Moving towards Openness in Donor Insemination: Variations on a Theme

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One of the central points of our article, "Secrecy and Openness in Donor Insemination," is that there are a number of different parties involved in donor insemination (DI), each having their own interests and concerns. That these interests and concerns do not coincide—in fact in many situations are in direct opposition—is to be expected. Like the field of study itself, the commentators' responses represent a range of interests and concerns, and this serves to highlight both the breadth and variety of perspectives that are associated with this topic. This is to be welcomed, as is the initiative of the editor in providing this forum for debate. The context of that debate is a journal that has a primary focus on issues of public/social policy. Many of the issues traversed in the article and the commentaries emerge from service delivery matters, ideological perspectives, morality, professionalism (and particularly professional authority and power), social attitudes, and research. Relating these to public policy is both daunting and exciting. I have tried to focus on the common themes in writing a response.

Discussion of how the family is viewed is the first of these themes. Achilles quite rightly points out that secrecy and openness in DI is about what constitutes a family, and what constitutes a "normal" family. Haimes's reference to anthropological and historical studies, showing that the family derives its authority and status partly from an appeal to the natural basis of a biological relationship, is an important point. That fact that DI poses a threat to this will mean that resistance will be encountered as new forms of family-making occur. That resistance is also likely to be encountered if there is a continuing emphasis on the family as being nuclear and heterosexual. Raboy and Haimes both argue that consideration needs to be given to families that consist of a single woman and children, and families where the partners are lesbian. Raboy is correct when she argues that if there is no husband to protect, one important plank of the secrecy argument disappears. She is also correct when she says that fundamental prejudices and exclusionary policies of sperm banks and medical communities have meant that single women and lesbians have not been able to obtain access to many clinics.

This is a point we discuss in a forthcoming paper (Daniels and Taylor, 1993) that focuses on selection and assessment policies in assisted reproduction. While the New Zealand information presented in the article shows that a progressive attitude towards openness is in evidence in this country, a conservative stance tends to be adopted in relation to single women and lesbians gaining access to DI programs. Lansac, in discussing the French experience, says embryos cannot be conceived outside the family context, and that this context is defined as a married heterosexual couple. It would seem that a continuum operates with France at one end, the United States at the other end, and New Zealand and other countries at different points in between.

Such a discussion naturally leads into my second theme, that of social attitudes. Bielawska-Batorowicz describes the prevailing social and religious attitudes in Poland, which are in sharp contrast to attitudes in New Zealand. Lasker also raises questions about the importance of culture in the different approaches to this issue. Smart (1987) has commented on how DI was seen as a threat to marriage and society up until the late 1960s, but by the 1970s the view had changed to one in which DI was seen as a way of enhancing family life for the childless. Childlessness was in fact the very antithesis of the nuclear family ideal. Bielawska-Batorowicz highlights the perception of deviancy that accompanies the diagnosis of infertility in her country, a point with which I agree (Daniels, 1993c).

Deviancy is essentially a social construct that has many negative ramifications. McWhinnie's and
Burfoot’s points about male infertility reinforce this. They agree with Achilles when they point out that because the dominant social meaning attributable to the arrangement is sexual, that this accounts for the lack of recognition of the donor. The observation by Knoppers that “secrecy is socially driven” makes clear the need for a sociological contribution from commentators such as Haines and Burfoot.

Another aspect of the social attitudes is seen in relation to the public discussion of the issues. Achilles comments on how little parliamentary or public debate there has been on the practice of DI in North America, and McWhinnie argues that the debate on the rights of children should take place in the public arena. Rowe, Rowland reflects another aspect of the social context when she comments that DI has been institutionalized to serve the desires of adults, with children being infantilized. When institutionalization occurs, it conveys social approval, and the state, on behalf of society, must take some responsibility for the outcomes in terms of social relationships.

The final point to be highlighted in this context is that made by Triseliotis—namely, that the difference between adoptees who do and don’t seek contact is not only a reflection of individual motivation, but also the social climate of the period, i.e. whether openness or secrecy is encouraged. The historical shift that has occurred over adoption reunions has led Triseliotis to observe that the current attitude is making some adoptees feel unusual when they don’t wish to seek a reunion. This dramatic change in social attitudes is likely to occur in relation to DI as well. Lansac would disagree, at least as far as France is concerned. He argues that all parents have secrets from children, and cites adultery as an example. His example is weak, in that adultery does not involve a third party—the doctor—nor is adultery sanctioned by society in the way that DI is. It also seems to me that the adults who conceive a child as a result of adultery have very different motives from those who conceive via a DI program.

A third theme relates to the professional dominance that operates in this area. The professionals involved are, in the main, doctors. Raboy reports that, at the time her non-profit community-based sperm bank began in 1982, some of the clients asked for a way to be developed so that donors could be identified by their offspring. She adds that this idea was unheard of, and was not offered by any sperm bank or physician in the United States. Shapiro, Saphire, and Stone (1990) conducted a survey of DI practices in the United States, and contrasted their findings with a similar study carried out in 1978. They found that only 35% of the physicians maintained records on the offspring, and 40% on the donor. They also state that these findings do not differ significantly from the results obtained ten years earlier. Lauritzen, citing the Office of Technology Assessment’s study of physicians, presents a similar picture. What this highlights is that many physicians in the United States have adopted a policy that will make it impossible for many children conceived as a result of DI to obtain full information about their biological and social heritage. This adds weight to Raboy’s contention that the medical profession and other institutionalized arrangements in society promote secrecy. She contends that doctors’ and sperm banks’ interests have been well served by secrecy, and argues that there is a need for greater accountability. Openness would assist in providing accountability.

Turner argues very strongly that doctors play a key role in this area, and she helpfully points out another reason why they may be reluctant to open up DI—namely, that some of them have been donors. Similarly, Lasker makes a helpful point when she notes that our portrayal of secrecy protecting donors and physicians does not acknowledge that these categories are not totally separate. Snowden also refers to the power of the medical profession and its unwillingness to accept the active involvement of policymakers from outside the profession. I am pleased to report a very different picture from New Zealand, where all major clinics (and probably many minor ones) keep full records. All donors recruited to four clinics—totaling approximately 60 donors—have agreed to be identifiable. This means that if offspring wish to contact them in the future, they will be happy for this to happen. Such a position represents a dramatic change from the system that was in operation ten years previously. The main reason for the change is that doctors changed their views, partly because of openness arguments that were presented to them, but also because they had moved from deciding what was best for patients to asking and listening to what the main “stakeholders,” as Raboy calls them, wanted.

The power of the medical profession is reflected in two main areas, according to Triseliotis. The first of these is in relation to obtaining access so that research can be carried out—something I have experienced (Daniels, 1986). His second point is the dynamics of the patient/doctor relationship and how feelings of gratefulness and dependency are likely to lead to doctors’ advice being accepted/followed.

A fourth theme that warrants comment is that relating to the studies, or lack of studies, concerning openness and DI, and the relationship of this to comparisons between adoption and DI. The lack of follow-up research on DI, particularly on the psychosocial aspects, is lamented by Raboy and Achilles. This is beginning to change, as evidenced by McWhinnie’s contribution. My work (Daniels, 1993a, 1993b) is also beginning to provide some data that gives consumer perspectives on issues such as secrecy and openness. Work by other researchers is also known to be in progress, and in response to Lasker’s call for more research in this area, it is good to note that work is now underway on bringing
together a small group of investigators to consider research topics and difficulties in this area. Triseliotis makes a strong claim that we do not need to wait for empirical evidence from DI—that the evidence from adoption is unanimous in its support for openness. Triseliotis also provides an extremely helpful summary of the evidence from his studies in relation to the factors that were found to be important to adoptees. Turner’s point that DI offspring do not want to locate their donor for a relationship—as he can never be a parent to them—is helpful. Haines doesn’t go as far as Triseliotis, suggesting rather that adoption provides “clues” for those involved in DI.

Lansac states that the vast majority of parents in France believe that it is not in the child’s interest to know his or her biological origin. He then goes on to state that the main thing for a child to know is that he or she was desired and is loved by his or her parents. Lansac implies that the above views are opposite and cannot be contained within one family. His belief is in sharp contrast to the evidence that Triseliotis presents from the adoption field. At the other end of the continuum, we have Knoppers arguing that the analogy between adoption and DI is a mistaken one. Her arguments are important and need to be taken seriously. I must say I would enjoy listening to a debate between Knoppers and Triseliotis! Cooke also, rather disparagingly, refers to the progressively less relevant attitudes to adoption produced in a previous generation. Haines’s more moderate position may have much to offer in that it acknowledges the similarities and differences that exist. It should be noted, though, that the case we made for openness in DI did not rest solely on the evidence from adoption that could be transferred and utilized.

The policy dimensions of secrecy and openness is the final theme on which I wish to focus. Bonnicksen (1992) says that the study of biomedical policy poses special challenges to students of public choice, and that biomedical issues are often laden with moral overtones that defy easy resolution. This is a point well-made by Haines when she comments on her study of decision-making within the Warnock Committee. She points out that the reason anonymity was favored by the committee was that this enabled the suspension of questions considered so fundamental as to be almost unanswerable. Holmes, in her commentary, also takes up the “can of worms” argument, suggesting that if resolution cannot be obtained, then DI should be stopped.

That this issue confronts people with major problems is not in doubt. The article was designed to remind us that the struggle needs to continue, a point alluded to by Rowland—albeit out of frustration. The article asks if DI is a private matter or a public concern. This is the fundamental question. Discussion of “birth records,” “public scrutiny,” “regulation,” “laws,” “society’s role as advocate for the child,” all place the topic in the public arena. There are no advocates for “private concern,” although Lansac comes close to taking this position. Even his position, however, is based on an organizational model that has an outside body auditing organizational performance. This body includes representatives from the fields of reproductive science and ethics, thus suggesting a public perspective. Having accepted that point, the debate then turns to the type and degree of public involvement.

To return again to Bonnicksen, she highlights how biomedical policy is an offshoot of the more established field of biomedical ethics, a field that generally assumes decision-making should take place in the medical sector, at the bedside, and on the basis of rationally derived principles. Biomedical policy, on the other hand, sets the focus for decision-making in the public sector. The end product of this model is action by public officials, and the model is process-oriented. In her helpful article, Bonnicksen proposes a third model that she describes as a “private policy model.” Within this model, regularized rules and procedures in the medical setting are the desired end of biomedical decision-making. She takes this position because she believes that public action is unlikely, premature, and unwise in many areas of biomedicine. While Bonnicksen is writing about human embryos and genetic testing, her arguments are relevant to examination of this issue also. This would seem to be a position that would find acceptance with Burfoot and Knoppers. Burfoot’s point—that she is against legislation of DI but in favor of openness of the procedure as it is defined by each group—illustrates this. The question is, what will achieve the goal of openness, which almost all commentators and the authors of the article desire.

Sweden adopted a legislative approach not followed by any other country. Early difficulties were reported, but Knoppers and Cooke do not do justice to the arguments made, namely that opposition to the legislation came almost entirely from one source—the medical providers. Collaborative work with Swedish colleagues is in progress regarding this issue, as are studies of semen donors in four different programs in Sweden. Early evidence from this work suggests that the donors have no difficulties with being identifiable. It needs to be noted that to argue the rights and wrongs of openness on the basis of the availability of donors is, as Triseliotis points out, irrelevant.

New Zealand, on the other hand, has tended to adopt what I would describe as an educational approach. As service providers have become more knowledgeable about secrecy and openness, there has been a significant shift in the different clinics’ policies. However, given that there is no overall policy body, individual clinics are free to pursue their own approaches. It should be noted that there was legislative change (Status of Children Amendment Act, 1987) that clarified the rights and responsibilities of parents and gamete donors, and against this
backdrop a more open approach was possible. Knoppers argues for a more "gradualist" middle road position, and I suspect that this is the one that is likely to gain a wide degree of support from service providers, politicians, and perhaps many consumers. Her position seems akin to that of Bonnicksen's private policy model. Cooke also argues a similar position, using as evidence the UK position with the Human Fertilisation and Embryology Authority. He argues for adaptation and encouragement, rather than a "doctrinaire" approach. It is, however, a "middle road" position, and most of the commentators seem to me to be advocating a policy of openness is desirable and necessary if the interests and rights of children are to be acknowledged and acted upon. Lauritzen reminds us that if the "rights of children" argument is to be pursued, it must be presented as powerfully as possible. Change has been and is occurring, although, as Snowden points out, this may be more descriptive than real. The debate reflected in this forum of ideas will almost certainly contribute to further change. Change will also occur as the result of the development of offspring and parent organizations cited by Achilles and Cooke. New Zealand is witnessing a similar development. We need to be wary, however, as Haines usefully points out, that openness and truth are not presented as unproblematically "good" and secrecy as unproblematically "bad." Our article has explored the reasons for secrecy and openness, and come out firmly on the side of openness. This is not to say that there are no problems. One such potential problem concerns opinion differences between male and female partners over the decision whether to tell or not tell the child about the DI conception (Daniels, Lewis, and Gillett, 1993). Another important need concerns the lack of "scripts" for how to tell the child.

One of the excitement of working in this field is that individuals from many different disciplines have a contribution to make. No one discipline can claim it as its own. The different perspectives presented in the commentaries are a welcome addition to my desire to adopt a holistic approach to the topic. Turner's contribution is particularly helpful, in that it reminds us that while we may focus on the "academic" consideration of this topic, at the very center of the issue are people such as her.

References