Doctors and Donors: A Comment on Secrecy and Openness in Donor Insemination
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majority of parents believe that it is not in the child’s interest to know his or her biological origin. The main thing for a child to know is that he or she was desired and is loved by his or her parents.

In natural reproduction, the child does not know the secrets of his parents. Perhaps he or she was not desired; perhaps his mother wept when she learned she was pregnant; perhaps she considered having an abortion; etc. All parents have secrets from their children—is it right for the child to know their secrets? In France, ten thousand births per year are products of adultery (three times the number produced through DI), and yet nobody claims that this should be revealed to the children!

In our Latin society, fatherhood is more an affective rather than a biological role. Under French law, the father of a child is the husband of his mother. It is necessary to go to court if the husband wants to disavow the child. In the law prepared for medically assisted procreation, it is mentioned that the donor is not paid and is anonymous. When a couple asks for donor insemination, the husband cannot disavow the DI child after it is born.

We do not agree with Daniels and Taylor when they write that the child (future adult) has largely been ignored in DI. In the CECOS system we respect the rights of children to be born with one mother and one father, but only one! Perhaps truth is not the same in every society?

Doctors and Donors: A Comment on Secrecy and Openness in Donor Insemination

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This article on donor insemination covers a wide range of issues in considering how and why the practice has been shrouded in secrecy from the very beginning. Indeed, the first recorded instance of donor insemination occurred in Philadelphia over one hundred years ago, when a medical school professor inseminated a patient with a student’s sperm, and never told the patient or her husband what he had done. It is only because another medical student was aware of what happened and wrote about it later that we know about this occurrence, suggesting that it might well have been a more widespread and long-standing practice that simply had not been revealed publicly.

Physicians who practice donor insemination have continued to urge secrecy upon couples, in some cases recommending that the woman never tell her husband he is infertile (Snowden et al., 1983). As Daniels and Taylor point out, this insistence on secrecy by physicians stands in total contrast to the recommendations of just about every psychologist, social scientist, or ethicist who has written about the topic (e.g., Annas, 1979; Snowden et al., 1983; Rowland, 1985; Baran and Pannor, 1989). Daniels and Taylor suggest that the source of the doctors’ position is in part their concern with the profitability of their practices, which they assume would be threatened by a requirement of openness, making it harder to recruit donors. Evidence from the Swedish experience and from studies of donors such as those carried out by Daniels that many donors would prefer, or at least not mind, being known to their offspring, has apparently not convinced most physicians to change their minds on this issue.

Daniels and Taylor’s analysis raises several questions that deserve further investigation. First, what other reasons contribute to this sharp division between most physicians and others who have studied donor insemination? It is certainly not irrelevant that most donors in the past, at least in the United States—where resistance to openness appears to be particularly strong—have themselves been medical students or residents. Many physicians practicing today relied upon sperm donation to help pay their medical school expenses. Thus, when Daniels and Taylor point out that secrecy protects the donors as well as the physicians, it is important to note

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that these categories are not totally separate. It is certainly possible that physicians' insistence on total donor anonymity is due in part to a desire to protect their own and their colleagues' and students' interests. When they say that a donor would not participate if he thought his life and possibly his financial interests would be disrupted by the appearance of a genetic child, this may well be more than an impersonal or business concern.

Most physicians being male, it is also likely that they identify with the embarrassment of the infertile father and base their recommendations on their own feeling that they would not want to be revealed as sterile. One fertility specialist I interviewed for a study of the technologies for conception (Lasker and Borg, 1987), carefully explained how he tells men that there's nothing wrong with being infertile—that it is no reflection on their manhood; yet a few minutes later he boasted about his having been in great demand for donation as a medical student, saying that he "must have been a real stud." It would be interesting to see if the increasing number of female practitioners approach this question any differently.

Secondly, it would be important to investigate whether physicians have changed their opinions in the recent past as a result of new evidence and, perhaps more importantly, as a result of the major shift in DI practice to using frozen rather than fresh sperm. Although many practitioners continue to recruit donors of fresh semen, a few years ago the American Fertility Society strongly recommended that only frozen samples be used so that the donors can be tested both at the time of donation and again six months later for HIV infection before the semen is used. With the transition to greater reliance on sperm banks, the admittedly difficult job of recruitment is less of a concern for practitioners. How has this affected their attitudes?

One other important point about physicians' attitudes is that we actually have very little data about what most practitioners believe about secrecy. We have generally had to rely on the writings of physicians, some of them from many years ago, and on reports from surveyed patients about what their doctors told them (Lasker and Borg, 1987). Thus, a new study of physicians, particularly one that compares several countries, would be highly desirable. Perhaps the endorsement of secrecy is not nearly as uniform as observers now assume.

Another question raised by this paper concerns the differences in attitude and policy among different countries. Why do Australia and New Zealand appear to have a more progressive approach? Is the difference one of culture, medical practice, or attitudes toward fertility and infertility? It is of interest that most of the studies of donors have been carried out by researchers there; of course, where secrecy is most highly valued, it is also most difficult to study donors. It would be useful to replicate such research in a variety of cultural settings.

Daniels and Taylor survey the wide variety of adverse effects secrecy is presumed to cause; once again, as they acknowledge, data on such effects are sparse even if the assumptions appear to be quite sound. Indeed, one of the effects of secrecy is the difficulty of carrying out research with children of donor insemination. Those who are aware of their origins tend to be either in unusually open families or in the opposite situation described in this paper, where the information is revealed in a hostile or damaging way. Thus, we know practically nothing about the "typical" child of donor insemination.

I would like to note one other negative consequence of secrecy, and this is the anxiety of parents about possible mistakes or fraud in the selection of a donor. Justification for such a fear was confirmed by the recent publicity surrounding an American physician who was convicted of having himself been the donor in many cases of DI, even though he had assured his patients that the donor was an anonymous man. In the recent movie Made in America, the character played by black actress Whoopi Goldberg is horrified to learn that her daughter's newly-found donor father is white. Several of the women I interviewed about their experience with donor insemination expressed anxiety over this type of issue, especially while they were still pregnant. Some were worried about racial mix-ups; others didn't really believe that the donor was matched to their husband's characteristics as they had been promised. One woman said that she and her husband had often joked that all the donors were really one man who would go behind a screen and put on a different wig depending on the request. Unfortunately, secrecy reinforces practitioners' control over donor choice, lending itself to abuse as well as to patient uncertainty. Once again, it would be useful to know how the increased role of sperm banks, which recruit from a wider range of potential donors and are subject to more external control, will dispel or enhance such anxieties.

Daniels and Taylor have carefully reviewed many of the important issues surrounding DI (Daniels's prior work has also been valuable in illuminating some of these issues). Their article makes it clear that this topic requires more research; hopefully the results of such research will help prospective parents as well as policymakers and practitioners make wiser decisions that will be in the best interest of the families and the children.

References


DI’s Dirty Little Secret

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Recently on the campus where I teach a local infertility clinic distributed flyers soliciting donors for its DI program. If Daniels and Taylor wanted evidence from the U.S. for their indictment of current DI practice, they would need look no further. On one side of the flyer were the unmistakable and ubiquitous signs of the market—a company logo and slogan. On the reverse side were the details important to safeguarding the interests of infertile couples and of donors—extensive screening on the one hand, substantial financial rewards on the other. Thus, even the most cursory examination of donor insemination practice in the U.S. suggests that Daniels and Taylor’s worry—that DI practice is too frequently driven by concern for the interests of the contracting adults and too seldom by concern for the persons that result from DI—is well justified.

So, too, is there concern about secrecy appropriately directed to the U.S. In 1987 the Congressional Office of Technology Assessment (OTA) conducted a survey of donor insemination practice in the U.S. OTA estimated that approximately 30,000 DI children are born yearly in the United States and that only half of the physicians doing DI keep records detailed enough to allow them to identify particular donors for particular pregnancies (Office of Technology Assessment, 1988). Moreover, of the physicians surveyed, a majority indicated that they would not release recorded information to anyone, even if all identifying information were removed. Combine this with the fact that only a few states require that records be kept, but that 32 states have statutes that define the consenting husband as the legal father of a DI child, and it is clear that in the U.S. both physicians and state legislatures encourage and facilitate secrecy.

So if Daniels and Taylor are right that secrecy is maintained to protect the couple and the donor, and that it does not in fact serve the interests of donor offspring, then their paper is a serious indictment of donor insemination practice in the U.S. Are they right? I think they are correct, but it is important to see how they make their case, because to change DI practice will require some very convincing arguments. I suggest below that although Daniels and Taylor are right to advocate greater openness in DI, they do not make the case for openness as persuasively as they could.

They begin their brief for openness by distinguishing four degrees or levels of openness that could be urged for donor insemination. The fact of DI might be shared with: (1) the child, (2) family and friends, or (3) society generally. In addition, (4) the identity of the donor could be made known to the child. Although Daniels and Taylor believe that there are good arguments for openness on all four levels, the core of their argument for ending secrecy concerns the DI offspring. It is here, however, that their argument needs to be strengthened. Their basic claim at this juncture is that failing to tell the child of his or her DI origin is a fundamental violation of the child’s rights. They write: “One of the major reasons for advocating more openness in donor insemination is the recognition that secrecy deprives the child of the right to know of the nature of her/his conception and thus is not in her/his best interests.”

My basic objection is that Daniels and Taylor do not defend the claim that the child has such a right and, indeed, that their use of “rights” language is much too loose. Do they mean that a child has a moral right to know or a legal right to know, or both? It is unlikely that they mean that the child has a legal right to know, because much of the evidence they present suggests that very few governments recognize such a legal right; certainly it is not recognized in the U.S. But they do not make the case that the child should have a moral right to

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