DONOR INSEMINATION: THE GIFTING AND SELLING OF SEMEN

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Abstract—The authors examine the implications for individuals and society of how semen is provided for use in donor insemination treatment. In particular, they focus on whether 'donors' make a gift of their semen or are paid. The role of health professionals in shaping the nature and meaning of semen provision is also explored. The currently predominant practice of buying semen is compared with other reproductive and biomedical exchanges: oocyte and embryo donation, surrogacy, and blood, organ and fetal tissue donation. The authors suggest that the commercialisation of semen determines and reflects the type of men frequently recruited to provide semen. This in turn influences the meaning that donors themselves, recipients, offspring, health professionals and society at large attribute to the provision of semen. Copyright © 1996 Elsevier Science Ltd

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INTRODUCTION

The first known instance of a birth following the use of donated semen was in the 1880s [1], but it is only in the second half of the 20th century that there has been a rapid growth in the use of this means of family creation [2]. In 1988 it was estimated that in the United States of America approximately 80,000 women a year utilise donor insemination (DI) and that over 30,000 children are born each year [3]. Figures available from the U.K. indicate that in a five month period from August to December 1991, over 4000 patients received DI at 85 different centres [4]. Despite DI's long history and extensive use, one of the main parties involved—the man who provides his semen—has received relatively little attention. Although several studies [5–18] have been undertaken to explore the characteristics, attitudes and motivations of the men who are usually referred to as 'donors', the results reflect a varied picture, probably accounted for by the fact that the policies of the clinics and professionals recruiting donors vary considerably. One of the areas explored in some of these studies is the extent to which financial reimbursement is a motivating factor in providing semen. Anecdotal evidence about early DI practice—limited as it is—seems to indicate that men who provided their semen for an infertile couple did so without any financial recompense. With the growth in the use of DI, doctors have reported increasing difficulty in recruiting men who would be prepared to be donors or who meet more stringent modern screening requirements [17] (p. 461); [19–28]. Financial incentives, as a part of recruitment drives, are now usually offered, although this is by no means a universal practice [29] (also Curson and Daniels, "Recruiting semen donors without financial incentives", under review). The way that health professionals, most notably doctors, view donor insemination is highly important in determining how semen provision is constructed. It can be argued that their policies and attitudes are a reflection of what they perceive to be prevailing social attitudes about DI and the men who provide the semen. However, doctors are a powerful group, and as such they influence social attitudes.

The evolution of thinking in relation to semen provision must be placed within the context of social attitudes towards donor insemination—a form of family creation that provoked considerable anxiety and uncertainty in its early years. Committees condemned DI and expressed doubts about the character of men who provided semen [30, 31]. Given this social climate, the participants in DI naturally wished to avoid exposure and a policy of secrecy was promoted by doctors practising DI [1] (p. 59); [20] (p. 3); [32–34]. This paper discusses some more recent attitudes to semen provision and providers. In addition, semen provision and the status of the providers are compared with other kinds of reproductive and biomedical transfers (oocyte, embryo, blood, organ, fetal tissue donation and surrogacy). While recognizing some of the similarities between semen and eggs, this paper focuses on semen provision. Particular attention is given to the notion of the 'gift' as an alternative model to that of the 'sale' of semen.

An explanation of terminology used here is necessary. Men who provide the semen for donor insemination have been called 'donors' by most authors, although other terms, such as 'vendor' (for
men who sell their semen) [35] and 'consignor' (for a man who hands over his semen and the rights to it) [36] have been proposed. In this paper the term 'provider' is used unless referring specifically to a man who gives his semen without financial remuneration (a donor). It seems inappropriate to refer to a person who is paid as a donor. The term 'provider' is neutral in that it does not suggest either gift or sale. It is necessary also to consider the term 'child' in relation to the outcome of DI. Rowland notes that reference in the literature to DI 'children' permanently infantilizes the persons who result from this form of assisted conception [37]. By viewing them as children we are in danger of adopting a paternalistic or protectionist approach, seeing them as needy persons who must be protected (e.g. protected from what others perceive to be unpalatable facts). DI 'children' become adults, and it is by mentally framing them as adults that we may recognize that they have the same needs and rights as other adults. The word 'offspring', although still not ideal, is preferred.

The discussion is in three parts. Part (I) explores the implications at a personal level for providers, recipients and offspring when semen is given or sold. Part (II) explores the roles of health professionals in commercial and non-commercial models of semen provision, and their mediating function in relation to potential gift-dynamics between the parties in DI. In part (III), the discussion widens to compare semen provision with other forms of third party reproductive transactions such as oocyte and embryo provision and surrogacy, and also, in the area of biomedicine, the provision of blood, organs and fetal tissue. It examines the status and profile of the respective providers and the responses of different societies' to potential or actual commercialization of reproductive and biomedical products.

THE NATURE OF SEMEN PROVISION AND ITS MEANING FOR INDIVIDUALS

There are two main ways in which semen provision can involve money. The first is when actual and reasonable expenses, such as the cost of travel to the clinic/sperm bank, are reimbursed. The second is when semen providers are paid a set sum for each sample (sometimes only useable samples), or 'reimbursed' spuriously to mask payment. The second set of circumstances is what the authors mean by 'selling' semen.

Whether semen is paid for has implications for the type of provider recruited and his motivations. Recently semen providers at two London DI clinics were compared (Daniels, Curson and Lewis, under review). In one setting payments were made for semen, and the recruits were mainly in their early- to mid-twenties, single and without children, the majority being students at the time of recruitment. A major reason for volunteering was the financial incentive offered, although helping the infertile was an important secondary reason. These men are fairly typical of about 75% of semen providers in the U.K. according to one authority [38]. In the second setting, providers were not paid or reimbursed for expenses. They they were older (30s–40s), almost all married and with children, and they were from a range of mainly middle class occupations. The motivation for volunteering was invariably a desire to help the infertile, and just under half of these men had experienced fertility problems in their marriage or knew infertile persons. The type of person recruited at these two clinics and their motivations were partly determined by fixed donor criteria at one clinic (the latter) and the targeting of certain populations (i.e. student) at the other. However, whether payment was offered would also appear to have been significant. The type of men who provide semen, and their motivations, are a reflection of the policies of the relevant clinics and professionals.

Whether or not payments are made for semen may impact on the quality of personal, medical and genetic information that a potential provider will disclose to a clinic or sperm bank during the screening process. Hummel and Talbert [39] note that a paid provider may be less inclined to tell the truth about his medical history if this means he may be excluded from the programme, and they remind readers that the American Fertility Society stipulate in their guidelines that payments should not be high enough to constitute the main motivation to volunteer [40]. In France, no payments are made for semen, and it is believed that this reduces false information giving [41]. However, there may be implications other than medical ones when payment is offered.

Implications for the men who provide semen

Payment has personal implications for providers. Several immediate factors may affect providers: travel to the clinic/sperm bank, time off work or study, abstinence from sex in some cases, embarrassment, and even the unpleasantness of having to masturbate to order in often in very unsatisfactory circumstances (e.g. in a toilet cubicle) and then hand the sample over to (usually female) staff. It may be felt as a recompense for the expenses, inconvenience or embarrassment involved, and no doubt some men could not actually afford to 'donate'.

There are also the deeper consequences of providing semen—helping to create new lives and families. The Glover Report to the European Commission suggests that payment for semen may have quite subtle implications such as allowing providers to avoid revealing other motives to staff or examining their own motives in any depth [42]. French sociologist Novaes suggests that when a
material reward is not available, "the donor may feel compelled to reflect on the meaning that he attributes to this altruistic action", which reflection could constitute a barrier to recruitment. She thus argues that remuneration is a way of "short circuiting" this potential barrier, and could "in the long run be an unethical means of obtaining the donor's consent" [43] (p. 645). The Glover Report talks of conflicting interests surrounding payment, namely that providers may view payment as "social recognition" or, conversely, payment may "remove some of the sense of having acted altruistically" [42] (p. 34). Studies published by the senior author [5] (p. 180); [6] (p. 124) (also papers on U.K. and Swedish providers, under review) confirm that, for many individuals, providing sperm for infertile couples carries psychological rewards. One Swedish donor told the senior author of how immensely grateful he was that 'scientists' had made it possible for him to help others through DI, and he spoke of his desire to help others experience something of the happiness he knew as a father. Unpaid donors in the London study already referred to (Daniels, Curson and Lewis, under review) typically expressed their sense of satisfaction that they could help others experience parenthood. French donors in one study reported quite complex and idiosyncratic psychological benefits, for example some felt they were 'paying back' society for help that they themselves had received [17] (p. 464). The more general psychological benefits—feelings of pride and increased self-esteem—are similar to those reported by kidney donors, whereby donation becomes a peak experience [44]. Of live organ donors, Fox and Swazey write: "The sense of oneness and ennoblement they often experience as a result of the life-giving and life-receiving acts...can greatly enrich them, emotionally and spiritually" [45] (p. 40). In providing semen, lives are not saved—new lives are created—so the comparison is not complete, but nevertheless worth noting.

From their New Zealand perspective (where most providers are donors) Purdie et al. express the view that the real rewards for donors are long-term, i.e. knowledge that children have been born and families formed as a result of their actions [26] (p. 1358). Their policies, probably typical of much DI practice in New Zealand, seek to reward and re-inforce donors by giving them information about outcomes and 'empowering' them in a number of other ways. They have responded to what donors and potential donors had indicated they would prefer. Studies ([5], p. 124; [6], p. 182; [9], p. 255; [11], p. 28; [12], p. 51; [13], p. 750; [14], p. 398; [15], p. 97; [16], p. 102; [18], p. 456) reveal differences, however, in that some providers want to be more informed than they currently are about outcomes or recipients, whereas others are not interested in knowing. It is possible that receiving payment may be a barrier against expressing interest in outcomes—after all, the attitude might be, they've been paid, the business is completed. Payment may finalize the transaction and suggest that nothing further is owed the provider. It is also likely that the interest or lack of interest is again related to the type of person recruited and whether financial reward was a motivation. A pioneering advocate of DI in America wrote, "We find that most students are matter-of-fact about supplying spermatozoa. They receive their fee on an impersonal basis and rarely ask leading questions or display any interest in the procedure after they hand over the receptacle" [1] (p. 36). It has been normal practice worldwide for providers to be told nothing about the use or non-use of their semen, thus the opportunity to return a non-monetary reward is lost.

It is pertinent to briefly note here that, at a societal level, semen providers are not celebrated, affirmed or even necessarily completely approved of, such that any private rewards received, whether monetary or psychological, are likely to be the only ones. This has implications for the need to normalize semen donation and raise its social acceptability, a point discussed more fully later.

Some might argue that the implications for individuals of providing semen depend entirely on individual motivations and attitudes. However, individual perceptions are shaped to a large extent by the way semen provision is structured in given communities and clinics. How semen provision is constructed in a particular clinical setting directly affects its meaning for the individuals concerned by means of the recruitment of certain types of suitably motivated providers, and through policies and practices with regard to payment and other issues, a point which will be examined further in connection with the role of the health professionals. In a recent discussion with a man who had provided semen eight years previously, he revealed that his motivation at the time had been purely financial, and that the payment meant that the matter was completed. It was only when he had two children of his own and had started to "understand and appreciate" the issues involved that he felt that by being paid he was "given permission" to forget about what he had done.

Implications for the recipients of semen

Whether or not semen is paid for may have implications for those who use DI to help them form a family. However, studies of DI recipients, even those which deal with psychosocial issues, are often lacking in any reference to the semen provider, a fact which is significant in itself. Where he is mentioned, it is usually in relation to the desire by the couple to retain anonymity and the 'need' to forget about his role in the conception of their child, described by one clinician as "a strong need to dissociate from thoughts and concerns about the meaning of the donor to them" [46] (p. 129). In one
The general attitude to the donor problem was that donor and couple should be mutually anonymous and that the donor should be without any known family history of hereditary disease [47] (p. 145) (our italics). David and Avidan found that couples, while concerned about the mental and physical qualities of the man who provided the semen, tended to regard the semen as a mere fertilizing agent [48]. Nijs and Rouffa go so far as to say that, "... from a psychological point of view, the donor doesn't exist; it is just a matter of ease" [47] (p. 145) (our italics). David and Avidan without any known family history of hereditary disease were kept at all except on a medical level), perhaps one result of paying the provider is that it assists recipients in minimizing his role. The biological father of the child is constructed as simply a man who handed over his sperm in return for money—he has been paid off. This may help to depersonalize the transaction, perhaps helping the recipient individual or couple to cope with the involvement of an outside party in the formation of a family. If the provider is unpaid, the recipients may find it more difficult to maintain the idea of him as a faceless source of sperm, as his lack of financial motivation could create pause for them to wonder, 'Why did he donate?'. Keeping the sperm provider at a greater psychological distance helps the recipients to brush off any threat that the figure of the child's biological father (the woman's reproductive partner) may pose to a marital relationship or to the parenting relationship with the child [52]. The donor's invisibility may in turn allow a recipient couple to forget their infertility—or at least try to forget it.

Implications of payment for the offspring of donor insemination

Reactions of DI offspring to learning that they have a progenitor other than the man they know as their father are influenced by several factors, including the timing and nature of the disclosure or discovery [52--58]. These findings are similar to those in the adoption field [55] (p. 82); [59]. However, it is also possible that whether the semen provider was paid or not has implications for offspring. Consider the well-known torrent of angry questions put by Suzanne Rubin, who was conceived via DI:

How do I reconcile my sense of integrity with knowing that my father sold what was the essence of my life for $25 to a total stranger, and then walked away without a second look back? What kind of man sells himself and his child so cheaply and so easily? ... I have asked several DI practitioners why young males sell their sperm. To quote one of the directors of a large Los Angeles sperm bank, "They do it for the bucks, Suzanne." How do I learn to live without profound pain and disappointment knowing that this man, who is my father and who is my flesh and blood, 'did it for the bucks'? [60] (p. 214).

The fact that the sperm provider was paid for his semen appears to have contributed to Rubin's feelings of degradation. However, she also seems distressed by the impersonal and anonymous nature of the exchange. As the rest of her article shows, she was also not told about her DI conception until she was an adult after her mother died prematurely of cancer, when her father felt able to break their pact of secrecy. The issue of payment for semen is only one issue in DI that may have implications for offspring, but commercialization contributes to the depersonalization, and, at least for Rubin and possibly for others, this is not a comfortable situation. When the circumstances of disclosure about DI are more appropriate, both payment and the impersonal nature of semen provision may not be as great a problem for offspring. Karen Topp was first told about her DI conception in terms that she could comprehend (seeds and mummy's tummy) when she was five years old, and she was able to share this information with close friends during her adolescent years. She has grown up with the knowledge of DI and it is not an 'issue' for her. As an adult in her mid-20s, she says of the provider of semen:

During my teens, I guess there were a few times when I had a healthy curiosity about who the donor was (and is ...), but I wouldn't dream of calling anyone but my Dad my 'real' father. I love my parents both dearly, but in many ways I am closer to my father. ... The donor was just some stranger (probably a financially strapped grad student). Maybe I would be interested in him if there were any way to find him, but I gather at that time no records were kept at all" [53] (p. 150).

Not everyone, of course, would be satisfied to think of half of their biological origins as 'some stranger' who sold his sperm because he was 'financially strapped', particularly in cultures where knowledge of ancestry is of special importance to a person's identity within the group. In New Zealand, Maori (the indigenous people) are opposed to the traditional approach of using the 'stranger donor', and would prefer someone whose tribal links are known. Whakapapa (similar to genealogy and based on knowledge of one's heritage) is a concept that is central to all parts of Maori society and an individual's identity and status in that society [61]. DI practitioners in New Zealand are struggling to meet this cultural challenge. Other ethnic groups, particularly in the South Pacific, have views similar to those of the Maori on this issue.
The implications of payment—beyond the individual

The impersonal nature of semen provision from the point of view of the various participants is not just a result of the fact that it is often a commercial transaction—gifts also can be impersonal. However, the fact that many men throughout the world are paid for their semen has perhaps contributed to the minimalization and depersonalization of their role to that of a supplier of fertilizing material. The implications of this go beyond the individuals involved and affect the perception of semen providers at a societal level. The practice of paying these men for their gametes may have helped foster an image of thoughtless men who ‘do it for the bucks’, when in fact many of them have altruistic motivations ([5], p. 180; [6], p. 124; [9], p. 252; [12], p. 51; [14], p. 398; [15], p. 97; [17], p. 464; [18], p. 455), a significant number are prepared to allow non-identifying personal information about themselves to be given to DI offspring and/or recipients ([5], p. 183; [6], p. 125; [9], p. 254; [10], p. 307; [13], p. 752; [14], p. 398), and some are prepared to consent to identifying information being released, particularly to mature DI offspring ([5], p. 183; [6], pp. 124–125; [10], p. 307; [11], p. 27; [13], p. 750; [16], p. 101).

(For an extensive review of the issues surrounding secrecy and openness in DI see Daniels and Taylor [62]). While this paper argues that payment for semen has the potential to minimalize the provider's contribution and in a sense to depersonalize the process, it needs to be acknowledged that the provider (and others) may feel that he is providing a service and that as such he should be paid for this. Similar arguments can be put forward in relation to altruistic and commercial surrogacy and other reproductive and biomedical transactions. Such a position conveys the fact that the service provided is accorded a significant status which is reflected by the payment that is involved. Payment therefore is a way of valuing the provider's contribution. It is important to note however that in the case of semen provision, it is the ‘contribution’ that is being valued, rather than the provider. This is reflected in some programmes where payment is only made if the sample provided meets the required standards.

THE ROLE OF THE PROFESSIONALS IN DETERMINING THE NATURE OF SEMEN PROVISION

The role of health professionals is one of the keys to the meaning of semen provision and indeed donor insemination as a whole. The clients in DI are usually infertile couples, single women and lesbian couples, and, as it is usually healthy and fertile women who undergo insemination, it is difficult to regard these situations as conventional doctor-patient scenarios. The medical or genetic problem is not treated by DI. However, professionals providing fertility services see their clients as patients suffering from the problem of infertility, and thus they seek to either treat or, in the case of DI, circumvent the infertility. It may be tempting in this medical model to view the man who provides semen as being the means to a ‘cure’ for the ‘patients’.

As professionals, the doctors and others involved in the practice of DI are accountable not only to their clients and their consciences but also to their peers, in that their practice must adhere to professional guidelines and/or ethics. In some cases, DI practice is subject to specific legislation, as in the U.K., Sweden and Austria [63–65]. On a more general level, health professionals are burdened with many difficult ethical dilemmas and decisions, and are expected by society to carry sometimes enormous responsibility. In the early years of DI, health professionals encouraged and facilitated complete secrecy for the couples they ‘treated’, partly to avoid possible legal complications resulting from the fact that laws had not yet caught up with this method of family creation ([11], p. 63; [20], p. 3; [32], p. 728; [33], p. 590). Recently, in New Zealand, health professionals have called for some form of regulation or at least more explicit national guidelines as they have been increasingly troubled by difficult ethical decisions in the assisted conception area [66]. As the socially (in some countries, legally) legitimised providers of DI, health professionals to a large extent determine the nature of semen provision by controlling who will be recruited and selected to provide semen, whether such provision will involve payment, who will have access to DI, what information will be shared between the provider and the other parties in DI, and therefore, the relationships that will be able to exist between these parties now and in the future.

Health professionals as brokers or intermediaries

In the predominant commercial model of semen provision, DI practitioners can be seen as both buyers and sellers of semen. They buy semen from providers and then sell frozen 'straws' to clients, usually with a price mark-up to allow for the costs of the recruitment, screening and payment of semen providers, semen testing and storage, and possibly (but certainly not in all cases) a profit margin. In this model, the clinician is the broker who brings purchasers' shortage and providers' surplus together without these two parties having to meet. Sperm banks represent a form of semen provision which is removed one step further from the recipient couple, in that most (except those operating for eugenic purposes [36], p. 58) buy semen from providers and sell this to clinics for a profit. In a much simpler hypothetical model of commercial semen provision, infertile couples would purchase semen directly from providers in a free market. However, both now and in the past, this is virtually unknown in practice. It is interesting to speculate whether society would have tolerated DI at all if it had
evolved in such a way that men sold their semen directly to couples or women. Perhaps health professionals, by acting as the brokers, have helped to legitimize the sale of something which otherwise would be considered to be outside of the realm of commerce.

In a non-commercial model of semen provision, health professionals are the intermediaries who obtain semen from men without payment and then make this available to their clients, the recipients. Of course, this is often at a cost to the recipients in that there are still costs in the recruitment and screening of providers, and semen testing and storage. The health professional in this model is again an intermediary whereby the two other parties never meet and usually do not know one another. More rarely, in some practices professionals may act as mediators between known parties when would-be recipients chose a known donor. This has been referred to in New Zealand as the use of a "personal donor" [11] (p. 28). A model of semen provision whereby providers give semen directly to recipients is not common, probably because some laws require DI to be carried out in the medical context under the supervision of a doctor in order to absolve the donor from fatherhood responsibilities and rights and to confer legal fatherhood on another man ([3], pp. 243–244; [63], chapter 37, s. 28). However, it is not unknown (as in the case of single women or lesbian couples seeking help outside of medicalized DI services) and the use of 'personal' donors is a move towards this, although the semen is still handled through the medical intermediary. In France, a couple waiting to start DI may encourage friends and acquaintances to donate semen to the clinic (for use by another couple), in return for which they may move higher up the waiting list [17] (p. 461). This is very interesting because, through the intermediary role of the clinic, couples may receive tangible help from a family member, friend or acquaintance without the semen being a personal gift to themselves. It is partly due to the difficulty of personally giving and receiving such a gift that transactions mediated by the health professionals are more feasible. We will return to this notion soon.

Commercialized semen provision and the task of the health professionals

What advantages might some health professionals see in a commercialized model of semen provision? Firstly, many believe that without the financial incentive volunteers would be too few in number to meet the demand for semen. Secondly, as we will argue, payment finalizes the transaction and removes the idea that providers are owed anything further, such as information about outcomes, counselling or social recognition. Related to this, if largely financially motivated men are recruited, they may show little interest in outcomes, thus reducing future work and complications for the clinic. Thirdly, financial motivations may be regarded by some health professionals as more straightforward and less 'suspect' than other motivations for 'donation'. Some of the above points will be developed further in our discussion of the social meaning of semen provision, but the controlling role of the health professional is relevant here.

Many health professionals see payments for semen as necessary to ensure supply. Practitioners point out that DI services depend largely on paid providers ([1], p. 36; [19], p. 35; [22], p. 63; [67, 68]). In the U.K., the Human Fertilisation and Embryology Authority (HFEA) initially stated that one of its goals was to gradually phase out payments for semen in favour of donation, but they are reviewing this [69]. The Authority commissioned a survey of clinicians at licensed centres which revealed that 88% believed that they would lose most of their 'donors' if they were not paid [27] (p. 886). A second and related study by the same authors showed that 99% of men who attended their first or second appointments at 14 DI centres believed that donors should be paid at the current rate at least [28] (p. 953). Sixty-two percent of respondents reported that they would not provide semen if the centre did not offer payment, with a significantly greater proportion of older donors than younger donors holding this view.

The legislation administered by the HFEA states that "no money or other benefit shall be given or received in respect of any supply of gametes or embryos unless authorised by directions" ([63], chapter 37, s. 12e). A direction issued by the Authority has stated that donors may be paid no more than 15, plus reimbursement of expenses [70]. However, as we have suggested, the issue of payment as an incentive cannot be separated from the types of men targeted by recruitment methods, and this must be borne in mind in discussions of the 'need' for payments. Students, whose income is typically limited, have been the target of recruitment by DI professionals. An alternative approach has been discussed by Curson and Daniels (under review) in a paper entitled, "Recruiting donors without offering financial incentives". The authors of one U.S. study made an astute comment when they explained why the majority of providers at their clinic would not continue without payment, i.e. that payment for semen is an established norm in their community [68] (p. 363). It would appear that historical choices made by professionals about how and whom to recruit has helped to establish the idea that few men would consider providing semen for the infertile without financial reward. May we go further and suggest that, by constructing semen provision as a commercial transaction, some potential donors have been discouraged from volunteering?
The role of payment in finalizing the transaction, and the possible association between paid providers and a lack of interest in outcomes, is another possible reason why many health professionals favour payments. In most parts of the world, men are expected to hand over some of their gametes in return for a small sum of money, and are also expected to show no interest in what happens afterwards (outcomes). The results of studies that have explored this issue vary, but many of these men would like to know something about outcomes ([5], p. 182; [6], p. 124; [9], p. 255; [11], p. 28; [13], p. 750; [14], p. 398; [15], p. 97; [16], p. 102; [68], p. 363). The variation in results is again likely to reflect a number of things, including the norms in a community, the attitudes and policies of the clinics, and the types of men recruited and their motivations. However, the process by which health professionals select semen providers may also influence whether those chosen are interested in outcomes. One author, for example, reported that doctors in her acquaintance were highly suspicious of men who showed an interest in the outcome of their 'donation' and, in some cases, this was used as a criterion for exclusion in the selection process [71].

Johnston, reporting on then current Australian DI practices, noted that an "unusual interest" in possible progeny is a reason for rejecting a potential recruit, and that volunteers must be prepared to provide semen "without any follow-up on its use or results" [2] (pp. 14–15). Such an approach by professionals may not only bias the population of semen providers towards men who are not interested in outcomes, but may also discourage these men from expressing interest later even if they felt it. This approach frees the clinics from having to perform follow-up tasks. It also helps them to focus on their 'patients', the infertile couple or single/lesbian woman, letting the man who provides the semen remain in the background.

The role of the intermediaries—the ‘tyranny of the gift’ and information sharing

One of the roles of the intermediary health professional in DI is to depersonalize of the source of the semen. This is not just to avoid raising issues of kinship (which will be discussed later) but also to prevent the provision from becoming a source of oppression to recipients. Given the significance of what is provided—the potential for a new life, the potential to become a family—and the impossibility of ever reciprocating this, the presence of an intermediary is helpful in avoiding the establishment of gift dynamics. Women or couples can feel vaguely 'grateful' towards the unknown man who helped them have a child, but the relationship between the recipients and the provider remains non-reactive rather than interactive [72]. This minimizes the potential for a 'tyranny of the gift' to operate, to use a concept arising from Marcel Mauss' studies of the nature of gifts [73]. Anthropological and sociological theory about the nature of gift dynamics is relevant to the present discussion in that both the commercialization of semen supply and its de-personalization can be seen as an attempt to negate the gift status of the semen, an attempt to prevent the formation of gift-dynamics between the givers and receivers.

Mauss wrote that receiving a gift creates a powerful obligation in the receiver to make a return of some kind—reciprocity is the essence of the gift. The more significant the gift, the more powerful the obligation to reciprocate. In cases where an equivalent gift cannot be returned, a 'tyranny of the gift' is possible. This is where the weight of obligation or debt lies heavily on the recipients and/or they become vulnerable to being controlled or manipulated in some way by their 'creditor'. It has been noted that giving gifts can serve the purpose of controlling the behaviour of others, whether in personal interactions or in the arrangements between parties in, say, a feudal society [74]. In the 1970s Newby and Bell explored the institutionalization of gifts within marriage and how this relates to gender power differences [75]. They point out that, as well as the traditional romantic gifts of flowers and chocolates, husbands are said to 'give' their wives babies, and even orgasms.

Some gifts made possible by modern medicine—such as live organ donations—are inherently non-reciprocal, that is, no equivalent return is possible. It was because of the disturbing dynamics surrounding some early live organ transplants that medical teams gradually set in place procedures for anticipating and preventing the tyranny of the gift [45] (pp. 35–36). For example, a potential donor (e.g. sibling or other family member) might be told that his/her tissue was not compatible with the would-be recipient's when in fact the real grounds for exclusion were psychological—some recipients had privately expressed either apprehension about owing a particular person such a great debt or apprehension about that person taking a serious risk on their behalf. On other occasions, transplant teams observed the family dynamics operating and made a decision based on the likely outcome of introducing powerful gift-dynamics into an already strained situation. It is of great interest to us that Fox and Swazey believe that, "The giving and receiving of a gift of enormous value ... is the most significant meaning of human organ transplantation" [76] (p. 5). Furthermore, they point out that this gift "takes place within a complex network of personal relationships that extends to families, the physicians, and all the members of the medical team who are involved in the operation." This psychosocial perspective of biomedical gifts can be applied to semen provision.

Through the involvement of health professionals as intermediaries current DI practice seeks to avoid
a tyranny of the gift. It creates a safe space in which something of enormous significance (the potential to have a child) can be received from another person without threat to the newly formed family. However, this is achieved by denying the existence of the gift in two ways—by making the gift not a gift, i.e. by paying for it, and through a tight control of information, i.e. anonymity and secrecy [62], (p. 155). There isn’t space to explore the latter (extremely important) issue in this paper, but a few points may be noted here. In DI there is the potential for a conflict of needs and rights between the various parties in terms of access to information. The policies of the professionals determine whose rights and needs will be met [77]. One of the roles of the health professionals is to collect information which they then may or may not share with the other parties. Where policies of guaranteed provider and recipient anonymity are followed, as is the norm around the world, the flow of information is restricted to a degree, but some non-identifying information may be exchanged. The flow of information is further restricted, however, when non-identifying information is withheld. Semen providers may not be told about outcomes, and recipients not told anything about the semen provider other than that he has been ‘matched’ to the inseminated woman’s male partner. Recipients and semen providers alike depend on the health professional as their source of information about the other parties in DI. However, offspring must first have been told about DI by their parents before they can even begin to approach this source of information. Thus, the parents act as a second intermediary between DI offspring and the semen provider, and can further control the flow of information or stop it altogether by not telling offspring about their use of DI, i.e. by policy of secrecy.

Health professionals—acknowledging the relationships in DI

In that the health professionals determine who will provide semen and whether they will be paid for doing so, and control the flow of information in DI, they regulate the relationships between the parties. One author says that blood and organ donation are examples of ‘impersonal’ gifts that, while not necessarily regulating relationships between specific individuals, “regulate larger relationships and honour important human values” [74] (p. 35). It is tempting to consider the relationships created through semen donation in this manner. However, although anonymous and depersonalized in most settings today, the provision of semen is different from the giving of blood or organs because another party, the offspring, is created as a result of the transaction. Such a transaction, and the relationships created, could never truly be described as ‘impersonal’ when part of a person’s genetic make-up is involved, and, should offspring learn of this, it could become a deeply personal matter indeed. Relationships do exist between the provider and the other parties in DI, but the nature of those relationships and the possibility for their development is determined by the extent of information sharing and whether semen provision is conducted in such a way as to promote its image as a gift or as a sale. Haimes concluded from her interviews with members of the U.K. Warnock Committee that some of them held a view of semen provision as a “‘limited act which would be of no benefit either to donor or child to develop further into any sort of relationship’” [78] (p. 129). This is in contrast with the recently published views of clinicians at a New Zealand clinic already quoted that, “A person is a sperm donor for only a short time; after that he is a man with children in someone else’s family” [26] (p. 1358).

As an alternative to being brokers and intermediaries, health professionals could function as facilitators in a more open and non-commercial model of semen provision. In this model professionals would facilitate a greater flow of information between a donor providing a gift of great significance, and the recipients of that gift. The reward for this gift is acknowledgement, and this could take the form of information about outcomes and recipients, and even some communication between the parties if this is desired. Currently, the policies of health professionals offering DI services seek to prevent potentially harmful gift dynamics and disruption to families, but these policies also deny the existence of the semen provider and his relationship with the other parties and downplay the social significance of his action. In a fascinating discussion of biomedical gifts, Murray writes, “Relationships governed by markets keep moral and social dimensions to a bare minimum. Gifts, by their open-endedness, defy such minimalisation” [74] (p. 35). While having due regard for the need to safeguard both the families created via DI and semen providers from unnecessary intrusion, we argue that there is a need for greater acknowledgement of men who provide semen, and of the relationships created through the giving (not selling) of a new life.

(III) THE SOCIAL MEANING OF SEMEN PROVISION

The donation of gametes is different in principle from donation of other human tissue, in that the capacity to create new life from donated gametes has significant and far reaching effects on children born of such donations. Gamete donation should be publicly acknowledged as the socially significant and responsible act it is [77] [Appendix 3.3.5.2(b)].

This statement by a Western Australia government committee is interesting on two counts. Firstly, because it highlights the uniqueness of gametes and, secondly, because it calls for public
acknowledgment of gamete donation. In this section we will suggest some of the factors that may have contributed to the low profile and low status of semen providers. We will compare their standing with that of women who provide oocytes. Society's response to the actual or potential commercialization of oocytes, embryos, surrogacy, and some biomedical exchanges—blood, organs and fetal tissues—will be explored. Finally, we will question whether a commercial model of semen provision attributes appropriate meaning to the process.

**Social perceptions of semen providers and donor insemination**

We may not be surprised to learn that in the 1940s and even the 1960s the character and motives of semen providers were regarded with grave suspicion by committees whose views reflected to a large extent those of the society in which they existed. In 1960, for example, the U.K. Feversham Committee (quoted in Haimes) pronounced semen donation to be "an activity which might be expected to attract more than the usual proportion of psychopaths"; although they conceded that, "The fact that in this country donors have not been paid for their services has, we understand, had the effect of excluding from the field undesirable persons" [80] (p. 58). This contrasts with the remark by one DI practitioner in the 1970s that, contrary to the views of the above Committee, he "would expect to find a rather mixed assortment of men volunteering their services" and recommended that paying donors is "desirable in terms of the quality of the product" [22] (p. 62) (our italics). This practitioner clearly regarded financial considerations as a more acceptable motive for 'donation' than other possible motives. Whether one agrees with the Committee or the practitioner in this instance, both views about the men who offered to provide semen are not wholly positive.

From our 1990s perspective, we may think that we can dismiss these attitudes as out of date, yet in an analysis of Warnock Committee deliberations Haimes found that, "The motives of semen donors are seen as questionable" by some members [81] (p. 91), and that semen provision as a whole is seen in a less favourable light than egg donation. Given the central role that semen providers play in the most common form of assisted reproduction, it is surprising to realize how marginalized this role is—to the point of being almost invisible. It is likely that many factors contribute to this state of affairs, including: the need for masturbation in providing semen, sociocultural concepts of the male and female roles, the sexual aspects of insemination, the stigma of male infertility and the kinship issues raised by DI. Furthermore, the commercialization of semen provision is probably another factor that has contributed to the lower level of visibility and status of semen provision in comparison with gifts in the reproductive and biomedical contexts.

**Semen provision—not much to it?**

Haimes found that the process of semen provision was minimalized or even degraded by some members of the Warnock Committee, one saying, in the context of a discussion about access to information by offspring, questioned whether "it was really in the child's interest to confront someone who had masturbated off as a donor" [78] (p. 129). (We note here that the committee member framed the offspring as still a child when meeting the provider, although this is not very likely to be the case). Another member saw semen provision as 'simply' the provision of a single cell, and also remarked, "... after all, they've been paid, it's just purely a commercial transaction as far as they're concerned". Raymond, writing on the subject of women's 'reproductive gifts' commented that, "Men donate sperm, of course, but sperm donation is simple and short-lived" [82] (p. 7). She goes on to quote another author who said that comparing the donation of eggs and wombs to the donation of sperm "is like comparing the giving of an eye to the shedding of a tear." These comments focus on the physical act of producing the semen sample rather than the psychosocial implications for the families created and for the semen provider himself.

Haimes suggests possible reasons for the fact that women who provide their gametes are regarded more favourably than men who do so, as reflected in the reports of various government-appointed and medical committees [81] (pp. 87–89). She believes that the attitudinal inconsistency is linked to widely held perceptions not only of the physical process of donation in each case, but also of dominant ideas about gender roles and characteristics. The oocyte donor, she explains, is generally perceived as a passive subject who undergoes invasive and potentially harmful procedures for altruistic motives—she is not usually paid. Furthermore, society (and feminists in particular) see the potential for women to fall victim to familial and societal pressures to be 'giving'. On the other hand, she writes, semen provision is seen to involve little physical risk but instead the possibility of 'illicit pleasure' (masturbation and orgasm), and the men are viewed not as victims but exploiters, 'donating' in order to 'father' many children, and potentially invading DI families if permitted. Oocyte donors are not seen as potentially disruptive to families. They do not replace the female recipient in all her reproductive roles, i.e. the recipient bears the child; whereas semen provided by a third party effectively fills the biological reproductive role of the recipient's husband. Receiving DI has a sexual connotation absent from receiving donated oocytes—early commentaries likened it to fornication and adultery. The oocyte donor is not the opposite sex of the recipient nor is she her
reproductive partner, and, unlike insemination, oocyte donation does not 'artificially' approximate the results of heterosexual coitus. All these factors may contribute to society's difficulty in acknowledging the men, but not the women, who provide their gametes for infertile couples.

Male infertility, although reasonably common, is not widely acknowledged or understood and is still associated in many minds with impotence, lack of virility, or inept sexual performance [83, 84]. It is not surprising that it is far more likely than female infertility to be stigmatized and hidden, as is reflected in the secrecy surrounding DI and, therefore, semen provision ([37], p. 393; [62], pp. 155–156; [85–87]).

**Provision of reproductive and biomedical material, and the construction of the 'family'**

In the early days of blood transfusion there was widespread speculation, even among experts, that an individual might take on something of the personality or characteristics of another person by receiving a transfusion of his/her blood [88]. Today most people would view this as unscientific. According to Fox and Swazey, in the field of organ transplants,

transplant teams were at first startled by the animistic experiences that many donors, recipients, and their families undergo in response to this exchange. Their conceptions of the modern and the scientific did not prepare them for such 'magical' reactions to this 'gift of life' [45] (pp. 32–33).

For example, some donor and recipient families personified donated organs and showed what doctors regarded as an unhealthy, even 'proprietal' interest in the other party involved in the exchange, i.e. they wanted to know about the donor or the recipient. Fox and Swazey note that medical teams responded to this manifestation of human spirituality by putting in place procedures to discourage such behaviour, including the policy of donor/recipient anonymity [45] (p. 37). (Like DI professionals, they did so to 'protect' all the parties.)

The provision of gametes, embryos and surrogate gestational nurturing, unlike the provision of blood, organs and tissues, involves the creation of a new individual, thus raising the issues of biological links and kinship. From time immemorial 'blood lines' have been regarded as an important determinant of a person's character, attributes and abilities. Today, although there is more awareness of the power of environment and parenting, genetic origins are still very important in most cultures. DI treatment, if kept secret by recipients, allows a heterosexual couple to pretend that their offspring are genetically related to both parents—thus allowing the family to apparently fit the cultural norm of genetic connectivity. The fact that families consisting of mother and father and their joint biological offspring all living together are not the only kinds of families we recognize today has not erased the social norm, or, therefore, the pressure to conform. Paradoxically, while a common argument made by DI parents for deceiving offspring about their conception is that 'There's nothing to tell—we're just like other families', the other side of the same argument revolves around the fear that disclosure of the genetic discrepancy in the family would harm or disrupt family relationships, in other words 'We're not like other families and we have to hide that fact'. Sociobiological concepts of kinship and parenting thus raise many personal issues for those who choose to utilize third party gametes ([37], p. 393; [52], p. 1219; [62], pp. 157–158; [85], p. 107; [89]). Furthermore, it is partly as a result of the kinship issues thus raised that the provision of gametes and embryos is seen as controversial. Simone Novaes writes of society's ambivalence towards the providers of gametes:

... whereas society seems willing to solicit and accept the donor's gesture as useful, it seems equally eager to dismiss, forget, or conceal him or her as a person, particularly when the donor's contribution is defined by existing law as giving access to parental rights [43] (p. 654).

She adds that society's "confused preoccupation with the biologic vectors of kinship overlooks the fact that procreative and parental roles are ... the result of socially prescribed relations" (p. 655). In her view, before gamete provision and assisted reproduction in general will attain social legitimacy, and before providers will be recognized and affirmed, society will have to come to terms with the various procreative and parenting roles now possible. Obviously this involves a change not only in the laws regarding parental rights, but in attitudes also. Until recently, many societies (and individual families) coped with adoption by trying to obliterate the birth parents from the life of the adopted person. Today, adoption practice reflects an improved ability to support adoptive parents without denying the existence of the relinquishing ones. Susan Midford writes of semen provision that, "The downgrading of this gift of potential life has devalued donors in the same way the relinquishing or biological parents in adoption have been trivialised and ignored" [90] (p. 6). The provision of gametes, embryos and surrogate gestational nurturing does not preserve the life of a person or even, medically speaking, cure or treat a person's illness. Rather it allows someone to overcome infertility or even just childlessness. Some might say that infertility is not an illness, and there is certainly still a lack of awareness in society about the extent and causes of infertility. Most people in the reproductive part of their life cycle assume they are fertile until they or their partners fail to produce children when desired [91]. Until they themselves or an acquaintance have difficulties in conceiving, many people have very little consciousness of the
role of third party gametes in assisted reproduction. In contrast, most people are aware of blood and organ donations as established aspects of health services. Many readers of this paper will have seen car bumper stickers which read something like, “Drive carefully. I’m a blood donor—you might need me one day.” Society has no bumper stickers, literally and metaphorically speaking, for the providers of semen, eggs, embryos or gestational ‘labour’. We can go further and say that while the providers of biomedical gifts are often celebrated in the media and conceptualized as good citizens, as altruistic, and even heroic (especially live organ donors), the providers of reproductive ‘gifts’ or ‘products’ are consigned to invisibility.

Commercialization of reproductive and biomedical material

A final point of comparison between various reproductive and biomedical ‘transactions’ (for want of a better word), is the extent to which their commercialization is tolerated. In some parts of the world, e.g. the U.S.A., Latin America and many Eastern European countries, individuals sell their blood to hospitals or blood banks in exchange for money or other benefits, or (in the U.S.A.) ‘donate’ it to obtain a guarantee that blood will be available for themselves or their families when they need it. In other places, such as the U.K., New Zealand and most European Community member countries, blood may only be donated (but imported blood/blood products are used in some cases). Whether blood is sold or donated may have implications in terms of its supply, quality (safety) and distribution [88] (p. 178). What is pertinent to the present discussion is that the sale of blood is something that many societies, if not all, have accepted at an ideological level.

However, even in countries where buying and selling blood is an accepted practice, the idea of buying and selling organs, particularly ‘live’ organs, is repugnant to many. The World Health Organization regards the commercial exchange of human body parts as a violation of basic human values and of the Universal Declaration of Human Rights. Despite condemnation at that level, it is believed that commercial organ traffic worldwide may be increasing due to the pressures of demand [92]. Concerns about the commercialization of organs—live organs in particular—revolve around notions of bodily integrity and human dignity, the exploitation of less affluent providers by more affluent buyers, and the potential for the sick to be exploited through the lucrative organ business. However, live-saving gifts of organs, as opposed to sales, are publicly lauded as ‘miraculous’ and special, and very few of us (except bioethicists) stop to think of the non-commercial pressures that may be brought to bear on the potential givers and receivers of these gifts, especially if they are family members [45] (p. 33–34). Recently, in the area of cadaverous organs, there have been proposals in the United States for: ‘regulated compensation’ i.e. a government death benefit for families if they agree to the use of their deceased relative’s organs; a ‘futures market’ in organs, where a healthy person receives reduced insurance premiums or other benefit in return for agreeing to their organs being ‘harvested’ on their death; and calls for ‘selling altruism’ more aggressively ([45] see chapter entitled, Efforts to increase gifts of life). Finally, debate about whether prisoners in the U.S.A. awaiting the death penalty should provide organs, “with or without consent” [92] (p. 2) is something that appears to go beyond the topic of gift or sale and into the realm of assault. In conclusion, the commercialization of organs is still highly controversial.

Respect for human dignity and fear of exploitation of live persons or the families of dead persons underlie the many concerns surrounding the commercialization of human organs. It is not often that one reads in the literature any concerns about the exploitation of semen providers, although recruitment of medical students is said to have caused ‘disquiet’ among clinical deans at one time according to editorials in the British Medical Journal ([20], p. 3; [21], p. 458). This was on the grounds that the deans of medical schools undertake not to ask students to take part in procedures for the benefit of patients and also on the grounds that students “come to medical school to be taught, not to be used” [20] (p. 3). As a matter of interest, the same editor feared that paying for semen could set a precedent which might lead to blood donors demanding payment. Although the issue of exploiting semen providers has yet to be addressed in the literature, we offer here a thought-provoking response made by a young man—paid to provide semen at one of the London clinics in our recent study—as to why he had decided to ‘donate’:

I was totally penniless and I needed a small regular income with which to continue job search. The alternative was to become an accountant! More interesting jobs take time to get. I don’t really mind about contributing to conception (although perhaps I would prefer not to) especially if it is to help infertile fathers. I like the strict anonymity. (Daniels, Curson and Lewis, under review.)

If selling organs is controversial, selling fetuses and fetal material is even more so. The Polkinghorne Committee, commissioned by the British Government to review guidelines in this area, expressed abhorrence at the idea that profit (though not necessarily recovery of costs) be involved in the provision of such material [93]. They recommended strict procedural guidelines to ensure that, (1) those persons treating or counselling pregnant women and those seeking to obtain fetal material should be distinct, preferably not working in the same institution and (2) that women’s decisions to terminate a pregnancy are not
deliberately influenced in that direction by considerations of how the fetal material could be used. The committee based these and other recommendations on the principle that fetuses or parts of them, while not 'persons', are entitled to special respect as human beings and, as such, neither commercial inducements nor encouragement to end their lives for the sake of a third party who could benefit from the action, are appropriate. Of interest here is that the Committee considered the moral significance of fetuses and then sought to guard against both their unnecessary death and the commercialization of human beings. In the case of gamete provision, the implications for individuals and society of the commercialization of reproduction might be considered equally important.

The sale of embryos is (as yet) not countenanced by any society, and the thought of 'embryo banks' would be uncomfortable to many. A general concern is that such a development would encourage commodification and the concept that some types of embryos are more desirable and valuable than others (a slippery slope argument). The United States Office of Technology Assessment considered the notion of the sale of embryos to be 'troublesome', noting that 'protecting public morality against a developing view of the commercial value of certain kinds of human beings is one basis on which restrictive legislation might be proposed' [3] (p. 228). However, unlike children or babies, embryos may be donated in some countries. Furthermore, this may be not only for the purpose of assisted reproduction, but sometimes for research and eventual disposal. Whether donating an embryo to an infertile couple/woman is more accurately described as a donation or a pre-pregnancy adoption will be viewed differently by different readers. It is perhaps partly due to society's uncertainty about what an embryo is precisely in relation to the human person that it may be donated or even used in research but has so far been kept out of the world of commerce. Gametes are understood in our technologised and medicalised world to be 'components' in the reproductive process rather than potential human beings, and this understanding has facilitated their commercialisation. However, individuals usually ascribe more than biological meaning to their genetic inheritance, and gamete provision therefore has undeniable psychosocial implications.

Surrogacy arrangements have been described as 'pre-conception adoptions', although it is clear that they involve quite different circumstances and intentions from conventional adoptions. In some cases, commissioning parents provide all of the gametes. In other cases, the 'surrogate' mother provides the egg as well as her gestational capacities to assist a couple in forming a family. She is usually artificially inseminated with the semen of the intended social father, or of yet another party—a semen provider. Rothman's analysis of the meaning of semen provision in the case of surrogacy is rather striking: The fathers in the surrogate cases do not donate their sperm. They are not donating or giving or selling. They are buying ... . If we legalise surrogacy, then to buy a baby one will need sperm and money ... . But what of men without adequate sperm? ... Sperm too is for sale [94] (p. 229).

While the controversy surrounding surrogacy arrangements is multi-faceted, relevant to our discussion is the fact that some people object to commercial surrogacy arrangements but not to non-commercial ones. It is interesting that the term 'compassionate' is often applied to only non-commercial surrogacy. Raymond points out that many state legislatures are taking action on commercial but not non-commercial surrogacy. She writes, "Altruism and voluntarism emerge as moral virtues in opposition to commercialism" [82] (p. 8).

In 1994, a New Zealand Ministerial Committee on Assisted Reproductive Technologies reported having no overall objections to surrogacy per se, but preferred "compassionate IVF surrogacy", where no profit motive or gametes other than those of the would-be parents are involved [66] (p. 112). It is partly the popular perception of surrogacy as 'wombs for rent' that undermines its acceptance, with the connotations (whether true or false) of prostitution and baby selling. The authors are unaware of any suggestion of prostitution attaching itself to semen provision, although early DI practitioner Finegold reported that this is exactly how one of his recruits felt on receiving his 'cheque' following news that his semen had successfully assisted a couple in having a baby [1] (p. 36). It would appear that society expects men to be willing to exchange their gametes for money quite dispassionately, perhaps based on the idea that men can 'separate themselves from the procreative process because they do not carry the baby' [71] (p. 46).

The transferral of oocytes from one woman to another has traditionally been framed as a gift and, unlike in semen provision, the giver and the receiver may know one another or even be related. It is only in recent years that some oocyte providers in the United States have been paid up to $5000 in return for undergoing the necessary procedures and the attendant risks [95]. Interestingly, one of the arguments put forward for paying these women is that semen providers are paid [96]. However, oocytes are still more likely to be given than sold. Frequently, women donate oocytes surplus to their own requirements during an IVF egg retrieval cycle. In the U.K., the HFEA permits women who agree to 'donate' in this way to receive preferential treatment at the IVF clinic, but not to be paid. Other women provide eggs in return for a free sterilization operation. The recent announcement of the world's first 'egg bank' in Australia may lead to significant
changes in oocyte provision [97]. Although this bank is currently intended to benefit only women undergoing chemotherapy or radiation treatment, it is likely that the newly perfected technique will one day have implications for egg donation. As we write, oocyte provision is still largely uncommercialized, but this may change, in the same way that the notion of a sperm bank turned semen provision into a profitable enterprise [36] (p. 58). The United States Office of Technology Assessment have commented that the sale of ova could probably be tolerated more easily by society, as sales of sperm are, if the associated medical risks could be minimized [3] (p. 228).

In the words of political scientist, Robert Blank, "Because of its widespread use and because of related developments in cryopreservation, commercialisation of AID represents the first wave of human reproduction for profit" [33] (p. 58). Semen provision in its early days was on a non-commercial footing and on a small scale. The use of providers known to the couples was undesirable due to the stigma associated with male infertility and the conflation of DI with adultery/fornication in the minds of some. Furthermore, legislation protecting DI families and semen providers from complications regarding legal parenthood was generally not then in existence. Health professionals initially sought the assistance of suitable medical students or house physicians known to them who would agree in the interests of altruism or medical science to donate in accordance with the requirements for discretion. However, this situation could not last because the demand for DI services expanded rapidly, and so more systematic and large-scale methods of recruitment had to be found. Instead of broadening the appeal for 'donors' to society in general, student populations continued to be targeted, but with money being added as an incentive. Today, students remain the most common source in settings where semen provision is commercialized. This is not universal, and in some settings there have already moves both towards attracting mature family men to provide semen and towards reconstructing semen provision as a gift rather than a commercial exchange [17] (p. 461); (Curson and Daniels, under review).

It would appear that semen has something in common with blood, in that they are both perceived to be commodifiable and readily commercialized. This is in contrast with organs, fetal tissues, embryos, surrogate nurturing and, to a large extent at present, oocytes. This is intriguing, given the vast differences between the outcomes of blood and semen. One donor in our London study, when asked if blood and semen donation were similar, responded, "Blood makes scabs, semen makes babies." Of course, blood donation is actually a very important and laudable activity, but, unlike semen provision, it is actually recognized as such in many communities.

**Gift or sale—Which model is more appropriate for semen provision?**

The view we wish to put forward is that a key difference between the gift of semen and the sale of semen is in whether a meaningful or appropriate reciprocation occurs. How semen is viewed—as human germ material of purely biological significance, or as the potential for a family to be formed and of psychosocial significance—determines whether money can be seen as an appropriate or inappropriate return. Novaes writes, "The fact that ... the donor is almost always remunerated indicates that semen donation is defined in advance as a commercial transaction, when in fact its meaning for the donor—and for society—may be totally different" [43] (p. 643). If one takes a psychosocial rather than biological view of DI, then the form of the return in a commercial model of semen provision is rather inappropriate. The social, psychological and spiritual significance of creating new lives and helping couples to form (or augment existing) families is not reciprocated in the payment of money. On the contrary the meaning of the provider's action is minimalised rather than being acknowledged by an appropriate return from the recipients, the professionals or society. The payment of money for the semen also reflects and reinforces our perceptions of the provider's motives and morals.

When semen is gifted, without financial recompense, there is equally the possibility that the gift will not be reciprocated in any way which is meaningful or in keeping with the significance of the gift. However, a gift model of semen provision does not involve the pretence that money is an equal and finalizing reciprocation, and therefore the role of donors is not minimalized to the same extent. By removing the notion of semen provision as a commercial transaction, one opens up the possibility of another kind of exchange—the gift-exchange—where the return reflects how the gift is valued by the receivers. It is vital to point out here that this exchange does not necessarily have to take place between individuals, but rather between groups—givers and beneficiaries, where the latter can be the infertile, clinicians or society in general. Indeed, Novaes [43] (p. 641) points out that Mauss' study of gift-dynamics emphasises the group's—rather than the individual's—responsibility to make gifts and to make returns [73] (p. 3).

The question of how semen providers can be made to feel that their gift has been received and reciprocated by recipients, professionals and society involves considering not just what happens at the clinic when the semen is handed over, but every aspect of semen provision—from recruitment and preparatory counselling, through to the facilities...
offered (a toilet cubicle?), ongoing counselling and the sharing of information. All of these aspects both reflect and construct the meaning of semen provision. Empowering donors and allowing greater information sharing in DI are very strong and tangible ways to acknowledge the gift of semen. The idea of a personal (even if anonymous) note from couples who had given birth was suggested by one Swedish donor, and this idea was greeted warmly by donors subsequently interviewed by the senior author (Daniels Ericsson and Burn, work in progress). At the level of clinic policies and practice, there may be many other ways in which the gift could be acknowledged appropriately.

CONCLUSION

We believe that it is in the interests of everyone involved that DI become a fully socialized method of family creation, and that means that all of the parties involved be recognized and acknowledged. In particular, we need to consider whether current practices in donor insemination appropriately acknowledges the men who provide their semen and the relationships created thereby. When semen provision has a commercial element and payment is regarded as finalizing all obligations toward the providers, this has implications not only for the status of the men who volunteer but for the individuals brought into the world by this method, and for DI as a whole. The ethicist Thomas H. Murray believes that the notion of the gift can “illuminate the appropriate stance we should take toward modern biotechnology” [74] (p. 30). Perhaps it is time that the meaning of semen provision was re-evaluated in this light, with greater attention being given to its psychosocial significance.

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