101, 111) along with the students' union bar and sport, usually rugby. A feature related to sex in the context of medical training is the absence of shame about the human body: Sinclair gives the example of the induction lecture for first year medical students at which a female student was told by the older student giving the lecture: 'Don't be shy! You can't be shy in medicine!' after he had summoned her to the front of the lecture theatre and instructed her to feel the femoral pulse in his groin (p.100). A contemporary example occurred during the period of my fieldwork, when the front page of the student newspaper *Student* displayed a picture of three relaxed, smiling, naked, male medical students, hands strategically placed, above the headline 'Trust me, I'm nearly a doctor' and a news item explaining why they were appearing like this on Edinburgh's Princes Street.

Sinclair also notes the significance of achieving and maintaining a high status during medical training, and how students who pass examinations with high scores

may be pitied or scorned for ‘not having a life’ if the achievement has been through hard work (p.163). If the students appear to have achieved without much effort, then ‘they are highly regarded, achievement without effort being the most prized result’ (ibid). Sinclair attributes this attitude to a sense of natural superiority possibly derived from the public school ethos in medical schools, and I suggest that it helps to explain the grudging admiration for the donor who earned so much money from donating semen that he could finance ‘a mistress’ as well as his medical studies.

Although a number of the donors had come to realise the benefit of their donation to childless couples, most had been motivated at the time by money. Some recognised that the recruiting doctors were also often motivated by money, or the need to satisfy their own desire to help. The financial motive helped donors to continue to ‘produce the goods’ even when, if donating to a private clinic, they were given no access to suitable facilities. These observations are not new but as Stoler suggests (2002:162), what we think we know is not necessarily all that there is to know. The picture that emerged in my interviews of men who donated semen in the 1960s to early 1980s was of exploitation of the sexual energy of healthy but relatively poor young students. Donors were not giving a gift but providing a service as a result of which the pretence could be upheld that infertile men were the genetic fathers of the resulting donor-conceived babies. The work of the donors was part of a commercial transaction brokered by the recruiting doctors and clinic doctors. Some donors cheerfully suggested that that was so: ‘it was purely mercenary’. Others were less at ease with the actions of their student days. The operation of the system was also intended to ensure that no gift-like qualities became attached to the donation. The donation established no new social relations and did not reinforce existing ones. There was to be no return between giver and receiver. The donors were not to think that a child was being created, but just that a pregnancy had been established. The donors were to be non-persons to the recipients and to any children.

The fact that no donors claimed to have told no one about their having donated, and that the number of people who knew included people who might claim an interest – a matter that I shall explore later – suggests, however, that the intention of the recruiting doctors to render the donors invisible, to make them non-persons, was not totally fulfilled. What the practice appeared to do was to portray semen

donors as particular kinds of persons. The requirement that the young men bring their pot of ejaculated semen, their 'product', to the clinic, is reminiscent of the practice of door-to-door salesmen, and, like sex workers, some donors were obliged to perform a sexual act, that of producing semen, in risky places. These sexual acts, it seems, were not allowed to defile the atmosphere of the private consulting rooms in the private clinics. In NHS clinics, the lack of resources would explain the absence of a comfortable room fit for the purpose of producing a semen sample, but also underlines the lack of respect for donors.

My ethnographic data is not sufficiently detailed to suggest how donors would react to my interpretation that semen donation involved exploitation, and attitudes towards the sexual aspect of semen donation are varied in any case. Whilst writing up my thesis, the National Gamete Donation Trust was offered a period of free advertising about the need for semen donors by B.D.P. Media which devised an internet 'viral' campaign called 'Give a Toss'. The Trust's advisory council (of which I am a member) and the trustees gave much thought to the implications of proceeding with the campaign, and it caused controversy. Social workers and infertility counsellors were divided in their opinion: some were appalled, whilst others thought that it reflected reality. The British Fertility Society decided to take a neutral stance. Of interest here, though, is the observation of a semen donor, who is a trustee, that 'men joke before getting serious', Semen donation is not straightforwardly a bodily practice, but has intentionality and long term outcomes.

## **Chapter Four: Reflections on/from the gene**

In this chapter I describe and discuss what donors said about the role and function of genes. I have shown in previous chapters how considerable emphasis was placed on the work of the genes by the medical practitioners who started donor insemination services in the UK and then later on by those who developed and expanded the services. The selection of semen donors from the onset was based on the idea that attributes such as intelligence, physical appearance, and skills were inherited, and that the donors, as genetic fathers substituting for a man with impaired fertility, would pass these attributes on to the donor offspring. The necessity of obtaining semen from intelligent, fit, young men with no family history of inherited disease, underpinned the recruitment strategies of the medical practitioners. However, I have also shown how the manner in which the donors were recruited, and then proceeded to make their donation, resulted in an emphasis on the sexual aspect of the process of donation and on the concept of sperm as a fertilizing agent. The potential in the sperm, its contents of message-carrying genetic substance, was deliberately ignored. To borrow an inspirational metaphor from Margaret Lock, the genetic element of donor insemination was eclipsed (Lock 2005).

With the passing of time, the subject of the genes had emerged into the thoughts of the donors that I met. It was not at all evident that this might be because of publicity about recent discoveries in the field of genetics. In discussions with donors the appearance of matters to do with the gene was usually oblique. The subject was as often implied as it was noted explicitly, and genes had different meanings and implications attributed to them by individual donors and by their families. One doctor donor worked in a speciality where, he told me, ‘a lot of harm is done by genes’. He was strongly in support of donor-conceived people being allowed access to identifying information about donors. In addition to donors, non-donor doctors, other infertility clinic staff, and donor conceived people and their parents all had views about the gene. For some of these informants, views shifted according to time and context, and to their responses to their knowledge about developments in genetics.

Questions about genes and the study of genetics increasingly became hot topics in public and academic spheres during my fieldwork. What are genes and what

is their role? What is their function? Who owns them and is it even possible to talk about ownership? Is an interest in genes based on fantasy about how they work or is it what Nelkin and Tancredi (1989) have described, with concern, as genetic essentialism? There were frequent reports in the media about new research findings about the possible influence of genes. Sometimes it seemed as though newspaper editors, in particular, were having some fun at the expense of their readers' fascination with the subject (for example: 'Genes determine woman's ability to have an orgasm', *The Independent*: 2005). The fascination can have strategic value for those personally involved with donor-assisted conception: a man whom I know well, who is the father of a young donor-conceived boy, told the story to a meeting of infertility counsellors of how his son, having watched on television the England football team go out of the European Cup competition in 2004, suddenly asked his parents whether his donor might have been foreign. He had then announced that he thought that his donor might be Dutch, and that he would support Holland from then on.<sup>1</sup>

For some anthropologists such as Kaja Finkler, an interest in genes and their influence is not a source of fun but a cause for concern (Finkler 2001). According to this view, the interest is not a harmless pastime, nor a useful airing of questions about autonomy and responsibility in human behaviour, but rather, a re-run of the so-called nature-nurture debate and a potentially dangerous revisiting of the theories of eugenics. Finkler suggests that the movement amongst adopted people to search for their birth relatives 'came into bloom in the 1960s, around the time that our collective consciousness concerning genetic inheritance came to the fore and notions about diseases as genetically programmed began to take root in biomedicine' (2001:240). Whilst this may be true for America, Finkler's proposal does not fit with the UK where, as Martin Richards points out in his commentary on Finkler's article, there was already a lay knowledge that certain diseases passed down in families, and adopted people had been searching for birth kin before the 1960s (2001:255). Richards also notes elsewhere that 'everyday observation of English family life suggests that there is a general interest in issues of inheritance' (1997:188), and that

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<sup>1</sup> Unfortunately his switch of allegiance was not rewarded, as Holland went out in the semi-final.

discussions about family photographs and the features of a new-born baby focus on the matter of resemblance, and ‘who takes after who’ (ibid).

### **Achieving a pregnancy**

Some donors who had donated in the 1960s told me that their semen samples had been mixed with the semen of other donors, or of the husband of the woman patient. They understood that this practice, of mixing the semen samples and then inseminating a woman with this mixture, was carried out in order to prevent any possibility of the donor being identified in future. This would help to ensure that donors could not be sued later for liability if anything went wrong, nor for parental responsibility if the child’s mother and her husband got divorced and the mother wanted to obtain financial support from the donor. From some non-donor informants I heard that the practice of mixing semen ended in the 1970s, but a geneticist told me that he believed that the practice continued into the 1980s. He did not approve of it for two reasons. Firstly it caused obvious problems for donor conceived people wanting to find out about their origins and secondly, the practice was scientifically unsound, because it prevented any genetic problem emerging in donor offspring from being traced back to the man who provided the sperm which helped to create that child. On a service provision level also, it became difficult to justify, because if it was suspected that there was a problem with one of the samples, then it became impossible to identify whose stored samples might be unfit for the purpose of further inseminations in future.

In marked contrast to the previous practice of mixing sperm, donor insemination services since the passing of the Human Fertilisation and Embryology Act 1990 are governed by regulations and professional standards the aims of which specifically include the prevention of any kind of mixing of samples. Further legal controls have introduced the principle of traceability through the EU Tissues and Cells Directive (HFEA 2006a). In infertility clinics in the UK, the current practice is for sperm from different kinds of donors to be stored separately in different storage tanks or dewars<sup>1</sup>. There are dewars for sperm ‘of ethnic origin’ and dewars for

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<sup>1</sup> A dewar is a vacuum flask named after its inventor, Sir James Dewar (1842-1923)

sperm 'for sibling use', that is, for storing sperm for use by recipients who wish to have a second baby using sperm from the same donor as before. In the few clinics which provide a service for storing semen from a man diagnosed as having HIV, separate dewars will be available to store their samples. The intention of separation is to avoid cross contamination as well as the mistake of inseminating a woman with semen from the wrong donor. Semen samples have their number recorded as well as the expiry date by which time they must be used, the donors' hair and eye colour, height, CMV status and blood group. CMV or cyto megalovirus, is carried by a high proportion of the population. It can lie dormant in the body for many years so that the carrier is unaware of its presence. Prospective donors and recipients are tested as a precaution because the virus can affect the neurological development of the foetus, and any damage done by the virus is irreversible. Clinics which recruit donors nowadays will screen them for HIV, hepatitis, cystic fibrosis, CMV and other conditions depending on the geographical origins of the donors' families, for example thalassaemia for men from central or eastern Europe, sickle cell for Africans and West Indians.

Infertility clinic staff take their responsibilities for full traceability of donated gametes very seriously. A recent television programme about a sperm mix-up in a clinic apparently upset one embryologist so much that she switched off the television. One of her colleagues, an infertility counsellor, explained to me that it was because the programme was giving a false impression of laboratory practice nowadays. Since July 2004, regulated infertility clinics must have protocols to ensure compliance with HFEA Directions about witnessing clinical and laboratory procedures. These are intended to prevent a mix-up of patients' gametes through handling errors, misspelling of patients' names, and missing unique identifiers of donors and recipients. Nevertheless, the likelihood of occurrences of such problems led to the HFEA to introduce an Incident Alert System in 2003. Its purpose is to warn clinics about any incident which could have an adverse effect on patient care and staff safety. Anonymised details of clinical and laboratory errors, and how they occurred, are emailed to all other regulated clinics, with the aim of preventing any similar occurrence. The staff in infertility clinics have welcomed this system. One

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unfortunate case which received extensive publicity during my fieldwork was that of the birth of ethnically mixed twins to a white couple due to the woman being wrongly inseminated with the semen of another female patient's black husband. At the time, some clinicians acknowledged privately that similar mix-ups had probably occurred before, but that in this case the mistake was obvious because of the differing skin colours of the babies. Although in the twins' case there was no legal doubt about the woman who bore the child being its mother, the matter of who was to be the legal father went to court, where it was decided that the legal father was the biological father, that is, the man who was the unwitting provider of the sperm. However he was not awarded custody and the mother's husband was encouraged to apply to adopt the twins (The Guardian 2003).

### **Hints of Eugenics**

The word 'eugenics' is associated with practices now considered unethical and degrading such as the compulsory sterilization of people declared unsuitable to reproduce, such as people with low intelligence. Although the policy is generally blamed on Nazi Germany, the practice was carried out in other European countries long after the ending of the Second World War. The meaning of the word may now have a different emphasis but still arouses concern. The existence of websites which match couples seeking an egg donor with young, female, healthy university students raises the issue as a contemporary one, causing unease amongst infertility counsellors and patient support groups concerned about informed consent and the long-term emotional implications for the children involved.

Doctor donors told me that they were sure that there was good reason why they were targeted for donating sperm. One did point out that medical students were often involved as research subjects on any number of projects, but mostly they believed that it was their intelligence and physical fitness which made them sought after as donors. The donor recruiters wanted to ensure that pregnancies would result from the donor insemination service. One told me that 'medical students were obvious candidates' to be donors but that some years ago 'the deans of the medical schools became protective of medical students' and discouraged their colleagues from recruiting them.

One donor recalled that after hearing about the need for semen donors at a meeting addressed by a speaker from the Eugenics society:

I contacted him, he had me along to the clinic, took a medical history which he didn't check and I mean looking back, when he said no inherited illness in the family, it was very laissez faire, and blood tests and your blood group because obviously they had a thing about that.

He added that 'as far as I can remember he asked me nothing about my personal life whatsoever', not even whether or not the donor was married at the time, which he was. The recruitment process did not appear to allow for the possibility of the donor passing on a heritable medical condition to a donor-conceived baby. The donor pointed out that despite Nazi beliefs about the need to sterilize people with low intelligence quotient, it was understood by many people that these were 'pseudo scientific'. For him, being recruited through the Eugenics society did not mean that he believed in selective breeding. He needed to earn money and the recruiting activities of the Society gave him the opportunity to do this.

One donor who was no longer practising as a doctor due to a career change, explained to me that he and other donors at the time had 'no ethical hang-ups' about being recruited to donate, but added 'perhaps we should have'. It was a matter of 'making a contribution to the gene pool, to the good of society, that might have been a motive' but he added that he and his fellow donors were 'wild students' at the time. As described in Chapter Three, several men who donated semen when they were medical students referred to this characteristic of their behaviour, and also recalled that their motivation for donating might not have been totally altruistic. One of the donors said that in relation to the motivation for donating, although 'part of it might have been giving' it was also in order to make a contribution to the gene pool. 'We were God's gift to everyone, us medics. We did talk a bit about it in that way'. The implication is that the donors were aware that the medical practitioners who recruited them were after their good genes.

One retired doctor who was involved in donor recruitment for many years recalled that in his DI service, efforts were made to match donors' characteristics with those of the infertile husband, 'but many of the women wanted handsome, intelligent, sporty types'. Similar comments were made to me by nurse co-ordinators of DI services. Some clinicians complained that a current shortage of donors at their

clinics meant that potential recipients had little choice of donor characteristics and had to accept insemination with semen from a donor with incompatible eye colour, for example. The retired doctor wondered which was more important, blue eyes or a university education. For himself, 'I'd be biased towards an absence of disease'.

A donor who was not a doctor said that he was sure that he did not think about eugenics when he decided to donate. He thought at the time that he was healthy and intelligent, which were sufficient and necessary characteristics for being a donor. Since the time of his donation, both of his parents have died at ages 58 and 65 and he has been diagnosed as having hereditary hypertension. He was one of the donors who was very willing to provide medical and other information about himself to any donor offspring who asked for it.

One doctor donor thought that he and his friend had donated because 'maybe some sense of good genes' and the political ideology of that time (1960s) was one of 'encouraging the intelligent to have babies'. Donating semen was a contribution to society. He stated his belief that the ideology of improving IQ persisted in the UK in the 1960s when he donated. At the time this was a boost to self-esteem, or even seen to be justified. This idea of making a positive impact on society contrasts strongly with today's appeal to men to donate as a contribution to help a limited number of individuals or couples to have children, as evidenced by the UK government funded 'Give life, Give hope' awareness raising campaign.

In discussion with donors, I frequently sensed attempts to put distance between the young man, the self-assured, body-confident, perhaps 'wild' student of then, and the respectable professional of now who was giving up time to discuss these issues with me. 'I don't want to think that I wanted my genes to continue,' said one doctor donor. He would prefer his motivation for donating to remain financial and possibly altruistic. 'I don't want to examine to see if I had deeper motives'.

The idea that donors might have such deeper motives is one that concerns infertility staff involved in donor recruitment today. An andrology laboratory manager told me 'donors who want to populate the world are scary'. This view was echoed by another andrology colleague who told me that in 2005 the number of enquiries to his clinic had increased but that 'some of them are a bit wacko' By this he meant that he found them odd, and their motivation unacceptable. One example he

gave was of a childless man who wanted to donate so that his political views would be passed to the donor conceived children. Of interest is why this motivation is worrisome for the clinic staff. Some of those that I spoke with, such as embryologists and infertility counsellors, were thinking ahead to the possible reactions of donor-conceived people in future years to meeting with a donor with such motivations, or reading the non-identifying information on the form which the donors complete when they are recruited. However, there is also an echo of the recruitment practices of the early medical practitioners and their assumption that ‘unacceptable attitudes’ might be passed on in the genes. The director of the Danish spermbank Cryos, which supplies several clinics in the UK, told me that his colleagues, both male and female, were guided by their personal reactions as to whether or not to accept a man as a prospective donor: they would not accept a man from whom they would not want a female friend or relative of theirs to receive a semen donation.

A consequence of the assumption that the donors of choice, medical students or young men whose wives had had babies delivered in the same hospital as the infertility clinic, were healthy and without a history of heritable diseases, was that medical records were seldom kept. Sometimes, as at Glasgow Royal Infirmary, they were kept until a year had elapsed since the birth of the baby conceived with donor assistance. If the baby showed no signs of inherited problems, the records of the donor were destroyed. The Western General Hospital in Edinburgh was highly unusual in keeping records from the start of its service in the 1970s and in introducing a policy of longterm safekeeping of those records. This was partly because of the sympathy of the clinic staff for the principle of access to identifying information for donor conceived people about their origins, and partly because of a concern that there might be a need for data for retrospective scientific research. More usual was the situation of the whereabouts of records being unknown, as one donor in the south of England discovered when he returned to the hospital where he had donated over 20 years previously and offered to donate again. Records have also been destroyed or hidden by private medical practitioners anxious to preserve the anonymity of past donors and to avoid possible legal claims from donor conceived people. According to Olivia Montuschi of the Donor Conception Network (personal communication) most of the records still in existence ‘are stored in the attics of

elderly gentlemen', that is, in the private homes of retired DI clinic doctors. It is not known why such records still exist, since anecdotally it is reported that many records have been deliberately destroyed in order to protect the anonymity of semen donors, but it is possible that some retired doctors are following early advice about keeping records as a defence against claims that donor conceived children inherited defects from donors (Brudenell et al 1976).

There is still a strong belief amongst many medical practitioners that recruitment was and is still carried out in a thorough enough way. During my fieldwork, an increasing number of clinicians who were against donor conceived people having access to identifying information about the donor, began to suggest that it would be acceptable or even beneficial for such people to have access to information about their medical history. Some went as far as saying that they had a right to that information. One commented that if the donor developed a serious medical problem in later life, then the donor offspring would be disadvantaged, 'not knowing that they may benefit from screening'. This suggestion that donors might actually develop poor health was a major shift in how clinicians had been talking about donor information, although there was some evidence that should have flagged up the matter already. An American study of gamete donors found that amongst seventeen semen donors, 47% had a history of minor depression and anxiety, and 35% a history of excessive alcohol consumption (Shover, Rothmann and Collins 1992). Obviously these health problems might have no genetic component, in the same way that the high suicide rates for doctors, and other indications of psychiatric illness, may originate in the professional dispositions of medical practice (Sinclair 1997:317). The possibility of the genetic cause of psychiatric illness and its transmission to donor offspring was never raised during my fieldwork except in a novel about medical ethics in the Living Literature Series, written by an academic nurse who was diplomatically and tantalisingly reticent, when I met with her, about the sources of her literary inspiration (McHaffie 2005). The usual perception was that donors remained as healthy as they had been at the time of donation and that the screening and taking of family history before the donor was accepted were adequate enough for donor conceived people not to have any need to access non identifying

information. A retired Professor of Obstetrics and Gynaecology, in his response to the Department of Health Consultation on Donor Information in 2002, wrote:

The only significant pragmatic argument for offspring being allowed such information is as a check for background genetic conditions. However, major genetic conditions should have been screened out before gamete donation is allowed. Thus what are the grounds other than curiosity for the offspring to know? This could relate to a desire to understand one's genetic kinship but, on balance the disadvantages outweigh the advantages of such knowledge but this should be outweighed by practical considerations.

The clinician here is emphasising that donor offspring do not need to find out about the medical history of the donor because the DI clinic will have ensured that there is no significant information to pass on, by only recruiting donors without any genetic conditions. This point was made by another doctor responsible for donor recruitment in a private clinic. He wrote in response to the consultation that donor conceived people should probably be able to obtain non identifying information about the donor, including medical and/or genetic history, but added that 'in well regulated clinics negative genetic background would be excluded'. A doctor now lecturing in medical ethics also agreed that this information should be available but pointed out: 'if selection is adequate there should be no relevant history'.

The shift in perception of donors as the providers of good genes to one of them as potentially flawed is well summed up by the British Fertility Society in its response to the Department of Health/s Consultation on Donor Information. In agreeing that people conceived using donated sperm should be able to obtain non-identifying information which would include medical and/or genetic history, the Society wrote that

the Society is of the view that parents need to be able to provide accurate medical background information to the child's general practitioner and other medical consultants. It is important that adult donor offspring are in a position to do this throughout their lives. The possibility of late onset conditions is also a concern. We recommend that donors be encouraged to up-date their records should they suffer any condition that might affect people conceived from their donation.

### **Gene potency**

Despite the rapid and well-publicised developments in genetics and microbiology in recent years, donors varied as to whether they mentioned them at all. One non-doctor

donor was sure that DNA would certainly have had an impact on donor conceived people: 'DNA is everywhere', he pointed out to me, referring to the current publicity about genomics research, about the anniversary of the discovery of DNA, and about research into the effects of particular genes.

Some of the doctor donors were dealing with genetics in their professional work, seeing patients with health, including, infertility problems that are either wholly or partially genetically determined. One of these donors remembered that there was a blood test taken before he donated, but not a family history as he would take himself nowadays. However he had known all four of his grandparents, indicating to me that this knowledge was a reassurance. Still, he mused that in his case, one reason for not considering registering with UK Donorlink so that any person conceived from his donations could contact him, was that 'a child might have problems' – any kind of problem, physical, emotional, and 'you'd wonder if it was your fault in some way'. He thought that in reality there would be no blame on him but 'perhaps ignorance is bliss'. And he added that his wife would say 'a gift is a gift', meaning that in her view what was given was not expected to be returned, and that her husband had donated with gift-like motivation. However as this donor had donated for money, his motivation had been financial. He explained to me that he knew that he was justifying his donation as altruistic as well, retrospectively, but pointed out 'I could have put genes in otherwise, by sleeping around'.

This donor was unique in my fieldwork in raising the possibility that the results of his donating might have had unforeseen and unwanted consequences. Whether this was because of his personality or of his particular type of medical speciality, or of a combination, it is impossible to say. In total contrast was the donor now working as a G.P who was so strong in his opinion that there was no connection between him and any donor conceived person that he denied any genetic characteristics at all to his semen donations. 'Sperm is like urine, reproducible and free' he maintained. He had been recruited as a fifth year medical student by a senior lecturer and had received no payment for his donations. He recalled that whilst at university he and flatmates, who were social scientists, had many discussions about 'nature-nurture'. There had been a fear of eugenics influence and a feeling that 'it would be nice if it were all nurture'.

Ambivalence about the influence of genes was sometimes linked by infertility clinic staff to stereotypical views about reproductive behaviour. A number of clinics in the UK have had a policy, plainly stated in their patient information leaflets, of not accepting as donors anyone who was adopted. When challenged as to the reason, they explained to me that adopted people might not know who one or both of their genetic parents were. Therefore, it was concluded, the prospective donor would be unable to give a full enough family history. Recently, given the shortage of donors, some clinics have explained that they would not reject all adoptees, just those who could not provide a full family history. They have also learned that the laws in all four nations of the UK now allow access for adoptees to identifying information about their birth families. In contrast, in no clinic did I ever see a policy statement about accepting or refusing as donors anyone themselves conceived with donor assistance. Clinic staff reacted with obvious embarrassment to discussion of this discrepancy. In one clinic where donors have never been paid any money for donating, not even reimbursement for travelling expenses, the clinic staff were clear that they would accept donor conceived people as donors and at the time had already accepted one young man who himself was donor conceived at their clinic. Their requirement was that a family medical history must be available.

It is possible that the clinic staff who are so wary about accepting adopted people as donors have a perception that the genes of donor conceived people, even if they do not know that they were donor conceived, are better quality those of adopted people, who might come from a different kind of social background. The impression given is that adopted people's birth mothers would not be able to provide an adequate family history and might not know anything much about the child's father because they are not very responsible women. An adopted person who is involved with the running of an adoption contact register in the UK and who heard about the clinics' reluctance to accept adopted people as donors commented to me that this was a surprise for her, because in the 1960s and 1970s 'the typical birth mother who gave up her child for adoption was considered "a nice girl" who had got into trouble'. However, the circumstances of most children who are placed for adoption in the UK nowadays are different. Most are not babies and they have spent time being looked after in public care, unable to return home for a wide variety of reasons. One

infertility clinician, who is known for outspokenness, described these children, in contrast to donor conceived children, as having suffered from ‘ghastly parenting’, and this perception also explains the reluctance to recruit adopted people as donors.

Beliefs about reproductive behaviour also appeared to work to undermine belief in the influence of genes. During debates about whether donor conceived people should be allowed access to identifying information about the donor, many infertility clinic doctors said that it was not important because research had shown that many people in this country are not the child of their mother’s husband. I explore this further in Chapter Eight, where I describe how this argument was used to justify the case for maintaining the anonymity of donors as provided by the Human Fertilisation and Embryology Act. One of the doctor donors whom I interviewed told me that the fact that there were so many people who had been conceived extra-maritally confirmed that genes were not important. He was one of the few donors who denied having any interest in knowing whether or not his donations had achieved pregnancies.

### **Resemblance through the genes**

There is a recurrent theme in narratives of and about donors and donor conceived people that a genetic connection between a man and the person he helped to create means that the two people will look alike or at least have some similar features. These features could be physical, such as shape of the hands or nose, or non-physical, such as social interests and preferences. Features such as mannerisms or skills may be ambiguous. Sometimes it is unclear whether there is a separation between the physical and non-physical and if there is, where the boundary between them is located and how the decision is reached about placing the boundary. One semen donor, who is the father of a young child, described the physical resemblance issue to me in very strong terms: ‘The minute you look at someone and they look like you, you know that that link is there...it’s incredible’. He went on to describe meetings with adult cousins for the first time,

people who look like you, like my brothers and sisters, people who look like me and at the same time, same characteristics, same stubbornness, same bad temper, whatever, same build it is just incredible, genetic, seeing my mother and father even though they have passed away. I am seeing them in my daughter, I can see my father’s smile.

Here the donor is making connections between his daughter and his own parents, and between himself and the relatives to whom he is connected through those parents, on the basis of resemblance. People whom he had never met before, his cousins, are connected to him not just through being descendants of siblings but also because the donor saw in them resemblances to his own parents. These resemblances are perceived to be both physical and non-physical, and the donor admitted to astonishment at the extent of the resemblances, which he attributes to genetics.

The emphasis on the significance of genetics for resemblances carried over to the use of the terminology which this donor used. He went on to tell me emphatically that in regard to his donation of semen in the past, he was ‘the genetic’ father, not the ‘father’ of any child conceived as a result of the donation. The donor conceived child would be ‘not my child. “Baby” is my first child. She looks like me’. The donor is making clear that the difference between ‘genetic father’ and ‘father’ is that the child of a ‘father’ will look like the father. The donor’s little daughter, referred to affectionately as ‘Baby’, is his child because she looks like him. The donor-conceived child would not be his child but his donor-conceived child, just as he is not the ‘father’ but the ‘genetic father’. However the difference between the status of father and genetic father is not solely based on resemblance, because as the donor later explained to me, contradicting himself, there is a likelihood that a donor conceived child of his would indeed look like him. The difference at this point is that the donor knows that his child, ‘Baby’, looks like him: he does not know what his donor conceived children, if there are any, look like.

The tendency to give significance to similarities is evident in the field of post-adoption. From her fieldwork in a Scottish adoption agency which specialised in the provision of post adoption services, Emma Frank (1994) noted how, in the context of reunions between adopted people and their birth parents, the recognition of resemblance between individuals was perceived to demonstrate the connection between them. Adopted people, adoptive parents and birth parents, as well as the social workers at the agency, had an awareness of the phenomenon of resemblance. Resemblance itself, Frank suggests, can be taken to be a characteristic of biological relations (1994:25). Situations which Frank put down to coincidence, such as a dislike of tea shared by an adopted person and his birth mother, was given meaning

by those personally involved. Frank quotes from an adopted person's description of never having felt a full sense of belonging in her adoptive family, made manifest in physical dissimilarity:

I could never work out whether this very big smile I have was part of me or not. When I met my natural family they all had this big smile and big teeth and I realised that was where it came from (p.26).

Adoption counsellors in the UK are aware that some elderly birth mothers are reluctant to meet, or even speak with, their adult adopted child because the adopted person might look like or sound like the birth father. If the birth father was prevented from marrying the birth mother by her parents, or the birth father was judged by the birth mother to have abandoned her, then any physical resemblance of the adopted person to the birth father might cause distress. Visual and aural similarities to the birth father will act as triggers to reawakened feelings such as loss, anger and regret. Huon Wardle (2004) describes this in the case of a Jamaican woman, Jeanette, who recorded for him her recollections of a childhood of physical and emotional abuse and then adoption. Jeanette's mother Ariadne had parted from her father Sam after Jeanette was born, because Sam had treated Ariadne so badly. Jeanette described how her mother 'did not care about me because of my father. She say, as she look at me she remember Sam. She say I look so much of him and she hates me for that' (2004:201).

One explanation for discounting a genetic connection is that the person is unknown. A consultant geneticist who discussed with me the issue of taking family histories from prospective donors, told me that he had not donated semen. He reckoned that if he had been a donor, and were now to tell his adult children of the fact, 'they would roar with laughter and look for people with cravats and brogues', this being a reference to his style of dressing. The anecdote reveals that this doctor's children, and perhaps he himself, suggested, jokingly, that any donor offspring of his would dress in a certain way, just like their genetic father. A similar perspective came from another doctor, who did donate semen, and who had informed his children about it. He told me that he agreed with them that any genetic half-sibling of theirs would be 'a small grey-haired person' like himself. Here too the resemblance was used to connect the donor with the possible donor offspring, omitting the

possibility that a donor conceived person might resemble their genetic mother, if they resemble anyone at all. The children of these two informants were connecting the unknown donor conceived people with the person that they themselves knew, namely their own father.

Another donor who told me that he was ‘an ex-sperm donor’ and that donating was a closed part of his life, reflected: ‘I do wonder if there are little clones of me out there. But I have no regrets’. Here too there is an assumption that any donor offspring will resemble their genetic father. Indeed it is more than resemblance that is suggested: the donor wonders if there are ‘clones’ of him, meaning exact replications. He has no regrets about having donated semen, but this statement serves to highlight his curiosity about the outcome of his donations. In her ethnographic account of thoroughbred horseracing in Newmarket, ‘The Sport of Kings’, Rebecca Cassidy notes the parallels between the English preoccupations with human genealogy and animal pedigree. She describes the ‘disproportionate influence with which the stallion is credited’ in the assessment of the horses, and how ‘breeders and pundits discussing a two-year-old will predict its ability in relation to its sire’ (Cassidy 2002: 150). It appears as though in racing society, maternity is denied or goes unnoticed, such that ‘the skewed structure of thoroughbred selection reveals a form of mono-geneticism similar to that identified by Delaney in relation to Turkey where ‘The male is said to plant the seed and the woman is said to be like a field’ (1986:496)’ Cassidy describes how the influence of the sire is continually emphasised through the resemblance which a young horse shows to its sire, because ‘this is taken as evidence that the yearling has inherited its sire’s racing ability’ (2002:151). Moreover the resemblance ‘is evidence of heredity itself’ (ibid).

The second idea which is revealed in stories about resemblance is that we ourselves know what we look like. I was alerted to the contradiction in this idea by a personal experience shortly before I started my research. A number of friends told me excitedly that they had seen me on the television, singing in a choral performance at a festival. When eventually I obtained access to a copy of the recording, what was visible of me, for about five seconds, was a profile of my head. I did not immediately recognise it as being me, because that is not the part of me which I see reflected in a mirror. I only ‘knew’ that it was ‘me’ that had been caught by the camera because of

my location in the group of singers. The problems about self-recognition are explored in Jonathan Miller's essay accompanying an art exhibition which explored the concept of reflection. Miller points out that 'a certain fixed proportion of our bodily self remains permanently invisible' (1998:134). In particular, we can never see that with which we see, namely, our eyes. Furthermore we cannot see the part 'by which we would expect to be identified and recognisable portrayed', namely our own face (1998:135). It is only the existence of mirrors which enable us to know what we look like. If mirrors are not available, then other reflective surfaces such as burnished metal or still water may serve almost the same purpose, although Miller explains that a true reflection from water is hindered by what can be seen through its surface.

Miller suggests that the reflected visibility of the self is a significant aspect of human culture, including its use 'in monitoring and modifying our *facial* appearance' (1998:13; italics in the original). To these uses I would add that of comparing our appearance with that of others. This ability to compare, which is made use of by individuals involved in thinking about or meeting with, genetically related others, clearly depends on our acceptance of the reflected image of ourselves in a mirror as an image of 'what we really look like'. Miller explains how humans are able to assume that the image in the mirror is a true reflection of themselves, and how it is that we know that it is ourselves, but this does not provide an answer to my problem about recognising my own profile. Nor does it explain why people would find similarities of mannerisms, such as the way in which a person tilts the head, or uses the hands to gesture in certain ways, between themselves and others. There is a circular argument at work: genetic connection is proven by resemblance, and resemblance is caused by genetic connection.

It is possible that identifying similarities may arise from a wish, hope or need to see these similarities as evidence of genetic connection. Some of the infertility clinic workers who I met, pointed to this. An embryologist described the situation of anonymous sperm donation as being like 'a broken mirror'. He told me that if he were a donor conceived person then he would want to see what his forebears looked like: 'I would have to re-assemble who I am'. However one of the doctor donors pointed out to me that photographs can be misleading, that we can read family resemblance into them, and he told me some stories to illustrate his point. Germaine

Greer makes the same observation in the poignant story of her search for her father's family origins (Greer 1989). However during my discussion with this donor, I mentioned that I was a sessional counsellor for UK Donorlink, the organisation which provides a voluntary contact register for donors and donor offspring, and that I had recently met with two young people who were thinking of applying to register. Immediately the donor asked me, with a laugh, whether either of them had looked like him. Yet he had previously denied any interest in knowing whether or not his donations had helped to create children. However, he was not the only one to catch himself out: I had met these two donor conceived people within a short space of time and knew that they had been conceived at the same infertility clinic, and during the meeting with the second person I became suddenly and foolishly aware that I was looking for facial similarities with the first.

### **Incest**

During my fieldwork, when family, friends and new acquaintances would ask about the topic or progress of my research, the possibility of incest was usually cited as one of the major reasons why they thought that semen donors should be identifiable. The possibility of a man starting a sexual relationship with his genetic daughter, or a brother and sister marrying, seemed to be a cause for concern. The situation seems to touch something deep in our society. Everyone knew of the ancient Greek tragedy of Oedipus who was reared by foster parents and later murdered his father and married his mother. In his analysis of the story, Segal (2001) notes that it has often been taken as a description of hidden sexual impulses but that the story is also about Western personal and cultural identity, about the issues of 'concealing and revealing terrible knowledge' (p.41) and the suffering which is brought upon individuals and families. Edwards' research informants in Bacup (Edwards 2000) perceived advantages in women and men helping their sisters or brothers by donating ova or sperm because it was keeping gametes in the family, and would mean that children would know where they came from, but the advantage of the closeness did not apply if there was unwitting incest. If young people who were donor-conceived did not know that they already had unrevealed prior connections, through the same gamete donor, then the closeness becomes 'too close' (2000:220). It might even produce problems, like the white Alsatian dogs described by Bacup resident Mrs Lawson

where the inbreeding resulted in ‘a load of mad Alsatians – really unbalanced and things like that’ (p.222).

The matter of unwitting incest did not appear to be of concern to the donors whom I interviewed. One doctor donor said that he had not worried about incest between his donor offspring and his children because ‘the gene pool is so massive’. Another told me that incest between his children and any donor offspring did not worry him: ‘such a remote possibility that the chances of incest are statistically so remote as not to be worth worrying about’. However he admitted that it has been a concern for his wife.

Another donor who did not know whether or not his donations had resulted in children, and who wanted to remain anonymous to them if they existed, was sure that he had not thought of the implications of donating when his teenage children began dating. He had not thought yet about the possibility of unwitting incest, and believed that the odds against it were too great to worry about. ‘You can never tell, though’, he added.

### **Genealogy**

The search for family history, of tracing connections back through the generations, has become of increasing interest in the UK. A genealogist and clan historian in Scotland has noted how the greater availability and ease of use of the records necessary for family history searches has been revolutionary in the last twenty years, particularly with access now being possible by means of the internet ‘where genealogy is apparently second only to sex in popularity on the World Wide Web’ (Mackenzie 2005). A few years ago, it was announced that the government in Scotland intended to invest £12 million in projects which would encourage overseas visitors to trace their roots in Scotland, responding to the ‘booming market’ of genealogy (Daily Telegraph 2000). Nevertheless, I was startled to discover that many doctors and others in the UK who are involved in the recruitment of anonymous semen donors or providing donor insemination, are engaged in tracing their own genealogies. It appeared to me that they were enjoying a source of knowledge and identity-building which they were denying to donor-conceived people. Some of those who had researched their family history were not in favour of donor anonymity, and so their position was less contradictory. One of them told me that he was much in

favour of the right of donor offspring to be able to access identifying information about donors, and thought that it was important to know about one's ancestors. He recalled a case of a husband and wife that he had helped at his private clinic to achieve a pregnancy with a donated ovum from the wife's sister. At their final meeting with him they told him that they had changed their mind about telling the child about her origins. 'I told them that they were rats', the doctor recalled, with considerable feeling. Another doctor who had moved from NHS to private employment in a pre-retirement move told me that he had added a section to his website, giving information about his family history. His reply to my astonished request for an explanation was that he thought that it would be interesting for his prospective urology patients to know something more about him than just his medical credentials, and it could provide a neutral talking point at the start of consultations. The webpages themselves are not so neutral: the doctor, who is an approachable, rather modest person, provides a brief genealogy of his Scottish roots (although he was born and brought up in England) going back to 1550, with a picture of his mother's coat of arms. There are also pictures of him on skis on a downhill slalom course, evoking an image of athletic ability and physical courage in a man well past middle-age. It would be interesting to know what his male patients with fertility problems make of this.

A non-doctor donor whom I met during my fieldwork but did not formally interview, spoke at the launch of UK Donorlink in 2004 about how he no longer wished to remain anonymous to any donor offspring, and how he would welcome the opportunity to help them to find out about their 'biological ancestry' (Kilby 2004:41). He continued: 'I love genealogy, and my own family history has become a little obsession, which I would love to share with anyone curious enough to have registered with *UK Donorlink* and found to match my DNA' (2004:41). This donor recognises that curiosity about genealogy might be a motivation for donor-conceived people to search for information about their donor. However, it is obvious that family history records only record the names of people who are believed to be related, and that certainly in the case of father-child relationships, the supposed and the actual genetic fathers may not coincide (Barnes 1961). There may be an element of make-believe in the attempt to assert biological links between people whose relationship

derives from a legal endorsement. One doctor currently responsible for donor recruitment in a clinic had a simple attitude to the issue of genes: if a recipient couple were asked, after the child was born, if there was a family history of a certain condition on the father's side, then he advised them to say 'No'. However, he would never accept as a donor any man who admitted that his father had died under 40 years of age, because that fact in itself might be an indication of a heritable medical problem.

This simple, perhaps simplistic, attitude irritated the geneticists that I met. They complained that their medical colleagues in infertility clinics do not know how to obtain a proper family history, and observed that an accurate family history is only as good as the knowledge and interviewing skills of the person asking the questions. One geneticist told me that 'good family trees can substitute for chromosome analysis'. He told me that the kind of questions that donors should be asked are more wide reaching than some donors are asked today, and certainly more so than for the donors who were recruited before donor insemination became subject to regulation in 1991. A nurse who managed an infertility clinic in the 1980s recalled that in cases of donor insemination, the recipients and their husbands were told what tests had been carried out on the donors so that they would be able to deal with questions from the antenatal clinic staff, as if the 'family history' which the recipients would be asked about included that of the husband.

A non-donor doctor advised me that the matter of screening donors was problematic: prospective donors today are not having as many tests as they could have, but he asked: 'where do we stop?' Knowledge of genetics has increased so much since the 1960s and predispositions to many medical conditions can be predicted now. This doctor suggested that the screening issues, combined with the anonymised donation of the past, 'will be a minefield for donor programmes' because prospective donors may not know that they themselves were conceived with donor assistance. Uniquely amongst my informants at the time, this doctor was concerned about the lack of research into the long-term health of donor conceived people. He was unusual, as he recognised, in being concerned also about the long term effects of donor insemination. For him, donor insemination is not 'treatment' but 'a palliation' of male infertility.

## **Conclusion**

In the context of current debates and publicity about genetics, donors and other research informants look backwards and forwards in their ideas about the gene – what has been inherited and what is being passed on. Many of my medical informants recalled that they had been learning about genetics in the 1960s and 1970s when they were university students, but the interest was not so much about what was inherited as to whether nurture was more important than nature, and as one doctor donor told me, ‘genetics was separated off from our donating’.

People think differently according to how they hope that the human gene works. For the early recruiters of semen donors, it was enough to know that the donors were fit, healthy and intelligent. The tests that were done could eliminate donations from young men whose sperm quality was not good enough for the sperm to be used for donor insemination. The donors themselves, as they recalled, often harboured hopes that their donations were doing more than helping to create a baby. They hoped, perhaps secretly, that the sperm contained genes, their genes, which would continue to exist as separate substance. The genes would carry something of themselves into the future and might thus ensure a genetic immortality. The genes would operate unseen, but powerfully, to create at least one generation of successful offspring or even, for donors now aged in their 60s permitting the thought that their donor offspring are now parents themselves, for two generations.

The views about resemblance represent two distinct ideas. The first is that there will be a resemblance between a person and his, or her, offspring. Research in Aotearoa New Zealand by Katrina Hargreaves (2006) into how families and kinship are constructed through donor insemination found that the references to physical resemblance were used as a strategy for highlighting the connection between a mother and child and thereby diminishing the contribution of the semen donor. Hargreaves quotes a father clearly annoyed by the tendency of people to suggest that his donor conceived baby daughter looked like him: ‘I found it very hard sitting there bouncing the baby and “Doesn’t she look like you? No hair” and all that sort of rubbish. Give it a rest!’. He added that the baby looked very much like his wife, which was a comfort to him (2006:274). Hargreaves notes that highlighting one

connection by physical resemblance will distance others, in this case between donors and donor-conceived children and their parents. People who are genetically connected to the offspring are ignored, or their contribution downplayed. As in other kinds of relations, they may be excluded or sidelined for various strategic reasons (Edwards and Strathern 2000). Finkler suggests that the idea of genetic inheritance is an 'ideology' and a 'social enterprise produced...at a particular moment in Western scientific and medical history' (Finkler 2005:1068), but ethnographers have described the belief in resemblance between parents and children in non-EuroAmerican societies. Nancy Levine (1988) describes how, for the polyandrous people living in Nepal, there is a keen interest in determining which of a woman's husbands was the father of a particular child. Although a woman would keep track of her menstrual periods and sexual activity, 'inevitably there are pregnancies where the father could be any of several husbands. Then the parents wait for the birth of the child and compare its appearance to the men to make assignment of paternity' (1988:167). In Suau, Papua New Guinea, Melissa Demian (2000) found that her informants emphasised the importance of having children because after a person's death, a child is the memory of the person by being their image. The child of a dead parent 'becomes their living memory or commemoration, their face a mnemonic for the face of a departed person' (p.97). In Suau it is important to have children of both sexes, not only for ensuring that one has helpers and caretakers (a boy for his father and a girl for her mother), but also as 'replacements in a future unimaginable except by means of the children who carry one's image into it' (p.97). I suggest that the ways in which semen donors talked about genes reflected their aspirations for and concerns about connection with possible donor offspring in a context of an increasingly normalised interest in the prospective and retrospective agency of the gene. Physical resemblance is taken as evidence of the biological link which was socially erased even as the donor insemination was taking place.



## **Chapter Five: ‘A man never really knows does he?’ The work of hypothetical procreation**

In Chapter Three I described stories by semen donors about their recruitment in the past and how the business of recruitment by private and NHS clinics relied mainly on the need of the potential donors for money in order to encourage them to donate. I also described how the donors recalled jokes being made by themselves and other students about donating and how these suggested an emphasis on the business of being a donor rather than on the purpose of donating. In this chapter I describe more of how donors recalled the activity of donating and how they spoke about what they thought had happened to their semen donations. This will include donors talking about ‘possible people’, that is, the people who might have been brought into existence as a result of their semen donations.

The context for this recall and sharing of ideas was one of increasing publicity in the UK during the time of my fieldwork about adoption reunions and about arguments and debates as to whether donor conceived people should have, or should claim a right and need to have, access to identifying information about their donor parents. The donors who I met were usually aware that there were media reports about these two matters, even if they had not read them, and they made some links between them in our meetings. However, most of the donors said to me that they had not explored the implications for their own situation as having donated semen anonymously in the past. Adoption and donor-assisted conception have important differences in two particular aspects, namely the meaning of the donation, whether that be a relinquished child or the donated gametes, and the policies about access to information for those with a personal involvement. These differences have been highlighted by professionals and academics interested in or involved with infertility treatment policy (e.g. Haines 1988; O’Donovan 1988; Deech 1998).

Although several donors had experience of family involvement in adoption and believed that that had had an influence on their way of thinking about donor insemination, the others had little or no information about adoption legislation, adoption agency practices in the area of search and mediation services, adoption contact registers or research findings about adoption reunions. Information for these

donors about adoption was usually limited to having met a birth mother. Nevertheless in the absence of knowledge of stories and research findings about the long term implications of being donor-conceived, it was to the adoption field that donors turned for enlightenment, particularly when they learned of my previous professional involvement in that field and hoped that I could shed light on some questions about the long term implications of being a birth mother or an adopted person.. As Edwards (1993) described for Alltown, the residents there did not draw out the kinship implications of reproductive technologies; rather, they used kinship as the frame within which to think about reproductive technologies. They used what was already familiar to them, in their own families and community.

In addition to the increasing publicity about people searching for information about their origins, there was a subtext to the publicity which suggested that adoption reunions were ‘a good thing’ because both parties wanted contact, whereas contact between donor-conceived people and gamete donors was problematic because the donors were not wanting contact and were also wanting to remain anonymous. The assumption being conveyed was that donors now knew that their donor offspring might want to find out about them but were not willing to do anything to help. A sociologist summed up the view of a number of psychosocial experts who had talked with me during my research by stating that the donors of the past were ‘in denial’. The implication was that times had changed since the donors made their donations and that the donors would have to respond accordingly. They must set aside the promise, which was given to them by clinics in the past, of total anonymity in respect of the recipients and the donor offspring, and of no involvement in the results of their donation.

### **A problem about knowledge**

Despite the increasing assumption that adopted people and their birth relatives will want to search for each other and perhaps actually to meet, the project of search and reunion is often laden with uncertainty, risk-taking, and the challenge of managing the absence of shared memories (Carsten 2007a; Carsten 2007b). Yet in a reversal of earlier perceptions about adoption, Roche and Perlesz (2000) suggest that ‘the choice not to search is one which goes against both the psycho-social and socio-political *zietgeist*’ (2000: 8). A British study which aimed to compare the characteristics and

experiences of adopted people who search for birth relatives with those who do not but where birth relatives have made an enquiry about them, found that a third of the 78 non-searchers reported being worried that further information about their adoption might be either unpleasant or upsetting (Howe and Feast 2000). Strathern (1999) suggests that in the context of kinship, knowledge is not neutral in its impact. It has 'built in effects' (p.69) and this may explain why people may be reluctant to look for further information. Obtaining information about one's origins will have an effect on one's sense of identity but has implications for other people too, because knowledge of how one is connected can lead to relationships. Rejecting or screening out information about a relationship may be interpreted as rejecting the person involved. It is evident that Strathern's helpful anthropological analysis of what is entailed in searching for new kinship information is also an indigenous, lay expression of concern about what the creating of new relationships might do to existing ones, if donor-conceived people were to obtain identifying information about their donors. She supposes that 'the debate on anonymity will be rewritten as a simple matter of concealing the technical facts of parenthood' (1999:84), but I beg to differ. The debate is every bit as complex as her theoretical analysis suggests, as the historical record shows and as the narratives of semen donors have begun to reveal.

### **The activity of donating**

For the majority of my informants the donations had been made 30-45 years before, and several of them pointed this out and apologised when they were vague about the circumstances in which they had donated. Nevertheless, I was struck by how several of them were able to tell vivid stories about being recruited and then about donating. It was not possible nor necessary for me to verify the facts in these stories and indeed during the two meetings where donors' wives were present, there were occasional disagreements between husband and wife about dates. I also received, in one instance, two versions of a story from two friends both of whom had donated semen. I had suggested to one of them that the subject of semen donation seemed to produce a lot of jokes, and I mentioned as an example his friend's story that one donor had suggested that all of the donors should demand a pay rise from the clinic for their donations. My informant immediately replied that the suggestion had actually come from his friend. He said that when his friend had telephoned asking if he would help

me with my research, his friend had recalled the story. My informant said that he had reminded his friend that he himself had broached the idea to everyone. The story of the pay rise proposal reminded my informant of another detail. 'We did actually think about going freelance,' he told me. He explained that he and the other donors 'could have approached the sad looking woman going into the clinic' although he did not think that they would have done so. Such an action would have produced complications.

Donors from different age groups and who were recruited to donate by different clinics all stated that the assessment process which they underwent in the clinic was a brief one. One doctor donor described it, with hindsight, as 'amateur'. Donors were aware that things are done differently now. One donor recalled that the process did not include any discussion about the possible psychological implications of donating semen. He remembered that the clinic 'had a thing' about what blood group he belonged to, meaning that it was important for the clinic to know what it was, so that there could be a match between the blood of the donor and the blood of the recipient's husband. This would help to avoid any discovery or suspicion by the donor offspring that his father was not his genetic father too.

A donor who was recruited in the early 1980s recalled that the process had expanded but was still a minimal assessment by today's standards:

Went along, had a personal interview and a medical, they did some blood tests and they said why did I want to do this. And I said, I'm not really sure and, um, have you thought about the fact that, you may well have some progeny from this venture, and eh, how do you feel about that. I said I wasn't concerned about that problem. That was it. A very brief interview. There was a questionnaire, by a nurse. There was definitely some sort of screening process.

As recalled by this donor, clinic staff did mention the possibility of there being children created as a result of the use of his semen. The word which the donor remembered being used to describe these children was 'progeny', a term usually used to mean genetic offspring in a genealogical sense, rather than children in one's family.

I have previously described how one donor made sure that his semen samples did not become cold and therefore of no use for insemination, by wrapping the container up warmly for the journey to the clinic. Men donating semen today are

expected to produce their sample in a room in the hospital or infertility clinic, partly to make sure that the semen is theirs and partly for the clinic's convenience. 'It ensures that the laboratory gains access to the sample within an hour of its production, which helps in preparing and assessing the sample for use. It also ensures that couples [seeking DI] are not in a position to swap the sample with a known donor' (Lee: 2003:77). The importance of preventing such a swap is twofold: some clinics are reluctant to allow the use of semen from donors known personally to the recipients, as I describe and analyse in Chapter Seven, and also clinics would be concerned about using a sample from a man unknown to them because he and his semen would not have been tested for certain medical conditions and diseases. The staff of the Danish sperm bank Cryos told me that one donor, who had come to their offices to produce a sample in the private room designed for that purpose, had left the room and handed over a pot of semen which the laboratory staff immediately realised could not have just been produced by the donor because it looked wrong: it had already begun to change consistency. When they confronted the young donor he admitted his mischief. The semen had been produced previously by a friend with red hair and the donor had brought it surreptitiously to the Cryos premises. Apparently the two young men knew that because the gene for red hair is autosomal dominant, there was a chance that a hapless recipient would give birth to a red-haired baby. Some clinics in the UK do allow production of semen at home if the 'donor' is the partner of the female patient, provided that the man lives near enough to bring the sample in to the clinic quickly. Clinic staff told me when I was doing clinic inspections that they realised that it would be possible for a couple to substitute semen produced by a friend or relative if they were absolutely determined to do so.

Production of the semen sample in the clinic setting, even if the room set aside shows consideration and respect for the donor by being provided with comfortable furniture, washing facilities, and guaranteed privacy, nevertheless means that the potential donor is having to masturbate to produce the semen under pressure of time. He knows that there are clinic staff who know why he is in that room and that there are laboratory staff waiting for the sample. A clinic nurse told me that the current trend for the recruitment of older men as donors meant that the clinic was having to allow longer for the sample to be produced and she and her colleagues had

to be respectful of that. Younger donors tend to be able to produce their samples quicker than older men, but even so, the feeling of being under psychological pressure to produce a sample was mentioned by the donors in my research, and they had been young when they donated. ‘We had to produce the specimen within one hour of getting there,’ one donor recalled.

Another donor recalled that the semen sample had to be delivered early in the morning because it would be used for insemination later that day, this being the time before the introduction of cryopreservation which allowed semen to be frozen and stored. Each donor recruited by the clinic had a particular time slot for handing in his donation. This timing was ‘an imposition’ but was accepted because of the financial reward and also because, according to this donor, few donors at this clinic as far as he was aware, complied with the requirement of the clinic that they must abstain from sexual intercourse and masturbation in the days before donating. A clinician who found himself responsible for the DI service in an NHS hospital in the 1970s told me how the young donors, usually but not always students, often brought their semen samples to his house in the morning, and sometimes they arrived in a rush to avoid being late handing the sample in, and smelling of beer from the previous evening’s drinking session.

Before cryopreservation was introduced, clinic staff working in a donor insemination service had the challenge of ensuring that donors and recipients would not meet. Any meeting would compromise the privacy of the recipient couple and the anonymity of the donor. It was usually arranged that donors would bring their semen samples in to the clinic in the morning at specified times and they would be used for insemination by the afternoon. A former nurse told me that there were occasions when the semen donor would be leaving the clinic by one door as the recipient woman entered by another. One donor who recalled that he often turned up at the clinic to hand in his sample looking rather scruffy, remembered the occasion ‘that I was very slightly late or there was a co-incidence and I actually saw the bloke who had brought his wife along’. This had an effect on the donor: thereafter he would always turn up at the clinic shaven and looking smart, in case he was seen by a patient’s husband. He told me that he had thought that it was ‘unfair’ on the man for the donor to look as if he had been partying all night.

## **Possible people**

The donors who I interviewed were not specifically told whether or not there had been children born as a result of their donation. This was the usual practice, and has remained so although it is not legally required to withhold the information. The doctors who managed the donor insemination clinics did not always know exactly either. One reason for this is that some clinicians deliberately avoided learning whose donation was being used to inseminate a particular female patient. The actual selection of the donation was done by someone else in the clinic such as a nurse. These clinicians indeed did 'refuse information' in order to avoid the consequences of being able to link particular parents and their baby to a particular donor. Another reason for the chosen ignorance of the clinicians was because of the practice in some clinics of mixing the semen of several donors so that paternity could not be traced. Donor semen sometimes was also mixed with that of the male partner of the childless couple so that the pretence could be upheld that any resulting child might be his biologically. Alternatively, or additionally, the couple receiving treatment would be told to go home and have sexual intercourse with each other as soon as possible after the insemination had been carried out, so that unless the husband was azoospermic there might be a chance that fertilisation was achieved with sperm from the husband. One donor related how the doctor at the private clinic where he gave his donations had justified mixing the sperm:

He said it's most unusual ever to get a man who has no sperm, so what I do is I check the blood groups and I mix the sperm from the husband with the sperm from the donor so the bloke can say to himself, in all truth this could very well be my son, you can't tell the difference.

The donor went on to tell me, 'and of course the blood group's right and of course at that time the idea of DNA testing was not there'. The implication of this clinical practice is not only that the recipient's husband could pretend that he was the genetic father of a child, but also that the donor could pretend as well. There was the chance that any child born after a woman had received DI was her husband's, and not the donor's.

It is uncertain how many clinics carried out the practice of mixing sperm before insemination, and for how many years. A speaker at a conference in 1972

noted that the practice was still being carried out in order to ensure that the paternity was unknown (Ciba Foundation 1972:7). As noted in Chapter Two, some of the early practitioners of DI were much against the practice, for reasons of safety. They thought that mixing sperm might enable a subfertile husband's defective sperm to succeed in reaching and joining the woman's ovum. The presence of other semen substance gave a chance to the husband's sperm to be successful. Donated semen might therefore act as a facilitator, and not simply as a vehicle for the donor's own sperm. This was giving 'nature', as in the 'natural' process of fertilisation after sexual intercourse, 'a helping hand' (Strathern 1992a:57) as opposed to relying only on the 'artificial' process of A.I.D. In using semen from a donor and a husband together, therefore, there was a risk of giving assistance to a husband's sperm when it might have been safer for the health of the future child if a donor's sperm had been allowed to work on its own.

Some donors made assumptions that children had been created, according to how often they were asked to donate. One donor did a calculation:

How many pregnancies? I wonder, I gave 40 donations every year for three years. Perhaps there would be a one in four or five pregnancy success rate, so, there would be 5-8 per year.

The donor assumed that there were between five and eight pregnancies each year. He indicated that a pregnancy may not be achieved from each insemination, but he made an equivalence between pregnancies and live births. There is a possibility that there could be up to eight children born from each year of his donating. He did not state a completed calculation that this would mean up to twenty four children born as a result of his semen donations, but neither did he take into account the number of inseminations which it might have taken for a pregnancy to be achieved. Figures from one clinic were quoted in 1972 at the Ciba Foundation conference showing an average of nineteen inseminations per birth using frozen semen, and of seven inseminations per birth for fresh semen (Ciba Foundation 1972:5).

One donor knew when he was recruited that the clinic had a policy of a limit of five donor offspring per donor and so, as he put it, 'I was retired after five hits'. His understanding was that there were five live births, although whether or not any of these births were twin rather than single was not mentioned. Although the donor

could have helped to create five children, a number with which he clearly seemed comfortable, it is possible that there could have been more than five. Although the law restricting to ten the number of live births (which might be singleton, twins or triplets) involving one donor was introduced by the Human Fertilisation and Embryology Act 1990<sup>1</sup>, increasingly the voluntary practice of a number of clinics before then had been to restrict the number of live births to that number. A medical practitioner who started up a DI service in the 1970s explained to me that the limit of ten donor offspring was based on a World Health Organisation guideline which had developed from concern about the limitation of incidences of unwitting incest between people who were genetic half siblings or genetic father and daughter. Therefore when this donor was no longer requested to visit the clinic and produce a donation, he ‘knew’ that his donations had been successful. Even then however, he could not know for certain whether the pregnancies had gone to full term, or whether babies had survived birth and beyond into childhood and adulthood.

The possibility that pregnancies had miscarried or that babies had died was not ever mentioned by the donors who I interviewed, and it was not one that I felt able to raise with them. Data collected by the Royal College of Obstetricians and Gynaecologists from all UK clinics providing a donor insemination service for the years 1977 to 1983 show totals of 5,118 live births, 815 miscarriages, 14 cases of termination of pregnancy, 39 ectopic pregnancies and 42 still births. The outcome of 559 pregnancies was unknown (Thompson et al 1985: 307-315). The clinician at one NHS clinic reported in 1985 that in a five-year period, out of 158 couples who commenced donor insemination, 43 failed to achieve a pregnancy. Fifteen of the couples had withdrawn from treatment after periods of between eighteen and thirty six months (Thompson et al 1985: 304).

Several donors told me that they did not know whether or not their sperm had successfully helped to create a pregnancy and live birth and they did not speculate about it. A few donors stated that their semen might have been used only for research purposes that is, they were suggesting that the semen had not been used for

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<sup>1</sup> Following the report of the SEED Review in 2005, the HFEA issued guidance which clarified that gametes from an individual donor should not be used to produce children for more than 10 families in the UK.

insemination in order to help to create a pregnancy. Donated semen has been and continues to be used for research into human male fertility and one non-donor doctor told me that, as a student, he had donated to help with such research. If the donations had been used for insemination then it would have been without his consent, he told me. He did not know for sure that the semen had not been used for treatment: he could only rely on trusting his medical superiors that the terms of his consent had been respected.

One donor told me that he and his fellow students had received no feedback at all from the clinic about the outcome of their donations. I asked whether that meant that he did not know 'how many children there might be out there' as I phrased it. He replied that it did, but added with a smile, 'maybe there is a dynasty'. This suggestion that there might be large numbers of donor offspring was echoed by several donors, and seemed to evoke varied and ambivalent reactions. One donor said that he 'didn't think of how many' there might be and that 'there is a problem in humanizing it'. This was a donor who feared meeting donor offspring in person because he thought that if he met them, he would be tempted to welcome them all into his family at what might be an inappropriate time. For this donor, the larger the number of offspring, the more problematic it seemed for him. In contrast, another donor said that he did want to meet all of his donor offspring and that he would like to 'throw a party for them all'. These views about meeting with donor offspring will be explored further in Chapter Six.

None of the donors with whom I talked suggested that their donations might not have been used for insemination purposes because of problems with the sperm. None of them had been given any indications that their sperm was not good enough to be used as a means to help achieve a pregnancy. Several retired clinicians told me, however, that at their clinics some donors produced sperm which could not be used because the donors were discovered to be subfertile. One told me, 'we would tell the man that his sample did not freeze well'. Since the capacity of sperm for surviving the freezing and thawing processes of cryopreservation does not seem to be related to fertility, describing a man's sperm as not freezing well was a face-saving way of rejecting him as a donor. A man whose sperm does not cope well with being cryopreserved may still be capable of impregnating a woman through sexual

intercourse, and so it was important, in the view of the clinicians, not to give the impression to the young man that he would never father children. Another clinician told me that he did not ever tell a prospective donor that there was a problem with his sperm and that the donor was subfertile or infertile. He and his clinic colleagues would continue to receive donations from a man, and never tell him that his donations were not being used for insemination purposes. He told me: 'Inevitably some donors were infertile and I didn't think that they should be told. We let them carry on donating for a while, for up to about six months'. The explanation which he gave for this decision was that it would have been wrong to draw the conclusion that a man was infertile if no pregnancy resulted from his donations, since the problem may be temporary. Also, being given the information that they were infertile might adversely affect a donor's relationship with a current or future girlfriend. This clinician and his colleagues would have been aware of the difficulty of diagnosing male infertility given the assessment techniques available to them at that time; studies in the 1970s had shown that about 3% of fertile men had an abnormal semen analysis, and that 25% of infertile male patients had a normal one (Aitken et al 1985:275). It is possible, therefore, that some men who donated at that clinic have continued to live with the idea that they have donor offspring, when in fact they do not.

It can be seen that there are several reasons why a young man might have donated semen but not have any donor offspring. His semen might have been used for research purposes, it might not have been good enough for donor insemination, the female recipient may not have become pregnant, or pregnancies did not result in the birth of a live baby. During the time of my research, the UK Department of Health funded a short but intensive research project (Daniels et al 2005) following the government's decision to introduce, from 2005, regulations allowing donor-conceived people to have access to identifying information concerning their donor. The decision had led to concerns regarding future gamete donor recruitment, and the purpose of the research was to interview semen donors who had donated altruistically at a particular clinic in London, and to seek their views on issues associated with recruitment, attitudes regarding information sharing and views concerning the offspring. Responses regarding information sharing with donor

offspring were compared with donors' views recorded at the time of recruitment which covered the years 1988 to 2002. It was agreed at the outset of the research that the donors who took part would be offered the opportunity to ask the clinic about the outcome of their past donations. Some of the donors took up the offer, and some of them discovered that their donations had not been used for insemination. One of the researchers explained to me that in the past, some samples had had to be destroyed because the process used at the time to heat-seal the straws containing the sperm before storage, in order to prevent contamination by HIV, was discovered later to have killed the sperm. The researcher also pointed out to me that 'one has to take into account that each ejaculate produces enough sperm for about two inseminations and the success rate with insemination (as opposed to IVF) is in the order of 10-15% per insemination. So you can see that it's tough going getting pregnancies with insemination using frozen sperm' (Ruth Curson, personal communication).

### **Unknowable knowledge**

Not knowing whether or not any children had resulted from the donating was not the end of the story however. Sometimes, despite an insistence on 'not knowing' whether or not there were offspring, either curiosity or some hidden feelings about possible donor offspring were revealed by the donors that I met. For some of them, 'not knowing' was a way of framing the issue of thinking or not thinking about donor offspring. A donor who was told by the infertility clinic doctor that his practice was to mix donor semen with that of the female patient's husband, noted how the practice of semen mixing was an important factor in his own thinking that perhaps there were no babies conceived from his donations, and further that he would have no idea of how they had grown up:

I don't know, what are the kids who are AI [Artificial Insemination] children like? I mean I suppose in a sense all that privacy in my case was because they weren't there, they were mixed with the husband's and that's entirely true and that in a way allowed me to avoid thinking, well, um.....

The donor recognised that the practice of the clinic in mixing semen helped to ensure that he would not think that there were actual children resulting from his donations.

Like the husbands of the female recipients, he was being encouraged to think that the resulting children were the genetic children of the husbands.

Not knowing whether or not children had resulted from the donations could be used to make the presumption that there were not any children created as the result of donating semen. It was a way of stating that there were no donor-conceived people in existence who might be wanting to know about the donor. The argument for some donors was: I don't know if I am a genetic father, therefore, I am not a genetic father. For donors with such a perspective, the idea of there being donor offspring was a hypothetical one. In theory, there may be one or more offspring out there, but it is only a theoretical possibility. Not knowing seemed to give permission to some donors not to engage in current debates about donor conceived people searching for information about their donor. It was noticeable to me that those donors, the minority, who emphasised 'not knowing' were somewhat harder to interview than the others. They tended to 'truncate' discussion<sup>1</sup> although they were no less thoughtful about the issues involved. I cannot say whether or not their emphasis on 'not knowing' was related to a personality type, for example to a tendency to be cautious and non-speculative. It is certain, however, that an insistence on not knowing can be used as a way to avoid spending the energy that goes into managing uncertainty. One such donor described our meeting simply as 'reminiscence' about his student days and about how he had been recruited as a donor. In total contrast was one of the eloquent donors who later, on the telephone, said how much he had enjoyed speaking to me: 'I was entertained by the evening. I can see why people like getting counselling – it felt so self-indulgent'.

The gap between having knowledge about the creation of a child, and having knowledge about whether or not the child had survived to adulthood and was still alive, was an echo of the experience of people who relinquished their babies for adoption in societies with closed adoption systems. A recurrent theme in the pleas from birth parents to have access to information, and an underlying purpose of Scotland's Birth Link and of other countries' adoption contact registers, is that birth parents usually did not know whether or not their child lived to adulthood and beyond. Comparisons and contrasts between adoption and donor-assisted conception

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<sup>1</sup> I thank infertility counsellor Jennie Hunt for suggesting this expression to me.

have been made by a number of academics, infertility clinic practitioners and other stakeholders in the field of regulated infertility treatment in the UK. Mainly they have explored the extent to which there is any equivalent sense of loss in the two situations (Deech 1998; Blyth et al 2001) although Shenfield (1994) who works as an infertility specialist and favours donor anonymity, asserts that the difference lies in the different psychological situation, with adopted children, in contrast to donor-conceived children, being ‘abandoned by not only one but two of the parents’ (1994:1350), and Haines (1988), writing before the passing of the Human Fertilisation and Embryology Act, draws attention to the extant support for secrecy in the adoption laws for England, Wales and Northern Ireland.

The experience of ‘not knowing’ for birth parents has been described as painful and stressful, even if the birthparent might not be wanting to have contact with, or meet with, the adopted person. Reassurance that the baby has had a good life with the adopted parents, and that therefore the decision to relinquish was not in vain, is often given as a valid reason for wanting information. For the donors who did not know if there had been children created, it seems that a psychological state of unresolved loss was not relevant. For birth parents of adopted people, ‘not knowing’ is compatible with a belief that the child is still alive. For the donors who were insistent that they ‘did not know’, their not knowing can work to support the alternative view that the child did not exist, and might not have ever lived at all. ‘It is totally theoretical’, said a donor who described his donating as being ‘like me helping you with your research’. Another insisted that the result of his donating was not known and that ‘maybe my sperm was never used to create a child’.

However, the not knowing did not always cut off the possibility. One donor was adamant that a prerequisite of his donating had been that he would not be identified and that no limit had been mentioned by the clinic as to the number of potential children. He said that therefore he did not know if children had been created or not although he did wonder about it. As our discussion continued and the donor gained confidence in sharing his views, a slippage towards imagining that donor offspring did exist became evident. I asked if he had heard of UK Donorlink, which he had not, and I then briefly described it for him. He said that although it was a good idea, he was not interested in registering ‘because I would wonder if they

would turn up. No idea that they will, but [I'm] not prepared to accept the possibility'.

For other donors, not knowing whether or not there had been children created did not prevent them from believing that they had been. These adult donor-conceived people were thought of not as theoretical people, but as 'not-known' people. They were also hidden people, in the sense that the donors did not know what they looked like nor what was their social identity. Yet they were not absolutely hidden because, unwittingly, they might have met. A donor offspring might even be one of the medical students or young doctors in a health setting where the donor worked, but their identity as the donor offspring was masked from view by the anonymisation of donors built into the donor insemination practices of the past. For donors who believed that donor offspring did exist, their existence was not described in theoretical terms, but in terms of real people who you had not met: 'small grey haired people out there'; 'They might be parents themselves now'; 'There may be girls, and my wife always hoped for a daughter'.

A donor who donated in the early 1980s recalled that, even though the practice of semen donation was still anonymous at that time, he had asked whether his donating would remain confidential. He said that he had been told that the clinic would try to maintain confidentiality but could not ensure it because the law might change in future. 'So, I had knowledge that a vague possibility of being contacted', he told me. In his opinion it would not breach the contract made with him if a donor offspring made contact with him. In addition, he would not find it a problem to meet with that person provided that it did not 'take away from' his children by his marriage. By this he meant that he would not want donor offspring to divert the involvement which he has with his family. This donor and his wife had written into their wills that only children of their marriage should inherit from them. They had done this because they understood that in law, donor offspring were not debarred from making a claim on the estate of the donor. This action demonstrated that for this donor and his wife, it was likely that donor offspring did exist.

A doctor who donated in the 1980s recalled being told by the clinic that the clinic intended to disregard the recommendations of the Warnock Inquiry about keeping proper records of donors. The donor thought that the clinic staff had said this

in order to put him off the idea that he might be able to return in future to ask for information about whether his donations had helped to achieve pregnancies. He told me that he had felt that he had a sense that he was helping to create children and he had joked with other students about ‘spreading my good genes’. He and his wife have a young son but the donor told me that he often thinks of ‘possible other sons’ that he might have somewhere.

Marilyn Strathern (1992a) suggests that different representations of knowledge are evident in the manner in which the terms ‘child’ and ‘parent’ are conceived amongst some EuroAmericans. A child is ‘recognised’ whereas a parent is ‘constructed’ (1992a:148). A child is assumed to have been parented, to have been recognised already as a child. A parent is only a parent in relation to having recognised a child. Parents exist ‘only insofar as their children are *known* to exist, since persons are not presumed to be parents unless there is some way of knowing that they have children’ (pp. 147-148). This observation was well illustrated amongst my research informants by one donor who was not satisfied with not knowing whether or not he had helped to create children. ‘It’s not nice, not knowing’, he told me, although he added that ‘there are always mysteries in life’. He also reminded me that ‘a man never knows, does he?’ referring to the possibility that a man may think a child to be his, whereas another man is the genitor. This donor was the only one at the time of my research who said that he had registered with UK DonorLink and this was a deliberate action on his part in response to his not knowing whether or not his donations had resulted in children being born. The ‘not knowing’ had an irony for this particular donor: he said that the hospital where he had donated as a medical student claimed not to know whether or not his record still existed and if it had not been destroyed, where it was stored. This donor, being a doctor, found this lack of rigour about records both frustrating and unsatisfactory. Nevertheless his ‘not knowing’ did not prevent him from having aspirations for possible donor offspring: ‘I hope that they are at peace, strong, fulfilled, if they exist’, he told me.

### **Describing the undescribed**

Like most of the donors, the donor quoted above talked of possible donor offspring in the plural. In contrast, insistence by some donors about not knowing if children had been created was associated with talking about donor offspring as a group.

Donors who reckoned through their interpretations of the clinic arrangements that there probably had been children created were more likely to speak of individuals, even if it was in the plural. The way that they spoke of donor offspring included the following examples:

‘If he came to the door and was in trouble I would invite him in. Or her.’

‘If she came to the door and looked like my family I’d invite her in’.

‘They may have children themselves now’.

‘If they turned up I’d just invite them in for a coffee’

In the last example, ‘they’ is being used as a generic term to include ‘he’ and ‘she’. These statements reveal that the donors are able to imagine situations where an individual donor offspring meets with them. The donor offspring are imagined as existing and as being individuals with lives, and perhaps troubles, of their own.

Some donors had considerable difficulty in giving any name, even a generic name, to donor-conceived people. One donor who used the term donor offspring without hesitation was involved with the media and therefore it was a term with which he was familiar. Other donors would refer vaguely to ‘people’ or ‘anyone’. I suggest that this was because some of these donors had not discussed the matter of donation for a very long time or in any depth at all. Monica Konrad noted a similar phenomenon when she first interviewed ova donors during her doctoral research (Konrad 1996). As Rosaldo points out in the context of the Ilongot, not naming ‘suggests a culturally blank space’ (1984:19) and Levi-Strauss notes that the namelessness of something is often associated with indifference towards it (Levi-Strauss 1962:2). A further problem for my informants was that the various terms in current use are experienced by researchers and by people with a personal involvement as clumsy or value-laden – donor conceived people, donor conceived adult, donor offspring, genetic children, remote adoptee etc.

In some situations, naming is a political act, and the allocation of a name may be fiercely contested. Women who have surrendered children to adoption may feel very strongly that the name describing them, such as mother, real mother, natural mother, birth mother, whether they gave up their babies voluntarily or not, should be their choice and theirs only (Farrer 1997). Nevertheless, it was clear to me that the less enthusiastic a donor was about being identified as the genetic father of a donor

conceived person, that is, of his donor offspring, the more uncertain he appeared to be about what term to use. And the less certain the donors were about naming, the more likely it was that they wished to remain anonymous to any person conceived with the use of their donation.

Giving a name may serve to make a human being real, a reality. It also can make the idea of being in contact less problematic. Giving a name can also reveal ideas about how one would react if there were contact e.g. whether the person is male or female, their age, whether or not they might be parents, their age relative to the donor's own children. The donors who thought of the donor-conceived people as real people were able to describe what might happen if one of their donor offspring were to make contact with them or even arrive at the door of their home:

'I'd invite them in'.

'I wouldn't mind being found'.

'I would worry if she looked like family, because I would then want to invite her in'.

### **Partial anonymity**

I started my research thinking that nobody talked about personal involvement in semen donation, but soon discovered that the situation was not as it appeared. An example of the discrepancy is provided by a study of the social and psychological consequences of secrecy carried out by Robyn Rowland (1985). Although the informants were from a clinic in Australia, donor insemination involved secrecy supported by medical practitioners just as it did at the time in the UK. Rowland found that of sixty seven semen donors interviewed, 77% had told someone else about having donated, including personal friends, parents, and friends at their place of work. Although I found it hard to find donors to help with my research, I was taken by surprise at how frequently and how widely the identities of my eventual donor informants were known to other people. This was also the case with donors who were identified to me too late for inclusion in the research or who proved so difficult to contact that time ran out and I had to give up. This raises the question as to the definition of a secret and how the secret has operated in anonymous donor insemination. An interesting aspect concerned the knowledge of who had offered to donate, although the offer might not have been taken up. One andrologist told me

that he recalled that when he was at medical school, male students were once asked to write their names down and pass them to the lecturer if they were interested in donating. The idea seemed to be that the identity of the prospective donors would not be made public. However, a few days later at the end of another lecture, a nurse from the infertility clinic walked in and read out a list of names of male students who were asked to come forward. My informant told me that this caused great amusement for everyone.

Only one donor whom I interviewed claimed that he had never told his wife that he had donated. All of the others told me that they had told their wives, whether or not the donating had occurred before or after marriage. One donor had told his father, his aunt and two nephews. I interviewed seven of the donors whilst other people were in and out of the interview space – wives, grown up children, a personal secretarial assistant. Only entry into the same room by young children immediately stopped the flow of discussion.

As knowledge of, and interest in, my research spread amongst people working in the infertility treatment field and in my social circle, people began to tell me that they knew someone who had donated. ‘There’s someone at my clinic but we don’t ever talk about it’ a clinician told me, for example. A scientist from Scotland whom I met at an overseas conference told me that she could introduce me to a donor and added, tantalisingly, ‘He’s crazy. He went around with a photograph of his sperm count’. Sometimes donors were remembered by the doctors who had recruited them, and by particular male former fellow students, medical and otherwise. Some men working in the British Broadcasting Corporation were said to be known by their colleagues, with whom I had occasional contact during my research, to have donated in the past. Equally there were doctors working in the infertility field who claimed that they did not know any donors, and could not think of anyone in their year at medical school who had donated. I had to believe them, and to think that this was either because at their university, medical students were avoided as potential donors, or because, as noted earlier, donors tended not to discuss with fellow students that they were thinking of donating or had done so. Thus the extensive amount of information which donors recalled is in contrast to Misztal’s theory (2003:88) that it

is the retelling of information amongst young people which serves to solidify memories for the future.

The response to the knowledge about donating was varied. The donor who told neither his wife nor anyone else in his circle of family and friends did tell two flatmates whilst at university, one of whom was another medical student. The flatmates were said to have been 'disgusted' although whether this was in reaction to the procedure or to the purpose of donating the donor could not tell me. The currently unmarried donor reported that his mother had 'said something like 'How interesting, dear' when I told her'. During my fieldwork, in response to learning about the topic of my research, two women and a man that I knew through my professional networks told me that they each had a grown-up child who had donated semen. The two women were respectively ambivalent and hostile to the practice of anonymous sperm donation whereas the man was angry about the proposal to lift anonymity from future donors. Both women spoke of having 'other grandchildren out there' and of feeling not happy that their sons had not consulted them before deciding to donate. One woman obtained her son's permission for me to telephone him for a discussion but I was unable to make contact before my fieldwork finished. The other woman's son I had met before I officially started my fieldwork, and there was no secret about his having donated. He had donated after 1990 but I excluded him from interview because he moved overseas. His mother told me that she had told him of her disapproval that he had donated semen.

A crucial aspect of knowledge about donation is the lack of agreement as to whose information it is. Most donors said that they told their adult children, and would be thinking about telling the young ones when they were older. Several reasons for delay were given. Firstly, it was known that small children like to know the nature of relationships between people and how to place them. They can be adept at finding role names for people, but the donor-conceived people genetically connected to donors' small children are so not through marriage nor cohabitation but through donation of semen, and the donors had no role name for them. Secondly, to explain about the possible existence of donor offspring would involve the donors in discussing or explaining about masturbation, which for some donors was thought to be even more difficult than talking about sexual intercourse. Several donors

commented that children are disbelieving, or put off by the idea, that their parents are sexual beings. Donors' views about whether or not to tell their adult children about having donated was therefore tinged with 'the problem' that semen donation was seen as involving a sexual act, and that parents and their children did not generally discuss sexual matters. They were considered a private matter.

Shared ownership of the information with wives did not mean agreement about the meaning and implications of donating. The absence of most wives from the interview space except as bearers of cups of coffee does not mean that they had no views on the matter and no influence on the thinking of the donors. Frequently, I was told, the topic had not been discussed between the time when the knowledge was first shared and the time of my contact with the donor. Wives' views, when reported to me, were sometimes in contrast to those of the donor. One donor with several sons, who was not certain that he wished to be contacted by donor offspring, believed that his wife regretted that 'there might be daughters out there'. He thought that his wife wished that she and he had had a daughter together, and that she was aware that there might be an unknown living donor-conceived person who was his genetic daughter. Two donors arranged that their wives would be part of our discussion and in one of these cases the donor wanted contact with donor offspring in future whereas his wife was against the idea. They told me that after our discussion they had talked long into the night together about the matter, apparently for the first time.

### **Conclusion**

Not one of the donors that I interviewed ever talked discourteously about donor-conceived people in general nor their own possible donor offspring in particular, even if they were aware of the increasing debates about donor-conceived people obtaining information about donors. If they did acknowledge that there might be donor offspring resulting from their donations, then they wished them well. Of course, they might not have chosen to respond to my request for help with my research had they thought otherwise. Equally, there are some donor conceived people who might not extend the epithet of courtesy to the views which donors shared with me, and who might suggest instead that donors should make themselves identifiable by, for example, registering with UK Donorlink. They might agree with the sociologist who suggested to me that semen donors of the past are 'in denial'.

However what I have endeavoured to show is that although denial may at times and for some donors be a strategy of claiming ignorance about the result of donating, it is also a response to the deliberate uncertainty built into donor insemination services before they became regulated by the HFEA Act 1990. Anonymity and anonymisation was supposed to create a veil between donor and the recipients and their children, the donor conceived persons, but it did not operate in the networks of the donors themselves. It seems that whilst UK law and the medical professions continued to work hard to support anonymity for many years, it was not accompanied by the secrecy which would be expected to accompany it. The way in which the donors were required to donate, and the focus of the infertility clinics on ‘the here and now’ of semen production, have implications for how donors situate themselves in the context of debates about whether there is, or should be, connection between semen donors and donor conceived people.

## **Chapter Six: Unscripted Connections**

In previous chapters I have related how semen donors recalled how they were recruited and how they donated. I also described how the donors talked about genetics and about whether or not they knew that there had been children born as a result of their having donated sperm. Given the age of the donors when I interviewed them, these ‘children’ would probably all now be adults, because prior to the introduction of cryopreservation of semen, donations would have been used for insemination purposes on the same day as they were given to the clinic. The introduction of cryopreservation allowed for semen to be quarantined, or to be stored for future use by couples returning for further donor insemination and wanting to use sperm from the same donor as before. The Warnock Report recommended that stored semen should be reviewed every five years and did not put an upper limit to the number of years of storage (Warnock Report 1984). The Third Report of the Voluntary Licensing Authority (VLA) in 1988, included the Authority’s response to the government’s White Paper ‘Human Fertilisation and Embryology: A framework for legislation’ in which the VLA recommended that the time limit for storage of semen which had been donated for use by third parties should be ten years.

In this chapter I describe and analyse donors’ perceptions about connection with donor conceived adults, about whether indeed there is connection and what the implication of that might be for the donors and their families. I also include the views and reported views of donors’ wives and grown up children. The matter of connection is manifestly not straightforward. In the free market of private infertility clinics in America, where donor insemination services are unregulated by state or federal legislation (Bonaccorso 2004), Charis Thompson demonstrates how it is possible for gamete and embryo donors and recipients to ‘craft’ their own definitions of kinship connection so that ‘the couples who seek and pay for infertility treatment – the intended parents – come out through legitimate and intact chains of descent as the real parents. All other parties to the reproduction, human and nonhuman, are rendered sufficiently prosthetic in the reproduction as to prevent (if all goes well) contest over who the child’s real parents are’ (Thompson 2001:175). In the uniquely tightly regulated system in the UK, the Human Fertilisation and Embryology Act

introduced a definition of ‘parent’ for the purposes of the infertility treatments provided under license of the Act. Like the ‘real parents’ of Thompson’s fieldwork in Californian infertility clinics, the ‘parents’ in the UK’s legislation are a cultural construct which serves to assuage concerns about rights over children where social and genetic ideas about parenthood are conflated.

I have made an assumption here in linking ‘kinship’ to ‘connection’ and it is one that was made by the donors even, or perhaps particularly, when they denied that the concepts were linked. What is meant by kinship and by connection was sometimes distinguishable and at other times not, between individuals as well as within individual explications. Perhaps this is unsurprising: some of the donors had not discussed with anyone, before I met with them, how they felt about perhaps having donor offspring. Even those who said that their wives knew about the donating, which was mostly the case, nevertheless had not necessarily discussed with their wives the possibility that the donation might have long-term implications. As I suggested previously in relation to donors talking of donating with their fellow students, ‘talking of’ is at a different level from ‘discussing’. Donors were invited by the activity of participating in my research project to move from a colloquial language framework to another type, a code-switching (Rapp 2000:63) from a compartmentalised view of donation to the uncertainties of what it now means to have donated in the past. The stories of donating which were related to me were not about ‘crucibles of tough decision-making’ (ibid:17), yet discussions about the ambiguities of connection with possible people within the donors’ life experience and value frameworks appeared to me to be sometimes tough for donors. I sensed that for men most of whose professional lives involve public performance and the making of digital decisions – to do or not to do – discussing ‘maybe’, ‘if’, ‘on the other hand’, required extra effort. As one donor put it after nearly two hours of discussion with me: ‘I’m all talked out’.

Although connection may be equated with kinship, it can be helpful to interpose ‘relatedness’ between them. Semen donors are connected genetically to the donor conceived people to whose conception they contributed, and this may be construed as meaning that they are related. Being related is not usually tightly defined in the UK. It can vary from the knowledge of several degrees of vertical and

horizontal descent shown by ‘Leosachs’ the indigenous inhabitants in the Hebridean island of Lewis, to the vagueness of several of my young English fellow students who were unsure if they had cousins. Being related is also a status with variable consequences and of variable duration (Bodenhorn 2000).

The question as to whether genetic connection has social consequences was raised by research carried out by Gary Clapton with birth fathers in the UK in which he found that the men felt a sense of attachment to children who they had never parented and might not ever have seen (Clapton 2000). The birth fathers were recruited with the help of seven UK post-adoption agencies whose workers contacted the men and informed them about the research. Other men responded to advertisements about the research project in the agencies’ publications. Interviewing men whose wives or girlfriends had relinquished for adoption babies conceived by these men, Clapton was interested in discovering how the birth fathers had felt about the adoption both at the time of the adoption and during the intervening years, whether there had been a change over time, why a birth father might want to seek contact with the adopted child and what claims they might have on their ‘unknown son or daughter’. (Clapton 2003a:13). Clapton noted the dearth of previous research into the views and experiences of birth fathers, especially ‘the less active, non-social dimensions of fatherhood such as the place of their child in the minds of the men and their self-perceptions of fatherhood’ (ibid: 29). The focus of most psycho-social research has been on birth mothers, and Clapton suggests that ‘it is popularly assumed that men’s connection to the child begins and ends with the physical participation in conception, if (it is) not followed by assumption of the social role of father’ (ibid:30). He quotes an experienced adoption researcher’s comment that ‘the birth father is often viewed as an illusory entity whose only link with the child is his involvement in the biological event’ (ibid:30, quoting Sachdev 1991:131).

Accepting that the reasons for this neglect may be paralleled in the paucity of research into semen donor assisted conception as I noted in my introduction, what is of particular interest for my thesis is that in adoption the birth fathers were not thought to experience any sense of long-term connection to their adopted children. Referring to recent authors in the adoption field (Brodzinsky 1990; Tugendhat 1992) Clapton suggests that birth fathers were perceived by adoption agencies as abdicating

their responsibilities towards the child and the mother, and of showing no interest in what became of the child. Clapton's findings contradict these views, with 28 out of his group of 30 birth fathers admitting to having thoughts about the child who was adopted even up to 50 years later. Fifteen of the men had never seen the child, for various reasons. They were deliberately excluded by the birth mothers' family or by social workers, they had parted with the birthmother or they were serving overseas in the armed forces. The birth fathers' thoughts about the adoption, as described to Clapton, encompassed a range of feelings associated with powerlessness and low self-esteem. Feelings when thinking about the child are listed by Clapton as curiosity, parenthood, worry/concern, responsibility, loss, love, guilt, regret, and feeling connected (ibid: 130).

Sixteen of the birth fathers interviewed by Clapton had already placed their name and current address on Adoption Contact Registers or with a social worker or adoption agency, in the hope that the adopted person would also register and contact of some kind would be made with each other. Ten birth fathers had already had contact with the adopted person and five were actively seeking, that is, not simply waiting for their adult adopted children to find them. However, this evidence of a sense of connection was not to be taken as a sign that the birth fathers saw their status as the biological father of the adopted person as giving them a role of social father as well. Clapton reports that 'I could find no expressions of any impulse to replace an existing (adoptive) father' (ibid:165). He quotes one man as insisting; 'she tells people that I'm her dad. But I'm not her dad'. Another explained, 'I can't turn round and say she's mine because I've never met the girl. Although technically, in one sense, she is mine. On the other hand she isn't mine'. Clapton's finding is that the birth fathers in his study made a distinction between the roles of biological fathers and social fathers. They were unlikely, in contrast to birth fathers in a North American study which he cites (Deykin et al 1988), to use search and contact as a preliminary to taking the child away from the adoptive family.

Whilst there are essential differences between adoption and donor assisted conception (Blyth et al 2001), Clapton suggests that his research findings that birth fathers have thoughts of 'a child unseen' (Clapton 2003a:207) also raise questions in the case of men who have been semen donors in assisted reproduction, particularly if

donor conceived people obtain the right to identifying information about them and therefore the possibility of tracing them. He suggests that the feelings and experiences of semen donors ‘may not be a million miles away from those of the birth fathers in this study’ (ibid). What may coincide, I suggest, are the responses of the men concerned to situations of shared ambiguity (see Edwards 2000:228) and of uncertain obligation (see Finch and Mason 1991). These situations have given rise to a growing literature for people with a personal involvement with adoption of personal narratives, advice and accessible research findings, all of which serve to normalise the diversity of post-adoption situations and to advertise the variety of ways of managing the possible problems and rewards of connection between adopted people and their adoptive and birth relatives (e.g. Clapton 2003b, Robinson 2004, Trinder et al 2004, Triseliotis et al 2005). In the field of semen donor assisted conception, such literature is barely in its infancy and mostly is comprised of the narratives of donor-conceived people who have met genetic half-siblings. Thus semen donors currently have no information for their guidance about how to manage connections with their donor offspring, and in its absence it may be their beliefs about what constitutes parenthood which act as a default.

### **Worries about connection**

Several donors were concerned about claims which might be made upon them by any donor offspring they might have. The concern was not about the potential number of donor offspring who might make a claim. As noted already, most donors did not know how many pregnancies had resulted from their donations nor how many of these had resulted in live births, and further, whether the resulting babies had survived beyond childhood into adulthood. It is possible that some donors might have helped to achieve more than 15 pregnancies each, but the number of donor offspring was not mentioned as being a significant aspect of the matter of connection. What bothered the donors who were concerned about claims from donor offspring were the kind of claims which ‘they’, ‘he’ or ‘she’ might make. As shown by the donors’ comments in this chapter, these potential claims are of two kinds: emotional and material. The emotional claims would be upon the donor’s time and attention. The material claims would be about money and practical support. One donor described how he would ‘feel it intrusive’ if a donor offspring contacted him.

When I asked him if he would donate semen nowadays if he were young he replied, 'Not if someone could turn up and say you are my father'. However he added that the 'threat' of someone 'turning up' is 'more powerful than the event'. His reason for not wanting to be contacted was that 'I don't have time and energy - life is busy enough'. He liked the sound of UK Donorlink because it 'provides some control for the donors over the contact requests from donor offspring'. 'I don't want people to hurt, but I don't want a blank cheque either' was how he concluded the discussion about it.

Due to the arrangements at the infertility clinic where he had donated, this donor was able to assume that there were no more than five pregnancies resulting from his donations. Another donor who did not know if there were donor offspring because he had donated at a clinic which gave no feedback to donors, was adamant that he wanted no contact at all. 'I don't want a knock on the door', he said. 'They might want money'. He described himself as an 'insular' person, happy with his family, feeling complete with his wife and their children. He had not heard of UK Donorlink and would not want to apply to register because 'I would wonder if they would turn up'. Although he had no idea that they would do so, he told me that he was not prepared to accept the possibility that they might.

Another donor who also said that he didn't know if he had any donor offspring, and moreover was not interested in knowing, wanted to avoid any kind of emotional engagement with donor offspring. He explained to me that he did not want to be identified and contacted by any donor offspring.

Jennifer: 'What about if they wanted to thank you?'

Donor: 'I wouldn't want personal thanks'

Jennifer: 'Why?'

Donor: 'I wouldn't want the fuss'.

I met this donor several times during fieldwork in his professional capacity as a doctor and was not surprised by his view about not wanting 'a fuss'. He was a reserved man, self-controlled in group situations where there were conflictual tensions, respected for his medical skills and care for patients, and very focussed on the 'here and now' needs of patients. He gave me the impression that he found it awkward to accept my thanks to him for helping me with my research.

One donor raised both emotional and material concerns about connection. Referring to the change in legislation which would make people donating from 1<sup>st</sup> April 2006 identifiable to their donor offspring, the donor's wife commented that non-anonymity of donors would be worrying. She was concerned that the donor offspring 'might turn up if they were unhappy. You hear of that, in adoption'. Her husband agreed. There would be 'no control' in that situation, he said, and 'maybe they would be wacko'<sup>1</sup>. I replied that several donors had mentioned that concern and then asked if he was worried about a 'knock on the door' because 'you aren't sure if donor-conceived people were brought up to be considerate? What are you saying about the parents?' The donor looked shame-faced and replied, 'I assume that they were brought up in loving families'. Later in the discussion I asked what would happen in the unlikely event that someone did 'turn up':

Donor: '*Maybe* I'd help financially. The person is not a *complete* stranger.

Not an alien. If I thought they were OK, trustworthy'.

Donor's wife: 'Tick boxes there!'

The donor's wife was observing that her husband's acceptance of the donor offspring's claim is conditional on the person being trustworthy. She also was suggesting that a donor offspring might be looking for emotional support, if life with their parents had been difficult, as she believed sometimes happens in adoption. She had heard of stories of adopted people going in search of their birth parents because of being unhappy. Whereas she suggested that donor offspring might be looking for emotional support, her husband made the assumption that donor offspring would be looking for financial support from him.

Finally, I relate the views of a donor who had another perspective on what counts as an emotional claim. He had already described to me his fascination with seeing resemblance amongst members of his extended family. His worry about connection was that if he were to open the door to a donor offspring who looked like his family, then he would be unable to prevent himself from inviting the person into the house. It would be 'very embarrassing'. However he believed that his views about connection were 'a constantly evolving thing' and that in the future, when his

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<sup>1</sup> 'Wacko' is a slang term meaning eccentric or mad.

own child was adult, then face to face contact with donor offspring might be alright. At the moment, however, it would be 'OK to be contacted, provided no knock at the door' and he added:

I think that at this moment I'd be quite happy to do everything that I could to give them everything that I could of, details of myself, that would not mean in any way that the child could find me and come and meet me and etc etc etc, and so that's where I think the line should be drawn.

For this donor the worry about connection is that it might happen before he feels ready to manage it, and that would create an awkward situation for everyone.

### **People in mind**

The ways in which donors were recruited and the arrangements made for them to donate were meant to impress upon donors that there was, and would be, no connection between them and the recipient couple and the future donor conceived persons. It was a matter of not simply 'breaking connections' (Edwards 2000:219) but of trying to ensure that no idea of connection was made in the first place. Only one of the donors whom I met recalled that the recruiting clinic staff had mentioned that there could be no absolute assurance of permanent non-identifiability. For several donors the tactic appears to have worked as the recruiting doctors intended. One donor told me that he had not thought about having donated for thirty years, until his friend, whom I had already interviewed, telephoned to ask if he would help me with my research. The man referred to in my introduction who had donated as a medical student and then subsequently become a lawyer and who refused to be interviewed, was said to have insisted to the doctor who contacted him that he had 'forgotten all about that time', although the 'vicious' way in which he said this, as reported back to me by the go-between, suggests otherwise.

For other donors, perceptions about connection were different and did not emphasise a worry about claims. Some of these donors had told their children about having donated as much as twenty or more years after the period of donating, when the children were teenagers or older. This was so even for a donor who had concerns about connection if that meant being contacted by a donor offspring. For others it was a live issue. An excerpt from my fieldwork diary after visiting a donor and his family reads:

I'd noticed [yesterday evening] that when he hugged his son good night he'd called him 'my favourite son' and caught my eye. Today he said that although it is a little game (others do it; I do it with my 'favourite' great niece who is the only great niece) he does often think of possible other sons existing somewhere.

Two donors with school age children had recently rewritten their wills so as to exclude children from outwith the marriage from inheriting from the donors and their wives. Both of these donors were doctors with no special legal knowledge but they had taken this action together with their wives as a precaution. Another donor had been thinking along the same line:

Donor: 'If somebody found out that I was their natural father and wanted to see me that would be fine'.

Jennifer: 'OK'.

Donor: 'Emotionally it would be fine. I might take advice about that'.

Jennifer: 'Mm hm?'

Donor: 'To make sure that..... (long pause)..I suppose that...did [my] will recently, and I wonder if ...leave things to my children would need to be defined in slightly different terms'.

The donor was thinking through the fact that the term 'children' might be taken to include donor offspring, as well as children from his marriage.

Thinking about possible donor offspring involved being curious about them as well. One donor said, 'I do think about them', and added that he would like to have known who they were. He would like contact from them and he would be 'proud of them if I met them'. He had donated before cryopreservation had been introduced to donor insemination clinics and he assumed on that basis that the number of donor offspring would not be large. He assumed further not only that there had been offspring created but that those offspring themselves had reproduced: 'there are more grandchildren' he asserted proudly, meaning that the children of his donor offspring were in addition to the grandchildren which he and his wife had through the children of their marriage.

Clapton notes that amongst his research informants some adopted children as adults had had children of their own before their birth fathers had had subsequent children. This in effect had caused an alteration in the birth fathers' life histories

(Clapton 2003a:173). They had discovered that they were already grandparents before becoming fathers again. For some of the donor donors in my research this would be impossible or unlikely given that they had got married and had children no more than ten years after the donating and usually much less. One donor and his wife had worked this out to reassure themselves about the avoidance of incest: their only child, a daughter, told me: 'Mum and Dad have said 'don't fall in love with anyone who looks like you, and don't go for 'the older man'.'. In my meeting with her parents her mother had said to me that her daughter had worked out not to go out with anyone aged over 28. 'And balding and with specs' her father had added.

One of the donors and his wife had started their family later than the others. The donor was curious about how many children might have been created, and what they look like and how they have done in life. His wife had been adopted as a baby but she explained to me that she is not wanting to search for her birth mother because she does not wish to upset her much loved adoptive parents and because she 'worried about what I might find'. She did wonder if she had any half siblings, who would have been born after her. During my discussion with her and her husband, I said that, given the age of the donor when he donated, his donor offspring would be old enough to be at university now. There was a short silence in the kitchen as we each considered the implications of this observation, and then noted that if the donor offspring did indeed exist, then they would not be like the two adorable small children playing in another room, but adult people. The donor would not only be the father of two children but also the genetic father of adults.

### **A moral responsibility?**

As with ideas about being connected to and thinking about possible donor offspring, donors had differing perceptions about whether or not they felt or should feel any kind of responsibility towards the people created as a result of their donating. It was not a question which I asked the donors. In similar fashion to donors telling me about how they were recruited and the arrangements surrounding the donating, the subject was introduced by the donors themselves.

Associating the matter of responsibility with that of curiosity, one donor said that his lack of interest in possible donor offspring surprised him: 'surprising, when

they have half of one's genes', and he contrasted this attitude to the one 'towards your child – you'd die for'. He thought that perhaps part of the reason for his attitude was that he did not know the donor conceived person's mother. Also there was already a husband: the child was his responsibility, the donor told me. The notion of sacrifice for one's child was also stated forcefully by another donor:

Somebody that looks like me, that's been made from love between me and my wife I would kill for that child, I'd do anything for that child, anything.

This donor has one small child and told me that fatherhood brings responsibility: 'I have nightmares in case I die'. In contrast, the donor who 'knew' that there were five pregnancies created as a result of his donating was clear that if a person conceived from his donations came to the door, and was in difficulty, then he would help. He was sure that he had 'a moral responsibility' to do so. The donor conceived person 'is just another person' and therefore there is nothing to fear, the donor said.

Whether or not donors had children who were not donor conceived, who were the children of their marriages, made no difference to the views about responsibility. I interviewed two donors who were unmarried and who to their knowledge had never had children other than from having donated semen. One of them, a scientist, did not fit my original research criteria in that he did not finish donating before 1990 and indeed told me that he was still donating at the time of my fieldwork. He was not donating at a clinic licensed by the HFEA but through one of several commercial internet-based sperm agencies which deliberately operate outside of the law. The agencies claim to act as intermediaries (The Guardian 2007) and do not freeze or store semen: the donations are collected from donors and delivered immediately to waiting recipients in their homes by courier services. The circumstances of donating are similar to pre 1990 donating: anonymity is promised although not legally guaranteed, and no counselling is provided. The donor had taken up the option of registering on the company's website as identifiable in future to any donor offspring and told me that his photograph and certain personal details were on the agency's website. He had stipulated that no more than three donor offspring were to result from his donations and that he would like to be approached in future by any of them. During our discussion it emerged that the donor had already provided 25 semen donations none of which, apparently, had resulted in a pregnancy. He speculated

whether his samples were being ‘handed on down the line’, meaning that the recipients were passing them on to other women who were not registered with the company and who would therefore avoid paying the intermediary service fee to the agency. He did not know until I informed him of the fact, that because he was not donating through a licensed clinic he could be held liable for the financial support of any donor offspring. This kind of connection and responsibility was not at all what the donor had had in mind when he chose to be identifiable.

The other unmarried donor, a doctor, was the only one of my informants who said that he had registered with UK Donorlink. The registration had involved the provision of a saliva sample for DNA testing and the opportunity, which he had accepted, of talking over the implications of registration with a UK Donorlink counsellor. He was sure that ‘if a person needed help, I would want to help’, and he explained that ‘you have to accept repercussions from life’. He would not have a problem about being contacted by a donor offspring, and it would be on the terms of the donor conceived people themselves. ‘If they turned up, I would just invite them in – “join the family” ’. Another donor also thought that there was a claim on him despite the fact that he had donated in the context of anonymity when he was a medical student:

Donor: ‘In life, I feel that you have to take responsibility for your actions’  
Jennifer: ‘Even though you were young at the time?’  
Donor: ‘I knew what I was doing’.

Two donors who were concerned about connection nevertheless agreed that they would be willing to provide medical information about themselves. Both have been referred to already. One was worried that the effect of physical resemblance, which he treated as evidence of a genetic link, was so powerful that he would be unable to deny access to a donor offspring who bore a family likeness. Here the genetic connection, made manifest in an actual person, would lead to a social connection which was untimely. The other donor insisted that ‘sharing genes does not mean social connection’. He told me a story of his mother and her two sisters who had fallen out amongst themselves and then ceased contact with each other. Years later, the daughter of one of the mother’s sisters, that is, the donor’s cousin, wanted to establish contact with the donor but ‘it didn’t mean anything to me’ the donor told

me. He went on to describe his views about connection with possible donor offspring: 'In donor insemination, the deal was that the legal father would be the father', meaning that the husband of the female patient who was inseminated with the donor's sperm became the father, not just the legal father but also the 'as if' genetic father also. 'I have handed it over, you have a father already, and he would *like* to be your biological father'. For this donor, it was not possible for a person to have two fathers. 'You can't have it both ways' he told me, that is, one cannot have a biological father and a social father who are two different people. In addition to the significance of intentionality in becoming a parent, the donor emphasized the relevance of nurturing in deciding about responsibility: 'I have children, I put time and effort into that. I have parental responsibility there'.

Apart from the significance of these views about parental roles and about the merging of the biological with the social, this donor's account has an interesting context. Although a few years younger, he was recruited to the same NHS clinic as a donor already mentioned who was sure that he had a moral responsibility towards his donor offspring. The two men are very different in personality and in the extent to which they have shared information beyond the immediate family about having donated in the past. And although the younger donor seemed so clear about the simultaneous separation and conflation of genetic parenthood with social parenthood, recent events in his family had given him pause for thought about it. The girlfriend of one of his sons had recently had a baby but for reasons unknown was keeping her boyfriend's family at a distance. The donor admitted to me that he so wanted to engage with this baby, his first grandchild, and he seemed sad and uncertain as to why he and his wife were being excluded from developing a relationship with mother and baby.

### **Donor offspring seeking connection**

Donors' views about why their donor offspring might want contact, and what the nature of that contact might be, were as varied as the hopes and fears that a connection might be sought at all. Several donors referred to the possibility of donor offspring wanting medical information. One said that he would be 'happy to give

medical information' about himself because that was just 'a small part of the whole thing. Like when a television doesn't work and you get a new part'.

Many of the donors did not know why donor conceived people might seek connection. As described above, several assumed that it would be in order to ask for money, and that was a good and even sufficient reason for the donors to want to remain unidentified and to reject the idea of registration with UK Donorlink. An important and problematic matter for donors was the worry that meeting a claim of any kind from a donor offspring would disadvantage the children born within their marriages. 'I see my children [donor conceived] as different from the ones I have with my wife – do you know what I mean?' one of them asked me. As mentioned already, several donors had or were thinking of arranging their wills in such a way as to include only children of their marriages. Why donor offspring should seek financial help from their genetic fathers was a question seldom answered and never fully explained. One donor told me that if he were a donor conceived person then he would consider asking the donor for money. During the course of my fieldwork two non-donor doctors supported the perception that there was an expectation that donor offspring would want money. One of them, on hearing of my hope to interview donors, commented that 'they will be getting paranoid!' and when I asked why, he replied, 'Because you are after them as well'. The other doctor told me that he was not sure that he agreed that the law on donor information should be changed, because donor conceived people 'would turn up on the doorstep, looking for money from the donors'. That is what he would do, in their situation. When I suggested that such an attitude was very mercenary, he readily agreed, but could give me no explanation as why he held the view that he did.

One donor told me that recently he had begun to understand why people might want to search for information about their genetic origins. He had read a letter in a newspaper from another, younger semen donor who wanted to be identifiable to any people conceived as the result of his donations. The letter had been written before UK Donorlink was set up and the author, who had been adopted as a baby, had explained why he had donated and why he wanted to be identifiable. He had hoped that by donating semen he could help a couple suffering from infertility without them having to adopt. I had seen this letter and had met the young man and

his birth mother. Similarities between donor insemination and adoption were often denied by people with a professional involvement in donor assisted conception and by those who perceived themselves as having a stake in policy making to maintain donor anonymity, unless they had personal experience of adoption. The donors in my research varied considerably in their knowledge about adoption. This was in both practical and theoretical spheres of knowledge. One married donor had adopted his stepchild, another donor's spouse was adopted, and another donor told me that he and his wife had adopted a baby. Neither of the adopters were doctors, but one donor doctor told me that he and his wife had experience of fostering. Adoption by doctors is not unknown but I am not aware of any doctor currently working in the field of infertility treatment who had adopted. The two donors who had adopted had dealt with the challenges which their respective family situations had entailed and they were aware of a number of psychological issues for people who have been adopted. Nevertheless, the stepfather adopter admitted that he viewed donor conception as being different from being adopted, and he wondered why donor conceived people wanted to search for information about their genetic fathers.

One doctor donor contrasted his own feelings of equanimity about having been a donor ('I am at peace with that time') with the guilt and loss which he had encountered in his medical work in situations involving adoption. He recalled a woman 'who was a natural depressive but it was very much focussed on the pressure she put on her daughter to give this child away'. The woman's daughter who was 'profoundly disturbed', as he put it, about having relinquished her baby for adoption decades previously, took part in a support group, 'almost an AA<sup>1</sup> group' the donor said to me. What interested the donor was that he had learned that the support group comprised adopted people as well as birth mothers: 'both sides'. He was curious as to why some adopted people still have a sense of incompleteness. 'Let me put it this way, that maybe some of the children who I created in this way, have a sense of incompleteness, if they know that they are AI children'. At the end of my meeting with this donor he reflected that he was thinking about aspects of having donated

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<sup>1</sup> Alcoholics Anonymous' website <http://www.alcoholics-anonymous.org.uk/geninfo/02whatis.shtml> describes the organisation as 'a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism'.

which he had not thought about before, and again raised the matter of adopted people:

I'm not sure, I mean I'm asking you, children who are adopted who had a successful adoption and want to seek out their, um, natural parents, is that because in the end they've ended up really as vulnerable adults?

Perhaps unsurprisingly, the doctor donor who had registered on UK Donorlink was the most eloquent about why he thought donor conceived people might want to search for information. When I told him that some donors, and many doctors in the infertility treatment society, were worried about 'a knock on the door' from donor offspring he replied with indignation: 'What about the person conceived's needs? Their identity?' He said that it might be suggested that maybe it was easier for him to think in this way because he did not have children, but he went on to elaborate:

It's important to know about your origins. I know mine. It gives you more control if you are allowed access to information about yourself. Donors' primary responsibility is to look after the people's needs.

For this donor, contact with donor offspring would be acceptable, 'but only if they wanted it'.

This donor was not the only one to comment unprompted about people having a need for information about genetic origins, and therefore his being unmarried and apparently without children apart from the possible ones conceived as a result of his donations, is not a deciding factor in him making these comments. Another donor said that he could understand why people would want identifying information and that if he were one of them, he would want to know who his donor was.

One doctor donor commented that ' "where did I come from?" is a natural question for all of us'. He knew a good deal of his family history and believed that that had been important to him, knowing these origins. He said that he would be happy to share this knowledge with his donor offspring. I commented that some people thought that it was not a good idea to be so interested in genealogy, and I described how social workers from the UK who believed that donor conceived people have the right of access to identifying information about their origins had raised the matter with other European colleagues at a conference in 2003. Danish

social workers had asked the ones from the UK, and I was amongst them, whether we were not being ‘eugenicist’ in holding such a belief. Some of the British social workers had been shocked at the suggestion and that it had been made at all, but recognised the likely influence of different histories underlying the Danish social workers’ question. The donor replied dismissively that ‘the Danes are screwed up about ART’. By this he meant that they are inconsistent in their thinking about assisted reproductive technology. He was sure that recent discoveries in genetics, which are significant for his professional medical practice, had made no impact on his views as a donor about connection between himself and donor offspring.

### **Responding to the making of connection**

If donors assumed that there were people who had been conceived as a result of their donations then they tended to assume that these people might wish to make contact in some way with the donor. How the donors anticipated their reaction to that contact gives an indication of their attitudes and beliefs about the nature of the connection. One donor said that he would want to ‘throw a party’ for the donor offspring, which suggested that he viewed the donor offspring as having a connection not only with him but also with each other. Since the offspring of this donor would be no older than their early twenties, the party idea conjured up the image of a convivial, almost public occasion. In contrast to this were the views of another donor who explained that a reason for not wanting contact was that he didn’t have enough time and energy to deal with it, and he added that donor conceived people ‘are strangers to me’. An approach from one of them would be ‘like a clan type thing’. It would be a socially manufactured connection like people working to establish links and relationship on the basis simply of having the same surname.

The donor who said that he would be proud of the donor offspring if he met them also thought that, if they wanted, he would be pleased to share with them the information which he had about his family genealogy. This suggests that he would be prepared to take time to find out about the donor conceived people’s interests, and if finding out about the family history was an interest, then he would pass on the knowledge which he had about it. The matter of contact as requiring time and also energy was mentioned specifically by several donors. For one of them, although ‘it

would be fine' if he was found by donor offspring, registering on UK Donorlink was not what he would do:

Um, to get on the register would be quite an active thing to do and it is not where I want to spend a lot of energy. Or any energy really.

Another donor had the same view. He thought that he would be happy to meet the person for a coffee, then wondered, 'but how would they fit in?', that is, how would they fit in with his current family. Another donor also thought that he would be happy to meet a donor offspring 'in my office, for a chat, like you and I are having now'. He thought that donor offspring 'are like a pre-marriage child, a stepchild'. They are related to him, but he would want to find out why they had searched for him and understand what was their need to do it.

One donor imagined the possibility of contact with donor offspring only if it excluded a face to face meeting. This was because if he saw any likeness, he would feel compelled to invite the person into his home and for the foreseeable future the donor felt that that was not appropriate. Thus in order to avoid creating a social relationship the donor wants to avoid being identified in person. He can envisage himself as a genetic father, in that he acknowledges a connection between himself and any donor offspring but he cannot take the risk of the genetic connection being transformed into a social relationship because of possible adverse consequences for his family.

### **Donating to a known recipient**

During the period of my fieldwork it became increasingly common for egg donors in the UK to be friends or relatives of women seeking donated eggs for their own treatment. The same was not so for donated sperm and the telephone survey which I carried out on behalf of the National Gamete Donation Trust, which I describe in Chapter Seven, suggests reasons for this. When talking with donors I asked some of them what they thought about the situation of donating to known recipients and whether they would consider doing so if they were not now prevented from being accepted as a donor due to their age. By 'known recipients' I meant female friends or relatives. The responses varied: there was an outright 'No' because the donors did not want to be identified at all, there was rejection of the idea because of the

complications which might result and there was ambivalence as well as acceptance. The donors who were most open to the idea of contact from donor offspring were less likely to raise it as a problem. I told one donor that infertility clinic staff had suggested to me that donors who know the recipient might interfere with the child's upbringing. He replied that, in his view, there is 'no evidence that genetic parents would interfere. We expect, in some families, a child's aunts, uncles and grandparents to be involved'. For this donor, genetic connection did not mean a threat to the role of the social parents, just as it did not in the case of other adults connected genetically to a child. Another donor thought the opposite: knowing the recipient was not a good idea because 'the donor would be able to say that that is my child'. When I pointed out that he was managing to be a step father without apparent interference from his child's birth father, he agreed that that was so and suggested that his perception was because he had not thought about the idea before our discussion. It was new to him and he had not made a link between his own experience as a stepfather and that of donating to a recipient known to him.

Another donor was certain that he would not donate nowadays because of having to be identifiable. 'Would you donate to family?' I asked him. He replied: 'Interesting that you should ask that. We had friends in the 1970s, 80s having trouble getting pregnant and we were having dinner together and my wife who had drunk a bit said "I'll have a bloody baby for you"'. The donor's story was not a direct reply to my question since the donor gave his wife as an example of being a known donor or possibly a surrogate birth mother, rather than himself as a semen donor. What was significant was that he acknowledged the possibility of gamete donation to known recipients and that he remembered the social event where the matter had been raised. In a later, unplanned meeting with this donor, I reminded him of our previous discussion and asked whether he would have donated personally in order to help his friends to have a child. He replied that he would, and went on to describe how his friends had never had children and he believed that the husband had suffered depression for a time as a result. For this donor, the concern which he had previously shared with me about the new government regulations making all future donors identifiable to their donor offspring was set aside when it came to the needs of friends for whom he obviously felt much compassion.

One donor's perceptions about connection with donor offspring were closely tied to his concerns about the relationship between himself and the recipient if he knew her. Knowing the recipient would inevitably draw him towards the child. He had enjoyed the experience of being a father to his children and believed that it would be hard to keep at a distance if he knew the child's mother. In Chapter Seven I describe the perceptions of this donor in more detail and how he perceives the inter-relatedness of a donor's connection between recipient and offspring, but it is appropriate to note here that a clinician who was not in favour of the removal of the anonymity provision of the Human Fertilisation and Embryology Act, admitted to me that one of the reasons that he wanted to maintain anonymity was because of the involvement that donors would feel towards their genetic children. Men of his age, he told me – he is in his 40s – would want to meet their genetic children. It was a natural impulse. They would want to invite their donor offspring in to their home, and so anonymity was a way of stopping these middle aged men from getting involved. In his view, young semen donors might have no interest in donor offspring, but older men have developed fatherly feelings and they would want involvement.

### **Wives' and children's views on connection**

As noted earlier, all but one of the donors said that they had told their wives about having donated semen. Some of them said that their children knew, because they had told them. Others were uncertain about whether or not their children knew. One donor did not think that his children knew 'unless they heard something in an unguarded moment'. Another donor said that he and his wife had told their two older children but had stopped short of telling their youngest child. Another stated that his adult children were aware that he had been a donor, and that it had not been a problem, apparently. After our meeting he drove me to the nearest railway station and the son in whose home we had met came along to provide directions. The son asked me what my research was about and when, having asked and obtained permission from his father I gave a brief description of it, there was a cry of surprise from him: 'Dad, you never told me that!' His father replied with equal surprise that he thought that he had. In a telephone discussion with the donor later, I commented on the matter, but he said that his son had not mentioned anything further about it.

Although I had indicated in my description of my research project to go-betweeners and to prospective interviewees that I hoped to meet with donors' wives and children, as noted in Chapter Three only two donors arranged for their wives to be part of the interview. Several donors mentioned that they would be telling their wives what we had talked about, others said that they would simply say that we had had an interesting discussion. I had a sense that wives were keeping an eye on the matter from a distance, not wanting to interfere but clearly interested in what their husbands were thinking about the matter of having donated in the past. Some wives were reported by donors as being protective of their family, and the donors would not make any decision about contact with a donor offspring without talking it over with them. One wife who participated fully in the discussion made an observation which encapsulates the ambiguous position of donors' wives. When her husband said that he would like to meet his donor offspring, and actually would like to 'throw a party for them all', his wife said, 'But darling, I might not like them!'

Another donor and his wife have a daughter, Anna, an undergraduate university student at the time of my research, and it was arranged that I would meet with her. She is the only child of a donor's marriage with whom I have ever had any kind of discussion about donor insemination. She had been told as a teenager by her parents that her father had donated semen as a medical student, in circumstances which could have been and probably have been handled differently by other donors and wives. Anna recalled, confirming her parents' outline of the story to me earlier, that during a family conversation one day she had joked that she would not have to share any inheritance with anyone because she was an only child. Instead of glossing over this observation her parents had responded with 'Well, actually...' and had then told her that she might have half siblings from her father's donations. After that time there was no secrecy made of the fact that he had donated, and Anna told me that some of her friends knew about it as well as friends of her parents. She was sure that the fact that the donating was not a secret made it much easier to deal with. What seemed to surprise her was the extent to which parents know all about their children but children, in her view, don't know about their parents' past. She had not guessed about the DI and she now realised that there may be other things that young people do not know about their families. Another example in her case was that she did not

know until told by her mother when she was a teenager that her mother has a brother and that he is living overseas. Until then she had not known about the existence of this uncle.

In respect of having any kind of connection with a genetic half-sibling, Anna said that it was hard to imagine these people at all because, as she understood the situation, they could not trace her father, or herself. 'It would be interesting to meet them,' she said, 'but they might be horrible'. It would be interesting also because she is an only child, but 'in reality, it is not like Hollywood'. Perhaps it was a good thing that they could not make contact for another reason too: she and her parents are a close family, she stated, and she could envisage that a half sibling turning up might mean that she would have to 'share my father'. However that was something to which she reckoned she could get accustomed, and anyway, 'you should not spend your life worrying'. I was struck by the realistic approach shown in this young woman's discussion with me and the perceptive way in which she noted the ambiguous status of donor conceived people with respect to the families of the semen donors. However like most of the donors in my research project she took a passive position about creating a social relationship with donor conceived people in that she gave no indication that she would consider registering with UK Donorlink.

## **Conclusion**

For semen donors who believe that they may have donor offspring there is a sense of time having passed, and the bodily fluid which they sold or provided a generation or more ago being now possibly embodied as genetic half siblings to their own children. However there is no pre-existing script for dealing with this concept, and for some donors it seems easiest to deny that donor offspring exist at all. Woven into the responses of a number of the donors is the issue about what the transformation of the genetic connection into a social one entails, and ambivalence about what moral obligation is involved in these kind of relationships (Peletz 2001). The lack of a script or even guidelines upon which to rely in this social situation of uncertainty, may provide an uncomfortable challenge for men whose professional lives involve making executive decisions or exercising fast judgement. The passage of time is also significant in underpinning and reflecting the lifecourse concept in the narratives of

the donors and their wives. At the time of the donating the donors were constructing and demonstrating their masculinity in various ways as they moved through the transition period from being a male child living in a parental home to becoming a husband, partner and father themselves (Morgan 2004).

Being connected or thinking about connection was clearly associated for donors with the effort which is required to negotiate new relationships, or to maintain control of an uncertain social situation. At a meeting in February 2007 organised by UK Donorlink to consider the need for intermediary services, some data were shared from the wider study by Daniels et al for the Department of Health which I have referred to earlier. The informants were semen donors who had been recruited between 1988 and 2002 at a London clinic and who were invited to take part in a telephone interview with open and closed questions. The interviews sought these previous donors' views on issues associated with recruitment, attitudes regarding information sharing and views concerning the offspring, and also on the provision of an intermediary service for people with a personal involvement in donor-assisted conception. One of the responses shared by one of the researchers gives an eloquent example of the concern about the effort which is required in creating and sustaining relationships:

I'm happy to divulge information but I could be on the email for life with 14 or 27 IVF descendents all battering away about who I am and what I had for breakfast today, that might be fun for some people but if you've got a busy life, and already have [ ] kids, then you know that extra burden of sheer time is also a factor and you don't want to be able to say to somebody, 'Oh, by the way I've just run out of time to answer you questions about your total identity', that's not an easy thing to do.....maybe the regulatory body is able to regulate that pressure.

Nevertheless some donors are prepared to accept, or even welcome, connection with donor offspring. They are less concerned or not at all concerned about placing limits on the biological relationships which would be made apparent in the reality of the donor offspring. They would use their existing repertoire of values, social skills and experience to deal with people who are not perceived as 'family-breakers' but rather, as one donor put it of any of his donor offspring, 'just another person'.



## Chapter Seven

### Risky Kinship

If I were to carry out a word frequency analysis of my fieldwork data, I would not be surprised if I were to discover that the word ‘risk’ stood top of the count. It appears in the technical literature of infertility clinics, in presentations to and discussions at British Fertility Society and HFEA conferences, and in consultation documents issued by the Department of Health, H.F.E.A. and HGC (Human Genetics Commission). In its Business Plan for 2005-2006, the H.F.E.A. describes how it will meet key challenges arising from its modernisation plan and from UK government and EU initiatives (H.F.E.A: 2005b). It notes that couples seeking fertility treatment should have confidence that treatment provided by licensed clinics is safe and effective, and therefore the H.F.E.A. will ‘fully implement a risk-based approach to licensing, inspection and incident management’(2005b:11). Utilised also as the equivalent of ‘danger’, ‘uncertainty’ and ‘likelihood’, the word ‘risk’ is threaded into debates and arguments about access to infertility treatment services, about the safety of all kinds of reproductive technologies and about the long term physical and psychosocial outcomes of treatment involving donor assisted conception.

In this chapter I focus on a particular aspect of such ‘risk talk’, by describing and analysing views about assisted conception using semen donated by personal donors, that is, donors whose donations are given to recipients who are known personally to them<sup>1</sup>. Many views were gathered in a telephone survey for the National Gamete Donation Trust and I also include information from people with a personal involvement in semen donation and sources which record the views of donor insemination service providers in the past. Those providers were running clinics contemporaneously with the time of donating by my donor informants and their views are often echoed by a number of current service providers whom I met during my fieldwork. My aim is to show how semen donors, recipients and people with a professional interest in donor-assisted conception services talk about the

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<sup>1</sup> In the UK a donor who is recruited by a patient and who donates for that patient is generally described as an ‘own known donor’. This is sometimes confused with ‘known donor’, a person who is recruited by a patient but whose donation goes to other patients in a “pooling” arrangement and who therefore remains unknown to the recipient. I follow the terminology of Adair and Purdie (1996) in using ‘personal donor’.

reality or possibility of semen being provided by personal donors, and how that illuminates contrasting beliefs, expectations and values about semen donation as a way of helping to create children.

### **Theorizing risk**

A number of authors have noted that the meaning of 'risk' has changed over time (Beck 1992; Douglas 1992; Giddens 1999; Lupton 1999). Contemporary use has extended both the meaning of the term and what it signifies. Giddens has traced the appearance of the idea of risk to the 16<sup>th</sup> century where it was used by European explorers. He suggests that the word 'risk' in English derived from Iberia where it was used to refer to 'sailing into uncharted waters', that is, sailing without being able to rely for guidance on pre-existing maps where hazards such as currents and submerged rocks had already been described. Later, it came to mean the 'calculation of the probable consequences of investment decisions for borrowers and lenders' before coming to cover a broad range of uncertain situations (Giddens 1999). In this early usage Nick Fox suggests that 'risk' was a 'neutral' term (Fox 1999:12) and that it has now taken over as a value-laden term for the description of something which will have an undesirable outcome. For example, in a guide exploring risk in the health field, the British Medical Association (BMA) uses it to mean 'the *probability* – the likelihood – that something unpleasant will happen' and notes that that is how 'most scientists believe the word should be used' (1987: 13, italics in the original). A recent example occurs in a press release from the HFEA announcing that its 2006-07 HFEA Guide to Infertility contains new information to help patients 'to balance risks and benefits of treatment' (HFEA 2006c).

The BMA notes that the word is 'often used pretty casually' (1987:13), but describe it as the likelihood of being harmed by a hazard. Risk can be managed, the BMA suggests, but how individuals perceive risk is influenced by their values and beliefs. The BMA's guide summarized the findings of a number of studies into people's perceptions of risk, and found that perceptions were most likely to be influenced by whether people had previous personal experience of a hazard, whether or not they could control it and whether the events were thought to be especially bad.

The guide concluded that opinions on risk which are strongly held 'are obviously very difficult to change, whatever the arguments' (p.151).

Fox suggests that the difference and relationship between risk and hazard are important in how the concepts come to be defined and what that reveals about how risks are assessed. Where once a hazard would have been defined as an inert object, it now can materialise into an active entity by being ascribed characteristics which pose a risk. Fox describes patient's blood as an example, because it may be contaminated by infection and thereby poses as risk to health professionals (1999:19). In noting that risk has come to be associated with unfavourable outcomes, Deborah Lupton points out that 'in everyday lay people's language, risk tends to be used to refer almost exclusively to a threat, hazard, danger or harm' (1999:8). Conceptually, these come to be perceived as equivalent. The significant role played by value and belief is implicit in Lupton's assertion that 'the term 'risk' is often used to denote a phenomenon that has the potential to deliver substantial harm, whether or not the probability of this harm is estimable' (1999:8).

A number of social scientists have explored risk in the context of risky behaviour (Bunton et al 2004, Lupton and Tulloch 2002). Certain kinds of personal behaviour, in certain contexts, will expose social actors to the possibility of detrimental consequences such as disease, injury, and even death. Sexual intercourse with strangers may lead to infection with HIV/AIDS, and sexually transmitted diseases; intravenous drug injection using shared needles may cause hepatitis. However, activities may be 'risky' without being classed as deviant for example participation in extreme sports such as downhill ski racing and white water rafting. This voluntary risk-taking may be age and gender differentiated (Bunton et al.2004). These kinds of behaviours are enacted by individuals. It is they who choose whether or not to participate in the activity although they may be under social pressure from peers to do so. These 'sought out' risks can be differentiated from risks which do not depend on individual behaviour but which are the result of arbitrary, external, non-human forces – 'gods, demons, or Nature' as Ulrich Beck described it (Beck 1992:98). Beck further distinguishes such risks from those which result from corporate decision-making about the 'hazards of megatechnology' (ibid). His interest lies in exploring the inconsistencies inherent in predicting security in a modern world

of nuclear, chemical and genetic technology. In the development of these industries and in the real and threatened destruction of the environment, our society, he claims, can no longer rely on the insurance principle to rescue us from the 'worst imaginable accident'. Faced with this situation, many institutions 'are specialized in the only remaining possibility: denying the dangers' (p101). Instead of the security provided by aftercare, there is 'the dogma of technological infallibility'; there is no preparedness for after-care because there is claimed to be no risk.

Beck's sombre exposition of how 'risk' applies to modern societies emphasises a shift from the probability calculus of insurance and gambling to the 'threatened possibility' (1990:52) of previously invisible hazards such as damage to water supplies and buildings from industrial pollution now becoming visible. What once was a possibility is now 'a fact in *abeyance*' (p.52, italics in original).

Mary Douglas (1992) discusses how the word 'risk' has acquired new uses, particularly in relation to 'danger' and how in this transformation, dangers to the body, children and nature, for example, 'are available as so many weapons to use in the struggle for ideological domination' (1992:13). Those who use the concept of risk as professional tools do so with the claim that they are being rational and scientific. However, taking risk analysts as an example, Douglas notes that by bracketing off culture from risk analysis, analysts can stand accused of irrationality. By claiming that risk analysis can be applied universally they deny that they themselves have their own bias and way of conceptualising risk. There is a political use of 'risk', Douglas suggests, in which there is not so much discouragement to take risks but rather a political pressure 'against exposing others to risks' (p.15). Risk here means 'danger from future damage, caused by the opponents' and as such it becomes associated with the possibility of attributing blame. To deny the relevance of 'risk' in a situation and to suggest instead that there may be 'uncertainty' is to be open to being charged with denial of responsibility (p.30).

The political aspect of risk assessment is also noted by Purdy: policy making may be based on risk assessments whose interpretations are guided by other policies (Purdy 2006). For example, a policy of recommending and permitting foetal reduction from three to two foetuses in the case of women pregnant with triplets, but not a reduction of two to one of twins, is based on the endeavour to avoid being seen

as unequivocally supporting abortion. Risk data in themselves do not give unambiguous indications of how they should be treated, because the context needs to be known.

So far, I have emphasised the negative connotations ascribed to 'risk'. The current tendency of many social theorists to use the term in this way has been noted by Caitlin Zaloom (2004) whose ethnographic research in a stock market suggested just the opposite. Whilst the traders whom she observed and interviewed were exposed to possible and considerable financial loss, their work aimed to reap reward from their risk-taking. Risk here is an opportunity, rather than a threat. Lupton and Tulloch (2002) also found perceptions that risk could be a positive action. Giddens also associates risk with reward and goes further in affirming the value of risk-taking: 'a positive embrace of risk is the very source of that energy which creates wealth in a modern economy' (Giddens 1999). Risk here is characteristic of 'dynamism' and 'innovation', two concepts which, I suggest, are not altogether value-free.

My summary of some theorising about risk has emphasised examples of risk-taking involving what can be described as one-sided individual or corporate actions. These examples will be found relevant to the ethnographic data which follow, but it is interesting to note Giddens' assertion that there is also a perceived risk in forming intimate relationships nowadays because of the uncertainty about how these relationship should work: 'Two or three generations ago, when people got married, they knew what it was they were doing...Where traditional cultures are dissolving, however, when people marry, or form relationships, there is an important sense in which they don't know what they are doing, because the institutions of marriage and the family have changed so much'. In these situations, individuals are 'like pioneers', and faced with uncertain futures it is inevitable, Giddens suggests, that people will begin to think in terms of risk. 'Pioneers' is exactly the word which, without having yet read Giddens, some infertility counsellors, myself included, have used in discussions with patients considering donor insemination to help to achieve a pregnancy.

### **Help from personal donors**

The risks of creating a pregnancy with the assistance of personal donation are a worry to many doctors and other health professionals working in infertility clinics. The worry derives not from the use of reproductive technology but from aspects of the social situations made possible by the technology. In this context it is not the technology itself which is perceived as risky but the social relations which others are attempting to draw out of the connections made possible by the technology. Particular reasons given by infertility clinic workers for not providing a service for patients wishing to use the help of a personal semen donor or for discouraging requests for it are wide ranging and include ethical, economic and welfare concerns. These concerns are frequently couched in terms of 'risk'. The anonymity of semen donors has nearly always been promoted in the UK as an essential characteristic of a safe and proper donor insemination service. At the meeting of the study group of the Royal College of Obstetricians and Gynaecologists in 1976 which was organised to discuss clinical practice and the scientific, legal and ethical aspects of donor insemination, it was made clear that donors had to be unknown to the recipient patient and her husband. It was noted in a presentation by two clinicians:

It is not uncommon for couples of various ethnic groups to request A.I.D. This may complicate the recruitment of suitable donors, but we have insisted that the donor should be of the appropriate racial group and that he should be anonymous to the couple.

Quoted in Brudenell et al 1976:82

There was no explanation given by the clinicians for their insistence on anonymity, and no reference to the possibility of exploring whether couples from 'ethnic groups' could easily accommodate the idea of a personal donor within their own cultural practice of reproduction.

I noted in Chapter Two that there was concern about the use of personal donors amongst the DI service pioneers but exceptions were noted in the case of egg donation (Leeton 1985:288). The necessary characteristic of anonymity between donor and recipient was also less emphasised in the case of egg donors during my field work, except where the egg donation was part of an egg-sharing arrangement. Most infertility clinics which provide an IVF service with donated eggs will do so to women who have recruited a relative or friend as their personal donor. The donor undergoes surgical retrieval of eggs which are then fertilised *in vitro* with sperm

from the husband of the prospective recipient. It was often suggested to me by infertility clinic health professionals that there are gender differences which account for the difference in service provision between semen and egg donation: ‘cultural attitudes to egg and sperm donation are different. Would a man accept another man?’ an andrologist pondered during a discussion with me. An embryologist commented, ‘I don’t know about the morality of it, but it [donation] doesn’t seem to be a problem with known egg donor’. A donor co-ordinator stated, ‘Sperm is a harder word to say than egg’, an observation made to me also by several infertility counsellors. One of them explained that the word ‘egg’ is used in contexts other than reproduction and is more a part of everyday vocabulary than ‘sperm’, and also that ‘egg’ is not linked to sexual activity in the way that ‘sperm’ is. The infertility counsellor noted that there were examples in other areas of medicine: in the area of fertility preservation when male patients diagnosed with cancer and about to undergo treatment likely to destroy their sperm-producing cells are offered storage of their semen, nurses felt uncomfortable using the word ‘sperm’ and the andrologists felt likewise when using the word ‘cancer’. The association of the word with the images which it evokes attributes other meanings to the word.

When I was carrying out the telephone survey on behalf of the National Gamete Donation Trust on the provision of personal semen donors by UK clinics, it was often reported to me that it had become increasingly common for egg donors to be either friends or relatives of women seeking donated eggs for their own treatment. It was explained to me that that was partly because it was the choice of patients but partly also because there were not enough anonymous altruistic egg donors for the number of women who required donated eggs if they were to achieve a pregnancy. Whatever scruples the clinics had about personal donation (see also Konrad 2005:137), they were overcome in a number of clinics by the perception that for compassionate and economic reasons, allowing patients to recruit a personal donor was better than the patients not having access to donated gametes at all. This was less the case when donated semen was required. The responses to the telephone survey suggested that of the 23 clinics which provided a service using personal semen donors, many of them did so with reluctance and with anxiety about whether it was the right thing to do. These concerns will be described later in this chapter.

However, anecdotally, the practice of providing a service to patients wishing to use personal semen donors did seem to increase in prevalence during the period of my fieldwork. There is no statistical data on this because the HFEA, in collecting information from clinics for its Patients' Guide, does not ask clinics to state whether both semen and egg personal donors could be used, simply whether 'known donors' could be used. Reasons given to me for the increasing use of personal semen donors include a preference from some ethnic minority groups in the UK for personal donors, and requests from lesbian women who do not wish to accept the risks of self-insemination using fresh sperm from untested, unquarantined semen. Heterosexual women with or without male partners may also decide to recruit their own personal donors in order to circumvent long waiting lists for treatment using semen from anonymised donors recruited by clinics.

### **Use of 'risk' by DI practitioners**

In Chapter Two I referred to the proceedings of a study group of the Royal College of Obstetricians and Gynaecologists (RCOG) which met in 1976 to discuss the development of artificial insemination services. One of the aspects of providing a service which clearly concerned the participants was risk. Three matters in particular were described as carrying connotations of risk: infections from the donor which could be passed on to the recipient and possibly the unborn baby, genetic defects in the sperm which could cause miscarriage, and using personal donors to provide semen. In a discussion about patient consent forms and what they should encompass, one of the participants, a physician running a private clinic, referred to the controversial matter of how extensive should be the testing of semen donors: 'I am anxious as to whether the form should mention the possibility that the patient could contract a venereal infection, through treatment. That is a real risk at the moment' (Brudenell et al 1976:177). The written report of the study group proceedings does not record any mention of this risk having been proven by actual cases of infection known to the doctors at the study group. The suggestion that the sperm itself could pose a risk was also made:

The possibility of infection is the reason why it is so important to know about the donors – which is why I personally feel so unhappy about using a highly

mobile population, such as students. I would much rather know the students personally. Husbands of grateful patients are highly valuable, and they are extremely unlikely to be carrying a gonococcus infection, or one of the other equally nasty infections. This emphasises the importance of knowing the donors, and of knowing them pretty well. (Brudenell et al 1976:128)

In a discussion about comparing pregnancy rates after A.I.D with the rate following normal sexual intercourse, it was suggested that the rate following both A.I.D and normal intercourse were low 'because human sperm contains such a high proportion of genetically defective sperm' (1976:155). The medical practitioners were concerned that there were risks from the sexual behaviour of donors, as well as from the unpredictable quality of human sperm.

The genetic risks posed to the recipient woman and future children were generally played down by those involved in semen donor recruitment who I met during my fieldwork. The view of the director of the Cryos sperm bank in Denmark, which supplies sperm to some clinics in the UK who claim to find it difficult to recruit donors locally, was that recipients should be accepting the same risk as women seeking conception naturally. The same point was made by an andrologist in the UK who suggested to me that semen donors are not being comprehensively tested before their donations are used but who then asked me: 'Where do we stop?' This andrologist was unusual in being concerned that the current statutory 6-month quarantine period for donated sperm was not long enough and should be extended to 12 months because of possible virus mutations in the donor. In his perception, the risks of donor insemination were greater than had been professionally acknowledged.

One of the medical colleges in the UK also accepted that there is a risk involved in the use of donated semen. In its written response to the government's consultation on donor information (Department of Health 2001) the Royal College of Physicians of Edinburgh suggested that 'information about health [of the donor], might be of value e.g. in supporting decisions about preventive health screening' (Royal College of Physicians of Edinburgh 2002:2). The College's response added:

The current consultation clearly reflects the current state of genetic knowledge. Decades from now, when the results of any consultation are beginning to filter through in practical terms, genetic knowledge may have advanced very considerably and the importance of donor identification might change, perhaps dramatically (2002:4).

The multi-disciplinary British Fertility Society also acknowledged the possibility that donated semen might contain the potential for damage in its response to the same consultation:

The Society is of the view that parents need to be able to provide accurate medical background information to the child's general practitioner and other medical consultants. It is important that adult donor offspring are in a position to do this throughout their lives. The possibility of late onset conditions is also a concern. We recommend that donors be encouraged to up-date their records should they suffer any condition that might affect people conceived from their donation (British Fertility Society 2002).

Another risk of donor insemination which was of concern to early DI practitioners was the use of a personal donor, on the grounds that this had adulterous connotations. A clinician at the meeting of the RCOG study group is recorded as insisting on anonymity between donor and recipient:

There is a certain logic in using the father or brother of the husband, and couples will occasionally request this. However, the possibility of subsequent emotional problems of a sexual nature, or in relation to ownership of the child, far outweigh any potential advantages. I would not agree to such an arrangement, although apparently successful cases of family donors have been recorded (Schoysman, 1975). The use of friends entails even greater emotional dangers, and lacks the genetic comparability advantage of relatives (Brudenell et al 1976: 62).

The clinician suggests here that the advantage in using a personal donor is that the child would be created with assistance of a man closely related genetically to the infertile husband. If it is important to be genetically related to one's children but if infertility prevents biological fatherhood, then the use of sperm from your father or brother ensures that there is a genetic connection. The donor would be half-brother or uncle to your child. However, two specific disadvantages are perceived to arise from the fact of the genetic closeness: one is the possibility of sexual feelings on the part of those involved, and the other is the anxiety that being the genetic father of the child would entitle a donor to claim the right to be treated as the legal father of the child too. The perceived increased risk inherent in using the help of a friend points up the possibility that a friend would not be constrained by being in a pre-existing family relationship to the child, such as grandfather, or uncle. A further reason for not accepting an infertile man's biological relative as donor was explained by a retired clinician: since it was known that male infertility could be caused by genetic

problems, it was not considered safe for his relative to donate. The relative might well be affected by the same genetic problem, and the genetic tests available at that time were not well enough developed to provide the necessary reassurance.

Another participant at the RCOG study day reported, that in his view, most patients had thought about the moral and ethical aspects of A.I.D., especially since the name of their husband, not the name of the donor, would be on the offspring's birth certificate. He pointed out:

the wife of a clergyman has had one A.I.D baby, another is eager to start treatment soon. One minister, however, described it as long-range adultery. A young and intelligent Roman Catholic had discussed it with her doctor and her Priest, who gave it his blessing to proceed. He said that marriage was for the procreation of children and if the husband was subfertile and her child was conceived with his consent by a donor, the child was his – the child of their marriage (Brudnell et al 1976:45).

I noted in Chapter Two that DI in general has often been viewed as an adulterous act in the UK particularly by faith groups (see Blyth 2006). Research by Susan Kahn in Israel analyses the physical and conceptual efforts which some faith groups have to make in order to avoid the possibility of DI being associated with adultery. She describes (Kahn 2000) how Ultraorthodox Jewish women have to undergo IVF treatment involving donated semen rather than the much simpler procedure of donor insemination because the latter process is categorised as adulterous. She also describes how the IVF laboratory workers are supervised by *mashgichot*, lay women whose role is to observe the workers' practice to ensure that there is no inadvertent mix-up of sperm through contamination or switching of samples, which would have serious consequences in kinship terms.

Provided that semen donors were anonymised as far as recipients were concerned, then the early providers of DI services in the UK apparently were not concerned that the practice itself was adulterous but rather, if couples were refused treatment, then women might be driven to commit adultery for real: 'Married women driven by necessity might look for extra-marital intercourse', a scientist suggested (1976:92) during a discussion at the RCOG study group about whether doctors had the right or duty to reject couples as service recipients because of concerns about the stability of the marriage or the woman's parenting capacity. The scientist noted that

‘the woman can go outside of the marriage of her own free will, and then the transgression is greater because adultery is involved’ (1976:92).

The medicalisation of the process of donor insemination at the time and since, together with the instrumental use of semen as a fertilizing agent, served to desexualise the practice, or so it was hoped. Donors were not to know anything about the recipients and vice versa, in order to prevent improper fantasies on either side. Nevertheless one infertility clinic sister at an HFEA inspection in the 1990s told me that she had noticed that in choosing a donor from the brief anonymised profiles provided by the clinic ‘how many women choose donors who are not like their husbands’ and she wondered whether there was an element of fantasy involved. Contrary to the fears about fantasies, knowing the donor personally can work the other way, by removing the likelihood of it. Referring to conferences organised by National Gamete Donation Trust and others in which young semen donors had participated as speakers or audience, one mother of a donor-conceived child who had attended these conferences commented later to me with some satisfaction: ‘I mean they were just ordinary blokes’.

One of the respondents in my telephone survey for the NGDT, an experienced nurse responsible for running the DI service within an infertility clinic, when asked why infertility clinicians were reluctant to provide DI by personal donors or were actually opposed to the practice, simply said that: ‘the doctors don’t like it because it is about sex’. By this she was pointing up a characteristic which differentiates egg and semen donation and which I highlighted in Chapter Four: an egg donor is seen to be giving a gift to an infertile woman so that she can achieve a pregnancy but a semen donor is also giving a gift to the woman, not to the infertile man. The ‘helping to service the wife for you’ jokes which infertile men speak of having to suffer from workmates and friends does not mean that the donor will help by giving semen to the infertile man for the woman then to be inseminated. It implies that the fertile colleague or friend will ‘service the wife’ by inseminating her himself by sexual intercourse. The giving of a gift to the infertile husband is treated instead as a sexualised donation to his wife.

### **Diffuse dangers**

Many of the 28 infertility clinic staff members who took part in the telephone survey which I carried out for the NGDT referred to 'ethical' risks inherent in a service involving a patient using semen from a personal donor. The risks were seldom described specifically and the taken-for-granted character of the concern was evident (Goffman 1997). When asked whether the clinic at which she worked would provide a service for patients wishing to use a personal donor, a senior embryologist replied that 'Consultants would send such cases to the Ethics Committee, because there are lots of complications, and lots of counselling is needed, more so than in anonymous donation'. Every licensed clinic has to have access to an ethics committee which is available to offer advice to the clinic about cases perceived as ethically complex and the automatic referral of a request to use a personal donor suggests that for the clinicians in this clinic, using a personal donor is not only complicated, it may also be unacceptable morally. Another senior embryologist concurred with this view: 'We provide the service if a patient requests it but the cases are referred to the ethics committee.....maybe there is a feeling in the clinic that it isn't appropriate'.

The belief of clinic staff, not just clinicians, that using a personal donor is wrong, was noted by several survey respondents. A scientist said, 'I don't think we would do that [allow patients to use a personal donor], I don't know why'. An embryologist said, 'We don't refuse point blank but we try to dissuade them'. Another said that at her clinic, 'We prefer anonymous donors because of the implications of using known donors'. She and her colleagues 'don't encourage own known donors'. A senior nurse explained that at her clinic, a service using personal donors was not provided because 'it is an ethically complex area'. The complexities were not described. At that clinic, the reason for the service not being provided was said to be because the clinician disapproved, but the nurse admitted to me, 'I'm not too sure what the consultant's reasons are'. She thought that for the clinic's policy to change there would have to be evidence that using the help of a personal donor was the way forward, 'sufficient to convince the consultant'.

Many survey respondents, all of them experienced in their work and often involved with the running of donor insemination services for many years, were particularly aware of the distress that might be caused if the personal donors'

donations were ‘not up to standard’. For example it is possible for a fertile man to produce sperm which does not freeze well and so would not survive the cryopreservation process well enough to help to achieve a pregnancy. Such a man might be deemed unsuitable as a personal donor, and be at ‘emotional risk’ (American Society for Reproductive Medicine 2003:1128). A sperm bank supervisor told me that although the help of personal donors was used frequently at her clinic, ‘it is a tricky process, because of confidentiality about results – to whom should medical information be passed [about the quality of the semen] and who is the patient?’ Roberta Lessor’s research in an American infertility clinic also found issues about the welfare of personal donors in the case of sister-to-sister egg donation (Lessor 1993). She notes the impact of ‘failure’ on the donors, if the recipient sister did not become pregnant, and points out that having already experienced fertility problems and failed IVF treatment, recipients were sometimes more prepared for failure than the donors

### **You can’t have more than two parents**

The potential for conflict and the uncertainty about rights and obligations was mentioned frequently by infertility clinic professionals as ‘evidence’ against using personal donors except as second best, when there was no alternative due to a shortage of anonymous donors. Respondents in the telephone survey raised the possibility of detrimental effects on family relationships which I noted earlier in the views of faith groups and of the DI service providers of the past. ‘Personally I have concerns about the future, and family dynamics’ an embryologist told me. One of the reasons for the ‘fraughtness’ of using personal donors, as an andrologist put it, was stated by many of the respondents as deriving from the difficulty which men have in accepting the fact of being infertile and sharing the information with others, even their close family. If the management strategy of this is to pretend, ‘as in it’s “really our child”’ as a clinic sister described it, then using the help of a personal donor would be out of the question because there would always be the possibility of the non-genetic status, and therefore the infertility, of the social father being discovered. An andrology laboratory manager whose clinic did provide a personal donor service nevertheless posed many questions about the implications, such as whether the

recipients would tell the child, what would the relationship be between the donor and the recipient, and would there need to be a legal contract concerning contact between the donor and the child. These were described as ‘ethical issues’ which would need to be discussed amongst clinic staff if the service was to be actively promoted to patients.

Even if the provision of a service using personal donors is viewed as an opportunity for more patients to achieve a pregnancy, the hazards for the patient are still uppermost in many infertility clinic staff’s concerns. A senior nurse manager said that it was unlikely that her clinic would offer the service, and pointed out that if the donor is known to the recipient ‘there is still room for secrecy’, meaning that parents would not necessarily tell their children about their origins, and that it is ‘not an opportunity for a three parent family’. She explained to me that the recipient couple want to be a family, and that personal donation may be right for some people but not others. She had a concern that a personal donor would ‘interfere’ with the upbringing of the child. When I asked her whether mothers-in-law and grannies ever ‘interfere’, she acknowledged that they do. She added that she had not thought about it in that way before. The difficulty with personal gamete donors is perhaps the way that they are perceived by the recipients and how they may, as the nurse manager suggested, ‘keep coming into mind’.

### **Risky donors**

I have noted how the early DI service providers were concerned about the physical risks from genetic and infectious material from the donors, and the emotional risks with personal donation. Infertility clinic staff in my telephone survey and those whom I met at conferences were also concerned about the emotional risks, as are a number of faith groups. I suggest that underlying these concerns are doubts about the motives of semen donors who do not donate for financial reward, as though semen donors are never seen as being as capable of altruism as egg donors. Before the formal start of an HFEA inspection in which I was participating, the clinician and the clinician inspector were talking about the situation following the Government’s announcement about removing the anonymity provision in the Human Fertilisation and Embryology Act. One of their concerns was about the kind of man now offering

to donate. The two doctors told me that some of their colleagues in the UK were reporting an increasing number of men telephoning clinics and offering to become donors who seemed 'a bit strange', who were emphasising in a manner which concerned the clinic staff that they wished to be identifiable to donor offspring. The clinicians asked me whether donors would now be able to trace their offspring and were relieved when I assured them that they would not. On another occasion, a scientist in another clinic told me that he also had heard medical colleagues voicing concerns about the effect of the new regulations: he said that they had described it as 'a strategy for paedophiles'. The removal of anonymity of donors would mean that the donors could be found by their donor offspring, which is what the donors would want, it was feared. This is despite the fact that access to identifying information about donors will not be available to the offspring until they are adult.

The doubts about the altruism of semen donors are longstanding. A physician working as a clinical assistant in a hospital infertility clinic reported to a symposium on A.I.D in 1972 that in her view,

People are not ready at the moment to give their semen free, as we donate blood. Possibly in another 10-20 years people will feel that they are helping couples who cannot have babies. At the moment the person who writes to me saying 'I feel it my duty to be a donor' tends to be, in my opinion, odd.

Ciba Foundation 1973:58

A urologist who developed and was in charge of an NHS donor insemination service for many years told me that at one time, the clinic had advertised for semen donors who would not be offered any financial reward, and that the men who responded 'were weirdos, wanting to save the planet, have lots of children etc. The £15-a-go students were more ordinary. Gave me the creeps, some of them'. When I asked why he rejected these men as donors, which he could do without hurting their feelings by telling them that their sperm did not freeze well enough, he explained that he suspected them of being unreliable, possibly giving false information about their sexual lifestyle. Like many other infertility clinic staff involved in donor recruitment, this doctor admitted to using his intuition in the selection process. An embryologist told me that in the 1980s, it seemed unproblematic to pay donors, because students were short of money. If donors wanted to help altruistically 'it set alarm bells ringing' for the clinic staff. When I asked what these prospective donors were like,

the embryologist replied that ‘maybe they were a bit unwashed’. If the donor was the kind of person whom you would have as your own relative, then he was acceptable.

These concerns about the risks of using identifiable donors, men who may be traced by donor offspring in future, might logically suggest that the easiest course of action would be for clinics wholeheartedly to encourage patients to find their own personal donors, so that the risk is born by the future parents. Again there is a gender difference at work: asking around one’s social circle for help by means of egg donation does not appear to carry the same stigma as asking for help for a male infertility problem. There is also the perceived risk inherent in any kind of actual contact between a donor-conceived person and the donor, regardless of the original motivation to donate. One clinician wrote in response to the Department of Health consultation on donor information that offspring should not be able to obtain identifying information because ‘there is a danger of relationships or fantasies developing between donor and offspring that would have their origins in a contract made for quite another purpose’.

The gendered nature of the idea of risky donors is apparent. It is semen donors who are thought to be likely to approach their donor offspring, whereas ova donors are not mentioned. This contrasts with the stereotype of the birth mother who in searching for the adopted person, according to Jonathan Telfer, may disrupt the sense of completeness for adoptive parents (Telfer 2004:254). Telfer notes that there is a distrust about birth mothers, despite whatever positive personal qualities they may have, because of the disruption which their searching activity might cause. The mother is ‘cast as the custodian of secret dangerous knowledge’ (p.254), namely, the information about the origins of the adoptee which may have been kept from the adoptee by the adoptive parents. The mother who relinquished her baby to adoption ‘becomes an artifice of disaggregation. Such typifications of biological fathers are rare’ (p.254).

### **Being a personal donor: past donors’ views**

During discussion with most of my informants who had donated semen, the matter of donating to personal donors arose. I asked them what they thought about the idea of donating to known recipients and whether they would consider doing so if they were

not prevented from being accepted as a donor now due to their age. The donors who were most open to the idea of contact from donor offspring, as I describe in Chapter Six, were less likely to raise it as a problem. As I related, one of the doctor donors told me that there was no evidence to show that genetic parents might interfere with the upbringing of donor offspring and in any case, it was expected that, in some families, a child's aunts, uncles and grandparents become involved with the upbringing. The donor here is referring to an assumption that certain kinspeople will take part in the upbringing of children to whom they are related. This involvement is not in the place of the parent but rather as an aunt, an uncle, a grandparent. The donor's view suggests that involvement is provoked, guided or informed by expectations about what it means to be an aunt, uncle or grandparent to a particular child as well as to children in general. These expectations were made explicit by the donor referred to in Chapter Six who described how he and his wife were being prevented from developing a relationship with their grandchild by the child's mother, that is, a relationship as he and his wife would define it, not as the baby's mother was said to be doing.

Two donors perceived a risk in the situation of personal donation and complications because of the nature of the relationship between a semen donor and a woman recipient if they knew each other. One of them I met in the company of his wife, who felt the same way:

Jennifer: 'What about donating to someone you know?'

Donor and wife (simultaneously): 'Oooh! Odd!'

Jennifer: 'Why?'

Donor: 'Too intimate'

Wife: 'Too much information. Like intercourse'

The donor's wife went on to comment on the difference as she saw between semen and egg donation and how donating by personal egg donors seemed understandable. In respect of personal semen donation she and her husband commented:

Donor: 'How would you tell the child?'

Wife: 'Like sleeping with the person'.

Even though personal donation of semen does not involve sexual intercourse between donor and recipient when the donation and insemination are part of a

treatment service at a licensed clinic, this donor and his wife both attributed a sexual characteristic to personal donation. Like the clinic nurse quoted previously, they perceive semen donation as a sexual act in a way in which egg donation is not. This gendered characteristic of semen donation would make personal donation a hazardous matter. Additionally the donor is raising a concern about how the matter would be viewed by the child.

The other of these two donors also had concerns about the relationship between himself and the recipient in a personal donor situation. 'I wouldn't be a donor if I wasn't anonymous...no question about it'. By this he meant that he would not want to be known personally to the recipient at the time of the donation. However, he did not discount the possibility of being identified in later years by the donor offspring created from his anonymised donations in the past, when they had become adults. His explanation for not wanting to be known personally was that being a personal donor would mean the recipient 'would have control over me'. The only way in which he could imagine being such a donor would be if the donation was made through him having sexual intercourse with the recipient. A related problem about being a personal donor was that it would create a situation of 'continued investment' for the recipient. He said that it

would draw me in, I am sure if you said, you know my husband's died and or we've broken up and I've got problems...mortgage... and if you were my sister-in-law, um, I in that situation, I might....I mean I have had pleasure out of my children and eh, you know, atavistic pleasure which I didn't expect and eh, I'm paying out, no question about that, and eh, (pause) I wouldn't like to feel I couldn't join in, that involvement.

The 'paying out' here is referring to the financial support required of him in university fees for his children, but it is a cost that is borne more or less willingly because of the enjoyment which he has had from the experience of fatherhood.

The donor went on to say that personal donation 'would complicate all sorts of things, and there would be from that knowledge, um, the ability to interrupt relationships which exist independently of each other'. Here the situation of being known as the donor in respect of a particular child inevitably creates the wish for a relationship with the child. Like donors who want to avoid face to face meetings with

donor offspring, this donor is suggesting that problematic social relations can result from transforming hidden, genetic fathers into tangible social persons.

### **Being a personal donor: recipients' views**

According to one of my informants from the Donor Conception Network, there are a growing number of Network members who are recipients of semen from personal donors. This follows a pattern of an increasing number of women wanting to use the help of donors who would be identifiable in future to their offspring. One infertility counsellor knew of a couple who had arranged to have sperm imported to the UK from Victoria, Australia, because they did not want to wait for the forthcoming change in the regulations covering donor information in the UK. By then Victoria had already set up systems for information exchange between donors and their adult donor offspring (Blyth and Speirs 2004). Another couple had done the same with a US sperm donor bank because they wanted to use a donation from a donor willing to be identifiable to his offspring. The NGDT donor recruitment co-ordinator reported at the HFEA annual conference in March 2006 that many new enquiries received by the NGDT in the previous year had been from recipients who decided, during the telephone call, that they would delay donor insemination treatment until the new regulations came into force on 1<sup>st</sup> April 2006. This trend had been noted by a clinician at an NGDT study day in January 2005 who commented that it was interesting how clinic practices were so different. 'We get people wanting to wait for an identifiable donor. They seek us out'. Such recipients contrasted with those described by some other people with a professional interest in DI services in the UK who warned that couples were likely to travel overseas in order to achieve conception in countries where semen donors were kept anonymous to the recipients (British Fertility Society 2002).

One of the members of the NGDT, Debbie, had had two children after assisted conception with sperm donated by a man known to her husband and herself. It was the donor's former wife who had suggested him as a donor. Debbie asked if I would like to interview her about the matter of own known donors because of her enthusiasm for the choice which she and her husband had made and her support for my research project. She was open about the social complications entailed by having

arranged DI with the help of a personal donor, and I speculated whether, as with several of the pre-1990 semen donors who I was meeting, a gratifying support for my research encompassed also a cheerful and practical view that there was no answer to the question as to whether genetic or social parenthood mattered more because the question was not that important. Indeed Debbie asserted that she had ‘learned a lot in the last few years about social and genetic parenting’. She had not got on too well with her father and seemed relieved that ‘I got small feet from my father, that’s all’. She contrasted her father’s parenting of herself and her siblings with that of her husband in respect of their two donor-conceived children: ‘He is so caring. He is so protective of them. Is it overcompensation?’ Debbie thought not: ‘He adores them’.

From the start, after Debbie and her husband discovered that he had fertility problems and they had decided to try DI, ‘we were certain that we wanted to know the donor’. Despite this expressed preference, the first infertility clinic approached by Debbie and her husband refused to help: ‘They told us that using an own known donor was an unethical thing to do’. Debbie explained to me that the preference was partly for the child’s sake, to ensure access to information about the genetic father in future for the children, but she added: ‘I couldn’t carry a baby if I didn’t know and like the father’. She did not pretend that the conception could have resulted from fertilisation of her eggs by her husband, nor did she deny the genetic link, as Bonaccorso reports of the way clinicians frame the practice of donor insemination in private clinics in Italy where ‘donated gametes are emptied of their properties and uniqueness’. (Bonaccorso 2004:96). On the contrary the donated gametes which made Debbie and her husband into parents connected them to a third party, a person whose characteristics potentially were carried in the genes of the sperm. Debbie recalled how she had got ‘quite a turn’ one day when she saw one of her children get off the school bus with one of the donor’s children, because to her they had looked so alike. No one else in the community has commented on this resemblance and Debbie believes that that is because no one suspects that the semen donor lives in the same area. They are not looking for the resemblance between the children and a local donor.

For Debbie and her family and the donor and his family, this absence of suspicion by others helps to maintain a degree of confidentiality, which in turn helps

to support Debbie's plan that her children should learn of the identity of the donor only from herself and her husband, when the time is right. However for the confidentiality to be maintained there has to be trust that those 'in the know' will keep to a promise not to share the knowledge with others who are not perceived as having a need to know. In the case of Debbie and her husband, the donor's parents, new wife and ex-wife know that he is the genetic father of their children, but Debbie believes that even so, she and her husband have control over accessing information about the donor. In future their children will not have to rely only on the HFEA's register for information about their genetic father and their genetic half-siblings, in contrast to donor conceived people whose donor fathers were anonymous to the recipient parents.

Debbie's perception of her children's genetic father is far removed from the anxieties of the infertility clinic staff and DI service providers about adultery and fantasy. 'Donors are to be celebrated' she stated to me firmly. By giving semen to help infertile people like herself, they were acting in an admirable way that should be openly acknowledged. In making this claim, this semen recipient had erased the adulterous characteristics which are often attributed to donations from personal donors by infertility clinic staff. Douglas suggests (1969:165) that, within a given culture, a behaviour which is considered wrong and therefore usually avoided or condemned, can be repositioned into a different ritual frame. Thus instead of Debbie and the donor being framed as adulterous and the donor as the perpetrator of a sexual act which might threaten the stability of the relationship between Debbie and her husband, there was an act whose sexual content was limited to the necessary physical production of the semen by the donor. The transmission of the sperm to the recipient was medicalised, the sexual overtones marginalised as the semen substance itself underwent the centrifugal process. The donor gave up his own time to make many visits to the clinic in order to produce semen samples and he had to undergo screening and testing the same as all donors. His intention in donating was devoid of the desire for pecuniary gain familiar to the infertility specialists and instead became an honourable giving. It was also a giving in which the gift retained a value for the giver after it had left the body of the donor. Debbie equated this with her views about

egg donation: 'I'd only have let my spare embryos go to a known recipient, to a good home'.

The involvement of a personal donor in assisted conception and the possibility that donor offspring might seek out their donor fathers raised concerns for many infertility specialists and clinic staff about two males competing for the role of father. The assumption was that in such a competition, the genetic father would win over the social one. The British Fertility Society suggested that if donor offspring obtained details about donors then 'it would create potential conflict between donors, recipients and offspring' (British Fertility Society 2002). Women and their partners who choose to recruit a personal donor to help them to achieve a pregnancy acknowledge the possibility of this but define this situation as one not of risk but of uncertainty. As Wickson (2005) points out for environmental decision-making, 'risk and uncertainty are inherently related concepts' but a process which is based on the principle not of assuming an objective risk 'out there' but rather of negotiating uncertainty, is likely to be more useful.

The assumption that personal donors might have a desire for social fatherhood can also be a concern in situations where male to male competition is not immediately foreseen, as in donation to a lesbian woman with a female partner or to a single woman without a male partner. Whilst not excluding males from the social circle of themselves and their offspring, some of these potential recipients have found that donors have claimed rights to contact with offspring which were not agreed at the time of the original discussions and decisions about donation. Lasker suggests that for single women, the absence of sexual and emotional involvement with a man may be seen as an advantage of seeking to become pregnant through a donor insemination service at a clinic (Lasker 1998:7)

Temporal aspects are evident in the use of personal donors by single heterosexual women. These women often talk about how their choice of DI was because 'the biological clock was ticking' and they had not found a suitable potential partner. For such women, it was not an impossibility that they might in future meet such a man and enter into a legal marriage or a permanent partnership. What would happen then to the pre-existing role of the personal donor in the life of the offspring? This was the uncertainty which was vexing Elsa when I met her. She was a 41 year

old single woman who had been offered treatment at a clinic using DI with an anonymised donor, as well as having received the offer of donation by a gay acquaintance. Elsa had already been offered a starting date for treatment at the clinic when I met her, but she preferred the idea of a personal donor 'for the sake of the child'. However the acquaintance was wanting to donate on condition that he would be a co-parent. Elsa was concerned about the potential for the donor and herself to have major disagreements about how the arrangement for 'co-parenting' would be managed. Having already experienced an unhappy divorce in the past, she did not want the emotional upheaval of 'another divorce' from the donor, as she put it, if the arrangement did not go well. She knew that if her acquaintance donated through a licensed infertility clinic then he would have no parental rights in law, but it would take time for the semen to be screened and quarantined, thus adding at least another six months delay to the fulfilment of Elsa's motherhood aspirations. A further consideration was that although she believed that it was better for offspring that she herself choose the donor, there was the risk of complications if she were to form another relationship with a heterosexual man in the future. She would expect such a man to develop a good relationship with her child, but this might bring conflict with the donor who might feel marginalised by the arrival of another significant man in the child's life.

### **Conclusion**

In his address to the HFEA annual conference in 2006, the President of the Royal College of Obstetricians and Gynaecologists, Professor Allan Templeton, suggested that some well established medical practices would have been banned today even before they were introduced. Sir James Young Simpson who, with some colleagues, carried out experiments on themselves with chloroform anaesthesia, would have been reported to the General Medical Council by numerous regulatory authorities and probably imprisoned. Professor Templeton, and the audience, clearly enjoyed the slightly mischievous dig at the HFEA and at the people who would prefer to have more state regulation than more responsibility by professional associations for raising standards in infertility treatment services. However I have shown in this chapter that in the provision of Donor Insemination services, risk analysis was never

applied to the practice as a whole. Risks were only identified in those aspects of it which are still anticipated by the infertility treatment community today, such as the transmission of infections, viruses, and genetic defects. The possibility of there being risks in anonymising the donors to ensure that there would be no social connection between semen donors, the donor conceived people and the donee parents, was never assessed. The anonymity of donors in respect of recipients and offspring was normalised, and the risk has been seen to be in reversing the situation, in allowing the connections to be made visible.

Lupton suggests that many theoretical discussions about risk miss taking into account the social characteristics of ‘the risk actor’, such as race, gender, age and social class. The risk actor is treated as ‘universal’, in a globalised society (1999:123). This is a tendency observable in the perceptions of some people with professional involvement in donor insemination, for whom perceived risks are thought to be the same for all donors and recipients whatever their values about kinship and reproduction. Jeannette Edwards notes how some of the residents of Bacup in England (Edwards 2000) thought that a semen donor’s sense of connection to donor offspring might cause problems for the social father. Edwards points out that there is a ‘cultural repertoire’ from which people select. Like her informants, the donor insemination service organisers, donors and recipients who I met ‘make up’ kinship through making different kinds of connections. For the recipients and several donors whose views I have described, kinship made through personal donation is not risky as much as full of possibility. I suggest that the doctors and other health professionals who are opposed to patients using personal donors are in a state of ‘risk stagnation’, not able nor willing to move from their current position, in contrast to those who can ‘risk navigate’ (Boeck et al 2006). The extent to which people see personal donation as a risk with an inevitably bad outcome, or as a hazard to be carefully negotiated, or as a possibility which provides the opportunity to achieve a longed-for pregnancy, depends on their cultural repertoire and the way in which they use it to frame risks (Flynn et al 2006).

A number of the views which I have described in this chapter show concerns for the boundary of the ‘English’ nuclear family. The concerns are both conceptual and moral. A family which is not modelled on the stereotypical arrangement of

father, mother and the children of their partnership is 'unclear' (Simpson 1998:xi). A family cannot logically as well as legally comprise more than two people who are parent to a child, and a child may be 'confused' by having involvement with more than two adults who are fulfilling the roles of mother or father. The boundary of the family is seen to be at risk of being breached in another way: personal semen donation involves another man in a marriage and this constitutes adultery in fantasy if not in fact. The association of semen donation with sexual activity recalls the earlier narratives of how the donors were recruited and the arrangements which were made by infertility clinics for them to donate. The association also extends into the concern (or fantasy) about known donors and recipients being implicated in an adulterous relationship. Yet as a description of sexual and reproductive activity, what constitutes adultery differs between societies. Interesting data which illustrate the dissociation of adultery from the practice of semen donations by personal donors was gathered by Bob Simpson (2004) in the course of research carried out in Sri Lanka. Simpson's discussions with the providers of, and ethical advisors to, infertility treatment services using reproductive technology, and also with patients, underlined how local people were making connections between these new procedures and the 'rather more familiar and certain worlds of custom and practice on the other' (2002:44). Simpson learned that traditionally, infertile couples have been able to circumvent physical infertility by means of engaging in intra-familial adoption and fostering as a means to achieving social reproduction. Intra-family semen donation was acceptable and was linked to an historical practice of adelphic polyandry (Tambiah 1965). This practice was thought to be the explanation for why it was considered reasonable and perhaps preferable for the brothers of infertile men to offer to provide semen. The practice was based on male, and especially, brotherly solidarity (Simpson 2002:53) and a view that made the comparison between donor insemination and adoption as kin-based solutions to infertility.

Significantly for my thesis, Simpson found that this practice was seen by infertility specialists as a problem, not as a solution. Their view was that semen should be provided by anonymous donors in order to avoid kin-based transactions which, although believed to be common, 'were seen to be ethically dubious because the family would know who the biological father was and this could impact on the

family in general and the child in particular in later years'(2002:52). One specialist was concerned that requests from couples for help with using an own known donor 'originated in a kind of kinship atavism which was clearly to be discouraged – his view of the technologies was clearly premised on heterosexual monogamy with the clinician occupying a position of considerable power in the process' (p.53) Simpson concludes that western medicine carries its ethical systems with it as it takes over in the spread of new reproductive technology. As an infertility clinician from a west African country explained to me at a conference in London, when I asked why he and his medical colleagues were providing an anonymous semen donation service in their clinic, 'That's what we learned to do when we trained in the UK'.

Despite the doubts and worries about the use of personal donors, several respondents in my telephone survey told me that in their clinics they were actively promoting the idea to patients that they should recruit their own personal donor. Anonymity was not needed as a protection for the nuclear family, 'saving it equally from intrusive strangers and the shadow of incest' (Strathern 2005: 31). In some clinics the encouragement to use personal donors was in order to help patients to circumvent the lengthy waiting time for an anonymous donor. The twin factors of economic necessity for the private clinics to keep providing a DI service, and the compassionate concern for childless people, were leading clinic staff to review their policies on semen donation. What appeared to be happening was not a transformation of everyone's beliefs, a total pushing aside of worries about personal semen donation, but rather an exploration of what beliefs each clinic staff member had, and the insistence, especially by embryologists and nurses, that their clinic's policy-making needed to be team-driven, thus reducing the influence of the clinician. Such a strategy also provided the team with access to each other's knowledge and experience of personal donation in other countries and of different kinds of family formation, such as adoption. For the clinics, childlessness itself is the greater harm than the use of personal donors. Hazards are 'sidelined' (Fox 1999:28) and the perceived risk becomes an opportunity.



## **Chapter Eight: Keeping it secret?**

In Chapter Seven I described the anxieties expressed by the people with a professional interest in infertility treatment about the use of semen if the prospective donors are known personally to the recipient patient. I showed how this kind of donation was perceived as risky, particularly because of the belief that donors might interfere with the upbringing of the donor conceived child, and therefore that it was not to be recommended to patients. Many infertility clinic staff were troubled at the idea of a woman being inseminated with the semen of a man known to her. There were concerns not only about that there was possibility of the donor interfering with the upbringing of the donor offspring, but also that the donor was like an adulterous ‘third party’ in a marriage. In addition, and related to this concern, was the suggestion that a personal donor would be a perpetual and visible reminder to the husband of his infertility. These concerns underpinned views that using a personal donor was a risky matter and therefore not to be encouraged, and perhaps even disallowed as a service to patients. In the situation where patients from ethnic minority groups claimed that their communities or faiths prohibited anonymous donation (see Culley et al 2006), the clinics had begun to give way, as they did with single women and lesbian couples. Otherwise the view persisted that the existence of social relations between donors and recipients were to be discouraged.

As I showed in my descriptions of how donors told me they were recruited and treated by the clinicians of the time, and how some clinicians also recalled it, there were no social relations supposed to be created between donors and recipients. The infertility specialists’ aim, to which their ingenuity, compassion, ambition and expertise were directed, was to enable a childless couple affected by male infertility to have a baby through the insemination of the wife with anonymised donated sperm. Once the baby had arrived, if no genetically caused disability or illness became evident, then the role of the infertility specialist ended. Babies are the desired outcome, as demonstrated by the dozens of baby photographs adorning the walls of waiting rooms in many infertility clinics at the time and still today. These photographs also symbolise the only social relations which did continue, those between the clinic staff and the grateful recipients of the donated gametes who were

successful in achieving a pregnancy and a subsequent birth and who returned to the clinic to express their gratitude and to show off the new baby.

I turn now to the situation where a woman receives donated sperm from a donor who is unknown to her but who, under new regulations which amended the Human Fertilisation and Embryology Act 1990, will be identifiable to his donor offspring born after 2006 (Department of Health 2004). These regulations provide for donor conceived adults to access identifying information about their donor if they so wish, at the age of 18 years, or earlier if marriage to a named individual is planned before then. The principle of allowing such access was not universally accepted: a number of vocal clinicians and others with a professional interest in the field of reproductive technology remained resistant to the new regulations even after they had been introduced. There were claims that the government had made a big mistake and that the new regulations should be replaced by the pre-existing system of anonymity because it was essential that donors' identities should be kept secret from their offspring. In this chapter I describe how some of these claims have been made and how they arise from a view that semen donors' identities should always be secret, in the sense of being hidden, from the donor offspring. Whereas the use of personal donors is said to pose a risk to the donor-conceived child and to the child's parents, a system of using semen from donors who are anonymised is supported because it is believed necessary in order to protect the recipient's marriage and the parenting role of the recipient and her husband. The protection is believed to be assured through keeping the identity of donors and recipients secret from each other. I show how the continued support for using anonymised semen from non-identifiable donors is thought to be necessary as a protection also for the donor from his donor offspring and that by extension, this protection is thought necessary for safeguarding the continuation of donor insemination services. I also show how even if donor conceived people are accepted as having a right to access to information about donors, a number of people with a professional interest in infertility treatment believe that the information should not be identifying.

### **The normalising of secrecy**

Secrecy has been one of the defining characteristics of the provision of treatment using donated gametes in the UK. The Warnock committee which enquired into

human fertilisation and embryology noted that ‘AID has tended, partly because of the legal situation, to be surrounded with secrecy’ and that the practice had involved an element of deceit, not simply a desire for confidentiality and privacy for the parents of the child conceived by donor insemination (Department of Health and Social Security 1984: 21). However, continued anonymity of the donor was recommended by the committee, partly to give legal protection to the donor and partly to ‘minimise the invasion of the third party into the family’ (ibid: 25). Dame Mary Warnock, later Baroness Warnock, who chaired the committee, recalled in April 2004 in her address at the launch of UK Donorlink that another reason was because the committee was told by witnesses that men would stop donating if their identity was not kept anonymous from the recipients and the donor conceived child. A report for the European Commission took the view that anonymity was necessary in order to protect donors, recipients and offspring ‘from legal complications and emotional difficulties’ (Glover 1989: 15). Social workers and infertility counsellors who worked in the field of donor assisted conception services in the 1980s and 1990s and who campaigned against anonymity in the 1990s during the consultative process of the Human Fertilisation and Embryology Act 1990 and who subsequently stated their opinion that this anonymity should be removed, were often challenged by infertility clinicians to provide evidence for the need to do so. The practice of keeping the identity of donors secret from recipients and offspring was promoted as the normal and proper way (Daniels and Taylor 1993).

In her very thorough long-term study of ova donors in the UK, Monica Konrad suggests that ‘the normative principle of anonymity’ encompasses a number of fears about the relations between the donors, recipients and donor offspring. They include the possibly adulterous relation between donor and recipient (or in the case of ova donation, the recipient’s male partner), concern about the lack of a genealogical link between child and both parents, concern about protection of the new family from intrusion by the donor, and protection of the donor from financial claims by the donor offspring or the recipient woman (Konrad 2005: 35). Konrad suggests that, given these fears, ‘anonymisation is about making persons (as relations) invisible’ and that ‘making persons into unnamed identities....both conceals and severs social relations’ (ibid). The situation of ova donation in the UK

can be described as ‘anonymous sociality’: links exist between donor and recipient ‘in terms of the real and imaginary effects of irrelational kinship’ (2005:49).

In the field of donor insemination, whatever the views of semen donors about whether or not they are connected to the recipients and donor offspring, the infertility specialists tried to ensure that there were no connections. It was a field which seemed not to involve social relations at all<sup>1</sup>. During the period of my research the situation shifted to one in which relations did become evident, in two significant ways. Firstly, and mostly independently of the infertility specialists, connections were made amongst themselves by people with a personal involvement in donor assisted conception. Several examples are evident in the 2002 documentary film ‘Offspring’ made by Barry Stevens, a Canadian who was donor conceived and born in London. He wanted to find out about his donor father and the film shows his search and his meetings with genetic half siblings. Secondly, a voluntary information exchange and contact register, named UK Donorlink, was set up in 2003 as a pilot project, funded by the UK Department of Health. The project aims to provide a service for donor conceived adults wishing to obtain information about their genetic origins, and for donors wanting to discover if anyone was conceived as a result of their donations. As of September 2005, there was a higher than anticipated number of donor conceived people who had discovered genetic half siblings by means of the register and were in contact with each other (UK Donorlink 2006).

A second example of social relations in the field of donor insemination becoming evident is provided by the public disagreements between a number of people with a professional interest in donor assisted conception and people with a personal involvement, as to whether gamete donors should be able to remain anonymous to donor offspring. To a considerable extent, the professionals, who included clinicians and academic bioethicists, appear to avoid engaging in direct discussion with donors, recipients and donor conceived adults. Instead, disagreements with the donor conception community are aired through the media, conveyed to policy makers in documents and meetings, and re-stated in internet spaces such as RBMOnline which are not readily accessible, except to other medical practitioners who are willing and able to pay a subscription. No donor, donor

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<sup>1</sup> I thank Professor Anthony Good for this observation at my Ph.D proposal review panel.

conceived person or parent of such sits in that capacity on the executive committee of the multi disciplinary British Fertility Society. I have found no published follow up study of the wellbeing of donors, donor conceived babies and the gamete recipient parents by infertility clinics in the UK. The initiative for research has been taken by sociologists, social workers, and psychologists and more recently, infertility counsellors. The absence of research and of mutual discussion, and the lack of inclusion of donors, donor conceived people and their parents in the policy-making of the British Fertility Society, has served to keep them invisible and to support the avoidance of social relations developing between those who have professional or personal stakes in donor assisted conception services.

The only exception to this of which I am aware is the Working Party on Sperm Donation Services convened in 2006 by the British Fertility Society's Chairman Dr Mark Hamilton who invited me to participate in my role as counsellor representative on the BFS executive committee. The purpose of the working party was to examine a proposal for the establishment of a national sperm donation service in view of the infrastructure and resource problems which were affecting donor recruitment in a number of clinics. The invited participants included representatives from Donor Conception Network and the National Gamete Donation Trust who had a personal involvement in gamete donation, as well as clinicians, embryologists, andrologists, and representatives from InfertilityNetworkUK, the HFEA and the UK Department of Health. The meeting which I attended involved amicable but heated, at times passionate, discussion and disagreement, and it was clear that the bringing together of these stakeholders allowed a sharing of information and experience, anxieties and hopes, and especially beliefs and values, some of which were previously unknown to each other.<sup>1</sup>

### **Theorizing secrecy**

Judith Modell's ethnographic study of the context and practice of adoption in America shows the complexity of the concept of secrecy in social life. She describes how the term secret 'has almost as many meanings in the history of adoption in America as there are individuals who use the word to comment on the phenomenon'

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<sup>1</sup> The Working Party's report and recommendations to the UK Government are due for completion in 2007.

(Modell 2002: 178). A similar point was made by Linda Paterson (1994) about the use of the words 'open' and 'closed' in her study of the attitudes of adoptive parents in Scotland towards birth parents. As described by Modell, secrecy involves a number of legal and administrative practices and a social context which discourages discourse about adoption. For historically complex reasons, adopted people in many of the American states are not allowed access to their original birth certificates without a grant of permission from a Court. This means that identifying information about their birth parents is concealed from them. Although Modell notes that at the time of her research there was an increasing debate about adoption, nevertheless adoption usually had not been talked about because of the secrecy with which the practice of adoption was imbued. The concealed information in legal documents and adoption agency records was paralleled by information about the fact of adoption itself being concealed within families – 'horror stories' as Modell describes the stories shared by many adopted people at support group meetings which she attended (p.54).

The concealment both reinforced and was maintained by an 'As-if- begotten' principle, by which biological reproduction provides the model for adoption practice and 'legally an adopted child is *just like* a child born to the adoptive parents (2002:5, emphasis in the original; see also Schneider 1984:172). Tim O'Shaughnessy (1994) asserts in his analysis of adoption in Australia, where adoption law for some time resembled the practice in many other EuroAmerican countries of forbidding access to their records for adopted people, that the secrecy was intended to uphold the pretence that an adopted child is really the biological child of the adoptive parents. In both countries, as Modell describes it for America, legislation and dominant discourse about adoption 'reinforce the effort to make "water" as thick as "blood"' (2002:184). As Modell's analysis demonstrates, 'effort' has a dual meaning, that of the continual striving to make the adoptive family not just legally but also socially, the same as a any other, and that of the amount of work which is involved in making that happen: a transformation of the social identity of the adopted child, strict legal control, and powerful ideology about what constitutes an American family.

The purpose of the secrecy in adoption therefore is protection, a characteristic which Simmel (1950:345) assigns to secrecy in general. Modell notes that opponents

to the right of adopted people to obtain identifying information about their birth parents express fears that it will cause the break-up of the adoptive family and remove the privacy of birth parents. She suggests that since the opening up of records enables people with a personal involvement in adoption to 'make and remake their own relationships', the fear of opponents is a fear of new kinds of family arrangements over which they have no control. American adoption is changing, increasingly involving access to records, meetings between adopted people and their birth families, and contact after adoption between adoptive and birth parents. For some people, Modell suggests, 'these changes represent chaos' (2002:60).

In his social history of adoption in America, E. Wayne Carp (1998) traces the ambiguities and ambivalences of adoption policy and practice during most of the last century, and confirms the highly significant role played by protection in the development of policies in support of sealed adoption records. Over time it was different sensitivities which were being protected, from the risk of adopted children being stigmatised, the fear of unwed mothers being shamed if the illegitimate birth were to be revealed, to the need to reassure adoptive parents that they would not be intruded upon by birth mothers and lose the love of their adopted children. Carp notes, as does Modell, how the function of adoption in Western societies like America is not a way of enriching ties between family groups as it often is in societies in Africa, Oceania and Asia. For similar reasons to those given by people in the infertility treatment community for disapproving of semen donation from a personal donor, as I described in Chapter Seven, disclosure in adoption is described by Carp as being 'fraught with anxiety' (1998: 3). Keeping in mind Konrad's analysis that anonymous ova donors are made invisible, it is significant that Carp notes how birth mothers and adopted people were subjected to the same process. In its emphasis on 'finding parents for dependent children and concealing the identity of unwed mothers', Carp suggests that the adoption social workers in America made birth mothers 'all but invisible' (1998:149). By the 1940s, adopted people were not just invisible, they did not exist as a category of person. Describing the work of an adult adoptee, Jean Paton, in pioneering the right of adopted people to gain access to information about their origins, Carp points out that 'when Paton began her research, both the mental and the experiential world of the adult adopted person was unknown.

From the perspective of adoption agency policy, there were no *adult* adoptees' (1998:141; emphasis in the original).

As with adoption in America, the secrecy which, until recently, has been fundamental to the provision of semen donor services in the UK can be analysed both as to its form and its content. That these can be considered separately was suggested by Simmel, who notes that the secret as a sociological form 'stands in neutrality above the value functions of its contents' (1950:331). Secrecy can be associated with good or evil yet it may be considered as one of the greatest achievements of humans because it is enriching: it offers 'the possibility of a second world alongside the manifest world' (p.331). It also holds a fascination because of the power which it bestows through its possession and consequent exclusion of those not in possession. The separation of form from content is also noted by Hugh Urban who suggests, moreover, that the 'strategies' of secrecy are significant. The content of a secret may be unknowable or, when known, render the secret no longer definable as a secret, but the strategy or 'tactic' of secrecy is transformative, turning a piece of knowledge 'into a scarce resource, a valuable commodity'. Being in possession of a secret 'bestows status, prestige or symbolic capital' (1998:210). However as Urban shows for the Kartābhajās sect in Bengal, secrecy can become oppressive, creating hierarchies and unequal relations within a society. Whilst secrecy can create problems for societies and for groups within them it can do so also for individuals because as Bellman notes, individuals vary in their ability to practise secrecy (1984:3). This was a significant issue in his study of Poro and Sande secret societies in West Africa where it was not the handed down secrets which were kept undisclosed but rather how secrecy was carried out. What is significant for Poro is not the content of the information but about how to perform secrecy.

Simmel suggests that 'the secret known by two is no longer a secret' (1950:346), which raises the question as to whether there are different kinds of secrets. Urban notes that some theorists have distinguished secrecy from privacy. According to Shils, secrecy involves obligatory concealment and prohibitions on revealing what is concealed with sanctions to encourage compliance. Privacy is about the voluntary concealment of information or behaviour (Shils 1956). This distinction focuses on the forms of secrecy and privacy. In either case, the content of

the secrecy or privacy is neutral in value. Other authors have distinguished secrecy from privacy according to normative characteristics (Warren and Laslett as cited in Urban 1998). Privacy covers morally and legally neutral behaviour whereas secrecy is about immoral or illegal behaviour. Lowry unequivocally describes secrecy as dysfunctional. One aspect of this is the disparity ‘between theoretical purposes and actual consequences’ (1972:439). Whereas secrecy may be deemed necessary for the efficient working of a system or organisation, there is a tendency for secrecy to be extended beyond its original purpose. In the context of national security systems, for example, Lowry found that ‘sensitive information increasingly came to be classified as secret’. He describes such behaviour as ‘playing safe’ (1992: 445) that is, perhaps, as risk related. His analysis suggests that the control of secrecy may be less to do with the original purpose of the secrecy and more to do with keeping hold of power for its own sake.

### **Keeping donors secret**

During the time of my research there was discussion and argument amongst people with a professional interest in infertility treatment services and also more widely in the UK, about the matter of donor conceived people having access to identifying information about their donor parents. As I noted in Chapter One, a public consultation on the matter had been promised by the UK government in 1995 (Hansard 1995) but it was not introduced before the subsequent election which brought a change of government. Indeed, no one interested in donor insemination services appeared to know of, or remember the promise, perhaps because it was tucked away in a debate in the House of Lords on legislative change for children in Scotland. The matter was not on the agenda of the incoming administration and it was not until December 2001 that a consultation paper was published by the UK Department of Health (Department of Health 2001)

From the time of the second announcement in 2001 of the government’s intention to consult on donor anonymity, I noticed an increasing tendency for infertility specialists to state that perhaps it would be all right if ‘people’ (meaning donor-conceived people) were given access to medical information about donors, “but not actually meet them”. Some clinicians gave the impression that they had

come to this position reluctantly, and that they would prefer the continuation of the pre-1990 situation, before the introduction of the Human Fertilisation and Embryology Act, when donor offspring, and their parents, could expect to receive no information whatsoever about the donor. Even though the Act allowed parents to obtain non-identifying information about the donor from the clinic, they were seldom informed of that right. Other clinicians indicated that they were in the process of thinking about the matter and might change their views about anonymity: 'I'm half way through on this' one of them put it, during audience discussion at a conference after a presentation on current adoption policy and practice. He was particularly interested in wanting to know whether donor conceived people would want to search for their genetic parents, like some adopted people do.

I often heard suggestions being made, and not just by clinicians, that if medical background about donors needed to be available for donor offspring in later years, then the best arrangement would be for the donor to be approached through an intermediary, preferably a doctor, for this information. The doctor then, so it was suggested, would pass on that information to the donor offspring and this would mean that the donor and the donor offspring would not need to meet. The implications of this proposed practice is that donors and donor offspring would not have any contact by letter, email, telephone or in person. The donor offspring would be given information about genetics separated off from any other information about the donor as a social person. The donors and the donor offspring would remain social strangers to each other. Just as the doctors had been the brokers between the donors and the patients at the time of the original semen donation, so they proposed to place themselves as brokers once more between the donors and the result of the donation, namely the adult donor conceived person. In order to protect the parties involved, they would act as intermediaries. They would not be like a 'go-between', aiming ultimately to bring the two parties together, but like a gatekeeper, preventing access to each party by the other.

The members of the Project Group on Assisted Reproduction (PROGAR), all of whom had professional and/or personal involvement with adoption or donor-assisted conception, noted that these concerns to have intermediaries between donors and donor offspring were similar to the situation in adoption, particularly in England,

where the birth parents and adopted people were thought by some policy makers to need not just an ‘emotional buffer’ to help in the process of making contact (Trinder, Feast and Howe 2004) but possible protection from each other altogether. This perceived need for protection led the government to propose that the adoption law for England should be amended to remove the right of adopted people to access to their original birth certificate. The government was persuaded by adoption agencies and the adoption community that this step was unnecessary and regressive (Hansard 2001), but the subsequent Adoption and Children Act 2002 introduced stringent regulations about the obligatory use of a registered intermediary service. These give a new right to birth relatives to ask an adoption support agency to provide an intermediary service, but the underlying principle of protection is clear.

Trinder et al emphasise the need for intermediaries in the post-adoption context to have the necessary experience, knowledge and skills, and the ability to avoid having protective loyalties to one or other party (Trinder et al 2004:31) and this was noted by PROGAR which decided, as a contribution to the continuing debate following the Department of Health’s consultation, to commission a set of briefing papers about donor anonymity. Of interest here is the paper by a geneticist who wrote that ‘genes are not complete predictors of future health. They do not carry all the information that offspring may wish to know’ and that ‘No matter how good intermediaries are, they inevitably run the risk of misinterpreting information, or unwittingly altering emphasis in their translation’ (Simpson 2003). Simpson also made the point that ‘donor offspring themselves have indicated that they do not always see their genetic donor parents as composed of two separate parts, the genetic and the social’ (ibid).

The proposal to allow access to information only through intermediaries raises the concern about the competence of the intermediary and also would mean that information about donors’ health and medical status might be divorced from the social context of their lifestyles and life events.

The separating of the person of the donor into social and genetic aspects was evident in many of the responses to the government’s consultation (Department of Health 2001) from respondents who declared on the form that they had a professional interest in the provision of assisted conception services. The consultation document

included a questionnaire which respondents were invited to complete and return by 1<sup>st</sup> July 2002. In all, 237 responses were received of which a number stated that their reply was to be treated as confidential. Copies of the 126 non-confidential replies were sent to me by the Department of Health for use in my research. Respondents included those with a personal involvement: gamete or embryo donor, gamete or embryo recipient, donor offspring, and those with a professional interest: infertility specialist clinician, other medical practitioners, professional medical organisations, scientists, embryologists, nurses, psychosocial experts, NHS trust members, ethicists, and ethics committee members. There were also replies from other members of the public. The Department of Health reported that a large majority of respondents were in favour of people having identifying information about a gamete donor if they had been conceived using sperm, eggs or embryos provided by that donor. Those respondents included people who had a personal involvement with donor assisted conception (Department of Health 2003a)

The reasons which respondents gave for being in favour of removing donor anonymity emphasised human rights, particularly a right to know of one's origins. The question as to whether there was such a right was posed during conferences on infertility issues at the time, whether there was discrimination against donor conceived people in comparison to adopted people, and whether there was a likelihood of the UK government being challenged in the European Court of Human Rights by one or more donor conceived people if UK law on anonymity were not amended. Amongst the consultation document respondents, the right to knowledge about origins was proposed for two distinct reasons. One involved the belief that such knowledge is necessary in order to promote good mental health including a sense of identity and self-esteem. The other reason derived from the belief that being denied information about one's origins may put a person at a disadvantage in accessing preventive medicine. Some respondents gave both reasons. Psycho-social professionals, such as psychologists, sociologists and social workers, made reference to research carried out with donors, donor conceived people, and people with a personal involvement in adoption.

For many of the respondents who declared a professional interest in the provision of donor-assisted conception services, the need for knowledge about

origins was confined to non-identifying information, and sometimes this was further circumscribed:

I can envisage no serious detrimental effect of providing such information on request if 'child' is aware of his/her origins. The information may help to form some sort of mental picture – however erroneous – of the donor.

(Clinical doctor providing egg donation service)

In addition to personal characteristics and medical/genetic history, this respondent suggested that 'hobbies, interests, pen portrait (with donors consent)' could be made available 'as long as this is non-identifying'.<sup>1</sup> The manager of a donor sperm bank made similar suggestions: 'this information – although brief - will help the child have something to identify with. I think it is unfair to deny any [deleted] no [added] information whatsoever'.<sup>2</sup> In addition to personal characteristics and medical/genetic history, the respondent suggested 'Religion. Hobbies. occupation. a brief description of the donors personality'.

### **A tradition of secrecy**

Many infertility specialists stated their belief that the system of anonymity in donor insemination had worked well, and therefore there was no need to change it: the pre-existing system of ensuring that donors remained unidentifiable to donor offspring had not caused problems, and had enabled many otherwise childless couples to have a family. They also pointed out that research showed how few parents had told their donor-conceived children about their origins, thus implying that keeping secret the fact of donor insemination, as well as the identity of the donor himself, was not having adverse effects. They always failed to mention the research studies which have found that a large number of parents have told someone else (see for example Lycett, Daniels, Curson and Golombok 2005). A study in England by Back and Snowden (1988) of 899 couples attending the same clinic whose children were donor-conceived showed that 42% of the 57 couples interviewed had told someone else, and that the records of the couples who were not interviewed showed that some of them had informed their children. (1998:196). Back and Snowden suggest that for parents, keeping the fact of donor insemination a secret from everyone was stressful.

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<sup>1</sup> I have copied the exact words written by each respondent. Some apostrophes may have got lost due to the photocopying process.

<sup>2</sup> The respondent crossed out the word 'any' and inserted the word 'no'.

It is possible that this is one of the reasons for recipients at another clinic in England also not keeping the matter to themselves, as reported by an obstetrician at the RCOG Study Group meeting in 1976:

Many of our patients who have had A.I.D. are not unduly 'confidential' about it. They themselves will divulge the fact and will tell the nurses in the maternity home, and everybody else, that this child was conceived by A.I.D.  
(Brudenell et al 1976:89)

A recent study by Lalos, Gottlieb and Lalos (2007) of couples who had conceived a child after DI found that 61% of the parents had told all of their children about the DI, but 89% had told one or more persons outside of the family. One woman and three men told the researchers that they were sure that no one apart from their partner knew of the DI, but the researchers found that two of these men had wives who had told a close friend about it, without their husband's knowledge. This study was carried out in Sweden, where legislation introduced in 1985 provides for donor-conceived children to obtain identifying information about gamete donors, but of note here is the researchers' finding that the attitude of healthcare staff was important to parents' decision-making. The parents reported that clinic staff had not always encouraged them to be honest with their children, but one of the reasons that parents had decided to tell their children was that they wanted to avoid the possibility of the child discovering the truth by accident, and to avoid the burden which keeping the secret was placing on their partner relationship.

The assertion that all was well in keeping DI a secret was reflected in much of the information given to patients by infertility clinics in the UK at the time of my research. Information leaflets about available treatments were compiled by staff in individual clinics or in groups of clinics which are part of for-profit organisations. These leaflets are inspected at a clinic's regular inspection by the HFEA, and as an HFEA inspector I noticed that they often contained incorrect or value-laden information about the social context of having a child with donor assisted conception. Some leaflets gave assurance that it was acceptable for the parents never to tell the child about his or her origins: 'there is no need for the child to find out', or that it was up to the parents whether or not to tell the child about this. Some leaflets contained inaccurate legal information about the parental rights and duties of the recipient's male partner in respect of the child. This even happened at a clinic where

the clinic's lawyer was in attendance throughout the inspection. It was clear that in this clinic, as in some others, no one had fulfilled the responsibility for ensuring that the information leaflets reflected the reality of the social circumstances of the family-to-be. Few information leaflets mentioned whether there was access to counselling and support after a pregnancy was achieved, although several infertility counsellors informed the inspectors that they made these services available at their clinics. Most clinics that I inspected gave incomplete information about patient support groups. The Donor Conception Network was seldom noted, and in one case, fifteen months after the organisation Infertility Network UK came into being, the information leaflet for patients was still listing the now defunct telephone numbers of the two smaller organisations which had disbanded and joined together to form INUK.

Such details emphasise the focus of clinics on the achievement of a pregnancy without being mindful of the practical problems and mixed emotions surrounding the parenting of a donor conceived baby, which recipient mothers and their partners reported later to the infertility counsellors or to other parents at support groups. The incompleteness of the written information for patients was usually mirrored by the lack of knowledge which clinics had about the laws governing different kinds of family formation. In its response to the Department of Health's review of the Human Fertilisation and Embryology Act, the British Infertility Counselling Association noted:

We are concerned about the continuing lack of clarity and understanding among some staff in licensed treatment centres about adoption and surrogacy and the resultant incorrect information that is passed to patients.

(British Infertility Counselling Association 2005:17)

In addition to the view that the system of anonymity in donor insemination had worked well, it was also asserted that there was no evidence that it had not worked well and therefore a change in the law was not required. This argument had to rely on disregarding the accounts of an increasing number of donor conceived people who had asked that the law be changed, much as the arguments supporting the sealed adoption records in America had discounted the voices of adopted people. None of the infertility specialists claimed to speak on behalf of donor conceived people as to what they wanted, rather, there were claims about what donor conceived people 'should' want. A good example of this occurred in 2002 during the period of

consultation on donor information, when a young female doctor had an article published anonymously in the 'personal view' section of the British Medical Journal (BMJ 2002) in which she described her feelings about being donor conceived and why she would like to know something about the semen donor who she described as giving her 'the opportunity of life'. She pointed out that, although the issues about donor insemination had been debated over the years, 'what are lacking are the views of the children created'.

She pointed out that at the time, the studies carried out about people like her 'have only used parental interpretations of our emotional state.....No one has questioned us....We have no voice'. There were five responses by email to the article: two from mothers of donor conceived children, one from a professor of social work, and two from doctors. One of the doctors gave an address in Canada and the other an address in India. The response from Canada commented on the importance of knowing about family medical history and made suggestions for minimising any difficulties caused by a donor conceived 'child' receiving information about the donor. The other doctor commented:

Thrilled to know your feelings as a child of DI. But what I personally feel what is the need of knowing your DI father, because once you come to know your DI father you will be interested in knowing other brother and sisters of your DI father and on and on....So better to stop here. Content yourself with being the son of your present parents.

There were no comments on the article from any other doctors and I never heard it mentioned except by social workers, and by parents and donor conceived people. It is possible to speculate that few BMJ medical readers would actually read the article due to its length and its obvious message from the beginning. Even the reader in India got the gender of the author wrong, as though the reading had been rushed. Perhaps UK medical readers agreed with the comment from India, which followed a familiar pattern of telling donor conceived people not just what they should be doing but also of what they should be thinking.

There were many examples of this in the responses to the Department of Health's consultation on donor anonymity. A clinician respondent who was against the release of identifying information wrote: 'the offspring do want cultural and social information, not a name and address'. No research evidence nor practice

wisdom from contact with donor offspring was given in support of the claim. An infertility clinic worker in favour of the release of non-identifying information only, explained: ‘This would give enough information for a child to be happy or unhappy about his/her origins’. Another such worker, with responsibility for recruiting semen donors at an NHS centre for reproductive medicine, was also against the release of identifying information to donor offspring:

I feel in most case that it is just a curiosity which needs to be satisfied in donor offspring to find their genetic father/mother. In view of the very low numbers of parents that tell their children, I think the impact on recruitment of donors and therefore treatment of patients would be very high, for such a small gain, and most offspring probably wouldn't pursue a long term relationship.

Although there was already research available, not mentioned by the respondent, into parents' communication with their children about origins, the respondent gave no evidence to support the claim of the possible impact on recruitment, nor the kind of relationship which donor offspring might seek with donor. The respondent assumes that it is not worthwhile unless such a relationship is long term. The interest in obtaining information is described as ‘just a curiosity’.

A response from the chairman of an ethics committee for an infertility clinic agreed that limited non-identifying information should be available, namely personal characteristics and medical/genetic history, but nothing more: ‘No – certainly not about relations or the social preferences/achievements which seem most irrelevant’. It is not explained why such information is ‘irrelevant’ nor for whom, and no mention is made of ethical considerations. One respondent who was unusual in supporting secrecy about the fact of donor conception itself, agreed that non identifying information should be available if the donor-conceived person already knew about being conceived that way. He added: ‘but the real question is whether or not and how the person came to know’. Obviously the respondent was against identifying information being made available to the donor conceived person, and he wrote: ‘The *need* for the AID child to have the same discovery rights as the adoptee is, therefore, by no means self-evident’ (emphasis in original). The respondent gave his professional interest as ‘teacher of medical law and ethics’, and he is medically qualified.

In a discussion about the issue with me after the consultation period had closed, it was clear that this respondent believed that secrets could be kept from donor conceived people. He was concerned that they should be happy, but this concern was based on a view of the individuals concerned only as forever children of the infertile couple, a phenomenon which Rowland (1985) calls ‘infantalizing of the AID offspring’ (p.391). The opinions of the donor conceived people as adults did not have a place, although it was acceptable, he said, for a person to learn of their donor conception origin if there was a possibility of a genetic problem. He stated his belief that secrecy was acceptable but that the discovery and use of DNA no longer made it possible to maintain secrecy. ‘DNA is all around’ he pointed out to me. It was the new knowledge from the field of genetics which was providing a challenge to his belief that the donor conception status of a person should be kept secret, not the views of donor conceived people that they would like to have the choice about access to such information.

Claims such as these about donor conceived people were not based on evidence about what worked in donor conception families, nor on practice wisdom, since people with a professional involvement in infertility treatment services, apart from infertility counsellors, have not sought out contact with donor conceived people. Rather, the claims were based on the presumption that years of trying to help infertile people and of recruiting donors had given the claimants expertise on the matter of donor conceived people as well. A clinician responding to the Department of Health’s consultation on donor information on behalf of his clinic suggested that donor conceived people should have access to non-identifying information because ‘total ignorance is not satisfactory’. He was against identifying information being available because ‘recruitment of donors will become impossible’. He gave no further explanation for these responses but had this to say about the consultation itself:

It is essential that those actually involved day-to day i.e. professionals – make these decisions. It is not for politicians or anyone with a passing interest, no matter how sincere, to make these decisions. **IN SHORT:- IT IS NOT BROKEN, DO NOT MEND.** (emphasis in the original)

What this respondent appears to be suggesting is that the lived day to day experience of being a donor conceived person is not relevant to the policy change being proposed at that time. Whatever that lived experience might be, it must not be

allowed to challenge the belief of ‘the professionals’ which was that the existing law and medical practice about access to donor information was the correct one and had more importance than the beliefs of others.

Another clinician who responded only on his own behalf, and who was in favour of non-identifying information being available wrote, ‘I do not see any reason for not supplying information about the donors medical and genetic history, for example’, and added, ‘I do not see any harm coming from knowing where the donors were born now that some sperm supplies are imported from overseas’. Although this clinician had told me previously during an informal discussion that he favoured donor conceived people having access to identifying information about donors in future, his written consultation response stated that they should not, unless the donors themselves agreed, and it would be up to the donors to decide just what the information would consist of. He declared his professional interest in the subject as being ‘provider of gamete donor service and first UK centre to perform egg donation in 1986 and to deliver egg donation children’. The respondent is suggesting that it is his expertise in providing infertility treatment using donated sperm and eggs that is the source of his opinion. In his case, such expertise does not include professional contact with past donors, donor conceived people, and their parents.

Acknowledgement by clinicians that they did not have sufficient professional knowledge to talk about what was in the best interests of donor conceived people was rare but was readily admitted by several whom I interviewed, who were senior infertility specialists clearly respected in their profession. They described to me how haphazard had been the development of an anonymous donor insemination service in the past, and how the need for patient confidentiality had been the major concern at the time. One of them told me that he did not have any research evidence about the welfare of donor conceived people and that his knowledge came from meeting with recipient patients when they returned to his clinic requesting donor insemination in the hope of achieving a second pregnancy:

Eh, we don’t know, you know, I’ve never been involved in long term follow up studies of the well being of these children, nor have I been in a position to compare them with the long term follow up of the well being of children from any other point of view. My impression’s always been that, many of these parents who come back for a second baby seem to be very happy with the way things are going.

The clinician was implying that his knowledge came from meeting with patients when they returned to his clinic requesting donor insemination again in the hope of achieving another pregnancy. The information which he had gained was from clinical contact with parents who had already had a baby conceived with the use of semen donated by a donor unknown to them. This contact would have been when the first donor conceived baby was probably still a child and may or may not have been told how conception had occurred. The clinician's observation was based only on information from the parents about their perception of the situation at the time of trying to achieve a second pregnancy. The parents' reported perception was that things were going well, at that time, in the family's relationships, between the parents and between them and the child. A retired clinician admitted to me that 'there may be problems of which I am unaware', but he had never heard of any. He had relied greatly on informal feedback from the clinic's nursing and administrative staff who would be speaking informally with patients when they returned to visit the clinic. He had managed to obtain resources in the 1980s for a small follow-up study of couples who had a donor-conceived child, but the results were never published and he believed that the data had been destroyed in order to preserve the anonymity of the couples.

Another clinician whom I interviewed told me that not only did he have no evidence about how things would turn out for the donor offspring and the parents, but also he wondered whether donor insemination using semen from anonymised donors was an acceptable practice at all. 'Whether DI is a good idea or not, is not clear cut' he stated, adding that 'there is the need of the woman and a "right" to have a family, but is this way OK? What about the needs of the child?' This clinician was unusual but not unique in sharing his doubts about DI so explicitly, and therefore I asked him whether he and his colleagues had ever discussed the matter in the past and particularly at the time when DI services were being started up in the UK:

Clinician: 'No, we didn't discuss it at all. Any debate, I had with myself'.

Jennifer: 'So what kept you going?'

Clinician: 'I don't know! Hopefully that I was doing more good than harm'.

The clinician said that he had remained concerned about the lack of follow-up data on donor conceived children, both socially and medically. He said that he ‘did not ever tell parents to keep DI a secret’. In keeping with an instinctive feeling that it was the right and sensible thing to do, because DI might have long term effects, he and his laboratory manager had persuaded their NHS hospital authority to guarantee to preserve the clinic records of donors for fifty years, long before it became a legal obligation to preserve such records at all.

### **The ‘uncertain paternity’ argument**

From the time of the Department of Health consultation on donor information, it was said publicly by a number of infertility clinicians that for donor conceived people to be denied access to identifying information about their donor father was not discriminatory, and therefore there was no reason to change the law on anonymity. They justified this assertion by claiming that a high percentage of children in the UK were not the biological offspring of their mothers’ husbands. These children, they claimed, would not necessarily know that the man whom they assumed to be their biological father, was not so, and that it was another man, not their mother’s husband, who was. As the consultation period proceeded, the alleged percentage of such children increased in the assertions. It did not seem to occur to the clinicians that in making this claim, they were associating donor conceived people and their mothers with marital deceit. Keeping the identity of the donors hidden was doing no more, it was implied, than what was happening anyway in many families in the UK. Finally at the annual H.F.E.A. conference in 2005 the then Deputy Chair of the H.F.E.A. gently chided a clinician who had queried why information about donors was important when as many as 14% - 17% of children were not the child of their presumed father: “I have heard quoted in Glasgow a figure of 25%. However I have never seen any research to support the claims which are being made”. Since the Deputy Chair was a Scotsman his comment was greeted with great amusement by the conference participants and whispered asides that no one else would have dared to say what he did about Glasgow. During my fieldwork no one was able to tell me about the origin of the research findings quoted by the clinician, except that it might have been a study in an English housing estate at an unspecified time. I found a reference to an investigation by a consultant obstetrician and gynaecologist prior to

1973 in which blood tests of some patients in an English town had found that 30% of the husbands could not have been the fathers of their children. (Ciba Foundation 1973:63). However it was noted that that did not mean that the paternity was unknown to the family involved.

Macintyre and Sooman (1991) suggest that estimates of non-paternity tend to be based on research of questionable reliability and validity. They describe the incidence of non paternity as having the characteristics of ‘urban folk tales – pieces of conventional wisdom which are widely believed but have little basis in fact’ (1991:869). There also seems to be different results from blood tests in comparison to DNA testing which produces lower percentages. The chief executive officer of the Icelandic biopharmaceutical company deCODE, Dr Kari Stefansson, suggests that the correct figure in the UK would be about 2% (Stefansson, personal communication 2003). Whatever the figures and however they have been arrived at, the relevant issue is that some people with a professional interest in donor assisted conception service used them to argue against a proposed change in the law about donor information. This is in contrast to their usual emphasis that all policy should be based on the outcome of randomised controlled trials. Equating donor conceived people’s lack of access to identifying information about semen donors with the ‘not knowing’ of people conceived extra-maritally serves to normalise the practice of secrecy in donor insemination.

The presumption that lack of knowledge as to who is one’s genetic father is not important was used to help the arguments of those infertility specialists who were against changing the law. However, the argument only applied to donor conceived people: it did not apply to donors. Many clinics made it explicit in their information leaflets for patients and prospective donors that adopted people would not be accepted as donors. Some clinics did not go so far as to reject donors outright if they were adopted, but made it clear that they would only be acceptable as donors if they knew their family medical history. Some clinicians stated that they would not accept adopted people as donors ever, on the grounds that, by their definition, an adopted person would be unlikely to have access to their family’s medical history. Paradoxically, although producing a birth certificate is standard procedure for part of the process of confirming identity if applying to be a donor, not all clinics had at

least one member of staff who knew how to interpret a birth certificate. They were thus unable to tell whether a person was producing a full or an abbreviated certificate, and therefore whether to ask the person whether or not they might have been adopted.

When I asked during H.F.E.A. clinic inspections whether donor conceived people would be accepted as donors, frequently the clinic's staff would look aghast, and usually admit that they had never thought of what they would do. Clearly the idea of a donor conceived baby growing up to become a semen donor had never occurred to them. An exception was a clinic where a prospective donor knew that he had been conceived as the result of donor insemination at that clinic. The clinic processed his offer to donate because they had kept good records which were extant and the clinician could trace through them back to the young man's donor. Towards the end of my fieldwork however, I heard from several clinic nurses and embryologists that when men made a telephone enquiry about the possibility of donating, they were asked if they were adopted, not so as to exclude them but in order to pave the way for discussing the matter of family medical history.

### **The dangers of removing anonymity**

After the UK Parliament passed the regulations<sup>1</sup> which would allow donor conceived people born after April 2006 to have access at age 18 to identifying information about their donor parents, a number of people with a professional interest in donor assisted conception continued to claim that the change was unnecessary, and went further by stating that the changes were dangerous, detrimental to donors in the long term, and likely to make it very difficult to recruit new donors. Potential difficulties in recruitment had been noted by some respondents to the government's consultation on donor information, with the corollary that this would mean a reduction in help available to childless couples. After the regulations came into force in 2005 a dispute arose as to whether, and if so, why, there had been a decline in the number of men offering to donate sperm after the government announced the new policy. The first chairman of the H.F.E.A., Sir Colin Campbell, wrote to The Times newspaper insisting that the policy must be reversed because of the reports about the fewer

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<sup>1</sup> Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulations 2004 (S.I 2004 No. 1511)

number of men prepared to offer to donate semen (The Times 2006a). The tone of his letter suggests that he assumed that his proposal would be accepted by the government. His successor as H.F.E.A. chairman, Baroness Deech, wrote to support his proposal and her letter provides another example of donor-conceived people being told what to feel about their position, and of the concern about the perceived ambiguous place of a genetic father who is not the nurturing father:

During my chairmanship the authority discussed the issue thoroughly on several occasions and remained firmly of the view that anonymity was right. This was not only in order to ensure volunteers, but out of respect for the husband of the baby's mother, who would assume the role of real father to the child in social and emotional terms (The Times 2006b).

The H.F.E.A. had previously denied that the current shortage of donor sperm was due mainly to the change in the policy about anonymity, since there had been a decline in donors for many years. Baroness Deech's successor, Dame Suzi Leather, insisted that the shortage of donor sperm was not primarily due to the introduction of the regulations, and that 'the evidence we have just does not back this up.....How can one clinic have doubled its number of sperm donors in a year when it works under the same law as everyone else?' (H.F.E.A. 2006b). At the H.F.E.A.'s annual conference in 2006, one clinician insisted that because of removing donor anonymity, DI services would cease, and another complained that it was impossible to recruit donors. In response, however, a clinician who supported the change in policy stated 'It is a nonsense, what you say, about the effect of the law. We are recruiting no problem'. Invited by the H.F.E.A. Chair to comment on these two perspectives, a representative of the National Gamete Donation Trust stated that enquiries from people about donating gametes had risen 500% since the new regulations had been passed, and that some had come from people who had waited until then, that is, they only wanted to donate if they were to be identifiable to donor offspring in the future.

The dispute about numbers and whether or not there was a 'crisis' caused by the change in the law divided those who were happy with the change and those who were not. Individuals from many infertility clinics told me of their surprise that they had received a considerable increase in enquiries following the publicity about the new regulations. Many clinics had insufficient resources to process the enquiries

because they had allowed services to shrink or cease on the assumption that no one would want to donate any more. A news item reported that:

Scotland is believed to have only one active sperm donor. Donated eggs are also scarce. Now doctors from the British Medical Association's Fife division, forced to turn away couples needing donor sperm, are calling for a return to anonymity. A motion submitted for the BMA's annual conference, taking place in Belfast this week, calls for a U-turn on the decision. Dr Stewart Irvine, BMA spokesman and a consultant gynaecologist at Edinburgh Royal Infirmary, said the effect on services after the law change had been "catastrophic". "Donor insemination services have more or less ceased across Scotland and in many parts of the UK," he said.

(The Scotsman 2006a)

Three months later the recruitment situation was reported as improved (Scotsman 2006b) with potential donors contacting several clinics. Olivia Montuschi, co-founder of the Donor Conception Network had been reported in an article in another newspaper suggesting that it was the 'negative approach' of the clinics to the new regulations about donor information which had contributed to the shortage of donors: 'There needs to be a shift in the attitude of clinics to recruit a different sort of donor. There's some evidence that they are currently not as welcoming and friendly to donors as they could be' (Sunday Herald 2005). The article's author, Mona McAlinden, gave three reasons as to why there was a shortage of donors. Firstly, there was the suggestion that the clinic staff did not see the new regulations as a good thing and this attitude was helping to undermine the regulations, by producing a shortage of donors. Secondly, the clinics did not appear to be trying to recruit the kind of donor who would not mind being identifiable in future namely 'the family man in his 30s'. Thirdly, the clinics were treating donors in such a way that they might be actually discouraging potential donors. Over a year later the situation in at least some clinics appeared to be unchanged:

We have recently heard from a man in Scotland who has not been able to get one of the clinics there to take him through the basic protocols for sperm donation. He has been trying for two years! They don't answer the 'phone, they don't have anyone who can speak to him, they are busy etc. etc. No wonder they have no sperm in Scotland!

(Olivia Montuschi, 2006, personal communication)

When I reported this message to a meeting of the British Fertility Society's executive committee, with Olivia Montuschi's permission, there were some rueful smiles and a

clinician working in England asked rhetorically, ‘He *wanted* to donate?’, implying that perhaps there was something odd about the man, otherwise he would not have persevered. No one knows how many potential donors have been lost not just in Scotland but throughout the UK due to telephone enquiries left unanswered, lack of clarity about who is responsible for donor recruitment, lack of accessibility, and lack of budgeting for services. The impression given is that the needs of potential semen donors are not taken seriously enough. Laura Witjens and Pip Morris respectively the Chair and the Donor Recruitment Manager of the National Gamete Donation Trust noted:

The clinics that have recognised the importance of ‘good customer service’ and have adjusted to the new type of donor are doing well. The successful recruiting clinics have accepted the change in legislation and are motivated and dedicated in actively recruiting donors (Witjens and Morris 2006).

Another perspective came from Sheena Young, Business Manager for the patients’ support group INUK, who told me, and also reported her view to the media, that INUK members had been prevented from putting up posters about the need for gamete donors in nurseries, GP surgeries and health centres. Her explanation was that there still seemed to be ‘a yuck factor’ in attitudes towards donation, and towards semen donation in particular.

### **The ‘knock on the door’**

Concern about the new regulations was revealed also in a view that if donor conceived people were allowed access to identifying information about their donor parent then they might decide to go in search of them. That was likely to spell unpredictable trouble. The patient information leaflet at one clinic noted:

The anonymity of the donor insures against any legal, material or emotional claim by him on the couple or child, or vice versa.

Clinicians who favoured keeping donors’ identity secret suggested that, for example, the people who had pushed for the new regulations were ‘biased’ and that ‘unhappy donor offspring are probably over represented’. At one conference in 2004 organised by the Progress Educational Trust, a charity which aims to promote scientific research into infertility and embryology, the concerns of these clinicians were given unsympathetic treatment by some gamete donors and recipients who were in the

audience. A man who had donated semen in the past asked why the doctors did not just accept the changes, pointing out that ‘searching is the new gardening’. Another participant, a recipient of donor sperm who had also donated ova, complained that:

A lot of scare stories are being made. Same as when adoption records were opened. They [adopted people] didn’t turn up on doorsteps. And I don’t feel that there will be total drying up of donors. Some donors will be pleased that the offspring will have right to information.....instead of contemplating this with horror, we should make donation positive.

I asked Barry Stevens, a donor conceived man who has traced and met with several half siblings, and who produced the film *Offspring*, what he thought of the expression ‘a knock on the door’. His reply was that the expression must tap into some deep rooted fears but that he resented the way that the expression was used by so many people in an unthinking way:

Of course I would never go knocking at someone’s door without phoning or writing first....of course, for the donor, someone’s coming to the door as opposed to writing, e-mailing, phoning, buttonholing on the street, or going to his office, means that the offspring will or may be seen by members of his legitimate family. This of course is the nightmare. On the one hand ‘his’ child is outside in the cold, on the other, your wife stands ready with the frypan to bash your head in. It’s a tough choice.

The image here is of the semen donor being subject to competing claims of duty and sympathy from the donor offspring and from his family. The donor’s wife is portrayed as the gatekeeper and guardian of the family, and as being antagonistic to the perceived intrusion of the donor offspring into her family. It suggests that the donor conceived person is not a relative of the wife, just as I noted in Chapter Six when the donor’s wife hinted, in her response to her husband’s wish to have a party for all his donor offspring, that she might not like them.

Concerns about the removal of anonymity involved just such dilemmas being faced by donors. No one seemed to recognise Barry’s observation that very few adult donor offspring would risk knocking on the door of a donor’s home because of the chance of what he called ‘brutal rejection’. Instead, some of those responsible for organising donor services shared their alarm that they would have the worry for years to come about whether their treatment decisions were correct, or whether the identifiability of donors might cause future problems over which they had no control. One clinician so emphasised his concern that his clinic’s infertility counsellor shared

with me her curiosity as to whether he himself had donated semen in the past. I had the opportunity to ask him later, but he said that no, he had not donated. He said that his belief is that some things in medicine are so hard to talk about that sometimes it is best to keep things secret so that there is no need to talk about them. After the announcement by the government at the HFEA Annual Conference in 2004 that regulations would be introduced to allow donor offspring to have access to identifying information about donors, one infertility counsellor said to me, with a sigh, ‘when I go back to the clinic tomorrow, half will be against the anonymity thing because it means more work with patients’. The counsellor was implying that the infertility clinic staff perceived the anonymity of donors as necessary because less work was involved than when gamete recipients were advised, as they often had been in the past, to keep the fact of donor conception a secret.

A clinical scientist told me that clinicians were worried also about how to deal with donor conceived people returning to clinics in future alone or accompanied by their parents, to ask for information about the original donor insemination treatment:

I have heard it argued from a number of clinicians that they do not want to be responsible for what may or may not happen in the future.....they do not want anything on their conscience or the possibility of their being contacted in the future and after their retirement.

He pointed out that some clinics are dealing with such enquiries already: it is time consuming and not budgeted for by health authorities: ‘as such, hospital managers take a dim view of it’ and moreover they might have ‘a duty of care’ to past patients which would be hard to meet: ‘Imagine an ex-donor making a reappearance 18 years later after being contacted by a child and for whatever reason it has all gone horribly wrong’. For infertility clinics and management, this reappearance would be like an unwelcome knock on the door, with the ‘ex-donor’ presumed to be demanding recognition, apology, and even compensation.

The expression ‘knock on the door’ or others similar to it are widely used in the context of debates about donor anonymity. At a conference in London in May 2002 organised by PROGAR to explore the issue of information for donor-conceived people, Baroness Warnock, who had chaired the Committee of Inquiry into Human Fertilisation and Embryology established in 1982, explained to the

audience that the committee had supported the concept of gamete donor anonymity because otherwise ‘perhaps ten offspring would turn up at the door [of the donor]’. The expression conveys the assumption that donors would not want ten donor offspring to do this and that to turn up at the door is threatening behaviour in some way which is never explained. One of my research informants, who is not a donor, wondered whether the expression conjured up an image of an unwanted and unexpected visit from the police. Newspaper reporters were never able to tell me why they chose the expression despite using it frequently, although I suggest that it may be related to the media’s practice of turning up at someone’s door, uninvited, and not leaving until they have obtained an interview with the occupant. The expression may simply be a powerful metaphor in a society in which few communities have the custom of expecting visitors to enter a house without waiting at the door. The door of a house is a literal and symbolic boundary between the place of the stranger and the place of kin. Allowing donor offspring into the house might imply that they could be transformed into kin. The house door serves as a physical and psychological barrier, and the doorway, like any threshold, remains a place of danger and vulnerability. The possibility of the barrier being breached by outsiders without prior negotiation is a fear which the media appear to play upon. The donor offspring, if allowed through the doorway into the house would have to be treated as some kind of kinsperson - a friend, neighbour or relative.

### **Conclusion**

In her analysis of English kinship, Sylvia Wolfram (1987) defines the indigenous structuring of kinship as the ‘beliefs about kinship matters which seem self-evident in this way within the society’ (p.197). What is self-evident is taken for granted. The need to keep donors secret, as anonymous to donor offspring and their parents, was fundamental to the provision of donor insemination services in the past and for a number of people with a professional interest, particularly some clinicians, it remains so. They have tried to prevent the introduction of regulations permitting donor conceived people to obtain identifying information about donors, and have disagreed with the views of past donors, parents and donor conceived people for whom time has moved on. For these infertility specialists, donor conceived people tend to be

treated as not visible, or when that is not possible, then as forever children, denied autonomy and the right to agency. As has been described for adoption, people with a personal involvement in donor insemination and in ova donation too, are beginning to develop their own kind of social networks and to talk openly about their status. For doctors trained and nurtured in the practice of protection through insisting on secrecy, this is another world, where semen donors have to be respected for themselves, not simply for the fertilising material which they can contribute, and provided with accessible services. Recognising the wish for secrecy to be abandoned also challenges the view that the social parents of a donor conceived person have to be protected because, as only social parents and not the genetic ones as well, they are vulnerable to the inevitable loss of their child to the search for the donor.

## **Chapter Nine: Summary and conclusion**

### **Summary**

In this thesis I have explored aspects of anonymous semen donation as it was practised in the UK for over seventy years. During the time of my fieldwork the law was changed, but without retrospective effect, so that identifying information about semen, egg and embryo donors will be provided to their adult donor offspring on application to the register held by the H.F.E.A. It appeared as though I were involved in a shifting ethnographic field, but the changes were of a particular kind and the resistance and ambivalence towards them were indicative of continuity and enduring social practices of human reproduction.

I began by exploring the professional interests and experience which led me towards the wish to explore an area of sociality which appeared to have been neglected in social anthropology. I had become aware of the absence of narratives from men who had donated semen when they were young and the tendency for individuals, particularly but not only in the medical profession, to speak as if on their behalf. It was partly the ethnographic silence which drew me to undertake research within a social anthropology framework. The obvious alternative of social work, with its emphasis on promoting social justice, human rights and social change (International Federation of Social Workers 2007) might have accentuated the activist perspective and these approaches to the issues in donor insemination were being and continue to be explored already. My location in social anthropology also provided the practical and conceptual tools for using a multi-sited ethnographic approach, a methodology which provided access to networks across both time and space. Importantly for my purpose, like water finding cracks in solid material, the methodology revealed agreements and differences in perspective and ontological understanding where I had not expected to find them. Neither ‘semen donors’ nor ‘clinicians’ or ‘medical practitioners in infertility’ are homogeneous groups; they may be part of a community of interest, along with embryologists, nurses and other infertility clinic workers, mutually involved in the project of helping to achieve a pregnancy, but they have their own individual motivations, fears and hopes. So also do the parents of donor-conceived children: they were not the focus of my research, but I met informally with many during my fieldwork, except for those who would

have used donor insemination before about 1980. The little that I know of their views now about DI has come to me through their adult children.

In Chapter Two I explored lay concerns from the 1940s onwards about the practice of A.I.D. as it was first called, and noted the practical concerns about its legality and safety and the ethical concerns about its implications for semen donors, donor-conceived children, and the institution of marriage. Anonymous semen donation challenged the moral edifice of the family, and the doctors who pioneered the development of DI services were well aware of this, continuing to provide the service despite express opposition from other colleagues and from other quarters such as law and religious bodies. A.I.D. was a medical solution to childlessness, but not to male infertility, and its focus was short term, to help childless couples to become parents. Responsibility for dealing with any long term implications was strategically avoided, firstly by recruiting the type of donor whose semen was presumed to be less likely to pass on disease or genetic defects, and secondly by discouraging any sense of connection between donors and recipients. The donor-conceived babies were to be passed off as the genetic children of their social fathers. As Modell described for a certain period in American adoption, there were to be no adult donor conceived people. They would be adults whose parents had concealed the fact of their origins and therefore they would have no personal identity as a donor-conceived person and their existence would not be revealed to the donors.

Donors' identities, likewise, were concealed from the donor offspring and their parents. Donors were supposed to fade into obscurity after their donations had been used to achieve a pregnancy or the birth of a healthy baby. For some donors, their identities were lost before then, when their semen was mixed with the semen from other donors. Only the development of DNA testing would be able to confirm the likelihood of a particular donor being the biological father of a particular donor conceived person. As donors were well aware, this mixing of semen worked to suggest the possibility to donors that they had no donor offspring at all. The deliberate obscuring of the donors was intended to encourage donors to forget that they had ever donated, and parents of donor-conceived children to forget that they had ever received a donation. The mediation of the infertility medical specialists prevented reciprocity by preventing the development of social connections between

donors and recipients. It was the specialist who received the thanks from the grateful parents who were delighted in their children, not the donors.

In Chapter Three I described how donors were recruited and became donors, and what motivated them. I set out to discover whether there were long-term effects for the donors, and what significance there might be for them that they had donated when they were young men. I discovered that some donors had regrets about having donated at all, and some were ambivalent about having donated for financial reward. Others gave no indication to me that there were any long-term issues for them, but clearly there appeared to be issues for the donors' wives. All but one of the donors were married, none were divorced or widowed and all of the wives except one were said to know about their husband having donated semen. Wives wondered about possible other children, and some of them apparently had concerns about the possibility of donor offspring causing interference in the donors' lives by making contact. According to what was reported of their concerns, donors' wives were anxious to maintain the emotional equilibrium of their families, and an unanswered question was whether wives perceived themselves as being related to their husband's donor offspring.

In Chapter Four I analysed a variety of perceptions about the influence of genes in a broad sense. As well as the interest in resemblance between relatives, some donors were aware that knowledge of genetic origins was currently gaining in importance for many people because of the increased emphasis on genetics in medical practice. For donors who worked in medical specialities where some diseases were known to cause health problems in their patients, this was a good reason to think that it would be understandable if donor offspring wished to meet with, and ask questions about, the donor and his family. Donors often referred to the longstanding interest in genealogy in the UK, an interest which is now being courted by the tourist industry. Even the doctor donor who denied any interest in meeting donor offspring and insisted that there might be none, told me not only that he had some Scottish ancestors but even the town where they had lived. As I described, he was not unusual amongst the medical practitioners whom I met, in having an active interest in genetic origins.

Chapter Five focused on the issue of semen donors not knowing the outcome of their donation. For a few donors, the fact of having donated semen was not significant, especially if the donor was apparently content to believe that perhaps no children had resulted from their donations. Some were not discomfited by the sexual aspect of donation nor the fact that the donation was anonymised. For others, it was an incomplete part of their biography. They did not know if they had donor offspring and perhaps would never be able to find out. The absence of knowledge means that there might be unwitting incest between their children and their donor offspring although the possibility of this was played down by donors, not because of the unimportance of incest, but because the chances of it occurring were considered so unlikely. In an extension of the implications of knowledge in anonymous semen donation, I noted how their having donated was not a total secret in the social networks of donors.

The significance of having donated in the past was made evident in the sense of connection to the possible people who existed as a result of the donations and I explored this in chapter six. The connection was created by the passage of time and the play of imagination. Donor offspring would no longer be babies but grown-ups, perhaps parents themselves now, with children genetically linked to the donor and to the donor's children. A number of donors were sometimes curious as to how the donor offspring had turned out and what they looked like. The distance between the time of donation and the present enabled the donors to perceive resemblances between genetically connected relatives, a perception which had a different implication from the time of the donation when any resemblance would be the outcome of passing on good genes, not the opportunity to make a social connection. Some donors acknowledged, even claimed, a moral responsibility in respect of donor offspring, should they be in difficulty. The connection to donor-conceived people through the renounced substance of kinship was accepted as the basis of conduct. It would be appropriate to act towards donor offspring as though they were relatives.

For other donors there was ambivalence about their place, if any, in the lives of donor offspring, especially because these people have parents who have brought them up, and in the kinship thinking of many of the donors, it is impossible to have more than one set of parents. The practice of DI served to obscure the parents of the

donor offspring as much as the donors, but their obscurity did not seem to free them from potential influence in the lives of the donors. Donors received no thanks from the recipients directly, but some donors and their wives were concerned that the donor offspring might make contact in order to make a financial claim. It is a particular kind of gift whose return comes from the child of the recipient, apparently as a reminder that the original donation was part of a commercial transaction. It was mainly donors with experience or understanding of adoption and fostering, in other words of families which do not fit the stereotypical nuclear model, whose 'cultural repertoire' allowed for different kinds of relatives to be able to play a role in the lives of donor-conceived people, who were able to imagine that they might have a place in the lives of donor offspring.

However, the nature of the connection between those who are related to donor-conceived people is marked mostly by silence and uncertainty, just as it has been for most of the time in which Euro-American adoption by strangers has been practised. For some donors, the enforced lack of social connection to the parents of the donor offspring was symbolic of connection being risky territory, a place of possible emotional danger and social disjunction: a divorced semen recipient might elicit an obligation of financial support for her donor-conceived child, the altruism of personal donation might become confused with adulterous feelings. This perception that risk adheres to certain kinds of social connection was also evident in the views of infertility clinic staff which I gathered in a telephone survey, and which I describe in Chapter Seven along with the views of donors and recipients regarding the use of personal donors.

In Chapter Eight I described some of the debates about the removal of the anonymity provision in the Human Fertilisation and Embryology Act 1990, theories of the phenomenon of secrecy and how secrecy and anonymity in donor insemination were presented as normal and traditional medical practices, with much dispute as to the social consequences. The medical specialists who developed DI had many reasons for keeping the practice as secret as possible, and recommending secrecy to donors and to recipients, until the 1990 Act legitimised donor-conceived children and clarified who were to be treated as the child's mother and father. The practice did not become subject to regulation for nearly fifty years during which the status of the

donor-conceived child was considered to be illegitimate, and male infertility itself was stigmatising. In this situation, secrecy was a practical virtue (Herzfeld 1990:309) whose purpose was the protection of everyone with a personal involvement. Keeping the donors and the recipients apart in every sense was thought to be necessary to avoid certain realities and fantasies, particularly the protection of the infertile man from the stigma of infertility, and the fantasies of donors and recipients of an adulterous nature. The child conceived by DI was thought to be protected by secrecy from the stigma of being conceived in that way, and from the confusion which it was thought the child would have if there were 'two fathers'. In addition, keeping the information from the child would avoid the possibility of the child abandoning its social father because it was thought to be inevitable that she or he would be drawn to the genetic father.

Despite the emphasis on secrecy, the hidden identity of semen donors, recipients and donor offspring was not paralleled by keeping the practice totally secret. Donors had all told someone at some time that they had donated, although the people who knew might no longer be part of their social circle. Non-donors tended to remember fellow students or friends who had donated, if they had been given that information. Only one donor claimed to have told no one else since the time of donating. Donors' families were said to be aware of the fact of donation and in some cases to be part of discussions about the implications. The fact that donors did not keep secret the fact that they had donated has been paralleled by the fact that research has shown that recipients may not have informed their children about their origins but have told other people, including relatives and friends. This inability or disinclination to keep secret the donor conception of their children was noted by Snowden, Mitchell and Snowden (1983:115) who found that parents found it stressful not being able to confide in anyone, and by Brandon and Warner (1977:339) who pointed out that research showed how adopted children were very likely to be told of their adoption at the age of about 8 or 9 years by people outside of the family such as neighbours and other schoolchildren. They suggested that donor-conceived children were at the same risk of discovering the secret of their origins accidentally.

## Conclusion

The historical context of donor insemination explains why the practice was secret. In order to protect everyone with a personal and professional involvement, the medical practitioners kept the identity of the donors and recipients from each other and destroyed the records of the donors. Why, therefore, did many of the medical practitioners and their professional associations continue to support secrecy and donor anonymity after the 1990 Act came into force in 1991? Writing two years later, Erica Haines suggests that many recipients of donated gametes were known to favour secrecy and donor anonymity and this might influence the doctors' views about keeping it that way despite the change in the law (Haines 1993). She also noted that gamete donation was taking place in a society which was unsure about the significance of genetic relationships for individuals and families and that future research into views about anonymity needed to include clinicians.

The need to treat the social father 'as if' he is the biological father is as strong in DI as it has been, and continues to be, in many Euro-American societies with regard to adoption. There is a fear that two men are in competition for the one role of 'father'. An example of the extensive work which the word 'father' has to do to in the UK to encompass all the functions of fatherhood is reflected in the use of the word in the Human Fertilisation and Embryology Act. It is a gendered matter: the Act makes it clear that the woman who gives birth to a child, no matter whose gametes have been used to achieve conception, is considered as the mother, even if it is a surrogacy arrangement, whereas the decision as to who is to be considered the father has sometimes had to be decided in a court of law. Sally Sheldon (2005) suggests that the nature of some public commentaries on the judicial decision in the case of the mixed-race twins (see Chapter Four) shows how in the UK, 'the search must be for the candidate (and for one candidate) who will best fit the role of 'real father'. This sets the scene for a debate as to whether 'real' fathering is about genetics or social parenting' (2005:546). Whilst Sheldon herself does not wholly agree with the aims and terms of such a debate, the title of her article, *Fragmenting Fatherhood* (italics added), and her suggestion that reproductive technologies 'offer the potential to break down parenthood into a number of constituent parts' (p.523)

both position fatherhood in the UK as a unitary concept within a specific legal and symbolic framework.

The fact that there is a fear that there will be a competition signifies another aspect of Euro-American kinship thinking, that biology is a basis for connection but more than that, the connection is so strong that it will exert more influence than social connection. Time and again during my research, in written texts and in discussions, I encountered the view that donor conceived 'children' might leave their social father in preference for the donor, the genetic father. This is not gendered: the recent attempt to revert the adoption law in England, so that adopted people would no longer have the right to obtain identifying information about their birth parents, was based on the same beliefs about social and biological parenthood as in the field of donor insemination. Social parenthood is seen as fragile and temporary, and not strong enough to support enduring claims and expressions of loyalty and affection between parents and children. Gay Becker's (2002) research in America with couples at an infertility clinic provides poignant examples of the uncertainty felt by non-genetic parents, and the worry that not being the biological father would give an excuse to the child not to love his father (p.127). In my own experience as an infertility counsellor, I have met couples where a man would describe himself as 'only' the social father, if he and his partner were to have a child by DI. Not providing the genes meant being inferior, until we talked about the daily (and nightly) rewards and responsibilities of being a father and then the matter seemed, pleasingly, not so clear cut. Back and Snowden (1988) note that research on donor insemination 'has shown that many barriers to openness do not have rational bases' (p.197). This is true: the insistence that there is still a need to maintain anonymity is based not on empirical evidence, but on deeply held beliefs about kinship. Support for secrecy is also based on beliefs about how kinship should be, on confidence that parent-child relationships will not be harmed by deceit, and that it is possible and correct to keep secrets from children even into adulthood if that serves to protect the parents' status as infertile from being revealed. There are temporal disjunctions here: keeping the knowledge of children's conception status from them means that if they offer to become gamete donors when they become young adults, they will be providing false family histories as part of the assessment process. Secrecy is

associated with self-deception about the integrity of the recruitment process, with the assumption that a prospective donor is the genetic offspring of his (social) parents. Furthermore, the need of medical practitioners to help involuntarily childless couples, and the desire of childless couples to become parents, synchronise in the agreement to use donor insemination as the means to achieve a pregnancy, but the project is diachronic. The activity of helping a woman to achieve a pregnancy by means of donor insemination is a time-limited one for the infertility specialists who have no subsequent role in the life of the family, but as social anthropologists suggest, kinship is a process in which different experiences of its lived reality produce differences and changes in perspectives over the life course.

These ideas about kinship were evident during my research. Donors who donated in the past have no single view about whether or not they felt a sense of connection to donor offspring, and other people with a personal or professional involvement in donor insemination also have varied views. There is therefore no single representation of 'what donors think'. The complexity of donors' perceptions, hopes and ambivalences have not been heard by everyone working in infertility clinics or lobbying for the recently introduced regulations on donor information to be revoked, partly because they have not been listening, partly because the idea that semen donors would want to have connection with donor offspring is troubling. It would be surprising if donors did not have any concerns at all, given that there is no script for how to deal with new kinship arrangements which identifiable donor offspring and donors would introduce, and that the donor offspring have often been suggested by the media as door-stepping fortune hunters.

Although for practical reasons the number of donors that I interviewed was small, nearly half of them volunteered to help with this research before being asked personally, an indication that they wanted to tell their stories and to reflect on what it meant to them that they had donated anonymously all those years before. Absence of revealed connection is not always comfortable nor wanted, and many donors were concerned that the absence might be a problem for donor conceived people. At the time of donating, their semen had been intended to create kinship, not for themselves but for the recipient woman and her husband. The longing of couples to be a family, to be like everyone else, and the response to their longing by the infertility medical

specialists, transformed the donors' semen into the substance of their kinship, not the donors'. I suggest that the anonymous donation of semen does not cut off the possibility of the donated biological substance creating a kinship connection for donors: for most of the donors who I met, there is a sense of being connected to the possible people that they helped to bring into existence, even if this connection is within the private place of their thoughts and imagination.

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**National Gamete Donation Trust**

Brief information-gathering about patient recruitment of own donors  
**Information to be gathered by telephone**

Researcher's introduction: JS to say who she is and that is speaking as a member of the National Gamete Donation Trust's Advisory Council, which has been discussing the matter of patient recruitment of own known donors, and the ethical and practical issues involved.

Informant to be told: 'The council would be grateful if you could help me to complete a brief questionnaire over the phone. I am helping the Council to do this as one of their volunteers. It will take about 10 minutes and the information given will be anonymised'.

Informant to be asked:

- 'Are you the person that I should be speaking to about this?' (ie are there different co-ordinators for egg and sperm)
- 'Is this a convenient time or can we arrange another time to suit you?'

Questions:

1. Does your clinic provide a service for patients wishing to use their own known sperm donors? Yes  No

2. Does your patient information literature make that clear to patients?  
Yes  No  Not sure

3. During consultation, are patients ever invited to consider using their own known sperm donors?  
Yes  No  Sometimes  Not sure

(allow for elaboration)

4. If service NOT provided, was a formal decision made?  
Yes  No

5. If so, which of the following made the decision:
- a) person responsible
  - b) consultant in charge
  - c) hospital trust
  - d) hospital ethics committee
  - e) clinic staff
  - f) other

6. What is the reason or reasons for not providing the service?

7. Are there any plans to make a formal policy?

Yes  No  Don't know

8. What would have to happen for your clinic to change its policy or practice and allow patients to use their own known sperm donors?

Are there any other comments or suggestions which you would like to make?

‘Thank you very much for your time’.

Centre:  
Date of phone call  
Informant

## Glossary of abbreviations and terms

A.I.	Artificial Insemination
A.I.D.	Artificial Insemination by Donor
A.I.H.	Artificial Insemination by Husband
A.I.H.D.	Artificial Insemination with the sperm of a Donor and the recipient's husband mixed together
AI	Artificial Insemination
AID	Artificial Insemination by Donor
AIDS	Acquired Immunodeficiency Syndrome
AIH	Artificial Insemination by Husband
Andrologist	A medical practitioner specialising in the diagnosis, treatment and management of disorders of the male reproductive tract, including cancer and infertility.
BASW	British Association of Social Workers
BFS	British Fertility Society
BICA	British Infertility Counselling Association
BMA	British Medical Association
BMJ	British Medical Journal
Cryopreservation:	The storage of sperm, eggs or embryos by freezing at low temperatures
DC Network	Donor Conception Network
DI Donor Insemination:	the process of placing sperm from a donor (a man who is not a woman's partner) into a woman's vagina, cervix, or uterine cavity, in order to achieve a pregnancy.
DNA	Deoxyribonucleic acid: the material inside the nucleus of cells that carries genetic information.
Ejaculate	To have an orgasm with expulsion of semen from the penis. Also used as an alternative term for semen.
H.F.E.A.	Human Fertilisation and Embryology Authority
HGC	Human Genetic Commission
HIV	Human Immunodeficiency Virus
INUK	InfertilityNetwork UK
IVF	In vitro (from the Latin "in glass" ) fertilization. Mature eggs are removed from a woman's ovaries and placed with sperm in a laboratory dish in order to achieve fertilization. The resulting embryo(s) is usually transplanted into the woman's uterus, or may be cryopreserved for future use.
NGDT	National Gamete Donation Trust
Oocyte	a cell which develops into an ovum
Ovum (plural: ova):	a mature egg cell released during ovulation from an ovary
PROGAR	Project Group on Assisted Reproduction
RBMONline	Reproductive BioMedicine Online
RCOG	Royal College of Obstetricians and Gynaecologist

Semen	The fluid, usually containing sperm, which comes out of the penis during sexual excitement
Sperm	Abbreviation of spermatozoon and also commonly of spermatozoa. Alternative plural 'sperms' found in some medical literature.
Spermatozoon (plural: spermatozoa):	The mature, mobile reproductive cell of male animals,
Urologist	A medical practitioner specialising in the diagnosis and surgical treatment of disorders of the kidneys and bladder