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Secrecy and Openness in Donor Insemination

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Abstract. This article explores the issues surrounding the notions of secrecy and openness in donor insemination (DI). Secrecy in DI is first placed in historical context, with an outline of some of the main reasons that secrecy has been advocated. The concept of openness is then introduced, and some of the arguments for a more open approach to DI are presented. On this basis, the responses of various governments to calls for more openness are outlined, and the social policy implications of these are discussed. It is concluded that more openness in DI would be advantageous to all of those involved. Couples, professionals, and policymakers are therefore urged to reexamine their views about the need for maintaining secrecy in the area.

It has been assumed that individuals conceived through donor insemination should never be told of the true nature of their conception. At the same time, insemination donors were assured of their privacy and told that their identity would never be revealed. This practice of intentional deception has placed a strain on the parents. The burden of maintaining such a "family secret" has created many dysfunctional families and not infrequently led to divorce.

—Arthur Sorosky

DONOR INSEMINATION (DI) is one of the oldest of the assisted reproductive techniques, and thousands of families worldwide have been created with its help. However, despite DI's long establishment as a means of responding to infertility, its use is still shrouded with secrecy. The persistence of the view that secrecy is "necessary" in DI has become a key issue for those involved in the process, and raises a number of difficult ethical and psychological dilemmas for couples and professionals alike. It also raises significant policy issues for governments.

The secrecy surrounding DI is perhaps one of the major reasons why it is viewed by the public as a questionable method of responding to infertility. This in turn has probably contributed to donors wanting their identity to be kept hidden, and even to an unwillingness on the part of doctors to be seen to be involved in the practice of DI.

Adoption research, and research into the effects of DI itself, have suggested that an open approach is more beneficial to all those involved. These findings, and the discussion they have generated, have encouraged governments in several countries—most notably Australia, the United Kingdom, and Sweden—to develop legislation/guidelines which are conducive to more.
openness and honesty. In the United States, however, the openness/secrecy debate is still in its beginning stages, with many people still unaware of the possible ramifications of secrecy, both for the practice of DI and for those involved with it.

To date, the issue of secrecy/openness in DI has been a matter of concern primarily to social scientists and mental health professionals. However, as this article will make clear, it is the attitudes of the professionals involved, doctors in particular, which will have the most impact on how couples and donors view DI—whether they will feel comfortable being more open about it, with friends and family, with their children, and with society in general.

This article explores the issues surrounding the notion of secrecy in DI, seeking to explain some of the main reasons why secrecy has been advocated. It goes on to examine the possible consequences of secrecy and presents some arguments for openness. Finally, legislative efforts in various countries which encourage a more open approach to DI are outlined, and the social policy implications of these are discussed.

Secrecy in Donor Insemination

The word secrecy has emotional and value connotations, the implication being that something shameful is being hidden from view. Perhaps the continuing desire for secrecy concerning donor insemination is not hard to understand when one considers that only 43 years ago an enquiry in the United Kingdom headed by Archbishop Fisher recommended that the practice should be considered a criminal offense (Report of a Commission Appointed by His Grace the Archbishop of Canterbury, 1948). Little had changed by 1960 when a UK interdepartmental committee, chaired by Lord Feversham, decided that donor insemination is "undesirable" and should not be practiced (Feversham Committee, 1960). Donation itself was also viewed with deep suspicion, with the personal motivation of donors being called into question. The committee decided that donation "is an activity which might be expected to attract more than the usual proportion of psychopaths" (quoted in Haines, 1988:58).

Blizzard (1977) noted that the responses to the public debate conducted in Britain, while the Feversham Committee was gathering evidence, were similarly negative—ranging from disapproval to abhorrence. There were virtually no expressions of support, except from the practitioners of DI themselves.

Not surprisingly, considering such negative judgments, people have viewed it as important to keep their involvement in DI a secret, and systems have developed to make this possible. In 1948, for example, an American doctor, William Cary, recommended that "patients were to be accorded complete privacy and were to cooperate with plans to assure no possible meeting or identification between donor and patient." He went on to add that this was accomplished by having the couple "contact the office from a near-by telephone for instructions ten minutes before their appointment" (Cary, 1948:728), an arrangement which may have caused them to feel as if they were involved in some kind of illicit liaison. Behrman reported that it was "routine procedure" to advise the couple "for their own protection that discussion of donor insemination should be limited to their doctor and themselves, or at most to include their religious counselor" (1959:250).

Although there are increasing calls for more openness in this field (Mitchell, 1982; Snowden, Mitchell, and Snowden, 1983; McWhinnie, 1984; Asche, 1985; Rowland, 1985; Daniels, 1988a), and more doctors are changing their practices in this direction, especially in Australia and New Zealand (Singer and Wells, 1984; Purdie et al., 1992), secrecy is still the guiding principle for many of those involved in DI today. Many doctors still advise couples not to mention their child's donor origins to anyone, even to the child her/himself (Andrews, 1984). The few studies which look at DI families show that most parents, or parents-to-be, of DI children have no intention of telling their child about the nature of her/his conception (Snowden and Snowden, 1984; Rowland, 1985; Daniels, 1988a).2 Donors are matched as closely as possible with the husband (so the child does not appear too different from the father); the husband is automatically the legal father of the child; and birth certificates carry no distinguishing mark.

In certain hospitals and clinics the notations identifying the donor are destroyed when the pregnancy has commenced (Asche, 1985). In fact, many DI practitioners have maintained no records of the use of, or conceptions by, donor semen. Neither the child nor the parents have any chance whatsoever of finding out the identity of the sperm donor. The donor in his turn has no way to find out the child's identity. The protection and privacy for the adults involved in DI is complete. It is imperative that questions are asked about whose interests are actually served by this practice of secrecy.

Many donor insemination practitioners have maintained no records of the use of, or conceptions by, donor semen; so neither the child nor the parents have any chance whatsoever of finding out the identity of the sperm donor.
Secrecy to Protect the Child

The reason most often given by those involved for keeping DI secret is the desire to protect the child. Snowden and Mitchell (1981) report what appears to be a genuine fear among DI practitioners that to reveal the truth to a donor child would create insurmountable social and psychological problems both for the child and for the family. DI parents, or parents-to-be, seem to agree with practitioners; many consider that telling their child will lead to psychological and emotional trauma (Manuel, Chevret, and Czyba, 1979; Snowden, Mitchell, and Snowden, 1983). Parents are also afraid to tell other family members in case they disapprove of DI and therefore reject the child (Rowland, 1985). There is also the fear that if the child's origins became common knowledge, the child would be stigmatized both by adults and by other children.

Another reason given for not telling the child is that if s/he is told, s/he may seek information about the donor. Because obtaining such information will not be possible in cases in which donor records have been destroyed, some DI offspring would have to endure the frustration of not knowing about half of their genetic heritage (Singer and Wells, 1984; Humphrey and Humphrey, 1986; Rowland, 1985; Lasker and Borg, 1989). Secrecy, when it is practiced for this reason, is being advocated as necessary to protect the child from the consequences of earlier secrecy.

However, although it is the children that secrecy is supposed to protect, it may be the adult parties (the couple, the donor, and even the medical professionals) who become most vulnerable if their involvement in donor insemination is made public. It is often their position (either personal or professional) which is threatened by the move towards more openness in DI.

Secrecy to Protect the Couple

It has been suggested by a number of researchers (Mitchell, 1982; Snowden, Mitchell, and Snowden, 1983; Snowden, 1984; Lasker and Borg, 1989) that it is the couple, especially the infertile husband, whom secrecy is designed to protect. Interestingly, a study by Snowden, Mitchell, and Snowden (1983) reveals that while verbal expressions of concern by parents were most often directed towards their children, the overall impression was that secrecy was maintained because of the benefits it would bring to the parents, particularly the father.

Infertility has traditionally been viewed as a condition to be ashamed of, and it seems reasonable to suggest that the stigma of infertility may be one of the major factors contributing to the perceived need for secrecy in donor insemination. However, as has been noted by Lasker and Borg (1989), the shame of infertility does not seem to encourage the same degree of secrecy in any of the other assisted reproduction techniques (e.g., in vitro fertilization, egg and embryo transfers, or even surrogacy). They suggest that this is because DI is used exclusively for male infertility, which is considered by couples and society as a whole as much more shameful than female infertility (Fopp, 1982; Rowland, 1985; Miall, 1986). This added stigma is due mainly to the fact that fertility in men has long been equated with sexuality and virility. To father a child is to prove oneself a "man."

Mitchell believes that it is "the wife's desire to protect her husband that lies at the root of the secrecy" (Mitchell, 1982:70). Fletcher (1954), discussing DI in the 1950s, noted that in many cases wives would ask the doctor not to tell their husbands that the insemination had taken place. In fact, some doctors actually advocated, if possible, that the husband be left unaware of his infertility, and of the fact a donor had been used (Snowden, Mitchell, and Snowden, 1983).

In a study of those undergoing, or considering undergoing, various infertility treatments, Lasker and Borg (1989) found that men are more likely than women to want to keep DI a secret, and women are more likely to cover up their husband's infertility by taking the "blame" for reproductive problems. They note that these findings give added support to the hypothesis that DI secrecy has to do mainly with the protection of the infertile husband.

Couples are also concerned that the child may respond negatively to being told s/he has been conceived by donor insemination and may reject her/his social father. Thus, one man in Lasker and Borg's study said, "I couldn't tell him. You know, I will have raised him all his life and I just wouldn't have the heart to tell him. I'm afraid he'd be ashamed of me. It might break my heart as well as his" (1989:139).

For many couples, a large part of their desire to protect themselves and their children from others knowing of their involvement in DI is that they are unsure of the attitudes of the general public towards DI. Rowland (1983) has suggested that the social taboos operating at the time that DI began were an important factor contributing to the secrecy which has surrounded it since. Fletcher, writing in 1954, pointed out that people's desire for secrecy concerning DI is natural "in the present cultural climate, with its tendency to surround marriage and parenthood with secrecy, and with its shame about non-biological parenthood" (1954:124).

But although attitudes have changed, and our "cultural climate" is considerably more tolerant than formerly, there seems to be a perception among those involved that attitudes concerning donor insemination are lagging behind. That many couples today still express a desire to protect their offspring from being known as donor children (Rowland, 1985; Snowden and Snowden, 1984; Daniels, 1988a) indicates that the couples themselves feel there is something "not quite right" about using DI.
Secrecy

Snowden, Mitchell, and Snowden (1983), in their study of DI couples, found that the most common reason for secrecy given by their respondents was fear of stigmatization. One man told them, “I would find it very difficult to tell people, because it isn’t so much the way I feel, I think it’s the way other people would react. You can’t rely on other people to be as thoughtful and understanding” (p. 106). Many couples fear that if their use of DI were known, their standing in the eyes of other people would be diminished, and they would be discredited in some way.

Finally, a major reason why couples do not tell their children about the nature of their conception is because they have no “scripts” to do so (Rowland, unpublished manuscript; Brandon, 1979). Most parents simply do not have any idea how to explain DI to their children. They find the traditional explanations they must give following the question “Where did I come from?” difficult enough, so it is not surprising that parents of donor children find the notion of telling their child about her/his origins somewhat daunting.

**Secrecy to Protect the Donor**

The other adult party that secrecy may serve to protect is the donor (Annas, 1980; Rowland, 1983, 1984; Beck, 1984; Schoysman, 1975; Joyce, 1984). Donors’ concerns for secrecy primarily revolve around two main issues. Firstly, donors fear that they could be considered legally liable for their DI offspring and that these children may be able to claim inheritance rights. Secondly, some donors are said to be concerned about possible disruption to their “normal” families should a number of their DI offspring have direct access to them (Beck, 1984; Rowland, 1985). Beck (1984) argues for keeping all DI secret, since there is a need to protect the donor from unwanted contact in the future. The results of a study by Rowland (1983) suggest that donors who had not told their wives or partners of their donations were also concerned about keeping their donation secret, as they were worried about possible repercussions within their marriage if they were found out.

**Secrecy to Protect the Medical Professionals**

It has also been suggested that the secrecy surrounding DI acts to protect the medical professionals involved (Annas, 1980). The main concern among DI practitioners is that if the donor’s anonymity were not protected, and records were accessible to the offspring, then men would no longer be willing to donate semen (Singer and Wells, 1984; McWhinnie, 1988). If there were no semen, of course, there could be no donor insemination. Rubin (1983), herself conceived by DI, points out that since sperm banks can be tremendously profitable businesses (at least in the United States), it is sometimes very difficult for those involved to “pay heed to the moral and ethical issues” (p. 212), and to consider the price of the deception necessary to keep donor children in ignorance of their true origins.

Practitioners are also unsure of the public’s reaction to DI. A number of doctors in New Zealand who provide DI have indicated to the authors that they do not advertise this fact because they fear adverse reactions from the public. As “service providers” to the public, doctors are constantly aware of the need to present a “respectable” image. For many doctors, and indeed for many laypeople, DI does not fit easily with this ideal of “respectability.” Thus, DI must be kept as a “private” and unspoken aspect of a doctor’s service.

**Secrecy to Protect the Ideal of “Family”**

Kirk (1981) argues that adoptive children’s attempts to trace their birth parents are seen to challenge the “domestic sovereignty” of the adoptive family. The same could be said of the DI child who insists on finding out more about her/his biological father. Haderka (1987), arguing in favor of the very secretive DI practices in Czechoslovakia, asserts that to allow the child the right to know about her/his genetic origins would be “an unthinkable intrusion into the privacy of family life” (quoted in Haimes, 1988:57).

The desire to protect the ideal of “family” also operates on a more personal level. Parents of DI children do not want their family to be different from everybody else’s families (National Bioethics Consultative Committee, 1988). Like most people, they fear being labeled as deviant, and subsequently being ostracized by others. They convince themselves that if no one knows how their child was conceived, then everyone will assume that the conception was a natural one.

Because DI is such a simple technique, and because the wife carries the child and gives birth in the usual way, donor insemination lends itself to secrecy in a way that adoption and assisted fertility techniques such as in vitro fertilization (IVF) cannot. This helps support the pretense that the conception, and therefore the family, is “normal.”

Parents of donor insemination children do not want their family to be different from everybody else’s families because, like most people, they fear being labeled as deviant, and subsequently being ostracized by others.
Openness in Donor Insemination

There is a growing body of opinion, amongst psychologists, psychiatrists, counselors, and social workers, which advocates a greater openness in relation to DI. It is a generally accepted norm in social relations that openness and truthfulness are to be preferred. Mitchell (1984) argues that secrecy in donor insemination undermines some of the foundations of our society: acknowledged and perceived roles, and trust. Family relationships and the roles assumed in kinship groups and in the community are open, known, and based on trust, and so too are professional practices. If an exception is to be made for the practice of DI, then the arguments against openness and truth-telling must be carefully examined to determine if such an exception is specifically justified.

Joyce (1984) suggests that there are four degrees of openness to be considered: (1) the fact of DI may be shared with chosen members of the family or close friends, (2) the fact of DI may be shared with the child, (3) the fact of DI may be shared with society in general, and (4) the identity of the donor may be made known to the DI child and, perhaps, to the family. Most of the experts advocating openness in DI are primarily concerned with the rights and needs of the child, and thus are most vociferously arguing for the child's right to knowledge of her/his DI origin (No. 2) and genetic background (No. 4). However, there are also some compelling arguments for couples sharing their DI experience with family and friends (No. 1) and with society in general (No. 3).

The arguments concerning these varying degrees of openness with respect to DI will be explored in the next section. Before outlining these arguments, however, it should be pointed out that findings from adoption studies will frequently be used to provide empirical support for these contentions since to date there is very little research concerning the experiences of DI children themselves (Andrews, 1984). Obviously, there are some aspects of donor conceptions that are different from the adoption situation. Whereas adoption involves preexisting individuals, DI is directed towards creating a child in order to create a family (Haines, 1988). Also, the child is the biological offspring (unless both gametes have been donated) of the wife, and the experience of pregnancy and birth has been shared by both partners, thus becoming part of their relationship with the child. Finally, there is an unevenness in the genetic relationship of the two parents with the child, one partner being the "natural" parent, the other being unrelated genetically.

Despite these differences, and despite the fact that the adoption experience is seen as irrelevant to DI by some practitioners (e.g., Joyce, 1984), it is the authors' view that what has happened in the field of adoption does have implications for DI. In both practices, several parties with conflicting needs and interests are involved. Those dealing with adoption in the past attempted to resolve such conflicts by denying the rights and needs of one of the parties—the child—in order to protect the rights and needs of the other parties—the relinquishing mother and, most importantly, the adoptive parents. It is obvious that this is what is occurring in donor insemination today: the child's needs and rights are being overlooked in order to protect the couple and the donor. Because of the similarity between the two situations, it is argued that the research relating to the experience of adoptive families can be helpful in trying to understand some of the issues involved in donor insemination.

Openness and the Rights of the Child

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. It is a fundamental tenet of Western family law that the best interests of the child should always be paramount, and this is reflected in the stated concerns of those who study DI (e.g., government committees, medical working parties, religious committees, practitioners, and social scientists). Their most regular recommendation is that before initiating the DI process, the outcome for the child should be the primary consideration (Ashe, 1985). Snowden and Mitchell rightly assert that "if we really believe that it is the child who is our primary concern, then the whole issue of keeping that child in ignorance of his or her true origins and of setting up procedures to ensure that such ignorance is maintained needs to be examined very carefully" (1981:79).

As highlighted by Spiers, it is interesting that we should even have to argue for the right of a child to know her/his origins. The reason for the dilemma is that "in the matter of [DI], the rights of children are in head-on conflict with the presumed rights to secrecy of donors and recipients of sperm" (1988:19-20). Rowland (1984) has argued that when it comes to such a conflict, it is the children who receive the least attention, because they have no voice in the discussions, and because there is a tendency to infantilize them and not see them as people who will become adults.

A child's right to know her/his origins has been upheld by Dame Mary Warnock, who in 1984 chaired the Committee of Inquiry into Human Fertilization and Embryology in England:

The child is being used as a means to the parents' ends, namely to have, or seem to have, a "normal" family; and I do not think that using one person as a means to another's ends can ever be right, unless the person has consented to be so used.... I cannot argue that children who are told their origins, if
they are [DI] children are necessarily happier, or better off in any way that can be estimated. But I do believe that if they are not told, they are being wrongly treated. (Warnock, 1987)

Adoption research indicates that feelings of genealogical insecurity can arise in children who do not know who one or both of their biological parents are. Sants argues that "a genealogically bewildered child is one who either has no knowledge of his natural parents or only uncertain knowledge of them. The ensuing state of confusion and uncertainty fundamentally undermines his security and thus affects his mental health" (1964:133). He also argues that adoptees are lacking those intangible things which most people take for granted, such as having physical, mental, temperamental, or aptitudinal likeness to a parent, a sense of belonging to a family in time and space, a place within the history of a family.

McWhinnie notes that while such children may not show overt concern about such deprivations at every stage of their development, clinical knowledge suggests that at some time, very often in early adolescence, they will begin to search for clues:

Such children will gather, directly or indirectly, every shred of evidence which they feel will put them on the right trail. The preoccupation can amount to an obsession in that genealogically deprived children feel that all their troubles are solved by the solution of this one. (unpublished manuscript:5)

Humphrey and Humphrey (1986) suggest that such feelings are more likely to arise where relationships are unsatisfactory in some way, an assertion corroborated by the findings of Triseliotis (1973). However, while they note that ancestral knowledge does not seem to be a prerequisite of mental health when the quality of family relationships is adequate to meet the child’s emotional needs, they point out that this is not to deny the reality of genetic curiosity in those people who do not know the identity of one or both of their biological parents.

Regardless of whether knowing one’s genetic heritage does or does not cause serious psychological problems, is it fair to deprive a DI child of information that other children assume is theirs by right? Is it fair to deny that child, and future adult, the right to know the truth concerning such a fundamental issue as her/his genetic background? Children grow up and will themselves play the parenting role in time. Most will reflect on their origins, the stock they came from, the genetic traits they will pass on to their children (McWhinnie, 1988). Because of the present policy of anonymity of donated gametes, many people will seek in vain for such information.

Keeping DI children in ignorance of their genetic heritage may also have wider repercussions. Rowland (unpublished manuscript) points out, for example, that if in ten or fifteen years time, society comes to understand that a significant number of its children are DI offspring, then all children will doubt their parentage unless they can check unequivocally.

Openness and Family Relationships

McWhinnie (1984) notes that another major problem with advocating secrecy in donor insemination is that the parents are then “caught in a web of a lifetime of deceit, not only with their child but with a network of relatives who will assume a relationship with the child based on kinship” (p. 19). Snowden, Mitchell, and Snowden found, from a study of families created as a result of donor insemination, that

the withholding of information from the child was seen almost entirely from the parent’s viewpoint. When the child, or indeed other relatives, were considered, it was in a paternalistic way and deception was justified by the claim that its purpose was to protect others from being hurt. Only rarely was it acknowledged that the other family members have a stake in this information which is of direct relevance to them. (1983:119-20)

Family therapy experience (Menning, 1981) and adoption research (Sants, 1964; McWhinnie, 1966; Triseliotis, 1973; Brandon and Warner, 1977) indicate that family relationships are damaged when they are based on deception, and that such deceptions lead to stress and anxiety. According to Sants, a common principle in family therapy states that “a conscious acceptance of the known facts, intolerable though they may appear to be, tends to improve rather than worsen relationships” (1964:140). Research in the area of adoption has revealed that children are, in fact, less upset by unpalatable or strange facts than they are by deception or lies, particularly from parents whom they trust (Sants, 1964; Triseliotis, 1973; McMichael, 1980).

In a family in which editing of information around a certain subject occurs to maintain a secret from some members, considerable tension is generated, tension which children pick up very readily (McWhinnie, 1984;
Lusk, 1988). In interviews with adopted adults, McWhinnie found that children do pick up hidden messages or clues from parental looks, embarrassment, anger, or avoidance of particular areas. She asserts that “we are deluding ourselves if we think that [DI] children will not also pick up such clues from the adults around them” (1984:20). This point is well illustrated by the following words from a DI child:

It was just a general thing—it was as if I’d always known there was something wrong. I’d always known there was something amiss—suddenly being told that, it was as if a huge great weight had been lifted off my shoulders. (quoted in Snowden, Mitchell, and Snowden, 1983:98-99)

What little research there is to date in the area of DI families has shown that keeping donor assistance a secret is very difficult. Mitchell (1982) notes that while young couples may be quite sure they can keep their secret, interviews with those whose DI children had grown up suggests that in a fair proportion of cases the truth comes out. Sometimes it is because a medical history is required and the nature of the genetic relationship needs to be considered, but more often a social situation arises where it is felt desirable to disclose the real situation.

There is a real danger that the child may learn the truth during a family argument, perhaps in adolescence when tensions are high in most families (Brandon, 1979; McMichael, 1980; Singer and Wells, 1984). It has been noted that while many couples do not intend to tell their child of her/his donor origins, they nevertheless tell others—for example, close family members (National Bioethics Consultative Committee, 1988; Rowland, unpublished manuscript; Daniels, 1988a). They assume that their confidants will not disclose the information, but experience with adoption indicates that people do tell, particularly around a crisis period (McWhinnie, unpublished manuscript). The DI child can also learn such information through another child (cousin, friend), who may have come to know of it “accidentally.” In such cases it may be brought up in an argument, with comments such as “He’s not your real father” being calculated to inflict the maximum amount of pain.

Unexpected disclosure to the child in such contexts may be very damaging, as the revelation would come as a psychological shock that some children would find hard to bear (Singer and Wells, 1984). Adopted children who find out their origins from someone other than their parents can feel deceived, and some may reject their adoptive parents, wondering, “If they can lie to me about this very fundamental thing, can I believe anything else they have told me?” (McWhinnie, 1984). In his study of adopted adults, Triseliotis (1973) found that, without exception, all those informed of their adopted status later in life or by third parties were resentful and upset.

For many, this betrayal of trust caused irreparable damage to family relationships. Most expressed the sentiment that it “would have been easier...to come to terms with painful facts about themselves than to live with lies and have their trust in their parents shaken” (Triseliotis, 1973:156). According to Aphrodite Clamar, if the child learns about her/his origins in a negative way (i.e., in the context of an argument, or “accidentally”) s/he may be prompted to search for the biological father: “If a child is told in anger, ‘you’re not my child,’ he will naturally wonder ‘Well, whose child am I?’ If the social father appears to be rejecting him, he will try to find a real father who loves him” (quoted in Andrews, 1984:22).

McWhinnie (1984) makes the point that although it may seem reasonable to advise a couple to keep DI entirely private, couples are not entirely private individuals. They are members of families and have relationships with other adults. McWhinnie (1988) also notes that many couples will consistently be hurt by casual comments of relatives and friends about “who the child looks like” and where her/his talents come from. Further tension can be caused when parents disagree with each other about whether they intend to tell the child. The stress on parents who attempt to keep this information from a child, and from others, must be enormous and may take a toll on the marriage itself.

Secrecy becomes even more of a burden if the marriage breaks down and one or both of the parents remarry. Could the secret regarding the paternity of the child be kept in such a situation? Because communication between the two parents of the donor child would be minimal, or even nonexistent, neither of them would be sure what the other intended to reveal. In addition, neither of them would be sure if the other had told her/his new spouse, and neither of them would know if the other had changed her/his mind about telling others, or even about telling the child.

Openness can be directly beneficial to the couple themselves. Confiding in relatives and close friends about DI means that couples will be more likely to receive moral support, they will have relief from the discomforts of evasiveness, and they will have better prospects of discovering others in the same position (Humphrey and Humphrey, 1988). Support groups can also be useful, especially for those couples who do not have friends and relations whom they feel they can confide in about DI. Rowland (unpublished manuscript) notes that the experiences of couples she has talked to seem to suggest that when they do tell people, the response is primarily sympathetic.

It appears, then, that secrecy can be potentially very damaging to family relationships and that more openness regarding DI should be encouraged. What little evidence exists from DI children themselves provides more support for this contention. A study by Snowden, Mitchell, and Snowden (1983) included interviews with
seven adults who had been conceived by DI and who had been told of their origins in their late teens or early twenties. None of them seemed to have found the revelation to be particularly traumatic, and none of them regretted the fact that their parents had used donor sperm. Many of them honored and respected their parents more. They felt good to know how desperately their parents had wanted a child, and that they were the child who fulfilled their wishes. As one of them explained: “they actually went to tremendous lengths because they wanted to have a baby. And I suddenly felt that they must love me a tremendous amount, that I was very important to them” (quoted in Snowden, Mitchell, and Snowden, 1983:98). In a study by Rowland, another DI adult commented: “Knowing about my AID origin did nothing to alter my feelings for my family. Instead I felt grateful for the trouble they had taken to give me life” (1985:395).

Openness and the Community

As has already been discussed, many of the couples who seek donor insemination believe that the community does not endorse their actions (Snowden, Mitchell, and Snowden, 1983), and this is one of the reasons they either keep their involvement secret or share the information with only a small and select group (Daniels, 1988a). However, studies have found that there is actually more public support for DI than most people realize. Perhaps such support for this new means of family making is a reflection of the tendency of our society to view the family as the central and most important societal unit (Rowland and Ruffin, 1983).

A New Zealand study (Daniels, 1988b) found that 76% of respondents approve of infertile couples using donor insemination to help them have a family. Three Australian studies have also found a high level of public support for DI. Rowland and Ruffin (1983) found 52% of their respondents supported DI, while Tyler et al. (1983) reported that 87% of those questioned supported the procedure. Rawson (1985) indicated that 70% of her respondents approved of DI. It is important to note that those studies finding the highest level of support were magazine surveys, which are more likely to have attracted respondents with a vested interest, and thus the results obtained by Rowland and Ruffin (1983) and Rawson (1985) may more accurately reflect the level of support for DI. Nevertheless, although these figures are lower, there is still a considerable number of people who view DI positively and endorse couples’ decisions to use it to create their families.

It is also worth noting that all the studies cited are from Australia and New Zealand, very little work having been done on community attitudes in other countries. In both these countries, openness is widely encouraged, and it is likely that the level of support shown in these studies reflects this. More openness on the part of those involved in DI, both the professionals and the couples, is directly beneficial in terms of encouraging community support. The more people know about DI, and realize that it is not something to be hidden away, the more supportive they will be of it. Secrecy hinders the dissemination of information about DI to the public, and hence many people remain unaware of the factors involved. This lack of information contributes to a lack of understanding, and sometimes even prejudice, about DI among the general public.

More community knowledge is helpful in terms of assisting the spread of information concerning DI to other infertile couples. Mitchell (1982) notes that secrecy restricts the amount of information to couples who could themselves benefit from DI if they only knew about it. Secrecy ensures there is less information actually available, and there is less likelihood that couples will hear of where they could procure the information that is available. Mitchell (1982) also suggests that secrecy restricts the provision of DI within the general health service so that couples, when they do hear about it, often have to travel long distances to get to a DI clinic.

Openness and the Donor

Probably the single most common argument against openness in DI, especially in the view of practitioners, is that secrecy must be maintained in order to protect the anonymity of the donor (Schosman, 1975; Johnston, 1980; Beck, 1984; Joyce, 1984). Many DI practitioners are concerned that if donor anonymity were not guaranteed, then very few men, if any, would be willing to donate (Braude, Johnson, and Aitken, 1990).

The two main reasons given for the importance of donor anonymity are that (1) if anonymity were not guaranteed, donors could be held legally liable for the maintenance of their DI children, and/or these children might be able to claim inheritance rights; and (2) donors might suffer an unwanted invasion into their family lives by DI children seeking out their genetic fathers. Neither of these reasons is convincing. As far as legal liability is concerned, while this has been a valid fear in the past, recent legal changes in most Western countries (e.g., New Zealand, Australia, Sweden, the United Kingdom)—whereby the husband or partner of a woman who had borne a child as a result of donor gametes is to be known as the legal father—absolve the donor of all rights and responsibilities toward that child.

As for the second reason, evidence from recent studies carried out in Australia (Nicholas and Tyler, 1983; Rowland, 1983; Daniels, 1987, 1989; Paul and Durna, 1987; Purdie et al., 1992) suggests that donors may not, in fact, be so concerned with their privacy as was first thought. Rowland (1983) found that 82% of the donors she questioned would not object if information about them, apart from their name, were given to the
couple for the child, and over half of them (60%) would not mind meeting the child at the age of eighteen years. Paul and Durna (1987) found that 68% of their respondents thought that nonidentifying information should be made available to the children, and 59% of donors surveyed said they would agree to their DI offspring making personal contact with them.

Daniels (1989) found that 68% of the donors interviewed would not mind if identifying information were given to the DI offspring after the age of eighteen to enable them to trace the donor. Seventy-seven percent of the respondents thought that children had a right to nonidentifying information about the donor. Seventy-three percent said that they would still be prepared to donate if their DI offspring could trace them later on. A study by Nicholas and Tyler (1983) found that 56% of donors supported a national register of names and addresses of donors and recipients.

Two New Zealand studies also looked at the issue of donors' desire for anonymity. The results of an earlier study (Daniels, 1987) were not quite so encouraging, with only one-quarter of the donors questioned believing that they would still be prepared to donate if offspring from their donations were able to trace them. However, this is still a higher percentage than many people would have predicted. The continuing importance of anonymity for many of these donors may have been due, in large part, to the fact that the practice of DI in New Zealand—especially in 1985 when the study was carried out—was not as progressive as that in Australia in terms of realizing the importance of breaking down the secrecy surrounding the practice. This hypothesis is supported by the results of a more recent study (Purdie et al., 1992) which found that 68% of donors questioned were agreeable to their identity being made available to their DI offspring when s/he reached maturity.

Sweden is the only country to have legislation in place which makes it mandatory for donors to provide identifying information for their DI offspring. When this legislation was introduced, fears were expressed that donors would not come forward. Back and Snowden (1988) point out that the number of available donors did decline, but that it is rising again. During visits to Sweden in 1991 and 1992, the senior author concluded that while there had been reductions in the number of donor inseminations, and the number of volunteering donors, a major cause was that couples were being referred to adjoining countries. This was being done to avoid the impact of the legislation. Workers in the field indicated that many medical practitioners were opposed to the legislation (with its emphasis on openness) and were advising couples to take this action. Another point made by Back and Snowden (1988) is that with the change in legislation came a change in the kind of men who were donating; previously they had been students, but now they were mainly older men.

The above studies, and the Swedish experience, present major challenges to accepted views regarding donors' attitudes. Donors, it appears, are not dispassionate males whose main interest is the payment they might receive for donating. The results of these studies suggest that some donors have other motivations—motivations of which many doctors seem to be unaware—and that these motivations lead to quite different attitudes toward their offspring. It should be noted here, however, that the freer and less self-protective attitudes of the Australian and New Zealand donors surveyed could be a reflection of the recruitment policies and practices of the clinics responsible for the programs and the more open attitude towards DI in these countries. Australian and New Zealand clinics only pay donors for related expenses, hence attracting a different kind of donor than programs, such as those in the United States, which pay donors for the act of donating.

It is interesting to note that American donors are, in fact, considerably more protective of their anonymity than Australian and New Zealand donors. One study (Handelsman et al., 1985) concluded that donor attitudes concerning offspring having access to identifying information were still predominantly negative. Releasing nonidentifying information was viewed more positively, but still only by a minority. Another study (Sauer et al., 1989) reported that 70% of surveyed donors were concerned with remaining unknown to their DI offspring. These donors also opposed the establishment of a national registry to record and track insemination outcomes.

Nevertheless, even if the donor insists on his privacy being respected, as indeed some American donors do, using this as a reason for maintaining donor anonymity is placing the wishes and needs of the donor over and above those of the child. As has already been pointed out, the consequences of never being able to identify genetic parents may be serious for some people. Moreover, while the donor chooses to involve himself in the DI program, the child is given no such choice.

Openness has benefits for the donors too, since anonymity can work against the donors as much as for them. Donors usually do not have access to any information about the use of their sperm. Most are not told if children are conceived as a result of their donation. Studies show that donors are interested in the outcome of their donation. Rowland (1983) found that 81% of her donors wanted to know if a child had been born using their sperm, and 48% claimed that they would feel a connection with that child. Ninety-six percent of donors in Daniels’s (1989) study indicated interest in knowing the outcome of their donation. Eighty-two percent mentioned that they actually think about their DI offspring.

As contributors of parts of themselves, donors have rights to information about the use and outcome of their contribution. Disconnection with the possible offspring...
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is not complete just because a system provides a total physical severing, as Atkken (1983) points out. The cost to some donors in terms of the unforeseen implications of their action for later life experiences may be high. There is a need for a good deal more thought about the position of donors and for clearer, more open discussion with donors about these aspects. Accordingly, the fear of losing donors if a more thoughtful donation is promoted will have to be dealt with.

The recent Australian and New Zealand research, and the new legal requirements in Sweden, suggest a need for changes in record keeping. In the past, donor records were often destroyed to protect anonymity. However, if donors are beginning to agree to allowing DI offspring access to information about them, both nonidentifying and identifying, then it is vital that these records be retained. Interestingly, in contrast to the American donors in Sauer et al.’s (1989) study, the donors in one of the Australian studies (Rowland, 1983) have actually suggested that their interests, and the interests of the children, might best be served by storing all information in a central registry, where access could be gained by mutual consent.

Openness and Service Provision

Less secrecy would also be beneficial in improving the provision of counseling services to couples going through the DI process. Snowden, Mitchell, and Snowden (1983) make the point that “secrecy...means that members of the helping professions such as social workers or marriage guidance counsellors are themselves ignorant of the problems to a large extent, and so unable to offer expert help and counselling” (p. 101). Bates (quoted in Barry, 1984) argues that before DI children can be sensitively told about their origins, parents must first come to terms with their infertility, their use of DI, and the child which has resulted from it. If feelings about infertility have not been resolved, they will not disappear with the birth of the child. Counseling of would-be DI parents is clearly essential. As McWhinnie notes, “they are taking on a great emotional burden for a lifetime. They need time and space to look at what such a step could mean for them and the family” (1985:11).

As pointed out earlier, many parents fear telling their children because they have no idea of how to do so. Rowland (unpublished manuscript) suggests that counseling “back-up” should be available to parents thinking of telling their children so that the parents do not feel completely alone. The recent publication of the book How I Began: The Story of Donor Insemination (N.S.W. Infertility Social Workers Group, 1988) is another helpful aid to parents who want to tell their children but do not know how. This book is a first attempt to address the difficulties parents face in explaining DI origins to their child. Its aim is to provide couples with a resource on which they can base their explanation of DI to their young children.

Parents should also be prepared to deal with an adolescent’s disapproval of their use of DI. Teen-agers tend to search for reasons to reject or dislike their parents, and DI may provide such a reason. Rowland (unpublished manuscript) points out that if the couples have been fully satisfied with their decision to seek DI and have good communication with each other, they will be able to support each other under what may seem to be a hostile attack from the DI adolescent.

Private Matter or Public Concern?

Keeping DI a secret is often stated as a claim to privacy, with couples making such comments as “It is our business” and “Why can’t we be left alone to get on with life?” Many parents of DI offspring say that others are left in peace to have their children, and ask why what is private for “normal” couples cannot also be private for them (Daniels, work in progress). Despite studies which indicate the contrary, donors too are perceived as desiring their involvement in DI to be a “private” matter, preferring to disassociate themselves from the outcome of their donation by remaining anonymous. Privacy (as opposed to secrecy) is usually seen as a good thing, something which must be defended and preserved. Obviously there are some areas in people’s lives which are theirs to keep as private and as secret as they wish. However, certain behavior or knowledge may have implications for others, and others may have a right to know facts which will have an effect on their own lives.

When considering this point it is useful to view the “secrecy” associated with DI as being made up of three separate components (Snowden, Mitchell, and Snowden, 1983). The first relates to the consultation between the health professionals and the couple. This consultation is obviously covered by the expectation of confidentiality. The second component relates to the health professionals and the donor, and this is covered by discussion of the right to anonymity on the part of the donor. The third component is that concerning the relationship between the parents and the child, and it is here where secrecy, in the true sense of the word, is an issue. The parents must decide whether to tell the child about the nature of her/his conception, or keep this fact a secret, pretending that the child is the biological offspring of them both.

As far as the first component is concerned, the couple are quite within their rights when they ask that the dealings between themselves and their DI specialist be kept private and confidential. The confidentiality of the doctor-patient relationship is protected by medical ethics and is generally accepted as a vital condition of medical practice. However, the other two components of
secrecy in DI, while they may be perceived as necessary to protect the couple and the donor, should be questioned with respect to their repercussions for the child. One must look beyond the successful pregnancy and birth and take into account the child and the adult who result from these procedures.

Decisions concerning DI, at present, are private ones, agreed to by the couple concerned, in consultation with a doctor. The infertile couple want a child and, as adults, they are seen to have the right to use all available resources to help them achieve this. The doctor has the skills and the desire to help the couple have a baby. The donors respond to the request for sperm for various reasons and have desired (or at least have been perceived to desire) anonymity in order to protect themselves from any responsibility for the resulting offspring. The child (future adult) has largely been ignored. In such situations, society seems to have a clear role to play as advocate for the child’s (and future adult’s) rights and needs.

As was pointed out by the Asche Committee (Asche, 1985), it is the function of a country to be concerned with the welfare and interests of children. Back and Snowden (1988) suggest that society may have an added duty to children conceived by DI (and the other reproductive technologies) which it would not have in other similar circumstances, such as extramarital relations, because DI is a publicly sanctioned and, in some areas, a licensed procedure.

The issues of the rights and needs of children, of public sanction, and of public licensing procedures highlight the social policy implications of secrecy and openness in DI. Any consideration of these issues is likely to reflect the more global issue of the role of the state in procreation. On the one hand, the argument can be made for the freedom of individuals to make their own decisions and follow their own inclinations. The United Nations Universal Declaration of Human Rights (United Nations, 1948) provides support for this view. It emphasizes the right to marry and found a family, free of any constraints, and goes further in saying that special care and assistance should be made available to mothers. Article 16 states that the family is the natural and fundamental unit of society and entitled to protection by the state.

The UN declaration begins with a focus on the rights of the adult parties and their decision-making. When the focus shifts to the needs of the children that result from these decisions, however, a different perspective begins to emerge. As Blank (1990) has highlighted, even if procreation is an inalienable right, it can be regulated by a society which is concerned with the existence of the child to be born and its own survival as a society. Reproduction in these terms is a right shared with society as a whole, and is part of a larger complex of rights, responsibilities, and obligations. It is probably not difficult for most people to agree with the above statements; what causes the difficulties is the implementation of the sentiments.

When attempts are made to produce policies, regulations, or legislation in this area, there are likely to be claims of state paternalism. What is often forgotten in such arguments is that the state has already accepted that it has a role in relation to adoption. That role is to protect the needs and interests of children. One of the difficulties in the assisted reproduction field is that there is no child, but rather a potential child. However, the consequences of any action are a valid concern, and in this respect, concern for the potential child is valid.

The question of public sanction is also highly relevant to this matter. A government may express its view on any issue by discouraging or encouraging it, or if it wishes to be more active, by mandating or prohibiting it. A further option is to adopt a laissez faire approach, and make no commitment to the issue. For a time this latter option seemed to be the one preferred by most countries, but as the implications of the developments in assisted reproduction became more public—with an accompanying range of reactions—many governments felt the need to respond. The most common response was for commissions or committees to be set up to explore all the issues and make recommendations to government. Many non-government bodies, such as professional groups, also set up committees to review and report on the policy aspects of the developments. A comprehensive and useful summary of all the reports and legislation was prepared by Walters (1987), and a more recent one was completed by Knoppers and LeBriss (1991). All of these reports accept that there is a place and need for government intervention. The debate continues over whether such intervention should encourage, discourage, prohibit, or mandate.

The United Kingdom has responded to its committee (Warnock, 1984) by developing both a legislative and a regulatory framework. By setting up a licensing authority, it has endorsed/approved certain procedures, but stipulated that these meet specific standards and requirements (Human Fertilization and Embryology Authority, 1992). The use of regulation—which can be modified more easily than legislation—has been seen as an appropriate way to proceed. Other countries have adopted alternative approaches or are still considering what action they will take.

Blank (1990) suggests that the policy problems originating from developments in assisted reproduction are among the most volatile and incisive issues imaginable. He argues that these issues:

raise the fundamental policy questions of the proper place of government in human reproduction, the most effective means of government involvement, the appropriate mechanisms for setting social priorities, and ultimately who
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decides and controls the use of genetic and reproductive technologies in a democratic society. At the most abstract level, these technologies return us to basic philosophical questions that have long framed Western political thought concerning the meaning of human existence, the relationship of the individual to the state, and the immutability of human nature. (p. 170)

Secrecy and openness in DI is a professional and policy issue, and debate of the topic must take account of the larger policy context, as well as the practices adopted by professionals in the field. Policies, when formulated, will set the pattern for professional practice. Governments are unlikely to mandate more openness, but they can provide clear encouragement, as they have most notably in Sweden. The Swedish legislation provides for information to be available to the child, when mature, and therefore provides the policy framework in which doctors and health professionals, and, through them, couples, are likely to adopt a more open approach. While research evidence on this is not available, discussions with Swedish colleagues indicate that such change is occurring, and that education has played a vital part in this.

The development of policies in this area will not be easy. What is appropriate in Sweden may not be appropriate in another country. Nevertheless, it is clear that consideration needs to be given to the policy implications of the secrecy traditionally associated with DI.

Elias and Annas (1986) suggest that decisions regarding the new reproductive technologies cannot remain solely in the domain of the medical profession. They suggest that the DI-private contract paradigm is outdated and inadequate to protect children, parents, the family, and social values. Australia's Asche Committee (Asche, 1985), as has been pointed out above, believes that a decision on the matter of openness in DI must take account of the changes that have occurred in adoption legislation and practice. The practice, experience, and research of the past twenty years in adoption emphasize that honesty and openness in family relationships—and being able to gain access to either medical or identifying information, or both—are essential to the healthy social and psychological development of children. The report goes on to say that regulations and structures should be established to maintain all records of assisted reproduction procedures, regardless of whether or not access is permitted to these records.

In comparison with adoption practice, which places the rights and the needs of the child above all else, donor insemination is parent oriented, with the interests of the recipient couple as its primary concern (Fopp, 1982). In modern adoption practice, the child is the client, and it is her/his interests which are upheld by the agency arranging the placement. In DI, the clients are the couple who are undergoing the procedure. However, as is pointed out by Australia's National Bioethics Consultative Committee in their report on access to information, it is important to remember that adoption practice once viewed the prospective couple as the clients:

The shift in emphasis came with the perception that the child had valid interests of its own, in competition with adult interests, which it was unable to defend. As well, adoption workers came to understand that traditional practice was causing psychological and emotional harm. (1988:16)

Unfortunately, at least until recently, DI practice seems to have been little influenced by developments in adoption practice. This may be due largely to the fact that adoption and DI are under the auspices of completely different systems. As pointed out by Brandon and Warner (1977), DI is under the control of the health services and the medical profession, while adoption is under the control of the welfare services. This system division has meant that much of the knowledge and research from adoption has not been transferred to DI.

The potential conflict of rights and interests inherent in DI has led governments in many Western countries to consider what action they need to take to deal with the issues involved, and changes are slowly being made. There are varying degrees of openness encouraged by the legislation/guidelines of different countries. In the United States, for example, although the American Fertility Society (1990) recommends it is "highly desirable" to maintain permanent confidential records of donors and to make such (nonidentifying) information available to offspring, there are no laws in place to ensure that these recommendations are met. In Sweden, on the other hand, legislation (Swedish Law, No. 1140/1984) allows donor offspring access to the name of their genetic father when "sufficiently mature." It should be noted that this change was strongly resisted by some in the medical profession (Edvinsson et al., 1990; Hagenfeldt, 1990).

In the United Kingdom the Human Fertilization and Embryology Act requires all DI centers to be licensed and to store, in the files of the licensing authority, identifying information about any person whose gametes are used for any assisted conception procedure. Failure to comply constitutes a breach of criminal law (Warnock, 1984). As has been pointed out by Braude, Johnson, and Aitken (1990), the intentions of such regulations are clear and admirable. Firstly, they will enable standards of practice, including counseling, to be set and monitored, and accurate statistics concerning DI in each country to be collected. Secondly, if a DI child should have a genetic disease, then insemination of other patients using the same sperm may be prevented, and the donor can be traced and advised of the risk he might have of passing on a genetic disease to his own children.
Most importantly, though, the act allows the DI child/adult, after the age of eighteen, to request information about her/his genetic origins. The intention of this law is to pass on only nonidentifying information, although the law, as it now stands, does not actually preclude identifying information about the donor being released by the licensing authority. This possibility is causing some anxiety among those who consider donor anonymity to be important (Braude, Johnson, and Aitken, 1990), even though release of such identifying information is unlikely, especially considering the recommendation of the Warnock Report that DI children “even if informed about the circumstances of their conception would never be entitled to know the identity of their genetic father” (Warnock, 1984: par. 4.22).

In New Zealand there is no statutory requirement for clinics or hospitals to keep records of donors or offspring, and decisions as to whether to do so are left to individual programs. At present, this issue is being considered by an Inter-Departmental Monitoring Committee on Reproductive Technologies (IMCART) set up by the government to act as a repository for information about assisted reproduction technology, to monitor the issues associated with it, and to advise ministers as required. The New Zealand Infertility Society has also raised the possibility of keeping a register of children conceived by donor gametes, and of donors (New Zealand Infertility Society, 1990). It was suggested that the register could be a clearinghouse for identifying information, thereby taking the onus from individual clinics. However, at present this idea is still at the discussion stage.

In Australia there have been moves towards greater openness and access to information regarding the use of donor gametes since the beginning of the 1980s. These moves have been encouraged by the recommendations of various state committees on reproductive technology and by the passage of various legislative acts. The first study into the use of donor gametes was undertaken in 1982 by the Waller Committee in Victoria. According to the committee, “whether or not a person pursues her or his origins, it should be possible for everyone to discover them. In this sense everyone has a strong interest in being able to discover some information about her or his origin” (Waller, 1982:26). The committee recommended that nonidentifying information should be given to both the recipient couple and the donor at the time of donation. It also recommended that a register of “comprehensive information” about donors should be established for providing the children born of donor gametes with information about their genetic background. These recommendations were incorporated in the State of Victoria’s Infertility (Medical Procedures) Act of 1984.

The views expressed by the Waller Committee were supported, to a considerable degree, by subsequent enquiries in other Australian states. With the exception of the reports from one state, all the committees recommended that access to nonidentifying information be allowed without restriction. Two reports recommended that children born from donated genetic material should have access to identifying information about the donor once they reach eighteen years of age, provided the donor gives consent (National Bioethics Consultative Committee, 1988).

The Demack Report (1984) stated that every child needs a name and identity and “access to a reliable medical (genetic) history.” Further, they left open the possibility of access, at a later date, to identifying information:

The Committee feels from discussion and a review of relevant literature, that the community attitude to secrecy and the right of a child to know its lineage is changing and its recommendations are designed to preserve the possibility that the child may, in the future, have access to information about its biological parentage. (Demack, 1984:57)

It is obvious, then, that in many countries efforts are being made to encourage more openness, at least with regards to the keeping of records concerning the donors. However, Haimes makes an important point when she notes that, as with adoption, whilst the “rhetoric of openness [is] important in indicating room for improvement and change, its manifestation in practice [is] more complex” (1988:53). She notes that in both adoption and DI, practitioners are urging parents to be open with their children, but at the same time are ignoring aspects of their own practice and of wider institutional arrangements which still promote secrecy.

In most countries where DI offspring are allowed access to information about the donor, the information they are given is nonidentifying. After this information has been gained, there are no more avenues open to them in their quest to find their genetic father. Obviously, the institutional practices which make DI possible in the first place do not exhibit the same degree of openness urged upon the DI family. As Haimes points out, one of the paradoxes of the prescription to be open is that it comes from sources which promote institutional secrecy.

Another example of institutional structures which make it difficult to practice openness is the legislation now in place in many countries (e.g., United Kingdom, Australia, New Zealand, Sweden) which enables the infertile husband of the inseminated woman to be regarded as the legal father of the resulting child (providing the husband has consented to the procedure). While this position has much to recommend it, particularly in terms of rectifying the anomalous positions of the donor and the husband, it creates problems for the child. Most notably, it erroneously implies that the husband is the
biological father, thereby providing potential support for the practice of secrecy.

Conclusions

Traditionally, the use of DI as a means of creating families has been shrouded in secrecy. Although there are increasing calls for more openness in the area, secrecy is still the guiding principle for many of those involved in DI today. The most common reason for attempting to maintain this secrecy is to protect the individuals involved. Secrecy is considered necessary (1) to protect the child from stigmatization and emotional trauma, (2) to protect the couple, especially the infertile husband, from stigmatization and embarrassment, (3) to protect the donor's anonymity, thus ensuring that there will always be an adequate supply of semen, and (4) to protect the medical professionals. It is important that questions are asked regarding just how necessary this protection is, and whether, in fact, it is more detrimental than beneficial to the parties involved. Those questions obviously involve the parties concerned, but they also involve those concerned with social policy, since they affect society and influence its response.

Decisions concerning DI are still, by and large, private ones, agreed to by the couple in consultation with the doctor. The child (future adult) has largely been ignored. As has been highlighted by the Asche Committee (1985), it is the function of a country to be concerned with the welfare and interests of children. In fact, society may have an added duty to children conceived by DI because it has sanctioned and licensed the procedure (Back and Snowden, 1988). As Elias and Annas (1986) have pointed out, decisions regarding DI cannot remain solely in the domain of the medical profession—the DI-private contract paradigm is outdated and inadequate to protect children, parents, the family, and social values.

The need for a new approach has been recognized by many Western governments, who are now starting to consider what action they should take to deal with these issues. The potential conflict of rights and interests inherent in DI has led governments in several countries, most notably Sweden, Australia, and the United Kingdom, to develop legislation/guidelines which are conducive to more openness and honesty in the area.

Research in the field of adoption, and early DI studies, have suggested that an open approach would be more advantageous to those involved in donor insemination. It has been repeatedly shown in numerous studies that deception and secrecy have a detrimental effect on family relations, and on the psychological wellbeing of the child. It has also been shown that there are practical difficulties inherent in trying to maintain a secret over a long period of time. Finally, it has become obvious that DI offspring have the desire, and the right, to know the truth about their genetic backgrounds.

The growing body of literature concerning openness/secrecy in DI is an important means of generating discussion and debate of the issues, and of challenging those involved—whether professionals, couples, or policy analysts—to reexamine long-held views about the need for maintaining secrecy in DI.

Notes

1. From his foreword to Lethal Secrets (Baran and Pannor, 1989:xi).
2. Although a recent New Zealand study (Purdie et al., 1992) indicates this may be changing. This study found that 51% of parents were definitely, and 32% probably, going to tell their child of his/her DI origins.

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