Having Your Baby by Donor Insemination

A COMPLETE RESOURCE GUIDE

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Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you, yet they belong not to you.
You may give them your love but not your thoughts.
For they have their own thoughts.
You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow, which you cannot visit, not even in your dreams.

Kahlil Gibran
The Prophet

Acknowledgments

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College of Obstetricians and Gynaecologists in England, Sissela Bok, Mark Karpel, Andrea de Witt and Iowa Resolve, Robert Snowden, Stephen Broder of the Southern California Cryobank, and Michael Leunig of *The Age* in Melbourne, Australia.

The personal quotes in the book have been distilled from phone calls, personal interviews, and letters from couples, women, and practitioners all across the country. By sharing their experiences with me they helped increase the depth and breadth of this enterprise. In most cases the source of the quotation is not identified to protect the privacy of those individuals. Often I did not even know the identity of the interviewee other than a first name, and these names, and locations, have all been changed. Every attempt has thus been made to conceal and protect all the parties involved and any similarity that could be drawn is purely coincidental.

Foreword

BY GEORGE J. ANNAS, J.D., M.P.H.

Sam Shepard's Pulitzer Prize–winning play, *Buried Child,* recounts the moral disintegration of a family haunted by a secret they have kept for years: they had intentionally drowned an unwanted infant and buried it in their backyard. During the play, their minister comes to visit the family, but wants to leave as soon as trouble is hinted: "I had no idea there was any trouble. No idea at all." Donor insemination (DI), of course, is concerned with having a wanted child. But it is likely that most people would say the same thing as the minister if asked about keeping anonymous donor insemination a secret: "I had no idea there was any trouble. No idea at all." After reading this book, such a statement is impossible.

It didn't take Alex Haley and *Roots* to convince us that our genetic heritage is part of us, of our identity, and of our birthright. Consciously depriving one's child of the ability ever to know his or her genetic heritage is wrong. As this book so well demonstrates, it is also counterproductive and harmful to family life. As in *Buried Child,* a lifetime of conscious deception can have disastrous consequences. Why does the practice of donor anonymity and secrecy remain almost universal? Why are no standard records kept of donors that can be matched to recipients? Why are parents reluctant to disclose not only the identity of the sperm donor, but even the fact of donor insemination (DI) itself, to their children conceived this way? What can be done to change this practice? These questions, seldom raised in a serious way, are central to this book. And they are relevant to areas well beyond DI.

Donor insemination has become the paradigm for all other forms of noncoital reproduction—from in vitro fertilization (IVF)

and embryo transfer to surrogate motherhood, from surrogate embryo transfer to the use of frozen embryos. Unfortunately, as Elizabeth Noble so well demonstrates, it is an unworkable paradigm. The notion that we have solved all the problems with DI is a fantasy. The truth is that we have almost no consistent policies regarding it, and those policies we do have more often than not are harmful to couples and children alike. By exposing the current anarchy of practice and the fetish of secrecy surrounding DI, we are confronted by the issues of donor screening, donor anonymity, legal presumptions regarding rearing parents, commercialism, and control by the medical profession. We need to face these problems as a society if noncoital reproduction is to be responsive to the needs of infertile people, and respectful of the best interests of the resulting children.

Three books have served as useful markers in the brief modern history of donor insemination. The first is Dr. Hermann Rohleder's comprehensive history of DI, *Test Tube Babies: A History of Artificial Impregnation of Human Beings,* which was published in 1934. The book is about artificial insemination with the husband's sperm, and Dr. Rohleder finds DI with "strange sperm" very disreputable. He writes, "What husband or wife, no matter how intense their longing for an heir, will consent to an injection of strange semen? Thank God that most people still have that much tact, decency, and moral feeling." Nonetheless, he believes physicians should be sympathetic to this "outlandish request," at least when made "in desperate, exceptional cases."

The second, much less well known work, is a dissertation by the Rev. William Kevin Glover for his doctorate in Sacred Theology at Catholic University. Entitled *Artificial Insemination among Human Beings: Medical, Legal and Moral Aspects,* it was published in 1948. Drawing heavily on Catholic moral doctrine, Rev. Glover concludes that DI is "obviously and empathically" morally wrong because the marriage union is *exclusive* (and a third party would violate this exclusiveness); the woman has no moral right to receive the sperm of another (and the husband lacks the power to permit it); and the specimen is always obtained by masturbation, a practice unlawful in itself.

The third book is a collection of papers, *Human Artificial Insemination and Semen Preservation*, edited by Georges David and Wendel S. Price, that were presented at an international conference in Paris in 1979. This conference was held years after the IVF birth of Elizabeth Brown, an event that immediately made DI seem technologically trivial. The collection reflects this reaction. Gone are the moralizing and handwringing about DI. Sixty-one of the seventy-eight papers deal with the scientific and medical aspects of semen collection, preservation, and delivery. The remaining seventeen deal with psychological and social issues. The field of DI is described as "young and growing," and having been given great impetus by developments in cryopreservation. One paper, a study at a French clinic, even deals with the issue of secrecy. The authors conclude that "the possibility of sharing the secret could help the couples deal with unavoidable difficulties, and may play a preventive role regarding the secret's potential toxicity."

DI has been written about from scientific, medical, moral, and psychological perspectives. Now we have a book from the couple's perspective. It's about time. Elizabeth Noble and her husband dealt with the issue of the "secret" directly and took steps to insure that both they and their child would know the identity of the genetic father. She tells their story in a compelling manner. But this book is much more. She follows her personal saga with a comprehensive summary of the major ethical, legal, medical, and personal issues any couple contemplating noncoital reproduction should deal with. No doubt some people will find this book disturbing, and will disagree strongly with the notion that truth-telling is appropriate in the DI setting. But this is an extremely useful self-help book for all who must reproduce noncoitally or not at all. Also, because its focus is so clearly on the best interests of the child, it is a helpful book for the future generations of children as well.

The book should also prove eye opening to physicians and legislators, many of whom remain as shortsighted about secrecy as Dr. Rohlelder was about the medical and social aspects of DI, or Rev. Glover was about its morality. With views like theirs common among professionals, is it any wonder that doctors counsel se-

crecy? I was pleased when Elizabeth Noble asked me for legal advice concerning her wishes for full disclosure to her future child; and equally pleased to write this foreword.

The times *are* changing; not just for medical technology, but also for the protection of the rights of children. Elizabeth Noble takes us beyond protecting the best interests of the sperm donor, to respecting the best interests of the child.

Author's Note

Throughout this book I shall be using the abbreviation DI (donor insemination) rather than the traditional AID (artificial insemination by donor). For consistency I shall also use the initials DI when quoting from references using the term AID.

The terminology for artificial insemination by donor needs to be updated for two reasons. First, it is important that AID not be confused with AIDS (acquired immune deficiency syndrome). The abbreviation AI is also more commonly known as artificial intelligence, and AID also means the (U.S.) Agency for International Development. Second, the term DI indicates that the donor is central to the procedure. (Also, calling the procedure "artificial" insemination is redundant because its artificial nature is already implied in the word "insemination.") "Therapeutic insemination," which has also been tried, is clearly patronizing and misleading, as DI is not a medical "treatment" despite its common presentation as such. I am aware that certain feminists/lesbians use the terms "alternative insemination" or "alternative fertilization" precisely to discount the donor.

I shall also refer to the DI child/adult as "she." In contrast, I shall refer to the adoptee as "he."

As explained in the Acknowledgments, the names and details of those individuals involved with DI who requested anonymity have been changed.

Articles and studies are identified in the text by the authors' last name(s) and date of publication. Complete references can be found in the bibliography at the back of the book.

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We Did It Our Way

THIS BOOK IS A GUIDE to help others make choices and take responsibility, as we did, in a difficult and controversial area—artificial insemination by donor (DI). Many individuals will not want to engage in such a deep level of personal responsibility, and will prefer to have their physician make the important decisions for them. Others will feel great anguish at reading what I have to say, because they followed their doctor's counsel and now it is too late. For the majority of DI parents, it will be too late to tell the child the truth about her parentage without admitting to years of deception and too late in most cases to retrieve information about the donor. However, guilt is a destructive emotion. Parents generally do the best they can given the circumstances at the time, although later they may look back and feel they would have done things differently. DI parents, like adoptive couples in the past, are victims in a system that is not in their or their child's best interest. I hope that the trend toward open adoption will influence the practice of DI and that the questions I raise in this book will force consideration of the most central concern—the rights of the child.

No one, of course, will ever have all the answers to such a complex issue as donor insemination. Every DI family situation is unique and we are learning as we go along. We also have to realize that learning occurs through mistakes. The information that I gathered for this book is primarily for the benefit of the parties involved in our particular situation, so that we all can be aware of as many dimensions as possible. I also deeply hope that by writing our story and sharing all the information and research I uncovered, the practice of DI will change. As with adoption reform,

greater public awareness will enable other parents to make a more informed choice, and provide support for an ethical position that will guarantee the child's right to know her paternal origins.

The Diagnosis of Male Infertility: A Heavy Blow

My husband Geoff and I spent our late twenties studying, traveling, and experimenting with different jobs and life-styles. The thought of children was happily postponed. Indeed, I can even recall casually making the comment that our marriage was so complete it wouldn't matter if one of us were infertile. Feelings certainly change! Reaching our thirties, we decided we were ready for the adventure of parenting. Geoff started running a business by himself, which he hoped would give him the freedom and time to interact with a child. I had my IUD removed to give my uterus at least a year to recover from that foreign body. I remember telling the gynecologist who pulled out the IUD that I didn't need any more contraception—I would play Russian roulette. He talked me into using a diaphragm.

About a year later, we stopped using the diaphragm and actively tried for a pregnancy. I had been keeping records of my basal body temperature for a few months, and was familiar with my most fertile time. I didn't worry too much when the first couple of months went by—we both had a heavy workload. But when no pregnancy resulted after a month's vacation in the Caribbean, I sensed that something was wrong.

We were driving back to Boston from Miami when I got that postvacation menstrual period. My temperature charts showed the expected dips and rises, so we suspected that the problem did not lie with me. We decided to have a semen analysis as soon as we got home. Not all laboratories do a semen analysis, and none of the ones that we contacted wanted to do any investigation without a doctor's order. Lacking any concrete evidence we did not see any need to consult a physician at this stage. It was annoying that a woman can get a pregnancy test without a hassle (finally), but a man cannot have his sperm count checked without medical refer-

ral. I put some pressure on one lab—stressing my paramedical background. After much discussion with the supervisor, the lab eventually agreed to do the test.

Several days went by and we heard nothing. So I called the laboratory to see how the semen analysis was proceeding. The test had been completed, but it appeared that we were not going to learn the outcome. A faint voice faltered across the line, "We *must* have the name of a physician to contact with the results. We are not supposed to give out any information to the patient." I knew immediately that something was seriously wrong. Quietly insistent, I pushed for the results. Finally the voice blurted out, "Are you sure your husband hasn't had a vasectomy?" The technician then went on to explain that *no sperm at all* had been detected.

I wanted to believe that a huge mistake had been made. Perhaps I had kept the sperm too warm when I drove to the lab with the sample inside my blouse? But then, at least dead sperm would be visible. *No* sperm? It just seemed incredible; some technician must have mixed up the samples, or the reports. On the other hand, I knew that I had not become pregnant. Still in the denial phase of my grief reaction, I reminded myself that we had tried for only three months, and it is perfectly normal for a couple to take a year to achieve a pregnancy.

As we slowly became accustomed to the truth, I was relieved that we had not waited any longer and that we at least had clearly identified the problem. Geoff took the news very quietly, whereas my emotions always rise quickly to the surface. His feelings were a mixture of dismay and "Well, there must be a cure." We both decided that now it was time to seek medical guidance.

Searching for Medical Care: Consumers' Frustrations

I did not know a single urologist in our area. I called a few friends with medical connections—but they had no one to recommend. Finally, I contacted an infertility organization in Boston and was given the name of a couple of urologists. The first recommended doctor was heavily booked for a few weeks, but his partner had

an opening within days. We were anxious to proceed so we made an appointment with the junior physician.

Geoff remembered that when he was about one year old he had spent several months with an aunt while his mother was confined in a sanitarium for tuberculosis. Seriously worried that TB may have been the cause of his sterility, we wrote the news to Geoff's mother in Australia. But she could not remember any childhood incidents or illnesses that might have caused the problem. Also, she told us that her TB diagnosis had been completely mistaken.

Perhaps Geoff's diagnosis would also turn out to be an awful error?

Now that we had the name of a urologist, I called around to check out his qualifications. My colleagues in obstetrics and gynecology, like myself, knew little about male infertility. In order to look into this urologist's reputation, I needed to be open about our problem. This was our first experience with the stigma attached to infertility. People reacted with discomfort, as if we were revealing that one of us had cancer.

Nobody could give us much information about the physician we consulted except that he was known to be keenly interested in infertility. He discovered no obvious abnormalities in Geoff's reproductive system, but a repeat semen test revealed the same result: no sperm. He explained the possible causes and recommended a biopsy of the testicles to determine if there was any kind of sperm production. The presence of sperm in the testicles suggests that there is a blockage of the sperm ducts. The potential solution is to cut and rejoin the sperm duct to another area of the testicle to circumvent the blockage. It was also made clear to us, as I had read in the medical literature, that the chance of success for this surgery was very low—about one case in four regained sperm in the semen. Even in these fortunate cases, the count or quality of the sperm was not necessarily normal nor was there any guarantee that a pregnancy would ever result.

A more experienced surgeon would have presented the option to us of doing both the biopsy and reconstructive surgery together during a single hospital admission and anesthetic. For couples who have decided that they want to try every possibility, this saves