



THE UNIVERSITY *of* EDINBURGH

Thesis scanned from best copy available:
may contain faint or blurred text, and / or
cropped or missing pages.

KEEPING IT IN THE FAMILY:
AN ANALYSIS OF DOCTORS' DECISION-MAKING ABOUT ACCESS IN
THE PROVISION OF DONOR INSEMINATION

CATHERINE MARY DONOVAN

PHD
UNIVERSITY OF EDINBURGH
1992



THE CONTENT OF THIS THESIS IS THE SOLE COMPOSITION OF
CATHERINE MARY DONOVAN AND IS THE RESULT ENTIRELY OF MY
OWN WORK

ABSTRACT

This qualitative study tests the hypothesis that doctors who provide DI in Britain make non-medical decisions about the suitability of both who should receive DI and those who should donate sperm and that these decisions show an allegiance to an ideal family model. Some supplementary questions are also asked: how and why doctors have sought to attain professional authority in the provision of DI.

This is a case study of DI practitioners. The collection of data was informed by grounded theory techniques and the fieldwork was conducted using semi structured interviews. Of the sampling universe (58) a non-random sample of 31 DI practitioners were approached and 21 were interviewed (67.7% response rate). A strength of the study lies in the size of the sample which is over half of the sampling universe.

The first chapter identifies some of the categories which emerged from the literature and were used to inform the interview schedule and data analysis: non-medical criteria applied to potential recipients and donors; non-medical professionals' arguments for inclusion in the DI process; some factors implicated in a medicalisation process. The second chapter outlines the methodology. The third and fourth chapters examine aspects of how DI practitioners have established professional authority in the provision of DI: in the third the medicalisation process is discussed; and in the fourth the exclusion of non-medical professionals.

In the fifth and sixth chapters the different elements of how the family is constructed by DI practitioners are examined, first by analysing the selection criteria applied to potential recipients and then discussing what constitutes an acceptable genetic father.

In conclusion the results are discussed in the light of the Human Fertilisation and Embryology Act (1990). The routine allegiance of DI practitioners to an idealised family - an idealised heterosexual nuclear one - is reflected in the broader public debates which have put 'the family' on the party political agenda.

ACKNOWLEDGEMENTS

I would like to acknowledge the following for their support in the completion of this thesis:

The Economic and Social Research Council for the financial support I received in the Competition Award. Without this I would never have been able to embark on my postgraduate study.

My supervisors Dr. Fran Wasoff and Dr. Stewart Asquith who have always been able to balance constructive criticism with positive feedback, a quality of supervision I have really appreciated.

Mike Adler and Professor Adrian Sinfield. For always being genuinely interested in the welfare of the postgraduates and making us feel a part of the department

The twenty-one DI practitioners who agreed to be interviewed. Not only for their time which is valuable enough but also for their willingness to be open about all aspects of their work in the provision of DI.

My colleagues and friends in Edinburgh: Jochen Clasen who graduated from room mate through colleague to friend so very smoothly and who made my time in the department good fun and time out of the department equally so when we had occasion to move our meetings to somewhere more congenial; Carl May who made a similar transition and who spent many a long hour with me discussing the finer points of anything over tea; Chris Flemming for her friendship and support; and Alison Hall who helped to make my stay in Edinburgh a good one.

My friends in Newcastle for always asking how "it's" going, particularly: the Tyneside Reproductive Rights Group as was, especially Pam Millar, Jaquie-Leigh Jobson, Sarah Bastow, and Julie Ballands for being so supportive when I was just starting up; Lucy Bowyer and Lucy Ward who helped with piloting the interview schedule and Lucy Ward especially for letting me use her home to work in and finish the thesis; Gerald Donovan, Richard Bliss, and Angela Foy who supported me during the last months and especially Richard who, unfortunately, helped me come up with the title; Cullagh Warnock and Trish Brady for making lots of visits to see me in Edinburgh; and Helen Stables and Ruth Charlton for caring that I get this done.

My mother and father who have respected my wanting to do this; and my sister, Marie Lousie, who always remembers to ask about it.

Melissa Jane Girling, my partner, who has been, at various times, my secretary, personal assistant, proof reader, typist, and tea- (and a lot more) maker, who has constantly been there for me and who has always known that I could do it. I wonder if she knows how much that means.

DEDICATION

If most of the doctors who are recorded in this thesis had been around and had their way when my parents were having their children, neither I nor my brothers and sister would have been born because my parents would have been considered unsuitable. For different reasons, I would be considered unsuitable if I was to consult them for DI. I disagree and would therefore like to dedicate this thesis to my parents, especially my mother, and all the lesbian mothers and daughters I know.

CONTENTS

Introduction	6
Chapter 1: The Literature Review.	18
Chapter 2: The Method	48
Chapter 3: The Medicalisation of Fertility	65
Chapter 4: Maintaining Control in the Social and Professional Sphere	105
Chapter 5: Selecting Recipients of DI	135
Chapter 6: The Donors, Their Sperm and Their Children	173
Conclusion	203
List of Abbreviations	225
Appendix A: Letter to DI practitioners	226
Appendix B: Interview Schedule	227
Appendix C: Examples of Donor Screening Schedules	233
Bibliography	236

INTRODUCTION

My interest in assisted conception techniques (ACTs) began in 1985 when I read *Test Tube Women* (Arditti, Klein and Minden, 1984). The strongest themes that emerged from this book for me were firstly the contention that women's bodies are being used as "laboratories" in order that experiments on conception, genetic engineering and reproduction can take place (Rowland, 1984:360). This resonated with O'Brien's (1981) thesis that men are envious of and alienated from the creativity of reproduction and childbirth and that this contributes to the explanation as to why men as gynaecologists, embryologists, scientists and doctors seek to control pregnancy and childbirth. The second theme was that the accepted knowledge that it is the treatment of infertility which motivates the development of ACTs is questionable. Any procedures which seek to enhance women's chances of conceiving are not used exclusively for those women who, with or without a male partner, have fertility problems, but may be used with fertile women and men for eugenic reasons. The goal of developing ACTs becomes not then to assist people to have babies they might otherwise not have had but to decrease the risk of reproducing imperfect babies (Stanworth, 1987).

This is borne out by the fact that not all women who could and would wish to have use of ACTs are allowed access. On the one hand childless women are sympathetically, and some might argue patronisingly, perceived to be 'desperate' women wishing to fulfil their maternal instinct or biological destiny. On the other hand it is felt to be unnatural at worst and selfish at best for certain women to attempt to do so (Stanworth, 1987). In realising that it is often the social context in which women find themselves which dictates whether they will be allowed access to ACTs the term 'infertility' becomes simultaneously both inadequate as a label for them but also one which powerful actors in the medical field of fertility have used to name and control within their field. This will be developed further with regard to Donor Insemination (DI) in the next chapter.

As a result of reading *Test Tube Women* (1984) I read other books and recognised the two distinct feminist approaches to ACTs. There are those who sympathise with or belong to the Feminist International Network Against Reproductive Technologies And Genetic Engineering (FINRAGE) and there are those who align themselves with the view that, rather than seeking to do away with the technologies as FINRAGE do, women should actively try to appropriate and control them.

My particular interest in the debate was the role of doctors in achieving diagnostic authority over those attempting to gain access to the use of ACTs and the resulting decisions they make about access. This in broad terms became the topic of study for my MA dissertation. It had become apparent to me that the provision of ACTs under the aegis of medical treatments for infertility was based on two incorrect assumptions. The first is that the decision-making that goes on is exclusively medical and therefore in some way value-free, and second that the ACTs treat infertility. In the first case the decisions doctors appear to be making are primarily social and not medical. That is, a judgement is made as to whether potential recipients are suitable to parent (e.g. Hanmer and Allen, 1980; Singer and Wells, 1984).

In the second case, rather than treating any medical problem, the procedures actually bypass them (McWhinnie, 1986a). In as far as this is true ACTs actually only treat - to the extent that they are successful - the wish for a child in those unable to procreate themselves. The veracity of this is illustrated by the fact that: women using DI must be fertile in order to ensure success (Steinberg, 1987); ACTs are often used for eugenic reasons when recipients are fertile; and some of the more technically sophisticated techniques like In Vitro Fertilisation (IVF) with egg and/or embryo donation are used with women who are fertile in order that their male partners may be given the chance of genetic parentage (Stanway, 1980; Leeton, Trounson and Wood, 1982).

It is the social context in which women find themselves that is the crucial factor in being labelled 'infertile'. In the next chapter there will be a discussion about the way in which in medicine the label 'infertility' is

assigned in the main to heterosexual couples. This means that, regardless of the individual status of each, the label is applied and the treatment advised and administered to the couple. In the field of fertility this has meant that women who are fertile undergo ACTs because of the social context in which they find themselves, that is being in a relationship with men who have fertility or genetic problems. In DI this naming of the procedure as a medical treatment for infertility has three effects:

- a. it conceals the fact that no one is treated by recourse to DI. Male partners continue to have fertility problems.
- b. it conceals the fact that women must be fertile in order to use it successfully.
- c. such naming has the effect of imposing or implying the existence of a particular social context as a precondition of medical attention.

Calling DI a 'treatment for infertility' only makes sense if the social context exists of a fertile woman in a relationship with a male partner who has fertility problems. This will be further discussed in the next chapter. What is important here is that the inadequacy of the term is understood. The term "involuntary childlessness" (Houghton and Houghton, 1987) is an inclusive and much more adequate term which recognises that the social context of those who want children is paramount in accurately defining the 'condition'. Anyone who wants to have children but is unable to for whatever reason is included under this label and especially those who are not in heterosexual relationships.

In my MA dissertation I initially set out to examine in greater detail the use of non-medical criteria in the decision-making around access to ACTs. On closer and broader reading around the subject its objective was narrowed to the non-medical criteria used in the provision of DI. This occurred partly because, contrary to my assumptions, DI is not a 'new' reproductive technology but has been in use in Britain since at least the 1930s although the basic technique of artificial insemination has been in existence for much longer.

Artificial insemination in animal breeding has been traced back to Arab stallion breeding in 1322 (Kleegman, 1954), although 1100 years earlier there is a reference to a hypothetical case of artificial insemination in humans in a Talmudic document (*ibid*). However the actual use of artificial insemination in humans is recorded by doctors. Artificial Insemination with Husband's semen (AIH) is on the record as having taken place under medical supervision in Britain in 1776 (Snowden, Mitchell and Snowden, 1983; Yoxen, 1986); France in 1838 (Yoxen, 1986); and America in the 1880's (Jackson, 1957; Yoxen, 1986).

The first reference to a successful case of DI was published in an American journal in 1907 although the case had purportedly taken place in 1884 in an American medical school (Gregoire and Meyer, 1965; Yoxen, 1986). In Britain the first medical article about a DI service was published in 1945 (Barton, Walker and Weisner, 1945). DI has developed within medicine as a solution for male fertility problems and this explains satisfactorily the medical context of DI. The implications of this for my dissertation were that there were already well established in the medical literature sets of non-medical criteria for use in the process of socially screening potential recipients of DI.

Feminist critiques of ACTs tend to umbrella DI along with IVF, egg and embryo donation and genetic engineering techniques (McDaniel, 1989) even while they acknowledge its uniqueness (e.g. Arditti et al, 1984; Pfeffer, 1987; Smart, 1987; Corea, Hanmer, Klein, Raymond and Rowland, 1987). This tends to give the impression that DI is both as technically sophisticated and exploitative of women as the rest of the ACTs. Very often DI is only discussed separately in the context of women inseminating outside medicine. Since the late 1970's (as far as recorded knowledge tells us: Hornstein, 1984; Duelli-Klein, 1984; Saffron, 1987) there has been an attempt to challenge the medical context of DI. Single heterosexual women and lesbians have attempted to assert the right they perceive themselves to have, which is to access to a procedure that can enable them to choose pregnancy; and because they have been rejected and because they, in

turn, have rejected the medicalisation of DI they have developed informal arrangements for self-insemination (ibid).

My interest in DI and its potential for women to be socially autonomous from men in making procreative decisions was another reason for narrowing my subject for the dissertation. DI offers women the ultimate liberation in that it separates sex from procreation not in the usual negative sense of preventing conception but in the positive sense of women being able to make decisions about when they will have children which are independent of their social context. DI is only different, as a method of achieving conception, from heterosexual intercourse¹ in the means by which sperm is placed in the reproductive tract. Women must be fertile in order for DI to have a chance to work and it can be carried out by women in their own homes. In this context DI is very powerful for women and, conversely, can be perceived as very threatening to men and traditional nuclear family life. It is not that men become dispensable on the contrary their sperm is vital but there need be no social and/or sexual relationship with them for conception or parenting. So long as sperm is available women can achieve autonomous motherhood.

My MA dissertation was mainly descriptive in comparing the non-medical criteria espoused by DI practitioners with those used in adoption within the context of the Warnock Report (the Report) (1984). The Report records the findings of the the Committee of Inquiry into Human Fertilisation and Embryology (1984). It too included DI within the gamut of ACTs and indeed the accepted approach to, and ethical resolutions of, issues arising from DI were used as the model on which IVF and the rest of the ACTs would be based. This achieved two important ends. First, by consolidating the definition of DI as a medical treatment for infertility it could be brought under the control of the proposed statutory licensing authority (SLA) so ensuring that its uniqueness as a procedure could be neutralised by medical control.

¹ Throughout this thesis 'heterosexual intercourse' is the phrase used to denote unprotected, penetrative, procreative heterosexual sex

Second, the ethical issues provoked by the use of IVF or donated eggs and embryos could be dealt with by recourse to comparisons made with DI and the argument "if we agree it can happen there it can also happen here". So donated eggs became acceptable for the committee, because donated sperm has been accepted, even though the actual collection of donated eggs and sperm is substantively different from the former and has provoked ethical questions (Lewis and Cannel, 1986).

Some authors (e.g. Spallone, 1987) and some respondents in this study believe that the Report (1984) stated that all ACTs should be restricted to heterosexual couples in stable relationships and that this statement amounted to a recommendation. This is a very important point because for the Report (1984) to have made such a recommendation would have interfered with - as they saw it - doctors' diagnostic authority. This was the furthest thing from their intentions. What the Report (1984) actually said was:

we believe that as a general rule it is better for children to be born into a two-parent family, with both father and mother, although we recognise that it is impossible to predict with any certainty how lasting such a relationship will be.
(Warnock Report, 1984, 2.11:11-12)

They were then in the position of having to resolve the problem of on the one hand arguing that infertility is a legitimate health need which is deserving of proper provision within the National Health Service (NHS), and on the other of believing that only certain people should have access to these health services. They recognised that there may be reasons why consultants might feel unable to offer treatment services to people and that this might be for social reasons, although they felt that everybody should be entitled to "expert advice and appropriate investigation" (ibid:12). It would seem that the Warnock Committee (1984) abnegated their responsibility and left the making of non-medical decision-making to doctors. The only concession they made to the danger of discriminatory practice was a recommendation that those who might be turned down for access for treatment should be given full explanations as to why so that they might then exercise their right to a second opinion.

As a result of this work I felt that what was missing from feminist critiques of ACTs was an analysis of DI which recognised its uniqueness as a procedure and sought to explain its anomalous place in medicine. If women are able to carry out inseminations themselves at home, and do so, why has DI been defined primarily as a medical procedure and why did the Report (1984) add credence to that definition and include DI in the gamut of treatment services and research that require a licence and regulation by a statutory licencing authority?

Another and related omission from feminist critiques of ACTs is the potential for genetic engineering that exists in the medical use of DI. Much is written about the development of preconception genetic screening and gene therapies, yet the necessity to recruit sperm donors for DI has meant that human genetic engineering has begun, pre-dating the development of these other more sophisticated techniques. The extent to which DI doctors screen donors of sperm indicates their subjective judgements of what is genetically desirable or not. Even if they make wrong decisions about heritability the fact that they believe themselves to be able to manipulate the quality of DI offspring I think deserves investigation.

The underlying justification of selection policies for potential recipients is 'the best interests of the child' and this takes on a new meaning when it is used to rationalise the genetic screening of donors and there exists a diagnostic category for DI which is genetic conditions in men. As Steinberg (1987) points out, the best interests of the child can be divided into the genetic and parenting fitness of its parents. It would seem that the best interests of the child include the decision that it would be better for a child not to be born. In my dissertation I also concluded that both positive and negative eugenic decisions are involved in the provision of DI when certain groups are selected as parents and others are rejected.

These three arguments brought me to my present field of study. First that DI doctors have managed to expand their field of influence to the achievement of conception in fertile women. DI has comparable success rates with heterosexual intercourse has been medicalised and consequently so has

fertility. Second, DI practitioners are engaged in making non-medical decisions about suitability to parent. They have only been able to take part in these sorts of decisions because they have successfully managed to medicalise DI and its provision. Third, by applying social selection criteria some, if not all, of which are based on the heritability of conditions, personalities and behavioural characteristics, they are also engaged in the application of both positive and negative eugenics.

The White Paper entitled *Human Fertilisation and Embryology: A Framework for Legislation* (hereafter called the White Paper) (DHSS, 1987) presented an opportunity to discuss possible formulations of the Human Fertilisation and Embryology Bill (hereafter The Bill, 1989) and was based on the Report (1984) and the following Consultation Paper entitled *Legislation on Human Infertility Services and Embryo Research* (1986). The Report (1984) had recommended that all clinics providing any of the named ACTs should only work under licence. They also recommended an SLA to monitor and grant licences to any clinics either wishing to provide any named treatment services or carry out any research covered by the remit of the Report (1984). The White Paper (1987) sought to explore what aspects of licenced treatments should be regulated by the SLA. Two of the suggested regulations appertained to the selection of potential recipients of any named licenced treatment and donors of either eggs or sperm. In view of the fact that these suggested regulations would affect the diagnostic authority of DI doctors it was decided to ask the views of respondents to these proposals.

The White Paper (1987) also proposed that potential recipients and donors should be provided with counselling in order for them to come to a position in which they could fully understand the implications of their decisions and make informed choices. The result of a wide acceptance of such a proposal would introduce a non-medical professional into the heart of the DI process in the preamble to decision-making. Although some DI doctors make available independent counsellors to their potential recipients of DI, such a proposal would signal an intrusion into the hitherto autonomously run DI services, both at the level of service provision and at the level of

professional intervention. It seemed important to gauge respondents' views on this matter to give some indication of their willingness to relinquish their professional autonomy in this area.

A third relevant proposal referred to children's right to know at eighteen years of age how they were conceived and to have some information about the donor. Hitherto, as evidenced by the medical literature, doctors recommended that DI parents say nothing about the nature of the conception of their children. This will be discussed at some length in the next chapter. In recommending this course of action doctors supported a quite different course of action from that promoted in adoption practice where adopting parents are not only advised to tell but given support and suggested scripts to use in giving explanations. The White Paper (1987) suggests a proposal that, if accepted in the final legislation, would make DI more akin to adoption in this important aspect. Such a move could signify the acknowledgement of the social aspects of DI to an even greater extent and warrant more non-medical professional intervention - especially from those with experience of adoption. Having already included direct questions about the usefulness of the adoption process to the provision of DI it was felt that a question about this aspect of the White Paper (1987) should be asked for the sake of completion.

Finally, and also for completion, it was decided to ask respondents in this study about the implications of the White Paper for the future of self-insemination. If DI was only to be offered under licence, and the handling of donated gametes made illegal unless done so at licenced clinics, the position of self-insemination was uncertain. If the control of DI is important in the service of protecting the interests of the child and the traditional nuclear family, it would make sense that respondents, as well as the White Paper (1987), would be keen to discourage the practice of self-insemination. Of course, in practice policing the ways in which women conceive would be almost impossible. Nevertheless legislation that attempted to criminalise such informal arrangements would set a moral tone that could have some ideological power. A question was therefore

included along with questions relating to self-insemination and the need for medical supervision.

These arguments were translated into research questions and form the basis of my PhD study. In the following chapter, in a review of the medical literature, there is an analysis of the sorts of non-medical criteria which are seemingly applied to potential recipients of DI. There is also a discussion about the way in which doctors who recruit and select donors are involved in applying both positive and negative eugenic principles. There is in the history of DI an association with the eugenics movement from which it is difficult to disassociate. These criteria elicit the central hypothesis that in making non-medical decisions about access, both for potential recipients and donors, DI doctors show an allegiance to an ideal type of family as the setting for the use of DI. Subsidiary questions that evoke a fuller explanation of the current medical provision of DI ask how doctors have been able to assert their authority in the provision of DI and why this has happened.

Additionally in this chapter I outline the arguments of other professionals who wish to be involved in the decision-making process about the suitability to parent of potential recipients. These non-medical professionals - so called to emphasise the fact that the decisions they might make are not medical and that they are not medical doctors - are adoption workers, social workers, psychiatrists and psychologists. I also outline relevant research on DI and identify the gaps therein, paving the way for the next chapter in which is discussed the method and methodology. Implicit in this is the question of how DI doctors come to be the sole arbiters of access to DI.

In chapter four I analyse the way in which women's reproductive potential has been medicalised within the context of a feminist critique. By identifying factors that exist in the medicalisation process and applying them to the medical provision of DI I attempt to show that a similar process has taken place which has resulted in the medicalisation of DI and fertility. Although establishing the fertility status of women wishing to use DI has been a focus of the medicalisation process, in practice the more important part of the DI

process is in the assessment of suitability to parent. Given this it could be argued that DI doctors should at least share the decision-making process with those more skilled in making such social decisions about parenting. In chapter five therefore I examine the respondents' views on the suggested inclusion of non-medical professionals in the DI process.

I examine the tension that exists between the medical and non-medical professionals who endeavour to claim DI as respectively all medical or at least equally medical and social. In denying the social context of DI, respondents repudiate the selection processes of adoption as unnecessary and harsh and the skills of psychiatrists and psychologists or medical social workers as irrelevant. This argument implies that respondents do not apply such selection criteria. However, in chapter six this is revealed not to be the case as similarities between the criteria used by non-medical professionals and respondents are demonstrated. The non-medical criteria are argued to be ideological in nature, that is they are based on value judgements about particular lifestyles, personalities, motives and so on. Three sets of criteria are identified under the broad heading of 'ideological' which are eugenic, structural, and environmental. Two reasons for applying such non-medical criteria are mooted although the results of the differently motivated are the same. In the main, respondents do show an allegiance to an ideal type of family which is the traditional nuclear one.

In chapter seven the eugenic practices of respondents are discussed and here too it is apparent that perfect babies who are free from all undesirable personalities and conditions are the goal of successful use of DI. This chapter also has a discussion about the way in which the control of sperm which is dislocated from its normative context, that is, a heterosexual man engaged in heterosexual intercourse in an ongoing and 'stable' relationship, is a very important reason for the medicalisation of DI for some respondents. There is a discussion about the way in which anthropological ideas about perceptions of sperm and the connections between donated sperm and the threat to the natural order as embodied in the traditional nuclear family begin to provide some explanation for the control of DI by

those who have an investment in the existence of the traditional nuclear family.

In the conclusion there will be a summation of the main points from the data including an appraisal of the method and the results. This will include a discussion about the central hypothesis that DI doctors show an allegiance to an ideal family structure in making selections of potential recipients and donors. This is followed by a discussion about the implications of *The Human Fertilisation and Embryology Act* (hereafter the Act, 1990) for this study. The fieldwork questionnaire was informed by all the relevant reports and governmental documents and respondents were asked their opinions about the White Paper (1987) proposals. It is therefore appropriate to make connections between their responses and the Act (1990) and to examine this within the broader societal context.

CHAPTER ONE: THE LITERATURE REVIEW

Most of the literature about the actual use of DI is written by DI practitioners and is based on studies carried out in the authors' own DI services. In this chapter the issues which have arisen from reading this literature and informed the research questions of this study will be outlined. First there will be a discussion about how medical language assists in medicine's colonisation of DI and its employment and second, in relation to this, how the language of medical discourse and that of social discourse are amalgamated in medical literature in a way which implies a normative context for the use of DI. There follows a discussion about the results of such an implication in that particular groups of potential recipients of DI are excluded from its use. An examination of selection procedures raises the question of whether other professionals might be usefully involved in the DI process and there is a discussion about the justifications used for applying such procedures. One such justification is the welfare of the child and it is here that there is an interface between potential recipients and donors of sperm. In examining the ways in which men are selected as donors, both positive and negative eugenics emerge as issues. Finally there will be an analysis of other relevant research in order to clarify what is known empirically about the provision of DI and identify the gaps in the research which can be filled, in part at least, by this study.

Language and Discourse

For such a technically simple procedure to be under the control of medicine a medicalisation process must have taken place. One of the factors which contributes to medicalisation is the language used to describe a procedure and its applications. The language used by authors of medical texts illustrates the power of the medical profession to name or label a condition and its management and therefore control it (Friedson, 1970). DI is named a 'treatment' for 'infertility' (e.g. Pennington and Naik, 1977; Chong and Taymor, 1975) or a 'cure' for 'sterility' (e.g. Kleegman, 1954). No one is

treated by using DI yet the terms 'infertility' and 'sterility' imply physiological complaints which are properly the preserve of medicine.

The success of DI depends upon women being fertile. They are not in need of treatment - they have nothing wrong with them - yet throughout the literature they are referred to as 'patients' (e.g. Dixon and Buttram, 1976; Murphy and Torrano, 1966; Ledward, Crich, Sharp, Cotton and Symonds, 1976). This label has the effect of implying that there might be something wrong with them, or that their use of DI is such as to render it problematic. This use of medical terminology may be nothing more than the use of familiar labels and terms in the absence of any more imaginative thinking on the part of the medical authors. However, the language also serves to infer medical status to the procedure. There is also evidence that the language of social discourse has been grafted on to that of medical discourse. This, I would argue, both contributes to the medicalisation of what is clearly a social need - the need of the involuntarily childless to have children - and the socialisation of a medical procedure. For example:

[DI is] a well accepted method of treatment for the barren couple in whom the male partner cannot impregnate his wife.
(Chong and Taymor, 1975:791 my emphasis)

The combination of discourses has the effect of implying that DI is a treatment for heterosexual couples who are assumed, if not expected, to be married.

This expectation that DI 'treats' male fertility problems within the context of heterosexual (married) couples is consolidated by the universal presentation in the medical literature of a list of male fertility problems which are addressed by using DI. These are azoospermia; oligospermia; Rh factor incompatibility; and the presence of deleterious genes in the male. This list is presented as the 'indications' for DI by most authors (e.g. Richardson, 1975; Dixon and Buttram, 1976), and as 'medical criteria' by others as opposed to 'non-medical criteria' which they also use (Kerr and Rogers, 1975; Kerr and Templeton, 1976).

Selection of Potential Recipients

Presenting these medical criteria or indications serves to legitimate the role of the medical practitioner in the DI process as they are the legitimate investigators of them. Yet the reference to the social remains implicit: a fertile woman must be present. The assertion of the centrality of the male actor in the process both plays down the crucial role of the fertile, female actor, and renders her invisible as the 'patient'. It also asserts the normative social context: heterosexual relationships. By relying on this medical model, single women and lesbians can be excluded: there is no male to be investigated, which is the medical context; and there is no infertile couple, which is the social one.

In the overwhelming majority of medical articles about DI, lesbians and single women are rejected or excluded as potential recipients of DI. There have also been articles devoted to the issue of whether these groups of women should have access to parenthood through use of DI. Arguments against their access talk about the need for children to have two parents, one of whom is male (Prince, 1978; O'Brien Steinfeld, 1983; Strong and Schinfeld, 1984; McGuire and Alexander, 1985); the need of children for a father who is a man and can act as a male role model (O'Brien Steinfeld, 1983; Golombok and Rust, 1986); the inherent instability of lesbian relationships (Case Conference, 1978; Golombok and Rust, 1986); financial insecurity (O'Brien Steinfeld, 1983; McCartney, 1985; McGuire and Alexander, 1985); the risk to children's 'normal' psychosocial or psychosexual development (Strong and Schinfeld, 1984; McCartney, 1985; McGuire and Alexander, 1985; Golombok and Rust, 1986); the risk to children from their peers or society's animosity towards their family environment (Kennedy, 1978; Strong and Schinfeld, 1984; Golombok and Rust, 1986).

Nevertheless, the evidence that exists pertaining to single heterosexual women and lesbians acting as single parents (with lesbians often actually involved in partnerships) shows that these women do as well as any other women, and that their children develop in much the same way as other

children. In conclusion it would seem that the only real difficulties faced by some single heterosexual women and lesbians are the same as other parents faced with low or no income; and those which result from living in a homophobic society (Hanscombe, 1983; Golombok, Spencer and Rutter, 1983; Strong and Schinfeld, 1984; McCartney, 1985; Golombok and Rust, 1986; King and Pattison, 1991).

There have also been some studies and reviews done on single heterosexual women and lesbians who have joined DI programmes. Although emphasising extra counselling and careful assessments of financial, emotional and practical support from relatives and friends, the results suggest that these women have positive experiences as a result of choosing and using DI. Of course, as with all studies of recipients of DI, these results are of predicted outcomes and have all the uncertainties which result from such predictive assessments (McCartney, 1985; Brewaeys, Olbrechts, Devroey and Steirteghem, 1989; Strong and Schinfeld, 1984; Dowie, 1988).

It would seem that there are no medical reasons for excluding single, heterosexual women and lesbians from DI but only social or non-medical ones which are based on subjective belief systems about families and parenting. The most important social criterion would appear to be what the structure of the potential DI family will look like. A heterosexual, monogamous, nuclear family emerges as the most vaunted structural context for raising children. In considering a case study about a lesbian couple who had been accepted for DI, Perkoff (1985) makes the point that the crux of the matter is in the definition of parenthood. If parenthood is primarily defined with reference to a physical commitment to an exclusive sexual relationship within marriage then, he argues, no one should use DI. If parenthood is defined in terms of family life which can only exist as a result of marriage then the ethical position would be that lesbians could not have children by using DI. However, he argues that :

if one defines parenthood as the on going commitment to love and raise a child, non-traditional families can raise children.
(ibid:530)

Further Selection of the Recipients

The evidence above suggests that, in the main, heterosexual couples are preferred over those who do not conform to the nuclear family structure. Selection does not stop here however. There exists a consensus in the medical literature that all (heterosexual) couples should be assessed before being accepted for DI (Kleegman, 1954; Behrman, 1959; Richardson, 1975; Glezerman, 1981). The most comprehensive list of non-medical criteria given by medical practitioners is that published by Kerr and Rogers (1975) and repeated by Kerr and Templeton (1976). Their work prompted me to ask on what grounds their particular criteria were sufficient to evaluate anybody's ability to parent and to want to investigate how widely their criteria are endorsed by other medical writers. As I go through their criteria I will acknowledge other authors who have replicated them in their own DI services.

- The first two criteria refer to the health of the woman and the man prior to receiving DI. They say if the man is "incapacitated" or he has an "uncertain future" they might still accept the couple provided they understand the situation they are in. On the other hand, they say, the health of the woman should not compromise the pregnancy and her "life expectancy should be reasonable" (Kerr and Rogers, 1975: 32). This difference perhaps reflects the different expectations the authors have of motherhood and fatherhood. They also state an age limit over which they would not inseminate (Behrman, 1959; Glezerman, 1981).

- The couple should be 'stable and mature' (e.g. Kleegman, 1954; Bloom, 1957; Pennington and Naik, 1977; Matthews, 1980; Glezerman, 1981; Carruthers, 1981). None of the authors suggest how such an assessment should or could be made. Kerr and Rogers also say that they would only accept heterosexual married couples and single women and lesbians would not be accepted as "appropriate parents" (1975:32)

- Communication between the couple. This must be seen to be free and open and there must exist a consensus between them about their desire for DI (e.g. Kleegman, 1954; Bloom, 1957). Again, exactly how this would be assessed they do not say.
- The ability of the man to come to terms with his infertility (e.g. Kleegman, 1954; Bloom, 1957; Ledward, Crawford and Symonds, 1979); his tolerance of the fact that he cannot biologically father; and his understanding that it is in the role of social fatherhood that his fulfilment lies.
- The woman's ability to come to terms with the infertility of the marriage (e.g. Kleegman, 1954; Glezerman, 1981); she must not be judged to be using DI as revenge on her husband for his failure to give her a child.
- The couple's motive to parent: it should not be based on a response to parental or peer pressure (e.g. Matthews, 1980; Glezerman, 1981); neither should it be seen as a means by which a 'shaky' marriage can be saved (e.g. Kleegman, 1954; Templeton and Triseliotis, 1983).
- The couple's understanding of the DI procedure and its legal implications (e.g. Bloom, 1957; Ledward et al, 1976).
- The couple's ability to deal with the moral and legal aspects of DI (Bloom, 1957; Ledward et al, 1976).
- The couple's willingness to trust medical practitioners in the choice of donor. Recipients must also appear reluctant to want to choose specific qualities for their child (Richardson, 1975; Ledward et al, 1976).

Other authors have made comments about the use of DI or have used criteria for selection which have prompted me to ask whether social class membership or income might be factors used to evaluate potential recipients. In a book about childlessness aimed at lay people, Dr Stanway (1980) states that middle class people are the biggest users of DI in Britain. Carruthers (1981) found that, of one hundred consecutive couples using DI

who were classified according to social class (as defined by the husbands' occupation), eighty of the couples belonged to the top three social classes. Other authors have also commented on the underrepresentation of social classes four and five in the use of DI (e.g. Ledward et al, 1979; Snowden et al, 1983). Furthermore Ledward et al (1979) collect a social work report on every potential recipient to check they have "stable" marriages and "suitable housing and financial conditions" (ibid:478).

It is clear that income is a barrier to using DI. Most clinics charge for the service and the distribution of clinics, geographically, is such that the cost of the procedure, and the cost of taking days off work to attend clinics, mean that some potential recipients cannot use the service (Ledward et al, 1979; Snowden et al, 1983). In a sociological analysis of the recipients of DI in one DI practice in Britain, the authors concluded that:

the majority of manual working couples who were interviewed had a lifestyle which, to a great extent, followed middle class values ... [this] confirms the findings of the retrospective survey that couples who avail themselves of DI tend to be middle class. (Snowden et al, 1983:83)

Additionally, there are authors who present membership of social class one or two as a factor that increases the success rate of DI (Glezerman, 1981; Hargreave, 1985). Neither of these authors suggest why this correlation should exist and obviously the use to which this knowledge could be put could work in favour of people from lower social classes or against them.

Race

There is some evidence that, in the main, DI is available to white people and that Black² people do not have equal access to DI. This may be partially because recruiting Black men to donate ethnically appropriate sperm is more difficult or at any rate does not seem to occur with the same regularity as recruiting white men. Steinberg (1987) suggests that most

² In using the term 'Black' I am referring to all peoples who are non-white. This is in recognition of the term as a "cultural, personal and political identity" (Joseph, 1983 in Kramarae and Treichler, 1985:73).

donors are white and that this implies there is an assumption that most potential recipients will be white. Carrutthers (1981) too points out that the vast majority of recipients of DI are white. However, there is also some evidence that the provision of DI is organised in such a way as to be in antagonism with the needs of Black potential recipients. For example, Humphrey and Humphrey (1987) describe how the ethnic origin of potential recipients referred to them for counselling affected their access. Out of a total of one hundred couples, thirteen of the total fourteen couples from an ethnic group appeared in the first fifty couples. In explanation they say:

at this stage, the value of counselling was queried when there were cultural and sometimes linguistic barriers to overcome. Thereafter ethnic minority couples were excluded from the AID programme unless able to communicate well.
(ibid:212)

Rather than adapting the counselling arrangements to those using them, any who were designated problematic were excluded. This, albeit sparse, evidence raises the question of whether Black people enjoy the same opportunity to use to DI as the white population

Inclusion of Other Professionals

Kerr and Rogers say of their list of criteria:

Since these criteria for acceptance are clearly ill-defined and subjective, they are difficult to apply in the clinical situation. It is unfortunate that little has been written on the subject, and there is no scientific evidence written on which to base an opinion ... There is a clear need for guidelines for the selection of recipients, and a comprehensive, long term follow up study is required to assess the results of any policy.
(Kerr and Rogers, 1975:33)

These authors suggest that medical practitioners of DI should be part of a team that consults with other 'experts' during the decision-making process. This, they believe, will add to the effectiveness of the selection procedures while allowing the doctors to remain an "integral part of the team" (ibid:33). This proposed team approach involves the inclusion of other, non-medical,

professionals in the DI process. The few articles that exist about social work intervention have often been co-authored by DI practitioners and social workers. These often propose a team approach to offering DI with social workers and possibly psychologists or psychiatrists being part of the assessment team (e.g. Stewart, Daniels and Boulnois, 1982). Other authors say they refer potential recipients to psychiatrists for evaluation (Behrman, 1959; Pennington and Naik, 1977), or psychologists (Richardson, 1975).

There is also a growing literature from these professionals and adoption professionals arguing that they should be included in the administration of DI. This literature, in the main, makes three points. First that the assessment of potential recipients is crucial to ensure the successful outcome of DI; second that such assessments are based on non-medical criteria and therefore require their skills to apply them; and third that they have already developed appropriate social criteria as a result of their own work experience which can be employed in the DI process.

Adoption

Those in adoption argue for their inclusion in the DI process because of the similarities they believe exist between adoption and DI which leads, they say, to their possessing transferable skills. These similarities relate to the comparison of both as methods of achieving parenthood and to the issues that can arise in the involuntarily childless and their treatment by professionals (Brandon and Warner, 1977; British Association of Adoption and Fostering (BAAF) Medical Group AID³ Working Party, [BAAF AID Working Party] 1984; Templeton and Triseliotis, 1983; McWhinnie, 1986b).

The similarities having been established between the two as methods of achieving parenthood, the point is made that DI and adoption are alternative methods of trying to meet a socially orchestrated, albeit a real and emotionally felt, need to have children. As such the arguments from adoption professionals address what they believe must be the common

³ AID stands for Artificial Insemination by Donor and was, until recently, the label attached to what is now called DI. The change occurred to prevent confusion between this technique and AIDS, the Acquired Immune Deficiency Syndrome.

social implications and consequences of using either method. An important area in this regard is secrecy.

Secrecy.

In DI the method of conception and the identity of the donor are kept secret by recipients. Hitherto in adoption the fact of adoption and the identity of the birth parents were also kept from adopted children. Those writing from a background in adoption refer to this withholding of information as being a two-layered secret.

Those authors who discuss the importance of more openness in the DI process usually refer to the early work of Triseliotis (1973) or McWhinnie (1969) or both, to justify their concern. In their path-breaking British studies with adults who had been adopted, these authors established two basic tenets which are argued to have most relevance to DI. The first is that adopted children want to be told, by their adoptive parents⁴, about their adoptive status and be given information about their birth parents and the circumstances which led to their conception. Second, and depending on how they were given this information about their origins⁵, adopted children, on reaching adulthood, do not necessarily wish to track down and meet their birth parents. It is worth pointing out at this stage that, in the majority of cases, the mother is the only birth-parent adopted children are likely to have access to information about.

Many reasons are given for the importance of telling children about their origins. One is the apparent self-evident strain of, as Cooper describes, "living a lie" (in Brandon, 1979:13), and the danger that the secret can, and does, come out in circumstances not always beneficial to the people involved⁶ (Brandon and Warner, 1977; British Association of Social Workers [BASW] Sexuality Interest Group, [BASW Sexuality Group] 1984;

⁴ It is crucial that the adoptive parents are the ones to tell the children McWhinnie (1969)

⁵ Triseliotis found that the way in which information was given about their adoptive status and their birth parents could seriously affect the well-being and self-esteem of the adopted children

⁶ The danger is not only that the secret may come out in an argument between the parents and children but also that some one other than the adoptive parents may tell the child, the point being that the secret is rarely only kept between the adoptive parents.

McWhinnie, 1986b). Another reason given is that not telling is *de facto* a fundamental violation of the rights of the individual (e.g. Holbrook, 1990).

There is also the belief, substantiated by research, that adopted children actually fare better when they are told the truth about their origins (Brandon, 1979). This belief is also given credence by the work of Sants (1972), who is given an important place in adoption research (according to McWhinnie, 1984), on the concept of "genealogical bewilderment"⁷ in which children are said to suffer because they have no or only uncertain knowledge of their natural parents. Those involved in DI have apparently misunderstood why openness is promoted in adoption and believe that it is because adoption draws attention to itself as the method being used to achieve parenthood. One of the reasons why both the people - most especially heterosexual couples - who use DI and the doctors who administer it are secret about it is quite simply because they can be. Many medical authors have either encouraged complete secrecy with potential recipients (e.g. Kleegman, 1954; Bloom, 1957; Behrman, 1959; Sandler, 1972) or, like the Royal College of Obstetricians and Gynaecologists (RCOG) booklet (RCOG, Fertility Sub-Committee, 1987) on information for 'patients' using DI have said that the decision to tell rests with the recipients of DI (Newill, 1976; Joyce, 1984).

Some medical authors refer to DI as a superior method for solving childlessness precisely because of the secrecy its use offers (Simmons, 1957; Newill, 1976). Two medical authors writing about DI in books about adoption also refer to secrecy as being the main reason why DI is preferable to adoption. Sandler (1979), who points out that DI has been called "semi-adoption" (ibid:82) and acknowledges other parallels that exist between DI and adoption, especially in the selection of potential recipients, nevertheless says that parallels stop at the point at which access to information about donors is discussed. The other medical author, Barton (1972) usefully summarises this position when discussing registration of DI births:

⁷ The term was first used by Wellisch in 1952 but was fully propounded and established as a valid concept by Sants in 1964. (Sants, 1972:67)

Moreover, to register the child as illegitimate and then adopt it would in most cases inevitably lead in the end to the defeat of the purpose of the whole operation - the completion of a normal family with no possibility of the offspring questioning his [sic] origin unless deliberately told by the couple concerned, who would then shoulder the responsibility for doing so.
(Barton, 1972:171)

To date none of the adoption professionals writing about the comparisons between adoption and DI write with any first hand knowledge of DI recipients.⁸ Two sets of authors who are not medical professionals have completed studies with DI recipients and it is interesting to see how near they are to the views of DI practitioners and not adoption professionals (Rowland, 1985; Humphrey and Humphrey, 1986). Humphrey and Humphrey (1986) argue that some doubt must be cast on Sants' (1977) claim that ignorance about one's origins can undermine one's sense of self and conclude that, if genealogical bewilderment is to be regarded as a significant factor in children of, as they say, "substitute families", then the onus is on proponents of the theory to show that its existence induces "psychological malaise" in children who have experienced family relationships "beyond reproach" (Humphrey and Humphrey, 1986:135). Having challenged the validity of genealogical bewilderment Humphrey and Humphrey (1986) then question the quality of information about birth parents that may be available to children:

In some ways it may be preferable to grow up in total ignorance of one's ancestry than to know enough to incite curiosity yet too little to satisfy it.
(ibid:136)

This view is supported in the medical literature (Joyce, 1984; Sandler, 1981) and by Rowland (1985) and Holbrook (1990) although the latter argues that this a reason for changing the amount of information known about donors and for the inclusion of social workers in the DI process. This view is also in opposition to the view taken by Triseliotis - based on the research he carried out - that some information is *better* than none at all (in Templeton and Triseliotis, 1983). Humphrey and Humphrey (1986) go on to

⁸ Although one of the authors has been conducting a study with parents of DI children - personal communication.

argue that future discussions about genealogical bewilderment should take into account the results of those studies in adoption which have revealed the importance of the following factors for the well-being of the adopted child and adult: the information available to the adoptees; the quality and quantity of information disclosed to the children; and the timing of the disclosure.

Humphrey and Humphrey (1986), like others (Rowland, 1985; Daniels, 1986), found that almost all of the potential recipients they counselled had no intention of revealing to the DI child the nature of their conception although over a third had told someone in confidence about their intended use of DI. The approach of Humphrey and Humphrey (1986) and Rowland (1985) in conceding to parents the right to decide whether to tell or not does appear to leave them open to the charge, from those writing from experience of adoption, of colluding with adults at the expense of the children as well as not recognising the precariousness of shared secrets. It is in the nature of DI as a method of achieving parenthood that it allows genetic parentage to be assumed because the majority of pregnancies occur in a recognisable social and structural context - a heterosexual (married) couple. It is however a paradox that, on the one hand society and the law value paternal genetic parentage, yet in DI genetics takes second place to the appearance of structural and ideological 'normality' (Haimes, 1990).

Another reason Humphrey and Humphrey (1986) give for secrecy is to protect the anonymity of the donor, a stand which is prefaced by the argument that the amount of information known will be limited:

it can be little comfort to learn that one's genetic father was a medical student or a public spirited volunteer.
(ibid:137)

Humphrey and Humphrey (1986) also make the point that in DI children are sure who their mother is and that this parallels adoption as it is usually the mother who can be traced. The implication is that if you know who your mother is then there is less need to establish the identity of the father. This

reflects too, the medical literature in which doctors argue that a sizeable percentage of children grow up without knowing that the man they call their father is not in fact the biological father - and that the man may not know that this is the case either (Phillipps, 1981; Joyce, 1984). Again this playing-down of paternal genetic parentage in a society whose property and inheritance laws are based on it is extraordinary and must be functional for those who advocate such a view.

Rowland (1985) also explores the difference between the position of the donor and the birth father in adoption and argues that, unlike adoption, there is no relationship between the woman using DI and the donor. The only relationship the donors have with anyone is with the staff of the DI clinic. This point illustrates the problem caused by the lack of a recognisable social context when women inseminate with a stranger's semen. The children offered for adoption are the result of a social-sexual relationship - regardless of the quality or length of the relationship or indeed the motive for having sex. Rowland (*ibid*) tries to argue that this lack of context in DI must make a difference. People writing from a background in adoption argue that children have the right to know how they were conceived and who their 'father' is. They apparently want the social notion of 'fatherhood' to apply to donors of sperm.

The point I am making here is that those writing about DI from experience of adoption attempt to impose a recognisable social context on to what is an anonymous, biological procedure. However this apparent misunderstanding on their part of what the insemination procedure involves is functional for them in that they can argue that their experience and knowledge of an adopted child's desire to know their origins and meet with their birth parents is useful and should be incorporated into the DI process. The denial of such a social context and the rigorous reinforcement of the position and value of the social father in DI by medical writers is also functional for them. In playing down both the need to tell and the role of the donor and in underlining the social father and the apparent 'normality' of DI families, medical writers can decry the social consequences and implications of using DI and reduce it to its biological, albeit medicalised,

component which only requires a medical professional with training and experience in fertility problems.

Psychiatrists and Psychologists

There is also a growing literature from psychiatrists and psychologists arguing for their inclusion in the DI process. Along with the concern for the need for more psychiatric-psychological study of DI, is the argument that psychiatrists-psychologists should be included in the DI process. In the literature there are three positions taken on this role. There are those who believe that the psychiatrist-psychologist has a counselling role to play (Rosenkvist, 1981; Alder, 1984; Richardson, 1987); an evaluative/selective role to play (Lamson, Pinard and Meaker, 1951; Heiman and Kleegman, 1966; Watters and Souza-Poza, 1966; Poyen, Penochet, Mattei and Choux, 1980); and those who combine or confuse these roles (David and Avidan, 1976; Humphrey and Humphrey, 1987). Although the size of these three groups is small it would still seem that those advocating an evaluative/selective role were writing earlier in the history of DI than those advocating a counselling role.

On the question of which, if any, non-medical professionals should be involved with the DI process, David and Avidan (1976) argue that a psychologist should be involved; Lamson et al (1951), Rosenkvist (1981), and Alder (1984) tend toward a team approach including psychiatrists, psychologists and social workers alongside the medical staff; and the rest referred, in the main, to psychiatrists being involved. Of the latter, Watters et al (1966) felt that the decision about use of DI should be shared between the psychiatrist and the doctor; and Poyen et al (1980) felt that the decision should rest with the psychiatrist. Most other authors did not state exactly what role non-medical professionals should have in the decision-making process. As will be shown below this was mainly because either a counselling role was advocated, which implied a non-decision-making role, or there was confusion between counselling and selecting, making the role of the non-medical professional seem ill-defined.

Almost all authors justify their argument to include a psychiatric-psychologic screening of potential recipients by referring to the dangers, as they see them, of indiscriminately giving babies to people. For example:

it becomes evident that indiscriminating attempts to give children to the childless can, in many cases, produce results detrimental to the welfare of society. The best adoption agencies reject all applicants who do not conform to a high standard of fitness for parenthood. Similar caution should be exercised in the selection of patients for donor insemination, since this is a major social operation, essentially the arrangement of semiadoption.
(Lamson et al, 1951:1063)

The need for selection having been established some authors also point out the inadequacy of medical doctors to carry out this selection, for example:

To infer lifelong mutual commitment from superficial impressions of a couple on their best behaviour could be misleading, and a more leisurely and cautious assessment of the childless couple calls for skills in which few infertility specialists have been trained.
(Humphrey and Humphrey, 1987:210)

Poyen et al (1980) write as a result of their experience in France and although they advocate an evaluative/selective role, the following illustrates the implicit confusion in the role they describe:

Amongst the aims of this interview, besides helping, preparing and giving the couple an opportunity for deeper reflection, the psychologist was more or less implicitly expected to make a final choice.
(Poyen et al, 1980:413)

They go on to discuss whether DI is a medical or a biological act. If it is the latter they argue there are no indications or contra-indications for DI but only requests. Although they point out the anomalous situation in DI in which a problem in a man is corrected by subjecting his female partner to a medical act "to finally cure the couple" (ibid:416), they argue that, in taking responsibility for rejecting 2% of the people they see, they have proved themselves to be on the side of those who think DI is a medical act. They

also argue that it is dangerous to avoid the responsibility by saying that if the couple were not sterile they would go ahead and have a baby and that they should, when necessary, say no.

That psychiatrists-psychologists should say no when they can is echoed by Richardson (1987) even though he advocates a counselling role. He says that one of the purposes for psychiatric intervention would be to:

Help avoid a medical intervention that would help bring a child into a predictably bad situation.
(Richardson, 1987:104)

In his article, Richardson reviews all the available psychiatric-psychologic literature based on both retrospective and prospective studies. He is most influenced by the work of Rosenkvist (1981) who studied couples already accepted on to a DI programme in Denmark. However, because of the predictive nature of assessment, Rosenkvist concluded that there was no evidence that selection could take place on the basis of "rigid socio-psychological/psychiatric criteria" (ibid:145)

Richardson accepts these findings and, together with his review of other literature, comes to the conclusion that the role of the psychiatrist is ambiguous:

The goal would be to find some useful role of service to the primary physician, patient and potential child.
(Richardson, 1987:104)

Poyen et al (1980) also acknowledge that one of the problems of assessments based on the evaluation of psychopathology is exactly that of predicting outcomes. They go even further and recognise the problem of subjectivity in the assessor as well:

the scientific knowledge that we have today is so poor in regard to prediction in the field of psychopathology that it is easy to imagine that the percentage can vary from 0% to 100% in function of the theoretical [sic] prejudices or originality of the psychiatrist.
(Poyen et al, 1980:416)

In a review of the available literature of studies done on the long-term success of DI, a medical writer concludes that there is no case for the systematic assessment of potential recipients by psychologists or psychiatrists (Walser, 1982). It is not surprising that medical writers would find against the case for non-medical intervention if my argument that they wish to maintain a professional monopoly holds. It is, however, very difficult for non-medical professionals to maintain their argument for intervention in the face of such ambiguous results about the effectiveness of any contribution they might make.

Richardson (1987) and Rosenkvist (1981) attempt to resolve the problem by advocating a counselling and advisory role for psychiatrists-psychologists. Alder (1984) also advocates the need for counselling even though, based on a study she carried out with parents of DI children, she has to contend with the result that none of the people she interviewed would have wanted to talk about their decision with a counsellor or similar person:

They felt it was their own decision, between husband and wife, and that the discussions with the hospital doctors (who were particularly experienced and sympathetic) were all they wanted. (Alder, 1984:195)

Humphrey and Humphrey (1987) and David and Avidan (1976) discuss both the advisory/guidance role and selective/assessing role almost without thought for the problematic relationship this must create with potential recipients. For example:

The role of the psychologist in AID treatment was found to be important for careful selection of cases. He [sic] can also guide and prepare these couples to face family life in the future. (David and Avidan, 1976:528)

Both groups of authors' discussions are based on prospective studies carried out with potential recipients of DI. When Humphrey and Humphrey (1987) describe the use of the questionnaire in their study the ambiguity of the project becomes apparent:

Questionnaires formed part of an assessment *and* counselling process.
(*ibid*:210, my emphasis)

Humphrey and Humphrey (1987), Richardson (1987), and Rosenkvist (1981) feel that the psychiatrist should have some influence in the decision-making process, not necessarily in order to say no, but to suggest further counselling before potential recipients proceed with DI. This use of counselling holds two uses for these authors. First, the role of the psychiatrist is validated; and second the role can become integral to the DI process without having to threaten directly the role of the DI doctor as final arbiter. What these authors offer are the skills and tests they possess and believe are needed to elucidate, evaluate and resolve issues which may emerge through use of DI.

All of the above non-medical professionals have identified the social aspects and implications of DI as being worthy of attention. They also believe themselves to have appropriate and transferable skills which can be utilised in order to achieve successful social outcomes of using DI.

Decision-Making

None of the medical authors say how or by what process anyone is told that they have been selected out, nor exactly how potential recipients are tested as to their ability to meet the standards of the criteria used. Additionally, none of the authors say how they decided that the criteria they use are the correct ones. Some authors give a very ambiguous presentation of the selection process (e.g. Jackson, 1957; Ledward et al, 1976): on the one hand they are adamant that the decision to ask for and accept DI must come from the couple (with some acknowledged help from the couple's GP), yet on the other hand the same authors assert their perceived responsibility by saying it is they who must make the final decision about the suitability of the recipients.

This ambiguity provokes questions about how the decision-making process occurs. This is a pertinent question in the light of the results of the study

done by Alder (1984). She found that almost all of her respondents who had used DI felt that it had been they who had made the decision about whether they should use it. Had it been in consultations with the doctors in this study that the latter had been making up their own minds about the suitability of the couples?

The Question of the Unborn Child

Those medical authors who are aware of their role as selector justify it with reference to the responsibility they feel towards the unborn child (Kleegman, 1954; Bloom, 1957; Templeton and Triseliotis, 1983) For example:

the physician practising AID takes upon himself [sic], not only the medical treatment but also the legal "guardianship" of a family that has placed in him the opportunity of creating life itself.
(Weisman, 1942 in Richardson, 1975:413)

In reading the medical literature it has become apparent that the responsibility felt by some medical authors toward the unborn child goes further than concern with the environment in which it may be brought up. The question of the potential of the child links the selection of recipients and donors. Medical practitioners can maximise the child's chance of being genetically healthy both by accepting the presence of a genetic condition in the male as an indication for DI, and by screening donors of semen for genetic defect.

To date I have only found one medical author offering DI who suggests that women's genetic background should be screened (Richardson, 1975). This absence of concern with the genetic status of women becomes an issue when such emphasis is placed on the power of the donors' genetic status:

if donors of outstanding excellence (physically, mentally and of high fertility) are available, it seems wrong not to go on using them. The characteristics of the offspring are a yardstick of success, and the full value of the donor becomes obvious.
(Jackson and Richardson, 1977:259)

Statements like this suggest that donors alone are responsible for the success of DI; success^{is} measured by the quality of children born; and it is only the donors' characteristics that show in the DI children. All those writers who specifically comment on the quality of the child (except for Richardson, 1975) have, at one time or another, espoused eugenic beliefs (Kleegman, 1954; Bloom, 1957; Jackson, 1957; Jackson and Richardson, 1977). The influence of eugenics on the selection of donors is another issue arising from the medical control of DI.

Selection Of Donors

Snowden and Mitchell (1981) examine the sociological implications of DI and review the medical literature about it. They present a list of recommended characteristics for potential donors which they have extracted from the literature and have this to say about it:

The absence of such criteria as social background, ethnic origin, religious affiliation and nationality may concern some couples but such concern is usually explained away by pointing out that they are included by implication (e.g. intelligence, physical resemblance, stable personality, etc.) and that to make them explicit might cause unnecessary offence. No one actually says that donors should be English and middle class but the implication is nonetheless present.
(Snowden and Mitchell, 1981:64-65)

Snowden and Mitchell also recognise the importance of the relationship between the medical practitioner and the donor, and the potential dangers inherent in the relationship:

Who the AI practitioner seeks and selects has obvious eugenic implications. The selection of donors in combination with the selection of suitable AI couples places great responsibility on the AI practitioner: a responsibility which because of the principles of confidentiality and anonymity, is being discharged without external regulation of any kind.
(Snowden and Mitchell, 1981:66)

Whenever the issue of third-party intervention in individual (and couples') reproductive decision-making is raised, the potential for eugenic

intervention to take place also occurs. For example Black feminists have challenged white feminists about the latter's use of the slogan demanding abortion 'on demand' because of the experience of Black women who have never had any difficulty obtaining abortions because of the eugenic and racist beliefs of some doctors that Black women should not be encouraged to reproduce (Bryan, Dadzie and Scafe, 1985)

Other authors have drawn attention to those doctors who have provided abortion 'packages' - which involves agreeing to sterilisation before an agreement is given to a request for an abortion - which have been offered disproportionately to Black and working class women (Leeson and Gray, 1978; Greenwood and King, 1981; Shapiro, 1987). Women with disabilities have also been sterilised under pressure because of the assumption made that they will not be able to use contraception effectively or that they do not have the right to choose to have children (Finger, 1990). There is evidence that Depo Provera, an injectable contraceptive, has been administered to Black and working class women in Britain, again on the grounds that they are not considered reliable enough to use contraception and that they should not have children (Bunkle, 1984; Walsh, 1980; Bryan et al, 1985).

The eugenic potential of DI was espoused initially by Herbert Brewer in Britain (1935) and Herman Muller in America (1936). Brewer called DI "eutelegensis" and proposed that, by inseminating women with the sperm of superior men, the quality of society's gene pool could be increased (ibid, 1935:121). Brewer abandoned this idea in the aftermath of World War Two and Hitler's eugenic policies. However Muller continued to champion the idea into the fifties. His belief in reform eugenics did not associate superior attributes with particular social or racial groups, indeed he espoused socialist principles (Muller, 1935). With the advances in semen freezing techniques Muller espoused "germinal choice" as he called it, as the way forward to eradicate the threat to the world's human genetic pool (in Kelves, 1985:262).

Male genetic disease in heterosexual partnerships is a well established genetic category for DI. This negative eugenic use of DI demands the input

of genetic expertise in people's reproductive decision-making. Genetic counselling - coined by Sheldon Reed to distinguish it from eugenic connotations (in Kelves, 1985) began to be established as part of the health care system in the 1950s. It offers information and advice for people who identify as having possible genetic problems and who seek to make informed reproductive decisions.

Obviously the ability of genetic counsellors to assist in informed decision making is dependent on them having appropriate information. Often this is not the case (Sorenson, Swazey and Scotch, 1981). Nevertheless, genetic counsellors are referred to in order to make decisions about whether DI is appropriate. This attempt to screen out genetically linked conditions present in potential male parents who are otherwise fertile, is evidence of the continuing presence of negative eugenics in the use of DI.

Positive eugenics in the recruitment of particular men as donors also takes place. The two DI pioneers in Britain, both women (Yoxen, 1986), stated that eugenics guided their selection of donors (Barton, Walker and Weisner, 1945; Jackson, 1957). Jackson went further by acknowledging the legacy of Brewer and Muller:

somewhat theoretically ... [DI] can be considered as a means of improving the stock by using donors with outstanding attributes.
(Jackson, 1957:203)

Most medical authors do not use the term 'eugenics' but some of them say that they would match donors with recipients for intelligence (e.g. Behrman, 1959; Schoysman, 1975; Jackson and Richardson, 1977). Other medical authors describe a dilemma in which they reveal their belief that intelligence is inherited and should be matched (e.g. Joyce, 1976; Edwards, 1976; Matthews, 1980). This dilemma is best illustrated by the following:

Most authors suggest the use of donors of "above average" or "superior" intelligence. Whether it is right to improve on what the husband might have produced is open to debate. No doubt the disappointment of producing a dull child could add to the strain of forming a well integrated family unit following AID. But whilst it may be beneficial to produce children who are slightly more

intelligent than their parents, a highly intelligent child in a very dull family could also result in considerable unhappiness.
(Joyce, 1976:63)

Joyce does recognise that maternal genes, the environment and genetic variation "are likely to swamp attempts to match intelligence individually" (Joyce, 1976:63). However he does not say how the intelligence of either the recipients or the donors are assessed. He offers the following conclusion:

At present the considerable majority of parents seeking AID in this country [Britain] are middle class, highly motivated and of above average intelligence, and the use of university students [as sperm donors] seems entirely appropriate.
(Joyce, 1976:63)

Previous Research

To date I have found three one-off surveys and one survey which is done annually for the RCOG which attempt to gain an overall picture of the way DI is provided within medicine. They are all postal surveys. Two were conducted in North America (Guttmacher, Haman and Macloed, 1950; Curie-Cohen, Luttrell, and Shapiro, 1979) and two in Britain (RCOG conducts annual surveys; and Steinberg, 1987). Three of the four were done by and for members of the medical profession. The fourth, conducted in Britain by a feminist, is the most useful for the present study.

The first survey done in North America was published in 1950 (Guttmacher et al., 1950). It canvassed the American Society for the Study of Sterility as the most likely of medical practitioners to perform DI. Seventy-one out of ninety-six responded giving a 74% response rate and of these 62% offered DI. No questions were asked about how or whether potential recipients were assessed. DI is placed in the context of male fertility problems. The most relevant questions for this study were those asking about how donors were screened. Respondents were presented with a list of four "commoner requisites" for donors and asked whether their selection was guided by any of them. The list was endorsed as follows: first, physical resemblance to the husband; "racial identity"; "mental similarity"; and religious membership.

Respondents were not asked how the matching was made or whether they should make such an attempt at all.

Then followed questions about what the donor was screened for and how their fertility was verified. What is interesting is that what in later years became a concern about consistency, was in 1950 interpreted as a demonstration of popularity. In the summation of the survey the results are presented as the best accepted practice of the majority. For example, eleven respondents said they matched blood groups while twenty-eight said they did not. Thirty-two said they matched the Rh factor while seven did not. This was interpreted as:

it is necessary to match the Rh factor but not the blood group of the recipient.

(Guttmacher et al., 1950:269)

Twenty years later a description of how DI practitioners operate is not enough and a willingness to criticize inconsistency is more apparent. The intent of the survey published in 1979 was to investigate the scope and method of DI with a view to facilitating the establishment of uniform policies on the procedure "particularly as these policies bear on its genetic consequences" (Curie-Cohen et al., 1979:585). Seven hundred and eleven members of the American Fertility Society, recent authors on the topic of DI and all medical school departments of Obstetrics and Gynaecology were canvassed. The survey had a 66% response rate of which 80% offered DI.

Again the survey asked no questions about the selection of recipients. Like the previous survey, the emphasis is on the quality of the donor, rendering the women, as recipients and as carriers of genes, less important. Results showed that 95% of respondents used DI as a treatment for male infertility. Genetic disease in the male was cited second and, much to the authors' surprise, 9.5% of the respondents said they had used DI with single women - the third most cited reason. This could not be investigated further because there were no further questions about selection of recipients.

The main body of questions related to how donors were recruited and screened, specifically for genetic health. The authors found that most of the respondents used medical or other students as donors. They say:

donors are not a random sampling of the general population but are a select group with presumably above average health and intelligence. Beyond the use of this select donor pool there is little further screening.
(Curie-Cohen et al., 1979:586)

The lack of consistent screening is something the authors feel is worthy of comment. However, any fears they have about the harmful effects of inadequate or ineffective screening appear to be allayed by the use of medical students as donors:

Donor selection tends to promote positive eugenics ... as well as negative eugenics ... since donors are usually healthy university or medical students.
(ibid:588)

Neither of these surveys ask if and how potential recipients are selected. The focus of both is on the screening of donors. The questions asked about screening are closed questions offering alternatives rather than giving respondents the opportunity to offer information about their screening protocols.

In Britain the earliest survey carried out by the RCOG occurred in 1977. Two references to it (Richardson, 1980; Newton, 1981) both give the impression that the purpose of the survey was a head count: how many centres offer DI; whether, or how much, centres charge; how many referrals clinics have received and so on. Neither account describes the questions that were asked, and of the selection procedures for potential recipients and donors they say, similarly:

there was no standard procedure for the selection and examination of donors, nor was there a standardized protocol for investigating couples referred.
(Richardson, 1980:12)

Most of the donors were students but there was no information given by either report as to whether this was a deliberate policy.

The survey has been conducted annually since then. Questions concentrate on the sperm used, the availability of donors, the tests performed on donors and potential recipients prior to using DI and the numbers of people using the clinics and conceptions achieved. Questions about charging potential recipients have disappeared by at least 1986. Respondents are asked how many potential recipients are rejected each year but no questions are asked about the grounds upon which this might happen or which criteria are applied in the first place. Questions asking about screening ask only about specific tests not what respondents screen for.

The returns of the 1989 survey (the latest available) had a response rate of 70% with forty-five returns out of sixty-four. The results showed that the availability of donors from different ethnic groups was very sparse. The most available Black group of donors was Asian (this includes those who labelled donors "Asian", "Pakistani" and "Indian"). Twenty-three clinics said they had this available. The next biggest group was five who said that they had "West Indian" donor sperm available. Forty-four clinics test the sperm for HIV antibodies and eight and nine respectively said they also test men and women. Forty-three said they test for hepatitis B and thirty-one perform a chromosome analysis of donors. Again clinics were presented with tests to affirm rather than asked what they screen donors for. Out of 2,886 referrals for DI at the clinics, eighty-six were rejected.

The fourth survey was conducted in 1985 of all clinics offering DI who were on the list published by the RCOG in that year. Its purpose was to establish what, if any, access policies were employed by clinics which might affect women wishing to use DI and was carried out on behalf of the London's Women's Reproductive Rights Information Centre so that they could inform women callers about the most appropriate clinic to approach (Steinberg, 1987). Steinberg (ibid) was most interested in whether clinics charged and whether DI was available to lesbians, single women and women with

disabilities. Her response rate was forty-three out of fifty and, she states, most answered her yes or no questions with detailed statements. Briefly stated, her results showed initially that:

AID treatment is available almost exclusively to heterosexual women and of these women almost exclusively to married women or women in marriage-like arrangements.
(Steinberg, 1987:185)

She found that the chances of lesbians gaining access to a DI facility increased the more money the clinic charged. Steinberg also found that many DI clinics operate a policy of assessing fitness to parent which is applied to women with disabilities. She did not ask questions about why particular access policies existed, neither did she ask any questions about the recruitment of donors.

All of these surveys are quantitative in approach and are primarily descriptive. Only the last survey asks questions about potential recipients' access to DI but this does not include asking why clinics have the access policies they have. The present study seeks to achieve some understanding of why DI practitioners attempt to replicate an ideal family model - if this is what they do - as the most appropriate for the receipt of DI, and how it is that doctors have established their professional authority in this area when other non-medical professionals would argue that they should have some input into the selection and assessment of potential recipients.

In understanding why doctors reject particular groups of women as potential recipients, it is hoped that some insight will also be gained into what DI practitioners regard as both acceptable and unacceptable about those seeking to become parents through use of DI. It was also hoped that by asking whether DI practitioners believed an ideal family exists in which DI would best be used, and what qualities they preferred to be present or would be concerned about if they were not present, some picture could be established of their ideal family model.

Evidence from Steinberg's (1987) survey suggests that there is a consensus about the ideal sort of family which should be assisted in being

created through use of DI. Her results show that the majority of DI practitioners only give access to heterosexual, married couples; and that, in the main, there is a bias in favour of able-bodied people and, by extension, there is an emphasis on the reproduction of children of high genetic and eugenic quality.

This study is to be empirical in order that I can to some extent verify the results of Steinberg's survey but also to include those who do not hold the majority view. The latter I felt was important so that an attempt could be made to compare the approaches of DI practitioners holding different views about access to DI. Additionally I wanted to get beyond the particular qualities and traits that individual practitioners favour or disfavour in potential recipients and explore the ideas that inform their selection of particular people over others.

Conclusion

The literature review has produced the following issues which the study seeks to address. First is the way DI has become subsumed into the medical sphere requiring medical authority over its use. Second, the literature review has revealed the nature of non-medical criteria used in assessing potential recipients. Given that other non-medical professionals argue that they are most suited to applying such non-medical criteria, this study will seek to ascertain how DI practitioners would respond to such non-medical professional intervention. Thirdly, the question of whether DI practitioners, in applying non-medical criteria, are involved in reproducing an ideal family and if so how is it constituted. Finally, are DI practitioners involved in reproducing ideal families through their recruitment of donors and if so what role does eugenics play?

From the review of the relevant research, the gap in the existing empirical knowledge about the provision of DI was identified. This is that there has been no attempt to ascertain why DI practitioners make the decisions they do in both providing DI to potential recipients and recruiting donors. In the next chapter, the hypothesis to be tested by this study is outlined together

with supplementary questions which seek an understanding of why DI practitioners offer DI in the way they do. There will also be a discussion about the methodology.

CHAPTER TWO: THE METHOD

In this chapter I will describe how and why this study was designed. First there will be an outline of the hypothesis to be tested. Following this will be a discussion about the design of the study which includes the methods that were considered to collect the data in this study and a description of the one chosen. The way in which the field work was conducted will then be described, including the questionnaire design, piloting, and demarcation of sample. Then there is a discussion about some of the issues that arose in designing this study and how they were resolved. Finally there is an outline of how the data was analysed and is presented.

The Hypothesis

The data collected for the literature review threw up problem areas and key concepts which were arranged into categories which are:

retrieval and organising devices that allow the analysis to spot quickly, pull out and then cluster all the segments relating to the particular question, hypothesis, concept or theme.
(Miles and Huberman in Tesch, 1990:86)

These categories were organised under headings:

- factors that affect access to DI of potential recipients, for example sexuality, race, social class, disability and so on including the decision-making process.
- factors that affect the birth of DI babies through donor recruitment, positive and negative eugenics such as screening for intelligence and mental health.
- factors that establish DI as a specifically medical technique, for example success rates, attitudes towards self-insemination, and so on
- factors that indicate DI practitioners' attitudes to professional autonomy; comparisons with adoption, intervention of psychologists, psychiatrists, and medical social workers.

After considering these categories in the light of the literature it became clear that decisions about the suitability of both donors and potential recipients were being made within the context of an assumption that a particular family model could and should be reproduced in the provision of DI. Discussions about this family did not refer to any concern with the resultant relationships between parents and children nor to the presence of parenting skills - assuming that these could be described. Instead there is an assumption throughout the literature that 'the family' refers to a particular model which requires no justification but which is generally accepted to be the ideal family model in which DI children will thrive. This ideal family refers not only to the parents or the environment in which they might bring up a child, but to the child itself.

In their recruitment of men as sperm donors the evidence suggests that DI practitioners endeavour to 'cause' perfect children to be born through DI. Furthermore the decision-making which purports to reproduce this particular family model depends not on medical but non-medical criteria about suitability to parent. These theoretical notions led to the development of a hypothesis to be tested in this study, namely that doctors providing DI in Britain make non-medical decisions about the suitability both of who should receive DI and who should donate sperm and these decisions demonstrate an allegiance to an ideal family model.

Supplementary questions were also asked to endeavour to make connections between all the preliminary categories. These were how have DI practitioners been able to assert successfully their professional authority in the provision of DI and why do they seek to maintain this control over access which allows them to make non-medical decisions about suitability to parent.

Design of Research

The existing research related to DI was discussed in the last chapter. These studies were quantitative in approach and remained mainly descriptive. The objectives of this study being to attain an understanding of what

respondents mean by 'family' in the context of their decision-making around access to DI and to understand the reasons behind their decision-making with regard both to potential recipients and donors, suggested that a qualitative approach was required (Bogdan and Taylor, 1975).

Using the concept of 'theoretical sampling' (Glaser and Strauss, 1967 in Tesch, 1990) by which the question is asked "what data to collect and where to find them" (ibid:86) I decided that doctors who offer DI should be the focus of data collection. This indicated a case study approach (Dixon, Donna and Atkinson, 1987) which enabled 'DI practitioners' to be the focus of the study at a particular point in time to examine their perceptions of their own roles in the provision of DI. This role has two facets one of which is as the provider of a service and the other which is the person who makes decisions about who should use the service. Those who offer DI work in different settings in both the public and private health sectors. The case study approach allows the study to focus specifically on the provision of DI even though the doctors included in the study may not exclusively provide DI. The other benefit of a case study approach is that it relies on evidence being gathered from as many sources as possible (Hakim, 1987). This study is informed by medical and non-medical literature relating to DI, the latter which includes Government Reports and legislative frameworks, feminist analyses and so on.

Method

The stated objectives of the study militated against conducting another postal survey and thus it was rejected as a possible method for this study. A postal survey would have enabled a greater and random sample to be used (Labovitz and Hagedorn, 1971). Nevertheless, unfavourable comparisons with a one-to-one interview schedule highlighted its drawbacks: a postal survey schedule would have to be short to ensure a good response rate; the meanings of questions could not be explained; and, most importantly, there would be no opportunity to probe the responses given (Labovitz and Hagedorn, 1971). It was not felt that a postal survey would attain the

objective of reaching some understanding of why certain decisions are made and would rather remain descriptive.

As a result of reviewing the literature it was apparent that much of what DI practitioners write about their DI services and the way they assess potential recipients and donors is assumed to be understood by all, that no explanation is necessary. Part of my reason for embarking on this study was to question these definitions or decisions. A postal survey would not allow DI practitioners' language or assumptions to be reflected back to them for clarification.

Non-participant observation in which I would have been an observer of DI regimes and medical consultations was also considered as a method for this study. This would have enabled me to observe how the interviews between DI practitioners and potential recipients are conducted. This method would also have allowed me to reflect back to DI practitioners these conversations in order to enable them to consider why they make the decisions they do. However this method was rejected for several reasons. There has been no empirical study done of DI practitioners in Britain which has covered the issues outlined as the focus of this study. Non-Participant Observation would not have allowed the breadth of cover required because this method is time-consuming and labour intensive. Additional problems with this method arise because potential recipients would also have become involved in the field work. Apart from the difficulties resulting from access and the ethical issues arising from observing conversations between potential recipients and their DI practitioners, this study was not intended to include potential recipients. Its focus is understanding how and why DI practitioners make the decisions they make about access to DI.

A third possible method which presented itself was the vignette approach (Wasoff and Dobson, 1992). In this, DI practitioners would have been asked to take part in a role-play in which I would have acted as a particular potential recipient according to a pre-prepared script with respondents being themselves. This would have allowed me to collect data about the ways in which DI practitioners consult with potential recipients and, by



presenting different categories of potential recipients, the social criteria which they rely on to make their decisions. However, this method could only present a limited number of 'types' of potential recipients to DI practitioners whilst the possible number of 'types' of potential recipients is immense. This study has as its aim to establish whether there is an ideal family model which DI practitioners prefer. In presenting only a few 'types' the study would have been limited to analysing DI practitioners' reactions to them rather than gaining some insight into the sorts of potential recipients in general who they prefer or would reject.

Asking general questions about what qualities they either preferred to see or which might cause concern was felt to be a better way of drawing respondents out on the 'types' of recipients they preferred or would reject. This was because it was believed that leaving them to think about those qualities which they believe to be negative and positive would better elicit those they perceive as important. This, together with asking about specific issues that DI practitioners may or may not discuss on their own initiative, was felt to be a better way to test the hypothesis.

In addition, there is a consensus in the medical literature that potential recipients should be seen together (always assuming they are referring to heterosexual couples). Being only a single researcher rather than being able also to 'present' with someone else as a 'couple' might have influenced the interaction between DI practitioner and 'patient'. This would have been the case especially if, as some of the literature indicates, the assessment is partially based on how potential recipients relate to each other in the consulting room.

This study is an empirical survey of the practices of DI practitioners but also relies on gathering data from the literature to present and support its results. The method of data collection chosen to conduct the survey was semi-structured interview schedules. The strengths of such an approach are that in the first place it would allow an empirical survey of DI practitioners to take place. In the second place a semi-structured interview schedule would allow the flexibility required to enable respondents to elaborate on their

opinions and reflect on their comments for further clarification of their position; respondents' definitions to be attained of key concepts they might assume need no qualification; and the study to ask why DI practitioners provide DI in the way they do to the potential recipients they select. A semi-structured interview schedule would produce the best data with which to come to some understanding about how doctors have established themselves as sole arbiters around access to DI and what subsequent decisions they make about access including data which would test the hypothesis.

A major drawback of using such a method is that in order to conduct the interviews respondents would have to be prepared first to meet with me and second set aside an amount of time to complete the interview. In a busy work schedule this can prove difficult both to make a commitment and the arrangement. Another drawback of using semi-structured interviews would be that in keeping the questionnaire as flexible as possible in order to respond and prompt responses given, the schedule might lose its reliability. Flexibility could lead to non-consistency in asking and following up questions, thereby making comparisons across the sample difficult to make.

Furthermore, including open-ended questions warranted use of a tape recorder to aid data collection. This produces its own problems such as making respondents self-conscious to the point of making their replies unreliable; and potential technical problems such as the placing of the tape recorder to achieve optimum recording. Transcribing the interviews would be time consuming and posed another possible drawback to employing this method. Problems related to designing the questions themselves are covered later. Nevertheless, on balance the benefits of using this method and achieving the objectives of the study were felt to outweigh any drawbacks.

The design of the interview schedule, as will be seen, was such as to clearly delineate four headings under which questions and responses might fall. This allowed the flexible approach to occur within a structure which assisted me placing the responses given within the relevant section.

Similarly when respondents went off on tangents this was easy to identify as their remarks did not coincide with any section and this could be dealt with by referring to the schedule and taking up the next relevant question. Familiarity with the schedule which was much helped by rehearsing it in the pilot interviews enabled me to gain confidence in responding flexibly to the responses given so that all of the areas I wished to investigate were.

The Fieldwork

The sample

The sample was collected on a non-random basis and 'theoretical sampling' guided its construction. This meant that questions were asked such that variables were identified which might affect the outcome of respondents' decision-making:

1. Doctors from the private health sector, the NHS and the non-profit-making charitable sector were included in the sample in order to assess whether the economical basis on which DI is provided affects people's access to it. In addition, because DI was offered by all three sectors at the time of the interviews, there was no good reason to exclude any of them.
2. The geographical spread of DI services in Britain has resulted in an unequal concentration of services in the South East, especially around London. It was felt that to include DI services from all around Britain would allow an examination of whether working in comparative isolation, or amidst many colleagues offering the same service, had any influence on the decision-making process.
3. To include doctors known to provide DI on the basis of the women's right to choose. This was felt important in order to compare the different approaches to the provision of DI.
4. To include as many doctors who provide DI as was possible to ensure a wide range of views, but which was both economical and efficient. The

geographical spread of DI services is very uneven. The distances and cost involved in travelling to achieve this goal meant that I had to include in the sample:

- a. those cities in which I had contacts with whom I could stay
- b. those cities which I could comfortably travel to and from in one day.

The sampling universe was all DI practitioners in the United Kingdom (UK). The RCOG annually collates a list of those who offer DI in the UK, although this is done on a self-report basis. Having written to the RCOG for the list this then became the sampling frame. There is no assurance that the list is exhaustive and its reliability is questionable too: two addresses I contacted from the list turned out to be incorrect. It was impossible to tell from the list whether doctors were women or men and, sometimes, whether they worked in the NHS or the private sector.

The sampling frame held fifty-eight names of DI practitioners offering DI in the United Kingdom. All the criteria were met for the sample of thirty-one DI practitioners or 53.45% of the sample universe, I approached. Twenty-one interviews were conducted between September 1989 and March 1990 giving a response rate of 67.7%. Of these twenty-one, three were from Wales, five Scotland and twenty-three from England. Eleven were interviewed in a public health sector setting and ten in a private health sector heading. Of the latter group, four offered DI from private consulting rooms; two were in the non-profit-making charitable sector; and the rest were in private hospital fertility services (see table 1 below).

Table 1: Distribution of respondents across health sector

Sector	Respondents
NHS	11
Private Sector:	
Consulting Rooms	4
Private Hospitals	4
Non-profit-making Charities (NPMC)	2
Total	21

Some respondents worked in more than the one health sector setting in which the interview took place. I did not have questions about workplaces other than the one in which I interviewed, but sometimes respondents offered information about it to show the differences between their NHS and private health sector work. Where this had meaning for my study I will refer to it. Eight (38%) of the respondents were women.

Of those who were not interviewed:

- two had asked that I re-write to them at a future date because of their work schedule but on doing so, was told that they could not make the necessary time to see me.
- I arranged two separate interviews with a respondent but on both occasions, arriving at the designated time was told that he was unable to see me. As this respondent was in London it was decided that a further appointment should not be made.
- One of the respondents who was not working at the address given on the RCOG list was not traceable.
- Six refused to give an interview.

Access

Initially an introductory letter was sent to the thirty-one clinics in the sampling frame. These were sent in geographical batches with the intention that interviews could be arranged in geographical areas to economise on

cost and time. Whilst in the main this strategy worked, I also had to adopt a flexible approach in order to accommodate respondents. The letter, written on University headed notepaper, introduced me, gave an outline of the study and of the interview schedule, made a request that interviews be tape recorded and gave assurances of confidentiality (see appendix A). One respondent required more information from me about the study and from my supervisor.

Recording Data/Interviews

Most of the interviews were tape recorded. However two respondents would not allow this although both allowed me to take notes. On one occasion the tape recorder did not tape part of the interview for unknown reasons. On a second occasion, after turning the cassette over I realised I had not pressed the record button. After the interview I wrote down as best as I could remember what the respondent had said during the time she was not being recorded.

The interviews took between forty-five minutes and an hour and a half. The average length was about one hour. On one occasion, due to a confusion about the timing of the interview I was only able to interview for half an hour. This resulted in only some questions from the third and none from the fourth section being asked.

Most respondents were apparently willing to answer all my questions in thoughtful and discursive ways. Some respondents were less willing to be prompted than others and gave shorter answers which were less revealing but also proved difficult to then prompt. Their tone of voice and body language made a clear statement: "I have answered your question, that is all I will say on it." Some respondents found the interview schedule too long and showed some impatience towards the end. Others were apparently well disposed to carry on talking for as long as was necessary. Clearly, their willingness to answer the questions in a relaxed way influenced the length of their responses and the thought that went into them. In two of the interviews the respondents were interrupted two or three times by

colleagues in one and by the needs of a patient in another. These interruptions made the interview feel very disjointed and it was more difficult to follow up and probe comments made and to keep the interview flowing in a logical way through the schedule than in those in which there were no interruptions.

Confidentiality

As several respondents required strict anonymity as a condition for granting an interview it was decided to keep all the identities of the respondents anonymous and they are identified instead by a number.

The Interview Schedule

The interview schedule was composed of four sections. This reflected the four main components which were the focus of the study. These were first the service provision protocol: on what referral basis DI is offered, for how long it is offered and with how many inseminations, what the success rates are and whether any policy of eligibility is existent at the clinic. This section also collected biographical data about the respondents and discovered in what context DI is offered. The second section concentrated on whether and how recipients are assessed, how decisions about access are reached, whether non-medical professionals are referred to and perceived as useful and whether any useful comparisons can be made with adoption. In order to obtain details about the access of potential recipients and the qualities or attributes which are preferred, a combination of general and specific questions were asked. Respondents were asked about the access of specific groups of women or about specific types of social criteria and whether they were applied. They were also asked general questions about what might concern them about potential recipients and what were the best qualities they thought were preferable in potential recipients.

Recruitment of donors was covered in the third section. First it was established how respondents obtain sperm. Then questions about screening methods and what respondents seek to screen out were asked.

Particular behavioural traits were asked about as to their heritability and as to whether respondents would screen them out. Respondents were also asked whether they felt the assessment to be a medical one and whether they were influenced by the sort of father they thought donors might make or children they might have. They were also asked about the availability of sperm from different ethnic groups. It was felt that the wording should be "ethnic groups" rather than "Black" because of the tendency to associate the latter with people from particular countries rather than, as I use it, to signify all people who are not white. The reasons for the inclusion of the latter questions is explained more fully below but were meant to give some measure of the availability of DI to Black potential recipients. In order to facilitate respondents in describing qualities they perceive as important to include or exclude rather than reacting only to those suggested by me, they were also asked to describe qualities they might look for to include men as donors or those they would identify as grounds for rejection.

In the last section respondents were asked their opinions about the Human Fertilisation and Embryology White Paper especially in relation to the proposals about selection of recipients and donors and the provision of counselling. They were also asked their opinions about self-insemination and finally what they thought about any moves to encourage or discourage particular groups of people to parent.

The schedule (see appendix B) had a total of seventy-six questions which were a mixture of open and closed questions asking subjective and objective questions (Foot and Whyte, 1982). All questions were checked for emotive or politically sensitive language (Sudman and Bradman, 1982).

I wanted to ask doctors whether they were aware of their decision-making role in the hope that they would reflect on their position and so begin to explain it. A further way in which respondents were encouraged to reflect on their role as social decision-makers was to include questions which asked about their referrals to other non-medical professionals who might be more readily associated with the sort of social decision-making DI practitioners are apparently engaged in.

In asking about how donors are recruited and potential recipients selected I wanted to establish whether they were aware that social criteria rather than medical criteria were being established and be able to reflect back their responses for clarification. 'Stability' emerges from the literature as a prevalent criterion in making assessments but again not one which is defined by those who use it. Questions were asked to try and establish what respondents meant by words such as 'stability' so as to begin to challenge their assumptions that these are self-explanatory.

Piloting

The questionnaire was piloted with two doctors who do not offer DI and three friends. The small numbers of DI practitioners and their geographical spread meant I did not feel able to use any in the pilot. Piloting with doctors assisted in checking that the language used was appropriate and understandable, that the order ran coherently and the tone was not provocative. The timing of the interview was also tested and it was judged that the interview could take up to an hour and a half. After these had been done some of the questions were rephrased and some were rescheduled as prompts rather than as main questions. Piloting with friends then took place to test again the language, sense and sequence of the schedule and questions.

Some Issues in Designing the Interview Schedule

Sudman and Bradman (1982) suggest that, in asking questions about possible emotive issues, questions that are of a general nature get more approval from respondents than do those dealing with specific aspects of that issue. Consequently there should be included some specific questions in order to test the validity of more general responses to general questions. Since the hypothesis is that DI practitioners choose ideal families in deciding about access to DI, a mix of questions asking generally and specifically about who might be rejected or included were asked. For example, respondents were asked whether any groups would not be

considered as potential recipients. To follow this up then questions were asked about specific groups of people, for example, women with disabilities.

Social Desirability Bias

Denzin (1970) includes in his criteria for measuring the validity of schedules, awareness of the social desirability bias. Sudman and Bradman (1982) point out the way in which the social desirability bias in interviews can be the result of a dilemma for respondents. On the one hand the latter want to be 'good' respondents giving the information required yet on the other hand they also want to respond in ways which will reflect well on themselves. Some of the issues covered by the interview schedule were susceptible to this bias. Describing ways in which particular potential recipients may prove themselves unsuitable as parents might cause respondents to feel that their role as judges might provoke disapproval especially if they felt the judgements they make to be unacceptable. On the contrary if respondents felt their judgements to be aligned with a perceived consensus in society or the public their ability to describe such judgements would be less inhibited. In order to build up a picture of what the ideal family would be composed of questions were asked about sexuality, race, social class, disability and lifestyle. Some of these lent themselves to direct questioning whilst others did not.

Sexuality

Questions asking directly about whether respondents allow single women and lesbians access to DI did not fall into the category of questions whose responses would incur social desirability bias. First, the issue of whether such women should have access was and is already being discussed in the medical literature and, indeed has been part of a public debate, and the issue of their access would not be unknown to respondents. Secondly, based on evidence from the literature review it would seem that negative responses to such questions have an amount of social sanctioning. Denying access to women from these groups could be viewed as taking

legitimate steps to ensure the welfare of children, the family and society rather than being evidence of an unacceptable prejudice.

Race

As stated in the last chapter, there were very few references to race in the medical literature. What evidence there is suggests that Black potential recipients do not enjoy the same opportunity to receive DI as white potential recipients. However it did not feel possible to ask direct questions about the access of Black people. Asking such a question as "do you discriminate against people from different ethnic groups?" would actually engender a response about respondents' self-perception rather than how Black people are treated by DI practitioners (Dixon et al., 1987). Furthermore, admitting to such a prejudice which is widely disapproved of might be harder to do. Instead questions were included about the recruitment of donors from different ethnic groups: whether respondents found this difficult to do and if they did, how they proposed to tackle the problem of availability of appropriate sperm both in terms of being able to provide DI to Black people and in being able to match donors and recipients. Although these questions are limited in their ability to reveal how Black people are treated in the DI process they do give some measure of how accessible DI is to Black people.

Social Class

Problems of definition made asking direct questions about whether social class affects the access of potential recipients to DI problematic. It was clear from the literature that people from lower social classes, as defined by husbands' occupational grouping, are under-represented as recipients of DI. In the interview schedule a variety of commonplace indicators of social class was adopted. These indicators were chosen to allow some analysis to be made about the cues respondents might pick up and associate with social class. It was decided that access to money with the concomitant access to the things that can be bought with money, would be acceptable as basic indicators of social class. For this reason respondents were asked whether they took any account of potential recipients' financial resources, their living and material resources or of whether either were in paid

employment. These questions were placed in sequence after questions asking whether any useful comparisons can be made with adoption and worded in such a way as to further the scope of comparisons thus: adoption agencies take into account the financial resources of potential recipients do you? This was done in order to place the question in the context of comparing social criteria with adoption rather than to focus on respondents' use of social class criteria.

Analysis and Presentation of Data

The data collected in this study was analysed in order to find connections between categories and, finally, explanations for the phenomena discovered. Although many of the categories were already identified in the literature review, when analysing the interview data some of these categories fell away whilst new ones emerged and merged with existing ones or remained separate. In this way categories were verified by, and some were grounded in, the data thus combining approaches to analysing the data (Tesch, 1990).

Grounded theory (Glaser and Strauss, 1967) is an approach which facilitates the development of theory which is grounded in the data rather than the other way round. As Strauss (1987) said, the whole point of theory construction is "to produce concepts that seem to fit the data" (ibid:28). In the present study the interview schedule was designed to throw light on the categories which had been provisionally conceived from the literature. Thus questions were asked about how sexuality might affect access to DI by asking respondents whether they would let lesbians and single women use it and why.

In analysing the data then, these initial categories emerged in the first instance and some were verified empirically whilst others were not. Additionally new codes were delineated as the question "what category does this incident indicate?" was addressed to the data (Glaser and Strauss in Tesch, 1990). At the same time 'theoretical memos' were kept which

recorded the codes, acted as catalysts to further codes and provided a means of developing and integrating theory (Strauss, 1987).

Once the final categories had been decided upon, 'axial coding' was performed. In this, relationships between categories and sub-categories are distinguished and refined (Strauss, 1987) and especially those occurring with those categories which were identified as core. In this study the core categories that were delineated provide a framework for each of the next four data chapters. Core categories are those around which the generation of theory occurs (Strauss, 1987). Most other categories are related to core categories and:

through these relations among categories and their properties, [they] have the prime function of integrating the theory and rendering it dense and saturated as the relationships are discovered.
(ibid:35)

The next two chapters address the core category of how DI practitioners have established professional authority over the provision of DI. In the first of these the sub-core category 'medicalisation of fertility' is analysed and unpacked with reference to the medicalisation process that has occurred in other areas of women's reproductive decision-making. The second of these speaks to the use which is made of medicalisation by respondents in defending the medical monopoly of DI and 'seeing off' other professionals' attempts to enter the DI arena.

In the following two data chapters the core category 'constructing the family' is unpacked. In chapter five, constructing the family at the level of suitable parenthood is examined by exploring the factors which are assessed and selected in and out in potential recipients; and by exploring how this is achieved and, to some extent, why. In chapter six constructing the family at the level of placing suitable children in suitable families is considered. This involves the analysis of two core sub-categories the first being that which constitutes an acceptable 'genetic father'. The second is that which is concerned with controlling sperm.

CHAPTER THREE: THE MEDICALISATION OF FERTILITY

For the majority of heterosexual couples, the achievement of conception has been, and still is, primarily a social experience although obviously it is a biological event too. The successful use of DI necessitates that women be fertile. In this biological sense the use of DI differs from heterosexual intercourse only in the method by which semen is inseminated. It is the social context in which insemination occurs which differs. In this chapter I will argue that, in order to establish professional authority over the application of DI, fertility and the achievement of conception have been medicalised. In the following chapters the argument will be developed that, in successfully medicalising the biological endeavour of egg-sperm fertilisation, doctors who provide DI have been afforded the opportunity to exert social control over the women (and their male partners) who seek to use DI to achieve parenthood and the men who donate sperm; and that this social control is articulated through the decision made about who is fit to parent.

In the first part of this chapter I shall discuss how the designation of DI primarily as a medical phenomenon is an extension of the process of medicalisation of women's fertility and reproductive potential. This develops that which was begun in the first chapter and will look at the medical literature relating to DI and compare it with the ways in which the medicalisation of pregnancy, childbirth, contraception and abortion have led to both the medical and social control of women's bodies, sexualities, and, subsequently, their lifestyles. In the second part of the chapter I will use data from the respondents in the study to discuss how their responses about the DI programmes compare to those described in the literature. I will also discuss the way in which the different and often contradictory practices surrounding the use of DI come to be presented as if they are 'medical facts' being objectively described and scientifically substantiated. Finally I will present respondents' views about home and self-insemination and the need for medical supervision. These responses suggest that, in fact, medical supervision is not required for application of the DI procedure itself

but that it is required to afford some respectability to the collection of sperm and so as to legitimate the status of DI as being one of the ACTs.

In conclusion I will describe the biological and technical aspects of DI and compare it as a method of achieving conception with heterosexual intercourse; as a technical procedure with the application of a tampon; and a medically dispensed treatment with AIH. The point to be made is that by virtue of its simplicity there are no medical or technical grounds for keeping DI in the medical sphere.

The Medicalisation of Women's Reproductive Capacity

Ehrenreich and English (1973a; 1973b; 1979) have documented the ways in which women have been pathologised by the medical profession. The point is not that women are not ever ill or in need of health care but that, during the rise of the profession of medicine in the nineteenth and early twentieth century, women were designated as being in essence sick if they were middle class and "sickening" if they were working class (Ehrenreich and English, 1973a:49). The basis for women's pathology is in our biology and more specifically in our reproductive system and sex organs. Thus women have been said to be ruled by our uteri, our hormones, our clitorides and our menstrual cycles and these views have been utilised by those - including doctors - who have wished to prevent women from leaving the private sphere of home, marriage and motherhood, and/or entering public life through joining professional occupations or career structures or any jobs previously defined as 'male'⁹, further and higher education, politics, in short, any sphere in which personal power, status, authority and autonomy are augmented. To a large extent women are still defined by their reproductive potential. Scully and Bart (1973) concluded from their study of American gynaecology textbooks published between the 1940s and the 1970s that because women were

⁹ as opposed to low-paid, and/or part time and certain sex-segregated jobs which poor women have always been employed in.

consistently described as automatically destined to reproduce, nurture, and keep their husbands happy ... gynaecology appears to be another of the forces committed to maintaining traditional sex-role stereotypes, in the interest of men and from a male perspective
(Scully and Bart, 1973:1045)

This fusion of an ideological perspective on women's reproductive capacity with the medical approach to the biological workings of women's reproductive capacity has led to a situation in which medical practitioners are able to exert social control over the women who come to them because they are having a baby (Oakley, 1975; Brighton Women in Science Group (BWSG), 1980; Antonis, 1981), they want contraception or sterilisation (Aitken-Swan, 1977; Greenwood and King, 1981; Thomas, 1985) or abortion (Aitken-Swan, 1977; Simms, 1985). The particular ways in which social control has been exerted will be examined in more detail in chapter five. It is sufficient to say here that, in making so-called medical decisions while meeting women's requests for access to medical reproduction-related services, doctors may also be engaged in social decision-making which influences both the type of 'treatment' received and the manner in which 'treatment' is given. As Thomas (1985) says whilst writing about contraception:

studies in other areas of reproduction have indicated that decisions made by doctors are influenced not only by the state of knowledge of reproduction but also by the perceptions of social and cultural norms.
(Thomas, 1985:45)

Oakley defined medicalisation as:

that which refers to people's dependence on medicine and to the control of health and sickness (and thus of people) by the medical profession;
(Oakley, 1975:640)

In the case of women's reproductive capacity, menstruation, conception, pregnancy and childbirth are for most women ordinary life events. The fact that doctors are able to exert such control - both medically and socially -

over women by pathologising these reproduction-related functions is a measure of how medicine has colonised every day life:

Having a baby is a medical, rather than a natural process. It has lost its character as a taken-for-granted aspect of adult life.
(ibid:640)

I am arguing that this medicalisation process has now expanded prior even to medicine's prerogative to "diagnose" pregnancy (Oakley 1975), to the achievement of conception through the use of DI. In the literature on the medicalisation of women's reproductive functions, and their access to reproduction-related medical services a further five characteristics of the medicalisation process emerge which reinforce the rationale for medical authority and control over these functions:

- the introduction of medical intervention in the 'diagnosis' and management of the 'problem'
- the introduction of medical technology as a 'guarantee' of the 'scientific management' of the problem
- the justification of the last two characteristics with reference to 'scientific' measurements - statistics
- the resultant problematisation or pathologisation of the reproductive system
- and the corresponding alienation of women from their bodies.

Medical Intervention

Two of the ways in which Oakley (1975, 1986) identifies the growth of medical intervention in pregnancy are the move from home to hospital deliveries and the development of antenatal care. Greenwood and King (1981) show how the location of provision of contraception, particularly with the development of the oral contraceptive Pill (hereafter the Pill) changed from voluntary agencies such as the Family Planning Association, adverts in newspapers and informal women's networks, to doctors' surgeries. This process culminated in the 1973 Family Planning Act which formalised

contraception as part of preventive medicine. This has particular consequences for women, as Thomas pointed out:

The increase in use of methods of contraception by women has been accompanied by a growing involvement on the part of the medical profession. Most female methods are deemed to require medical intervention.
(Thomas, 1985:45)

The same change in location has occurred with abortion. Simms (1985) points out that although illegal abortions were often carried out by unqualified people, and many illegal abortions ended in death, chronic illness or sterility for women, many illegal abortionists were also very competent and experienced. The 1967 Abortion Act put an end to medically unqualified persons carrying out abortions and located them in hospital settings which had to be licenced if they were in the private sector (Simms, 1974).

As far as written records tell us, DI was initially located in the medical sector rather than the social sphere. Some women began self-inseminating in the 1970s (Duelli-Klein, 1984; Saffron, 1987) and it was during the seventies and eighties that there has been more medical literature about the problems related to successful use of DI - notably the female factor in infertility and ovulation timing. Furthermore The Act (1990) requires that DI be carried out in licensed fertility clinics. The location of DI in fertility clinics - to the exclusion of doctors providing DI from private consulting rooms or GPs surgeries - reinforces its definition as a medical 'treatment' for a fertility 'problem' and places it amongst an array of much more technically complicated reproductive options, as if DI is not distinguishable from them as another medical solution to 'infertility'.

With the rise of antenatal care the contact with the medical profession is regimented and protracted. As with DI, women seeking contraception are neither ill nor have a mental or physical health problem (Greenwood and King, 1981). Women who seek abortions have a physical condition which is predominantly a social problem for them but, in the main, does not present a life-threatening health problem. The vast majority of women having

abortions have early abortions which Simms (1974) argues are as safe to perform as it is for women to give birth. Further, she argues women's groups could carry out abortions themselves.

The provision of contraception too it is argued does not need to be controlled by the medical profession. Greenwood and King (1981) argue that there is an apparent contradiction in medical thinking about contraception: on the one hand doctors are reluctant to give advice about birth control yet on the other hand they do not want to give up control over its provision. Medical supervision is argued to be justified for the Pill because of the drugs involved, yet many women actually get minimum medical supervision and contraindications are missed (Greenwood and King, 1981). The Intrauterine Device (IUD) can also be fitted by nurses and midwives (Shapiro, 1987) therefore suggesting that lay women could also be shown how to fit them.

In the medical provision of DI the actual insemination process has been problematised. In the medical literature describing the use of DI there is implicit a mystification and problematisation of the procedure. In the first chapter medical language was implicated as a way in which DI has been colonised. This process is continued by the use of medical language to describe insemination. First of all women have to be in the right physical position. This might be the lithotomy position (e.g. Barton, 1945; Goss, 1975), the dorsal lithotomy position (Chong and Taymor, 1975) or the dorsal position (Pennington and Naik, 1977). Her buttocks might be raised to an angle of between fifteen and twenty degrees (Behrman, 1959; Goss, 1975) and then her vagina and cervix may be prepared:

after *exposure* of the uterine cervix and *appropriate cleansing*, the cap was placed on the portio. Vacuum was produced by a small hand pump. The tubing of the cap was then closed with a clamp, the semen-containing syringe was attached, the clamp was opened, and the semen was injected under vision.
(Glezerman, 1981:181, my emphasis)

Once the woman has been inseminated she may need to “rest” or “lie still”:

because the semen must stay in contact with the cervix for some time, the woman is required to remain *supine with her legs flexed for 30 to 40 minutes* following insemination
(Beck, 1976:6, my emphasis)

This language serves to infer that the technique of DI is complicated and that women are reduced to the status of patients because of this. The extract from Glezerman (1981) above also illustrates the way in which the introduction of medical technologies has contributed to the medicalisation of DI.

Just as Oakley (1986) points out how antenatal care provision exerts social control through establishing medical authority over the knowledge about the career of pregnant women and the technology which might be employed during pregnancy, so too in DI there is a similar regimentation and surveillance of women's menstrual cycles in order to establish whether they ovulate, whether they ovulate regularly and at what point in the cycle they ovulate. The doctors' ability to both gather information about women's menstrual cycles and predict when they should be inseminated is linked with the amount of control they can exert over them. The emergence of technology which assists this surveillance is another characteristic of medicalisation.

The Emergence of Technology

Oakley identifies two strategies by which the medical profession have been able to establish the basis for antenatal care: a claim to having more knowledge about the internal workings of women's uteri than individual women do of their own; and the ability to control the onset of labour (Oakley, 1986). The association of technologies with male medical practice which allowed them to demonstrate their supposed superior knowledge of childbirth began with the use of forceps in childbirth by male midwives. As Faulkner says:

the doctors practice of midwifery was becoming distinguishable by its very technical aspect.
(Faulkner, 1985:93)

The development of stethoscopes to hear foetal heartbeats and of pelvimeters to measure women's pelvic or childbearing capacity (Faulkner, 1985) was also part of this process and established the superiority of the embryonic medical professional over midwives in the realm of pregnancy and childbirth (Faulkner, 1985; Ehrenrich and English, 1973b, 1979).

Oakley (1986) identifies the development of reliable and 'scientific' pregnancy testing methods as of primary importance in the growing surveillance of pregnant women, and the subsequent development of technologies to visualise and survey the foetus. Most of these screening devices are used routinely on pregnant women yet none have been scientifically evaluated for either their beneficial contribution to foetal or maternal health or their ability to predict which women or foetuses may be at risk (Oakley, 1986; Antonis, 1981). Although knowledge about women's reproductive systems has increased enormously, doctors would be unable to demonstrate this without also having the technology. Again as Oakley argues:

the obstetrical pursuit of more and more knowledge about the foetal condition and lifestyle in utero is integral to the obstetrical claim to expertise in general.
(Oakley, 1986:183)

The existence of technological innovations within medical practice may also serve to act as proof of the scientific, and therefore 'respectable', use of procedures which are used in areas now colonised by medicine. Walsh (1980) argues that the introduction of the Pill as a birth control option in the hands of the medical profession promoted the respectability of birth control in general because of its association with science. Greenwood and King (1981) also argue that abortion, like contraception, became more respectable to doctors and to society because it was, and is, provided by the medical profession. Contributing to this veil of respectability is the hope that if doctors have authority over access to contraception and abortion then

some sort of social and moral control will be exerted over access to these procedures, for example that abortion will not be allowed on the demand of women but on the decision of the doctors.

In DI the intervention of technology has occurred at three main points in women's reproductive career: the establishment of her fertility status, the detection of ovulation and the method by which semen is placed in her reproductive tract.

1. Establishment of Fertility Status

There is great variation in the medical literature as to whether, how and when women's fertility should be demonstrated. It seems plausible to suggest that such variation occurs because of the ambivalent position of women as users of DI in the medical sphere. Previous fertility investigations will have identified the male of a heterosexual couple as having fertility problems which leads to DI being suggested as a way of bypassing this obstacle to parenthood. However it is women who must use DI and in order to do so successfully they must be fertile. If it is men's fertility problems which bring potential recipients to DI practitioners women have an ambivalent medical status. One perception of women is that they be assumed to be fertile and therefore healthy actors seeking, (often in conjunction with male partners) access to parenthood. This perception means that women are not patients. An alternative perception of women is that they potentially have fertility problems. This perception assumes that women's fertility status should be established before employing DI, designates women as potentially problematic and more easily coincides with a view of them as patients consulting for treatment. It would appear from the medical literature that it is the latter view of women which is prevalent.

The medical literature is divided between those who say that women's fertility status should be demonstrated before inseminations begin (e.g. Murphy and Torrano, 1966; Pennington and Naik, 1977) and those who say that a full evaluation should be carried out only after a few cycles of

inseminating have been unsuccessful (e.g. Guttmacher, 1960; Warner, 1974; Arnold and Joyce, 1982). The latter group also includes those who think that if there is any indication of fertility problems in women then full evaluation should be carried out before inseminations begin (Strickler, Keller and Warren, 1975; Dixon, 1976; Glezerman, 1981; Schoysman-Deboek, van Roosendaal and Schoysman, 1988). This group also differ on the number of cycles of inseminations that women should undergo before being fully investigated. The variation ranges from after two inseminations (e.g. Warner, 1974; Richardson, 1975) to six (e.g. Dixon and Buttram, 1976; Arnold and Joyce, 1982).

In none of the medical literature, while dealing with the question of when to evaluate women's fertility, is it taken into account that some women conceive beyond six months of insemination. It is not known why this variation occurs between women. However the decision to evaluate within six months appears to be based on the scientific data that 'shows' that *most* women who use DI will achieve pregnancy within six months. This does not alter the fact that medical interventions to establish women's fertility status may be performed on women who are fertile.

Full evaluation is evidenced by the use of a hysterosalpingogram (HSG) to test tubal patency or laparoscopy or endoscopy for internal surveillance¹⁰. The following two extracts from the literature show first, the intricacy of the decision-making involved to rationalise the use of these invasive technologies which carry risk and discomfort for women; and second, the extent to which women's reproductive system may be placed under surveillance when there may not be any indication that they have anything other than a healthy reproductive system:

Laparoscopy has, of course some disadvantages, including hospitalisation as well as anaesthesia. In good hands the risks are extremely low ... [but] quite a few diagnoses ... are possible only by laparoscopy. Some teams have decided that it is better to know all aspects of the gynaecological status of the woman prior to starting AID. Since the larger number of women will prove to

¹⁰ Murphy et al were still using X-Rays to establish tubal patency in 1966)

be normal, most teams will prefer to proceed with the usual examinations and request laparoscopy only after a few cycles (Schoysman-Deboek et al, 1988:720)

She [the 'wife'] was requested to keep a basal body temperature chart for two months, and her plasma progesterone concentration was determined 7 days after the estimated time of ovulation. A hysterosalpingogram was performed following a menstrual period, to ensure the fallopian tubes were patent. During the two cycles in which the wife recorded her basal body temperature, samples of cervical mucus were obtained at the approximate time of ovulation. Three tests were performed with the cervical mucus. (Quinliven, 1979:157)

What is interesting is that, as the first comment above indicates, the necessity of such high technology tests has not been conclusively shown. On the contrary Kovacs and Lording (1980) have changed their policy of performing routine HSG and laparoscopy prior to initiating inseminations because their detection of abnormalities was so low. Strickler et al. (1975) perform HSG and laparoscopy only when indicated by screening tests. However, they then concluded that the screening tests were not effective in predicting which women would succeed using DI.

A past history suggesting potential cause for infertility in the woman was more often associated with failure than any other factor.

(Strickler et al, 1975:848)

The very fact that such variations and contradictory practices exist in the practice of DI, indicates the lack of systematic evaluation of the application of DI. Individual clinics publish reviews of a series of recipients of DI and may offer some evaluative comments of their techniques in terms of their success rates and/or in conjunction with discussion about other studies they have consulted. However the apparent contradictions in the literature which are mirrored in the respondents' DI regimes go unresolved. The use of invasive technologies on women's bodies has consequences for the women who are asked to undergo them. They are not, in the main, seeking treatment for a physical problem, but a baby. Even when authors have written review chapters of current practices there are no comments on the implications for women of such opposite policies concerning provision or

even that such contradictions should be resolved. They are only described in such a way as to present each as valid practices of individual DI practitioners.

There is a tendency for medical authors, when writing about their particular DI regime, to present the rationale for such a regime as if it were based on scientifically evaluated evidence. In discussing the various interventions in pregnancy and childbirth, for example the use of episiotomy, epidurals, induction, the BWSG (1980) say:

These scientifically determined rights and wrongs may in fact be as transient as fashion. Recent years have seen the pendulum of medical fashion in full swing over the pros and cons of breastfeeding. Yet we women 'beneficiaries' of this knowledge are persuaded that it is 'objective fact'
(ibid:177)

I have referred to the truths presented by medical writers and respondents when they are speaking about their provision of DI as 'medical facts' to indicate precisely that they are not objective but belong to and originate in a particular context in which they have been constructed, that is, a medically managed one.

2. Detection of Ovulation

Unless women inseminate around the time of ovulation DI will almost certainly not succeed. The ability of doctors to develop reliable ways of pinpointing ovulation will almost certainly enhance their medical authority in the provision of DI. Richardson (1975) in a review chapter about DI identified six methods of detecting ovulation. The most common method is the basal body temperature chart (BBT) (e.g. Fish, 1965; Stone, 1980). Women take their temperature as soon as they get up and record it on a graph so that a picture can emerge of their cycle. The obvious flaw in this method - from the point of view of the medicalisation process - is that women fill in their own charts. After an experimental period of trying BBTs, Cary (1948) gave up because he said that women could not be relied upon to fill them in properly.

Other doctors use BBT in conjunction with examination of the cervical mucus (e.g. Shields, 1950; Traub, Boyle and Thompson, 1979). Many tests can be carried out on cervical mucus and some authors refer to establishing the cervical mucus' score (Kovacs and Lording, 1980; Schoysman-Deboek et al, 1988). Others use BBT in conjunction with menstrual calendar charts (Haman, 1954; Dixon and Buttram, 1976) and/or plasma progesterone tests (Bromwich, Kilpatrick and Newton, 1978).¹¹.

By the end of the 1980s the two most technologically sophisticated tests for ovulation detection are ultrasound scanning to test for follicular development (Stone, 1980; Arnold and Joyce, 1982; Foss, 1982; Teper and Symonds, 1983) and assays on lutenising hormones (LH) in the urine or blood (Arnold and Joyce, 1982; Foss, 1982; Teper and Symonds, 1983). Arnold and Joyce imply that both methods have been utilised in their DI provision but say that "these methods are not yet accepted as routine" (1982:1326). Foss (1982) also looks forward to the day when these methods will allow DI success rates to go over the 70% level attainable with fresh semen. Pennington and Naik (1977) use hormone assays on urine samples. The following description indicates the level of disruption to women's lives required to perform this more technologically sophisticated test:

Twenty-four-hour samples are collected on cycle days 3, 7, 10, 11, 12, 13, 14, 15, 22, and 26 in a regular 28-day cycle. Adjustments in the days of collection are made if the cycle is longer.
(ibid:1328)

It has not been shown that either of these methods yield a higher success rate in DI than use of BBT in conjunction with mucus tests. Stone (1980) acknowledges the existence of these more technically sophisticated

¹¹ I found the earliest mention of a more technical means of establishing ovulation in 1959. At that time, Behrman was performing a test to establish the level of lutenising hormones in women's urine. The use of such a more technical test in itself is only one way in which women become the objects of medical surveillance. The other way in which this sort of test medicalises the fertility of women is that women have to attend clinics with urine samples at days in the cycle not connected with ovulation. An obscure and only once mentioned test comes from Murphy et al (1966) who used BBT, calendars, mucus and a rat ovary hypernia test.

methods but concludes that there is no need for greater accuracy than that afforded by BBT charts and in their review of the literature Schoysman-Deboek et al (1988) say that those using LH determination tests do not get higher pregnancy rates than those using BBT with mucus score. The latter also conclude that because of the practical problems presented with daily determination of LH in urine or blood, and the cost of laboratory time, hormone assays tests should only be carried out on women with irregular cycles or with women who have been given ovulation stimulation tests. They recommend similar employment of ultrasound.

3. Method of Insemination

There are three ways in which semen can be introduced into women's reproductive tract: intravaginally, intracervically, and intrauterinally. The technology used depends on the method chosen. Intrauterine insemination is almost universally condemned in the medical literature pre-1980s for causing severe menstrual cramps and introducing the risk of uterine infection (e.g. Barton et al, 1945; Seymour and Koerner, 1936; Guttmacher, 1960). Some say that they would use it rarely (Behrman, 1959; Beck, 1976). In recent years, however, there has been comparatively more tolerance of this method. Arnold and Joyce (1982), for example, do not even mention the possibility of cramps or infection in their occasional use of intrauterine insemination. Kovacs and Lording (1980) also use this method when ovulation is induced and similarly do not mention any side effects. Schoysman-Deboek et al (1988) argue that "contractions" associated with intrauterine insemination resulted from the use of untreated sperm and with washed sperm, they say, these "rarely occur" (ibid:723).

Inseminating semen into the uterus requires both a technique with which to carry out the insemination and a laboratory with which to treat the sperm. Similarly with intracervical insemination, where sperm is placed into the entrance of the cervix, special syringes and - perhaps predictably - a "gun" (Pennington and Naik, 1977:1328) or "pistol" (Schoysman-Deboek et al, 1988) are used to place the sperm. Caps such as the one referred to earlier are also employed to keep the sperm in close contact with the cervix - the

so-called pericervical method - and to allow women to go about their business.

For intravaginal insemination any kind of syringe can be used (Schoysman-Deboek et al, 1988) although these authors warn that this method has a high rate of sperm loss. Behrman (1959) suggests inserting a "Fertilo Pack" (a plug) to prevent just an eventuality and if buttocks have been elevated to between 15 and 20 degrees and the 'patient' remains 'resting' for 25 to 20 minutes presumably the sperm will have just as much chance to travel through the cervix as it does in women who have heterosexual intercourse.

Scientific Measurements as Rationales

The collection of so-called 'scientific data' (Antonis, 1981) is often used to substantiate claims of success of particular approaches to designated health problems. The biggest rationale used by the medical profession and the state for antenatal care and hospital deliveries is the decrease in this century of maternal and perinatal mortality rates (Oakley, 1975; Leeson and Gray, 1978; Antonis, 1981). However the correlation between increased medical intervention and decreased mortality rates is highly contested (Oakley, 1975; Leeson and Gray, 1978; Antonis, 1981; BSWG, 1980).

Reference to success rates in the provision of contraception is one of the reasons why the Pill is predominantly prescribed by doctors. Apart from the challenges to the validity or usefulness of these statistics their effectiveness as a treatment may not be the only consideration to take into account when making a decision to use any particular method. For example, the combined Pill and progesterone-only Pill have effectiveness rated of 99% and 98% respectively (Oxford Women's Health Action Group (OWHAG) 1984; Shapiro, 1987). But these contraceptives are also linked to cardiovascular disease, various cancers, liver failure and so on (ibid; ibid) and should only be dispensed dependent on women's age, previous health and reproductive history, smoking habits and so on.

One of the problems connected with the use of these sorts of statistics is that women are compared with an idea of a norm based on an average response to, or result from, a proposed treatment - apart from the fact that effectiveness as a contraceptive does not mean that women's health is not affected in any way. In pregnancy and childbirth the use of statistics to show that a particular form of care reduces mortality rates can mean that:

The desire to create better, safer facilities for labouring women has turned into a system whereby women are processed through pregnancy and after, according to some 'average' pattern. (BWSG, 1980:166)

In DI there has been some discussion about the usefulness of comparing the success rates of different series of women who have inseminated and of the validity of success rates *per se* (Richardson, 1975; Jackson and Richardson, 1977). This debate has occurred because success rates are collected differently. As Schoysman-Deboek et al. (1988) say:

In spite of an enormous number of publications from the centres world-wide, it is still hard to determine the pregnancy results one can expect from AID. An effort has been made to improve the evaluation of AID by establishing statistically valid methods of study. The major difficulties with these reports are the number of parameters involved. (ibid:724-25)

This question mark over the validity and usefulness of success rates has not prevented their use in rationales for particular DI regimes. Two of the most important factors connected with the success rates of DI are the numbers of inseminations per cycle and numbers of cycles of insemination offered. Many of the success rates given in the literature show that most pregnancies occur within six months of inseminating (e.g. Chong and Taymor, 1975; Quinlaven, 1979; Matthews, 1980). Some of the early writers about DI say that if pregnancy has not occurred within the first three or four cycles the 'prognosis' is 'poor' (Cary, 1948; Shields, 1950). However there are also those who "show" that the longer women inseminate the more chance they have of succeeding (Jackson, 1977; Foss, 1982) and although these may also 'show' that most pregnancies will occur within the first six months they argue that "persistence" is "the most important factor in success

with AID" (Bergquist, Rock, Miller, Guzik, Wentz and Jones, 1982:198). Most of these authors do not, or do not say that they, restrict the number of insemination cycles offered. Some authors say that they do.

Pennington and Naik offer women six cycles which "constitutes a course" (ibid, 1977:1329). However, their results show:

The treatment cycles in which pregnancies occurred are spread evenly over the six cycles and suggest that extension of the treatment period would result in a higher rate of success.
(Pennington and Naik, 1977:1329)

Bromwich, Kilpatrick and Newton (1978) suggest that a continued chance of conception occurs up to fourteen months of 'treatment', thereby giving a justification for offering 'patients' one year of treatment. Guttmacher (1960) on the other hand advised women to give up if they had not been successful after three cycles and then to try again after a six month interval:

on the theory that fertility fluctuates; although I candidly admit I have no scientific evidence for such a concept.
(ibid:780)

The use of frozen sperm has added another dimension to the debate about the length of time women should inseminate, and their chances of conceiving. Some medical authors have found that the use of frozen semen has decreased success rates (Richardson, 1975; Traub, Boyle and Thompson, 1979) possibly by one third compared with fresh semen (Jackson and Richardson, 1977; Arnold and Joyce, 1982). However there are also those who have 'shown' that an increase in the number of inseminations in a cycle and in the number of cycles can compensate for this (Pennington and Naik, 1977; Arnold and Joyce, 1982; Teper and Symonds, 1983). Further, Bromwich et al. (1978) 'found' that there was no difference in cumulative success rates between frozen and fresh semen beyond six months of insemination.

According to the literature the number of inseminations per cycle offered also varies from one to twelve. However the necessity for many or few has not been demonstrated. There are those who, in advocating many, argue

that the number of inseminations is more important than where and how the semen is deposited (Guttmacher, 1960; Richardson, 1975). There^{are} also those who argue that increasing inseminations above two in a cycle shows only a marginal increase in success (Arnold and Joyce, 1982) or no increase in the chance of success (Stone, 1980).

Using comparisons between individual women and the statistical norm can often result in the problematisation of women who do not have 'normal' cycles, that is, either not of regular lengths over time or of lengths deviating from a twenty-eight day cycle. The worst effect of this comparison is that women might be diagnosed as having irregular cycles and prescribed drugs to control them, or in the case of women who sometimes do not ovulate, to stimulate ovulation. The most named drug in this respect is clomiphene. There are health risks attached to the use of clomiphene: spontaneous abortion, multiple pregnancy and ovary enlargement (Stone, 1980; Glezerman, 1981; Foss, 1982). It is also the case that clomiphene is given when irregular cycles do not fit into DI regimes or merely when it becomes difficult for doctors to predict ovulation (Stone, 1980; Foss, 1982).

Sometimes women develop irregular cycles or stop ovulating as a result of the stress involved in embarking on inseminations. Clomiphene is often 'prescribed', allowing medical management of these stress-induced reactions (Beck, 1976; Bromwich et al., 1978; Glezerman, 1981). In one clinic 84% of the women were put on clomiphene because of a stress-induced drop in luteal function (Vere and Joyce, 1979; Arnold and Joyce, 1982). Women must be continuously regular - in a twenty-eight day cycle ideally - or medically managed to manipulate their cycles. Little divergence from this 'norm' seems to be tolerated (Pennington and Naik, 1977). But women do not all have regular cycles all of the time and only some of us will have regular twenty-eight day cycles (OWHAG, 1984). In their retrospective of women they had seen, Schoysman-Deboek et al. (1988) - the authors who recommended the use of LH assays and /or ultrasound only in women with irregular cycles or those on ovulation-stimulating drugs - had this to say:

the perfectly normal cycle as described in most text books is not more than a "mean value" and in practice rather an exception than a rule.
(ibid:721)

The differential use of medical technological interventions and different DI protocols are rationalised as medical facts with reference to scientific measurement of success rates. These measurements are also often used to justify the comparison of the treatment of women with "average" women the existence of whom has not been proved.

Pathologising Women

The underlying theme running through the three factors already described is that women's reproductive tracts and their biological functions are fundamentally pathological. Many writers have pointed to the way in which pregnant women are made to feel that they must be 'ill' or temporarily abnormal and may only recover under medical management (Oakley, 1975, 1986; Breen, 1978; Antonis, 1981). Antonis argues that this pathologising has the effect of allowing pregnancies to be pronounced normal only after the event, that is, after a "normal" delivery (Antonis, 1981:65).

Certainly in the provision of contraception and abortion it is only comparatively recently that women could receive either of these from the medical profession for anything other than medical reasons: since the 1974 Family Planning Act for contraception and 1967 Abortion Act for abortion (Greenwood and King, 1981; Simms, 1985). However, the fact that women seeking abortion can only do so with doctors' approval underlies the fact that even social reasons for abortions must be seen to have medical validity.

In DI this pathologisation is exemplified in two ways. The first occurs because, as Oakley wrote:

to maintain the definition of pregnancy and childbirth as medical phenomena, the doctor must treat the patient *as if she were ill*.
(Oakley, 1975:640, her emphasis)

In DI this transformation can be illustrated with the emergence of 'female factors' as a consideration either before or soon after the inseminations have begun; the use of drugs to control 'irregular' cycles for whatever reason and in the language used to describe fertile, healthy women as 'patients' who need to be medically managed. The medical perception of women is that, rather than being healthy actors seeking parenthood, they are potentially patients who must demonstrate their health by 'passing' the medical investigations.

Alienation of Women from Own Bodies

The extent to which the pathologisation of women's bodies has taken place can be indicated by the extent to which women are alienated from their own experience of, and knowledge about, their own bodies. Oakley (1986) argued that, through use of fetal visualisation technology, women have been bypassed as intermediaries between their foetus and doctors. Further, she argues that the use of propaganda to undermine women's informal sharing of knowledge, information and experience of pregnancy and childbirth further bolstered the idea that antenatal clinics and hospital deliveries were the best option for them and their children (ibid). Evans (1985) found, in her study of 200 women who had given birth, that even though they had experienced minimal control over the care they received and were dissatisfied with how they had been treated, they argued for increased use of technology and had implicit faith in the doctors. She concluded:

women were more disturbed by the social relations within which technology is organised than they were by its use *per se*.
(ibid:113)

Similarly in DI the fact that such a simple procedure is used within medicine and not at home deserves comment. The belief that not only do doctors and their technological props know best but that women do not feel themselves to know enough in comparison is, I would argue, indicative of the extent to which women have experienced alienation from their own bodies and reproductive experiences. David and Avidan (1976) found none of the

women in their study wanted their husbands to inseminate them but believed that doctors should do it because it is a “treatment” (ibid:531). The notion that recipients do not feel technically competent to carry out inseminations and that medicine provides respectability and takes responsibility for inseminations is something that many of the respondents referred to. This shall be explored in the next section. As McLaren (1984) argues using evidence from anthropology:

the introduction ... of scientific explanations of the process of procreation can, in the short term, lead to lay persons becoming ‘ignorant’ of the functioning of their own bodies
(ibid:113)

In ‘modern’ societies I suggest we could substitute “scientific explanations of” for “medical technology into” and that this could then provide some explanation for women’s lack of trust in themselves *vis-a-vis* their reproductive potential.

The Respondents

The responses to questions asked about the DI regime of each respondent were as varied as they are in the literature. Specific regimes were also substantiated with reference to ‘medical facts’ about the use of DI. I have ordered the responses under three of the headings referred to in the previous section to illustrate the existence of medicalising factors in the description of DI regimes. These factors are medical intervention in DI, the emergence of technology and the use of scientific measurement. The fourth factor, the way in which women’s fertility is pathologised, runs as a theme throughout the respondents’ comments and has not been separated as a category. The final part of this section seeks to establish whether the medicalisation of DI is warranted on medical or medical-technical grounds.

Medical Intervention

Two of the ways in which DI has been ensconced in the medical domain as a ‘treatment’ were illustrated by responses given to the questions both about the medical indications for DI and whether they accept self-referrals.

Only two respondents referred to the fact that women who use DI must be fertile, and only three referred to women without male partners who wish to conceive as an indication for the use of DI. Of the rest, over thirteen referred to azoospermia; twelve to oligospermia; six to male infertility; two to the duration of infertility; one to 'poor sperm'; twenty to genetic reasons in the male; four to the rhesus factor; four to the presence of sperm antibodies; and five to males who have had a vasectomy or a failed vasectomy reversal.

For the vast majority of this sample DI is only available to women whose male partners have fertility problems. These 'medical' indications serve two functions. First they impose a social context on the conditions for use of DI. Secondly and conversely, by focusing on male fertility factors they emphasise the medical prerogative: medically defined male fertility problems are emphasised at the expense of the probable lack of fertility problems in the women. This reinforces the definition of DI as a medical treatment for a medically defined problem which means that women's *fertility* is submerged beneath the presentation of male fertility problems or even the 'couples' fertility problems:

- 05 (pause) Well - first - poor sperm. ... I would talk to them, along the lines that "*your* chances of conceiving using *your* current sperm is going to be quite low, and therefore have *you* contemplated the use of donor, - go away and think about it, and then if *you're* still not pregnant" *they* can come back having formed a view. (My emphasis)
- 12 Lack of sperm or severe reduction of sperm. I think genetic disorders is very much an indication and where there is a problem with (pause) that you feel that you couldn't be sure of the outcome of pregnancy in someone who's had recurrent abortion say with a chromosomal mosaic or something of that sort and you were worried about that then I think AID is very useful in that sort of thing.

In the last comment the respondent gives as an example of a medical indication, recurrent abortion because of chromosomal mosaic which would occur rarely. Genetic reasons were most often given last, if at all by

respondents and I often had to ask as a prompt whether genetic reasons were a medical indication for DI. Presenting a minority indication, in such detail, emphasises the pathology of those seeking 'treatment' with DI. The use of DI for genetic reasons especially when those genetic reasons complicate women - as the last comment above does - pathologises men and women using DI but can also expand the definition of what a fertility problem is. Clearly women who can conceive but who recurrently abort have fertility problems. But, do women and men who are at risk of reproducing a child with genetic problems have fertility problems? They are able to conceive and she is able to give birth. In this sense they are fertile. If they are advised not to do this because of the chance of genetic disease occurring in the offspring the issue is that they cannot reproduce the right sort of baby.

The use of DI for heterosexual couples in which the male has had a vasectomy raises the question of what constitutes 'infertility'. Usually an association is made between infertility and childlessness. Men who have had vasectomies may not be childless but may want to have children with a current partner. It is his social circumstances which leads him to define himself as having a fertility problem and seek help. At one DI unit the policy of eligibility excluded people who have had children in previous liaisons on the grounds that they were less of a priority than those who had never had children.

Self-Referrals

Only four respondents accepted self-referrals for DI. A further two said that they had accepted some self-referrals but preferred not to. Five respondents said that they would see self-referrals but would then like them to get a referral letter from their doctor. Of these, most said that if general practitioners (GPs) would not give referral letters on moral grounds in relation to the use of DI *per se* they would not let this objection stand in the way of potential recipients' access. The remaining respondents said that they would not accept self-referrals.

The major objection to accepting self-referrals was the resulting lack of information from medical sources pertaining to potential recipients. In the main this lack of information referred to medical histories but there were some respondents who sought reassurance from another doctor about the integrity of potential recipients. The alleged need to gather appropriate medical information achieves two effects. First, if referring doctors observe the medical criteria for DI they will refer 'infertile' couples in which men have a fertility problem. This ensures that the potential recipients are appropriate medically and socially, that is, that a male exists in relation to the woman seeking DI. Secondly, the status of DI as a medical treatment is enhanced.

Furthermore, the status of women who seek DI is reduced to that of 'patient' rather than, for example, 'client': their ability to give an account of their reproductive potential is undermined as is their ability to recount any reproductive history that may be relevant to their use of DI. The referral letter will do this for them. They may have to be ready to have their fertility status fully evaluated even when there is no reason to suspect a fertility problem. Lastly, they have to fulfil medical criteria that do not actually refer to them but to their supposed male partner. The possibility that DI is a technically simple procedure offering a social solution to a social problem is 'disappeared' under such a veil of medicalisation.

Of those who accept self-referrals the two who had the most 'open door' policy and correspondingly least medical approach were those respondents working in non-profit-making organisations. This approach acknowledges that women -with or without male partners- are able to define their own need and consult with appropriate services to meet that need:

- 17 Well they're sometimes referred by their GP but I would say that's probably in the minority. A lot of people have read about us somewhere and ring up and ... once other people have come in they might have been referred by somebody else that they've talked to and we also have some patients through the National Association of the Childless because I actually help them out now and then with some medical advice so it's a two-way process (laughs).

The two who have accepted self-referrals, but who prefer not to, each illustrate one of the two functions referring fulfils. The role of screener of the medical:

Q18: Do you accept self-referrals?

07 Well I might do it, it depends on the circumstances but you know one needs to get a medical history as detailed as possible in order not to waste time, time is very important. So I prefer to get a referral through a doctor who has some knowledge of the patient or can give me the detailed information of what has been done or hasn't been done in relation to investigations.

and screener of the social:

09 some couples are not (pause) working in liaison and it's a two person decision and you've got to be two nil and I think some of them come up - it's a check on their background which is simply nice from our point of view, to know that the couple are a genuine couple, you know, know their background.

The five respondents who will see self-referrals but who then require a referral letter used the same rationales: that it is better to know the background of the potential recipients than not. Two respondents also mentioned the usefulness of having another medical person involved once the inseminations had begun and had been successful. This again reinforces the medical prerogative as viewed by the respondents in possession of greater knowledge and skill in managing people using DI;

05 generally I believe, because of the stresses and strains that are involved, having ... another medical person involved, is worthwhile and if they get pregnant that GP's going to then have to look after them, ... I mean they're going to have to establish a relationship with the general practitioner anyway. So - it's very rare that patients don't come on referral or that approach us, I mean, even in the private sector

Of those who refuse self-referrals the need for some knowledge about the potential recipients' background was the primary reason. This approach, emphasising the possibility of pathology - either social or medical - of those seeking DI is in contradiction to those four respondents who are happy to accept self-referrals. The supposed necessity for medical referrals and evidence that some evaluation has been made before potential recipients arrive is another example of a 'medical fact' in relation to DI:

Q18: Do you accept self-referrals?

08 No

Prompt: Why?

08 Because we do feel that although we see the patients, but we do need some extra confirmation that the couple is known to another sort of medical set-up as well which will be either consultant, and we feel that especially the GP, they know more about the couple and their background and their social relationship and so on, so we feel a bit more comfortable that the patient is known to another practitioner before they are seen at the clinic.

A further objection to self-referrals came from respondents who made it clear that they were not a DI service but a clinic addressing general fertility problems. This response emphatically locates DI within a medical context, reinforcing its use as a treatment which may solve a medical problem:

Q18: Do you accept self-referrals?

02 No. It hasn't arisen. The Professor generally says we would like a GP referral for all fertility problems. We don't really get referrals for AID to be honest. We generally get referrals to investigate a couple's fertility problem and we discover over time what's the problem.

Intervention of Technology.

Respondents were not asked questions about which methods they used to inseminate, whether they fully evaluated women's fertility, or how they timed ovulation. However in response to other questions such as those asking how many cycles women inseminated for, how many inseminations were used per cycle and whether women could take the semen home to inseminate, respondents revealed the extent to which they have medicalised the provision of DI by their reliance on technological intervention.

1. Method of Insemination

When the questionnaire was devised I had assumed, because of the medical literature, that the use of intrauterine insemination would be non-existent. However six of the respondents referred to their use of intrauterine insemination and none of these spoke about any health risks to women using it. One of these respondents spoke about its use as if it were located one step along the medical conveyor belt of technological solutions to infertility:

- 08 If they haven't succeeded to become pregnant after six months thereafter they'll be given options of either to carry on with the insemination for another six months or to choose another method with a higher success rate is what we call intrauterine insemination And we combine that with stimulating the ovaries to produce, hopefully, more than one follicle - and we're getting something like about 18-20% success rate per cycle with intrauterine insemination. So ladies are going from ordinary, what we call intracervical insemination, to intrauterine insemination after six months of the failed ordinary insemination.

In this DI unit routine insemination was intracervical insemination. This level of technological intervention denies any simplicity about the DI procedure and substantiates its status as a procedure requiring knowledgeable and technically competent staff. Another respondent also referred to the routine use of both intrauterine and intracervical insemination when he defined DI:

- 02 Artificial insemination by donor can be defined as a process whereby donated sperm are injected into either the cervical canal or intrauterine cavity using specially designed catheters for this purpose.

Four respondents in all referred to the routine use of intracervical insemination.

2. Full Fertility Evaluation of Women

Six respondents referred to the use of either laparoscopy or HSG to evaluate women's fertility status and most of these offer them after inseminations have been unsuccessful. The range of cycles after which they suggested these technological interventions was between five and twelve months. One carried out HSG before inseminations began. This respondent did not attempt to rationalise this regime but merely described what happened to the women presenting for DI. This level of investigation is routine before there is any indication that there may be any female fertility factors involved. Again the presentation of this as 'normal' is another way in which 'medical facts' are expressed - without justification but just as if they stand without need of an objective rationale to substantiate them. Another of these respondents explained why women were not routinely fully evaluated until after six months of unsuccessful insemination:

- 08 after six months of a well-timed treatment, if they haven't achieved a pregnancy we check their fallopian tubes. Fallopian tubes are not checked beforehand in this clinic because otherwise you would be submitting a very high proportion of patients to a unnecessarily invasive procedure.

Another respondent in this group referred to a review which had been carried out of the practice at his clinic of performing laparoscopy after eight cycles of unsuccessful inseminations and provided him with the basis for his 'medical fact':

- 20 we've decided that after five cycles the number of patients - women - with pelvic abnormalities increases quite considerably so we then do laparoscopy after five. If the laparoscopy is normal then we would continue up to twelve usually, sometimes more, depending on the individual.

With other respondents waiting for ten to twelve months before suggesting that such invasive exploratory techniques be carried out, it is clear that the level to which women can be pathologised in this way is variable across clinics.

3. Ovulation Detection.

Five respondents referred to their reliance on technological intervention to detect ovulation. Two utilise ultrasound and one of these, with two others, monitored the LH level in blood or urine. The fifth referred to the necessity for women to attend the hospital for ovulation monitoring which was taken to indicate the use of one of these technological interventions.

4. The Conveyor Belt.

As I indicated in the last chapter, the majority of respondents offering DI do so from within high technology-oriented hospital settings. In the main these units offered the whole range of reproductive technologies including IVF and Gamete Intra-Fallopian Transfer (GIFT). Both of these techniques require both a high level of medical-technological intervention and a high level of medical management of women's lives. Another way in which DI is medicalised is by locating it alongside such technologically dependent interventions as another 'treatment' for 'infertility'.

What emerged from a quarter of the respondents was the way in which this embedding has been successfully carried out within their clinic setting. In response to the question about how many cycles of insemination were offered to women these gave time limits of between six and twelve months after which women would - routinely - be offered either IVF or GIFT:

- 03 Well what is going to happen here is that they're going to have six months and the review decision then is really whether they go on to the IVF programme or not ... We're not going to do insemination past six months.

Other respondents let women determine how long they will inseminate for. One of these told an anecdotal story about a woman who had refused to give up inseminating until she finally conceived after three years of trying. This respondent worked from her consulting rooms and three other respondents working from private consulting rooms were all equally happy for women to determine the number of cycles they would inseminate for. This self-determination could be a result of payment for service in that women are able to assert themselves in a situation in which they are paying a fee. Another factor could also be that private sector doctors are highly motivated to indulge women's insistence on proceeding with DI because of the money to be made. All of these doctors regularly reviewed women's situation regarding on-going insemination and recommended fertility assessments when indicated.

Determining whether either or neither of these factors influence the policy of self-determination in private consulting rooms was not an objective of the study. However the contradictions inherent in such variable DI provision again deserves comment. DI can be offered on a basis of low-level technology - as in the private and charitable consulting rooms - and on the basis of high-level technology as illustrated by the fertility services provided in hospital fertility departments. These opposite methods of providing DI, often each defended with reference to 'medical facts', are themselves variable and contradictory. It is perhaps illuminating that two of the respondents who offer the most highly technologically-oriented clinics described DI as being a very unsuccessful procedure. One of these stated that DI compared very unfavourably with GIFT. A respondent working from private consulting rooms on the other hand described DI as the best of all methods - including GIFT and IVF but, after reflection, excluding ovulation induction - for achieving conception.

Use of statistics

In response to the question about respondents' success rates the method of measurement and range of success rates were as varied as those in the medical literature. Three methods were given: percentage success per cycle; percentage success rates over a specific period of time; and just a proportion or percentage figure. Of the five who presented their success rates using the first method, four said success ran at 10% per cycle and one 5-10% per cycle. Of the six who used the second method one said 80% over eight months; two gave 35-40% over six months; one gave 60% over twelve months; another gave 60% over nine cycles and a further respondent guessed at 35-40% over eight cycles. Of the four who gave percentages, the range fell between 40-70%; and of those who gave proportions, all gave one in three.¹²

It is meaningless to try and compare these figures. The only thing that can be said is that the range over which they fall is quite large. What is important is that any particular DI provision might be rationalised with reference to the success rates which for some respondents meant conception but for others, conception within a specific period of time.

Respondents also referred to their success rates whilst justifying their particular protocol for the application of DI. The way in which medical authors have ritualised the insemination process was mirrored in the respondents' individualised protocols, where variations occurred in the numbers of cycles of inseminations thought sufficient for conception to occur and the numbers of inseminations to administer per cycle.

1. Cycles of Insemination

As indicated in the last chapter a minority of those respondents working in the private sector imposed a time limit to the number of insemination cycles offered to women. One of these had a limit of ten cycles and the other said

¹² One of the respondents did not have any success rates to give as the DI programme had been stopped in 1987 due to poor success rates and was only in the process of starting up again.

that women could inseminate for up to two years. Of the eleven respondents working in the public health sector only one said that there were no time limits on cycles of insemination. Of the rest, the range fell between one who allowed four "perfect" cycles of insemination and another who allowed eighteen months of insemination.

Two of the respondents referred to medical facts which justified their policy of no time limits:

- 01 I say to every patient "look the chances of you getting pregnant are 5% per cycle, they're one in twenty and that comes out to one in three chances in six months and about a fifty-fifty chance in a year. We can't guarantee that you'll ever get pregnant but what we do know is that the more cycles of treatment you have the more chance you have of getting pregnant, and we will treat you for as long as you want".

This respondent refers to the 'scientific data' which shows that the longer one inseminates the more chance of success there is. Another respondent who had no time limits referred to another medical fact as justification: the effect of stress on women who feel they have to succeed within a time limit endangers their chance of success.

Conversely a further respondent referred to the 'scientific data' which justified limiting the number of cycles of insemination offered to six:

- 21 Each couple are given a chance of six insemination cycles and if they don't achieve a pregnancy within these treatment cycles then - we have a long waiting list of people and we can't offer them more treatment but I think if they get pregnant second or third or fourth attempt that's normal. There is, you know, in the medical literature there is (pause) a consensus that if the couple haven't conceived by the sixth or seventh attempt then probably the chances of pregnancy may not improve.

The 'scientific data' this respondent refers to does not say that women cannot become pregnant after six months only that the success rate per cycle does not improve after six months. This rationale for limiting cycles of

inseminations demonstrates a different objective to that of women. What is implicit in this respondent's comment is the goal of achieving the best rates of success within the shortest period of time. Presumably women seeking parenthood would be quite happy to go on inseminating past six months if they are fertile and could conceive. The fact that this respondent works in the public health sector may influence the clinic's interpretation of the 'scientific data' and he does refer to waiting lists which must exert pressure to achieve as many pregnancies as possible in the most efficient way.

Two other respondents working in the public health sector, including the one offering four perfect cycles of insemination, mentioned the demands on the service as a reason to ration resources. The other also charges recipients for DI so in this context the ability to pay does not affect the self-determination of the women. This respondent also acknowledged that women could conceive after twelve months of insemination but felt that, because of the waiting list, inseminations should be rationed so that others can use the service. The policy of twelve months' insemination had been recently changed from six months because:

- 11 women got pretty uptight towards the end of their six months so we continued it for a year. So our general principle now is to go for a year. We feel after that only a very few women are likely to become pregnant and that really the service cannot only extend to them. They have a try for a year and then that's it.

Again where the objective of fertile women is to become pregnant and there is an acknowledgement that some could do so after the twelve month limit, it seems an arbitrary decision to put the cut-off point at twelve when at other clinics the cut-off point may be at eighteen months and at others there are no cut off points. The decision is not made for any medical reason. And women could inseminate themselves at home without taking up hospital staff time.

2. Inseminations Per Cycle

The number of inseminations offered per cycle also showed variation across the respondents. The range fell between one and four with most

respondents offering two. Two respondents in the private sector preferred recipients to have more than one insemination and offered financial inducements to this end. Two respondents offered only two inseminations because they felt that their timing of insemination was so precise as not to warrant any more than this. One of these used ultrasound scanning and monitored LH levels providing an example of the way in which use of technological intervention can be used to justify different service provision;

- 06 One or two depending on the, the exact timing because as I said ... we will time ovulations so we do not find that there is a need for more than one in general in the majority of patients.

The other respondent who used ultrasound scanning said that women received, on average, 2.3 inseminations per cycle with a range that fell between one and four. Clearly the extent to which technology is used to influence the provision of DI is also variable. Another respondent reflected the medical fact that:

- 14 Yes. We've tried one, we've tried two, we've tried three and the success rate is no different at all.

It emerges from the data that respondents offer quite variable protocols of DI so that what is routine for one respondent is decried by another. Nevertheless they are each able to rationalise their particular regimes with reference to medical facts about the factors which affect the successful use of DI.

The mainstay of being able to control access and use of DI is that it is a medical treatment for a medical problem with the procedure being of such a technical nature as to warrant medical supervision. The final part of this section examines this through presentation of respondents' answers to the question of whether women are offered home insemination.

Home Insemination

If it is agreed that inseminations can be carried out at home by recipients then it is my argument that much of the basis for the medical management of DI and the subsequent medicalisation of fertility is undermined. Problematisation of both women and the insemination procedure has resulted in a medical perspective that defines and locates DI as medical, belonging in a medical sphere. The clearest indication that an alternative is possible is evidenced by the fact that one respondent runs the DI service he manages on a self-insemination basis only. Women either inseminate in the hospital or, more recently with the purchase of transportable semen banks, at home:

Q11: How many inseminations per cycle are carried out?

13 Entirely ad hoc. It's up to the couple so, using the transportable bank there's no problem in terms that the couples can inseminate seven days a week if they like. It's not dependent on a doctor being present. Our clinic is quite different from everywhere else I think because we get all the ladies to do their own inseminations. All we use is an ampule - little ampules - and a syringe - insulin syringe - and they're instructed just to pop the sample high into the vagina, stay laying down for fifteen minutes with buttocks elevated and that means that if they can take the samples home most ladies will inseminate twice per month.

This respondent's success rates were exactly the same as that of the respondent who used ultrasound scanning and monitored LH levels - 10% per cycle.

A further five respondents had sometimes offered home insemination. When agreeing that home inseminations are possible the technique is described as being *easy*:

09 Yes the husband can collect sometimes. ... the actual insemination procedure's relatively simple unless there's problems, but basically there's no reason why the husband shouldn't collect the semen on the way

home, and he can easily be taught - it's only a little plastic - like a syringe - which they squirt in the vagina. They can be taught to do that. Also you can be taught to use an insemination cap.

The majority of respondents did not offer home insemination as an option. The reasons given for not offering home insemination were threefold. One reason was the lack of medical management allowed by home insemination. Ovulation monitoring was given as an example of the medical management required:

Q14: Can women inseminate at home?

11 No

Prompt: Is that clinic policy?

11 Yes. We do it, time it with blood samples of progesterone and we want to make sure that it's done properly.

Another of this group referred to the preparation of sperm as a reason for keeping DI medically managed.

The second reason given was the interests of recipients. This somewhat paternal attitude reflected a belief that carrying inseminations out in the clinic removed unwanted responsibility from recipients:

12 Although we have an overall success of 40% that means there is a 60% failure rate and one of the problems is, I think that individuals might then think that the failure to conceive was associated with a lack of technique in some way in which they had failed to handle the semen properly and hadn't put it in the right place and so on. Whereas, I think if we do it that it makes it easier for them actually.

This respondent uses statistics to rationalise his medical fact that people prefer inseminations to take place in clinics. He also makes the quite extraordinary statement that people may not know where to put the semen. The following respondent makes an equally extraordinary assertion which

is based on her experience of one heterosexual couple who attempted home insemination:

- 18 I've never actually from this clinic had anyone who's gone ahead with it. I've had people who've thought about it. I'm very willing to hire them a sperm bank and to train the husband and we had one ... husband who did it but that was from the clinic and he didn't actually succeed in getting her pregnant and they found it quite upsetting. Most husbands don't like playing doctors and nurses (pause) and putting a speculum into your wife with whom you're going on with, you know, is quite tricky emotionally. I think this is why they won't do it.

The fact that one respondent encourages all the women in his DI service to inseminate themselves clearly exposes the extent to which these respondents have both mystified and problematised the insemination process. Such contradictory views call into question the extent to, and capacity in, which doctors are necessary in the use of DI as a procedure for achieving pregnancy.

The third reason given hints at a role for doctors which has nothing to do with medical management but their sense that they are morally or socially responsible for DI:

- 21 Well (laughing) I don't know whether they're inseminating themselves and I don't want to get tied up with adultery cases and goodness knows what at home so I would rather, I know we're ultimately, we're responsible here, I would rather them come here I would rather them be inseminated by - usually by a doctor and that's it, that's the situation.

These comments do not refer to the need for medical management in terms of knowledge or competence in performing inseminations but the worry they have for what women may do with the semen once it leaves the clinic. The issue of sperm separated from its ordinary social context, that is, males engaged in heterosexual relationships, emerges as a key issue within the

context of the debate around the role of doctors in the provision of DI. This issue will be picked up in chapter six.

Conclusion

This chapter has concentrated on the way in which DI has been medicalised through the emphasis that has been placed on medical management, technological intervention, the use of statistics and the pathologisation of women. Both the insemination process and women's fertility have been problematised in a way that reinforces both the medical definition and preferred location for DI. This chapter has also described the way in which respondents follow quite different and contradictory protocols which they justify with reference to medical facts. There now follows a discussion about the biological and technical aspects of DI. The purpose of this is to deconstruct insemination as a method of achieving conception in order to discuss whether there are any biological or technical grounds on which DI should be medicalised.

The Biological and Technical Aspects of Using DI

1. As a Method of Achieving Conception

Human fertilisation takes place when the nuclei of egg and sperm have combined. This is the same whether DI or heterosexual intercourse is the method of conception. In both, insemination has to be timed to occur around ovulation. Knowledge of our menstrual cycles is important for women to manage our menstruation; to avoid conception; and to achieve conception.

Fertility awareness methods of contraception require women to monitor the different physiological changes that occur during our menstrual cycles. The calendar method has about a 53% reliability; using BBT charts about 80-85% reliability; cervical mucus tests also have between 80-85% reliability; and the symptothermal method which combines all three methods and any other observations women make of their own bodies has a reliability rate of between 85-93% (Shapiro, 1987). When women want to become pregnant

and do not find it easy to do so they are advised to fill in BBT and calendar charts and to check their cervical mucus in order to time heterosexual intercourse (Pfeffer and Woollett, 1983; Philipp, 1984). If women can learn to identify their fertile period in order to avoid or encourage conception by heterosexual intercourse, then those wishing to use DI could as well.

2. DI As a Medically Dispensed Treatment

The mystification of DI as a 'treatment' has been discussed in a previous section. The point I wish to make here is that DI does not differ from AIH except that a stranger's semen is used in the former. The successful application of both requires that insemination takes place around the time of ovulation. Yet many medical authors suggest that, since recipients can be 'taught' how to inseminate, they should be encouraged to carry out AIH at home. This is both for convenience and in order to lessen the stress involved in inseminating in a clinic atmosphere (e.g. Barton et al., 1945; Philipp, 1984). Furthermore, the use of portable semen packs enabling recipients to carry out DI at home has also been discussed in the literature (McLaughlin, Bromwich, Macken, Walker and Newton, 1983; Schoysman-Deboek et al., 1988). If AIH can be performed at home and it is possible to arrange DI at home it is difficult to understand on what grounds DI warrants medical supervision.

3. DI as a Medical-Technical Procedure

Whether carried out at home or in a clinic, by a doctor, nurse, partner, friend or oneself, the actual insemination of semen is, with the detection of ovulation, the most important factor affecting its successful use. During heterosexual intercourse semen is deposited high up in the vagina near the cervix and for the majority of fertile women this is enough for conception to take place. The placing of semen into the vagina with a needleless syringe, turkey baster, teaspoon or whatever can be likened to inserting a tampon. The respondent who operates DI on a home-insemination basis used exactly this analogy.

These three comparisons have been made in order to establish that insemination is a procedure akin in technical difficulty to putting in a tampon (or possibly a contraceptive cap or diaphragm) which, as evidenced, does not need to be carried out in a clinic environment. Male partners are encouraged to inseminate women with their own semen and DI is available on a home basis. Women are encouraged to gain knowledge of their menstrual cycle when being heterosexually active requires it. In short, all the elements of insemination are biologically and technologically simple - the timing of inseminations and the insemination itself.

Yet this simple procedure has been co-opted by the medical profession. The respondents explain this by saying that DI is a medical procedure that requires their supervision because women have to be diagnosed fertile and their menstrual cycles monitored in order to time inseminations perfectly. Some respondents also allude to their role as responsible managers of semen. The fact that DI involves the use of a stranger's semen to inseminate fertile women emerges as an issue explaining the medicalisation of DI and will be discussed further in chapter six.

This chapter has described the way in which the precondition of women's fertility, the necessity to predict ovulation accurately and the method of insemination have been co-opted by DI practitioners as medical. The result of this medicalisation process has been that these features have become the defining ones of DI, and the social aspects - the decision about whether potential recipients are suitable to parent - have been made peripheral to this definition. In the following chapter I will describe the way in which this emphasis on DI primarily as a medical phenomenon is used to support respondents' views on the intervention of non-medical professionals in the DI process.

CHAPTER FOUR: MAINTAINING CONTROL IN THE SOCIAL AND PROFESSIONAL SPHERE.

In the last chapter I argued that there has been a medicalisation process by which DI has been defined as a medical procedure requiring medical authority in its administration. I challenged the basis on which this has happened, arguing that because insemination is a simple technique and women could be assumed to be fertile - in the absence of evidence to the contrary - there is no technical or medical reason why DI should be administered by doctors. In practice, what appears to happen is that whilst the medical and technical aspects are overemphasised in the naming and definition of DI, the decision-making actually revolves not around medical-technical issues but primarily whether potential recipients are suitable to use DI. This assessment of suitability involves a non-medical decision about fitness to parent.

In chapter one I discussed how medical writers have established the need, as they see it, for assessing the suitability of potential recipients of DI in respect of their ability to parent in both social-material and emotional-psychological terms. Non-medical criteria have also been proffered for use in DI by non-medical professionals such as adoption professionals, medical social workers, psychologists and psychiatrists. If non-medical criteria are to be used in assessing and selecting potential recipients for DI, it could be argued that non-medical professionals are better equipped to apply them. In this chapter, first of all the kinds of non-medical criteria non-medical professionals suggest should be applied are described.

Secondly, the respondents' reactions are given to the suggestions that non-medical professionals should be involved in DI at the assessment stage. This will involve a discussion of the respondents' comparisons of DI and adoption and a corresponding discussion about secrecy. Finally, there will be a comparison made of respondents' attitudes towards the use of counsellors as opposed to the above-named professionals.

The Non-Medical Professionals

In the literature written by non-medical professionals about DI, an area of tension emerges which revolves around the fact that they recognise that DI is not only a medical procedure but a multifaceted process. They have identified the social-material, and emotional/psychiatric/psychological components as being as, if not more, important than the biological-insemination component. The primarily medical definition of DI has not been challenged, that is, the diagnosis and insemination part of the procedure has been accepted as requiring medical intervention. Indeed the physiological and diagnostic authority of doctors to decide who should be admitted for DI treatment is deferred to. But by emphasising the social and psychological implications and consequences of the use of DI, non-medical professionals argue for involvement in the administration of DI.

A tension exists because the question of 'who shall have access' which is revealed to be 'who should parent' has been recognised and identified as being not medical but social. The challenge being made is to the decision-making process about who should use DI. The non-medical professionals argue either that they should have some part in doctors' decision-making process at an assessment level, or that they should have involvement in the decision-making process of potential recipients at a counselling level. These professionals problematise the social and psychiatric/psychological¹³ components in order to rationalise and justify their intervention in the DI process.

It will be shown that the term 'success' is used by non-medical professionals in quite a different way to that which respondents and medical authors use it in relation to DI. Primarily, the latter use the term in relation to pregnancy rates or live birth rates. As I have argued in the last chapter, this use of the term 'success' provides the 'objectively' arrived at statistical

¹³ Often the authors referred to both psychiatric and psychological testing and/or interviewing making it difficult to tell if they were advocating a particular professional. I have, therefore referred to psychiatric/psychological intervention throughout unless the author specifies a particular field. However I have inferred that all these authors advocate psychiatrists' involvement as they all identify as psychiatrists at the beginning of the articles.

evidence which is required in order to reinforce the medicalisation of the application of DI. Non-medical professionals use the term 'success' in discussions about the social implications and consequences of using DI, for example whether the resultant family thrives in a loving and mutually beneficial way.

Non-Medical Criteria of Non-Medical Professionals

1. Adoption Professionals

The most important issue for adoption professionals is that the social implications and consequences of the two methods can be compared and therefore those involved in the provision of DI can learn two lessons from adoption practice. First, the fact that DI has been the method used to achieve parenthood should not be kept from any resultant children, the parents' relatives, friends or, indeed, society. Discussion about being open about the use of DI usually, but not always, then extends to giving resultant children information about the donor - their biological father. The second lesson is that the social success of the method depends both on the careful assessment of suitability to parent of potential users of DI and their counselling to ensure that they have come to terms with the situation in which they find themselves.

Many authors with adoption experience advocate both counselling and assessment for potential recipients of DI (e.g. Joint Working Party¹⁴, 1984; BAAF AID Working Party, 1984; BASW Sexuality Group, 1984). The need for counselling and assessment leads to some confusion about the exact role of the social worker in the DI process. For example:

Another question is ... who is to select for AID and how? What are the criteria to be used? If counsellors are working in AID clinics should they also be involved in making assessments and in implementing decisions? How would this affect their role as counsellors?

(McWhinnie, 1986:18)

¹⁴ Joint Working Party Representing Family Care, The Scottish Council for Single Parents, British Agencies for Adoption and Fostering (Scottish Centre) and National Association for the Childless (South-East Scotland Branch) (1984)

It is interesting that the selection criteria proposed by most adoption authors do not differ significantly from those already employed by many of the medical authors reviewed earlier. For example:

We therefore recommend: that the AID child should be born into a stable marriage or heterosexual relationship in which there is an expectation that both parties will be able to provide for the emotional, social, familial, educational and economic needs of the child until he or she reaches maturity.

(BAAF AID Working Party, 1984:14, their emphasis)

Additionally, Brandon (1979) refers to the parallels between the criteria proposed by Kerr and Templeton for DI and McWhinnie for adoption.

2. Medical Social Workers

It was discussed in chapter *one* that Ledward et al (1979) have a social work report carried out on every potential recipient to assess for social and material resources. Stewart et al. (1982) argue that DI is a psychological as well as a biological phenomenon. They say that DI literature is strongly biased toward the biological because of the traditional role of the gynaecologists. They recommend a team approach to decision-making that involves medical social workers and psychiatrists in assessing potential recipients. Daniels states that the criteria used for assessing the suitability of potential recipients for DI were established by "drawing heavily on information obtained from the literature on adoption" (Daniels, 1986:51). The five areas of concern identified for potential recipients by Daniels (1986) and Stewart et al. (1982) are: the duration of the marriage - they only accept heterosexual couples who have been married for at least two years; the stability of the marriage; their personal characteristics; their "social functioning" (ibid:855); and their understanding of, and commitment to, DI.

Clayton and Kovacs (1980) recommend not that social workers select but that they offer counselling and information sessions to potential recipients. Areas they identify for discussion are the couples' (all recipients are married couples) reaction to 'infertility'; their feelings about DI; confidentiality; the

couples' own evaluation of their relationship; religious implications; legal aspects; and donor selection.

3. Psychiatrists and Psychologists

A typical theme addressed early on in any article authored either by psychiatrists/psychologists or co-authored by the latter with doctors, is the lack of knowledge about the psychiatric/psychological implications of DI. This theme usually sub-divides into two: the lack of both prospective and retrospective literature. The dearth of such literature was being bemoaned in 1966 (Watters and Souza-Poza, 1966), and equally so in 1987 (Richardson) even though the importance of psychiatric/psychological implications of DI was being written about in 1951 (Lamson et al., 1951). The literature that is available is criticised either for being too anecdotal and unrepresentative, or for not being systematic enough (e.g. Rosenkvist, 1981; Humphrey and Humphrey, 1987). In general, it is recognised by these authors that one of the biggest obstacles to retrospective studies of DI is the secrecy surrounding those who use DI. They believe that recipients of DI are loathe to be the subject of study - psychiatric/psychological or otherwise - because this may lead to their secret being threatened or because it will raise an issue they would rather forget.

The main themes that emerge from this literature are the stated ability of psychiatrists/psychologists to identify and evaluate so-called psycho-social issues with potential recipients; the subsequent ability to counsel the potential recipients about the psycho-social issues; the usefulness and importance of psychiatrists/psychologists both to provide the necessary skills and practise them in the DI process; and the apparent lack of any threat¹⁵ to the doctors' role as final arbiter. Regardless of whether authors felt that psychiatrists and psychologists should have an evaluating or a counselling role, all identified similar issues they felt should be the subject of counselling or evaluation. These were: motive to parent (Lamson et al., 1951; Watters and Souza-Poza, 1966; Rosenkvist, 1981; Alder, 1984; Richardson, 1987); secrecy (Alder, 1984; Humphrey and Humphrey, 1987;

¹⁵ certainly it would seem from the more recently writing psychologists-psychiatrists

Richardson, 1987); the emotional and sexual relationship of potential recipients (Lamson et al., 1951; David and Avidan, 1976; Rosenkvist, 1981; Alder, 1984, Humphrey and Humphrey, 1987, Richardson, 1987); the reaction to infertility and DI (Rosenkvist, 1981; Humphrey and Humphrey, 1987; Richardson, 1987); relations with own parents and home life (Richardson, 1987); and psychiatric, alcohol, and child-abuse factors (Humphrey and Humphrey, 1987; Richardson, 1987).

In a similar way to which DI practitioners pathologise the fertility of women seeking DI, so do the non-medical professionals pathologise the social/psychological aspects of potential recipients' ability to parent. That is, they maintain that not everyone can or should parent and that everyone is potentially a social problem in this regard. For example, Humphrey and Humphrey (1987) administered the "Ryle marital test" to measure the exchange of affection between partners and the current state of the marriage. They said that, of one hundred couples referred to them, they could only recommend fifteen couples to be accepted for DI without reservation. A further thirty-one were recommended with small reservations, forty were unsatisfactory to some degree and two were rejected "owing to gross marital and sexual problems" (ibid:209). Similarly, in a study by Rosenkvist (1981) 23% of the women and 31% of men were classified as having psycho-pathological traits.

The fact that the first authors could only recommend fifteen for DI without hesitation and the second classified a quarter of the women and a third of the men psycho-pathological is indicative of the extent to which the social aspects of DI have been problematised by non-medical professionals. All non-medical professionals propose blanket social or psychiatric/psychological assessment and/or counselling of and for potential recipients in order to identify those who are unsuitable to parent using DI. They argue they are better equipped to make such assessments than DI practitioners. They have also suggested non-medical criteria they believe should be applied to potential recipients and non-medical issues which should be discussed with them. If these professionals can offer

expertise in evaluative and counselling skills to assess the decision-making in DI what is the response of DI practitioners to this offer?

The Respondents

Adoption

Respondents were asked two questions directly related to adoption. The first asked what respondents thought about the argument that DI and adoption are so similar that DI practitioners can learn from the adoption process in selecting recipients. The second asked whether they thought DI could be run by adoption-type agencies. Answers to these questions usually referred to three specific issues: whether DI and adoption could be compared at all as methods of achieving parenthood; respondents' criticisms of the selection criteria they believed to be employed by adoption agencies; and the medical content of DI requiring its location in a medical rather than an adoption-type context. A combination of the the first two themes was most often given in answer to the first question about adoption while a combination of the second and third themes was given in answer to the second question.

Only two of the respondents who answered the first question ¹⁶ felt that there were some similarities worth learning from. The line of argument used by the majority appeared to follow a similar pattern. The questions would be answered either by denying that there are any similarities and/or giving examples of the differences that exist between DI and adoption. Then might come a criticism of the harshness of the selection procedures believed by the respondents to be employed in adoption. This criticism would have implicit in it an allegiance and sympathy with the needs of the potential recipients on the part of the respondents which they believed adoption agencies to be lacking; and an implicit statement that respondents neither agreed with nor employed the sorts of criteria used by adoption agencies -

¹⁶ One respondent referred me to a chapter he co-authored about DI and adoption. The part about adoption was not actually written by him so I have left out his response to this question.

except with good reason. Then would come a confirmation of the essentially medical nature of DI and its rightful location in a medical setting.

1. Comparisons Between DI and Adoption

Most of the respondents argued that there are few similarities between DI and adoption. In illustrating their opinion respondents compared the two as methods of achieving parenthood and/or concentrated on the unique nature of DI to argue that adoption practices are inappropriate in DI.

a) Comparisons as methods of achieving parenthood

A quarter of the respondents picked out a facet either of adoption or DI to illustrate how they differ as methods of achieving parenthood. For example, one respondent described how adoption is a legal process which therefore requires accountability, whilst DI is a medical treatment and therefore entirely different. Two other respondents focussed on the differences in the success rates between DI and adoption. Success here refers to conception and childbirth and the fact that DI has a greater success in providing newborn babies to people wanting to be parents. Two further respondents pointed out the different status - as they saw it - of the resultant children. Whilst implying that DI is the better method, these respondents pointed out that DI children would never feel rejected, unlike adopted children who, they felt, would (by their birth parents).

b) Specific Nature of DI

The majority of respondents emphasised the uniqueness of DI which distinguishes it from adoption. Half referred to the experience of women using DI and five of these respondents also referred to men in DI who can experience their partner's pregnancy and childbirth; and finally a third pointed out that DI affords secrecy about the method used to achieve parenthood.

i) Experience of Women

No respondent who referred to the experience of women who use DI spoke about the fact that these women are the genetic parents of their children. In all their remarks women are referred to as the biological mothers of their children who conceive, carry and give birth to their own babies as opposed to adoption wherein women (and men) adopt a baby or child who is already born. As I will show in chapter six respondents were very anxious to describe and emphasise the genetic screening that goes on to establish the quality of semen being used in DI. The fact that no respondents mentioned the genetic parentage of women who use DI is an important omission within the context of that discussion.

One respondent developed her line of argument about the unique experience of women in DI. Her logical conclusion is that DI allows the secrecy that cannot be had in adoption:

- 19 and then of course they've [adopted children] got all the problems of whether or not they're going to find their natural parents ... with this [DI] it would be very difficult for a child to trace his biological - Nobody, the rest of the world don't have to know that the couple are doing this. The woman becomes pregnant, nobody asks any questions about how the pregnancy arose. I think it is very different really.

Often, respondents would begin a discussion about the fact that the woman is the biological mother of the child and then develop this into a discussion about telling the child or not. The following respondent exemplifies the oft-stated belief that telling the child is a decision for the parents to make:

- 12 In donor insemination the difference is that you have one biological parent who lives with the individual. The other biological parent is not there at all, doesn't exist and as far as the child is concerned it depends on the attitude of the parents as to whether they're going to tell that child or not tell that child.

The next respondent's attitude implies that it is because people who use DI do not have to tell that they do not, as opposed to adoption where they tell

because they have to. He presents his medical fact - statistics - as if this is proof that not telling is just a phenomenon of DI entirely unrelated to factors such as being encouraged to tell or not:

- 05 I think there are similarities yeah, but it is different in that the woman is carrying the child and I think ultimately that makes a big difference to the attitudes of the parents [and] at the end of the day, to the child. And you know the fact that less than 5% of couples actually tell their child they're an AID baby whereas in an adopted situation ... the percentage ... is the majority.

One of only two respondents who felt that there might be something to learn from adoption referred to the issue of secrecy in this regard. However because of the experience of women in DI he felt that the issue of secrecy has an ambiguous place in DI. This respondent also seemed to negate the ability of women to produce babies that are related to *themselves* when they are inseminated with a stranger's sperm:

- 13 Are the parents going to tell the child about donor insemination or is it a dark secret? And if they do tell the child about this is the child going to feel a void and a need to know? Now clearly that's been the case with adopted children who, neither father nor mother is their biological mother. I don't know whether it's so important with a donor child where the mother is the biological mother and so that child is *perhaps* more biologically related, than clearly the adopted child is.
(My emphasis)

ii) Experience of Men

A quarter of the respondents also referred to the experience of men. The following respondent told an anecdotal story about a DI baby who had to spend the first week of its life in intensive care, and the parents who came to visit it every day. At a consultation the respondent had with the woman, he was surprised to find her husband in attendance:

- 14 and I said "You know, now it's all over, any regrets?" and he said "Oh gosh no! D'you know I went through that pregnancy with my wife, I was there for her delivery. When my wife came home from hospital ... and we were going to see it my wife was very worried

and I was climbing the walls doctor". Now I don't think adoption could replace that.

Whilst the genetic aspects of parenthood are played down both by omitting women's contribution to DI babies and by emphasising the social experience of men during women's pregnancy, childbirth and during their parenting of the DI child, respondents also manage to infer that because of the biological aspects of pregnancy and childbirth, DI is a superior route to parenting than adoption. This implies then that there is a difference between the social parenting experience offered through adoption and that offered to the man through DI: even if it is not his child, the fact that he has experienced his partner's biological (and genetic) pregnancy and childbirth gives him vicarious access to biological parenthood which is to be preferred over the experience of parenting adoption offers.

The next respondent expands on this very point both by emphasising the man's involvement in the pregnancy and birth and by underplaying the experience of the woman. For this respondent, DI is *almost* like natural birth even though for the women it is *exactly* like natural birth. This respondent defines 'natural' to include the social-sexual relationship between the woman and her male partner:

- 18 I think there are similarities but I also think there are differences because a couple with DI - it feels so much more like a natural birth by the pregnancy happening and him being there for antenatal care and so forth, that once they've made the decision to go for DI and he's accepted that being a DI father is something he's willing to do.

iii) Secrecy

The issue of secrecy recurs throughout the debate about DI. The secrecy afforded those who use DI by virtue of the method was perceived by some respondents to be a positive reason for choosing DI over adoption:

- 06 [with DI] there is more ability of being secretive about it. You see the couple will keep it between them, is not known whether the child will know or not and the family may not know and the society may not know and

therefore it can pass just like that. Rather than with adoption - everyone knows. So the ability to handle is related to the inability to lie in the case of adoption, while in the case of donor insemination it's up to the couple to decide.

The ability to keep DI a secret is perceived as a positive function of its use. This illustrates the point made earlier about the misunderstandings that seem to exist between professionals in adoption and DI. Respondents believe that secrecy would be kept in adoption if it could. It is only because the method precludes secrecy that openness is called for. In DI the reverse is so. Secrecy can be kept and therefore it is. As I have argued, this misunderstanding is functional for respondents especially when they assert that it is the parents' right to decide whether to tell the child. If the parents were to be encouraged to tell the children then this would involve some recognition of the social consequences and implications of using DI. Such an acknowledgement could then allow non-medical professionals, especially those with experience of adoption, to argue that they should have a role in the DI process - either counselling potential recipients on the issues that arise from telling, or evaluating whether potential recipients are suitable to meet the demands of being a DI parent who must tell.

The one respondent who did feel that something could be learned from adoption on the issue of telling the child, asks donors to fill in adapted dataline questionnaires which ask donors to score themselves on several scales purportedly indicating personality, interests, hobbies and aptitude. These are kept for recipients of DI to have and pass on to their children in the event that the latter are told. He said that no recipients had ever asked him for these sheets but that they were kept on file in case they ever did. Because he seemed to think that the issue about telling was so important I asked him whether he encouraged recipients to tell their children:

- 13 No I don't. No, no. I don't know what the right answer is. We simply point it out as an area of difficulty and we leave each couple to make up their own decision. (Pause) I suspect there have been many marriages through the centuries where the wife has actually become pregnant by somebody else and known it perfectly well and has kept it a secret from her

husband. Probably, in that it's never come to life, no great harm has been done, although how much mental turmoil that's caused her through the years I don't know.

The idea that knowledge about paternity is an elusive goal regardless of the method used to achieve fatherhood is again used here to negate the argument from adoption that children need to know the identity of their biological and genetic fathers.

In relation to secrecy, respondents were asked their opinion about the suggestion in the White Paper (1987) that children should have the right to know at eighteen of their origins. Only one respondent said that she believed that parents should be open with their children about the circumstances of their birth. Nearly a third of the respondents said that children should not be told anything about their origins and four respondents said that non-identifying information could be made available to them although they differed on what form this would take. A third said that this was a decision for the parents to make and not one which they would actively take part in or approved of the government taking a part in either. One respondent would not be drawn on the subject at all saying that what happened once recipients left his surgery was entirely outside his concern.

In the main, answers to this question concentrated on the consequences of such a policy to the supply of donors. The majority felt that men would stop donating semen if they thought that their identity would be revealed at some later date. The other line of argument against revealing a child's origins to them was couched in terms of the effects on the family of doing so.

It is here that one of the real differences between the respondents and those writing from a background in adoption is illustrated. By insisting on the ordinariness of DI families, and their right to make their own decisions about what and who they tell about their experience, respondents firmly reject the idea that similarities exist between DI and adoption in any way that should influence the provision of DI and policy relating to it.

One of the ways in which respondents answered questions about adoption was to discuss whether useful comparisons could be made between adoption and DI as methods of achieving parenthood. This was done in two main ways. First, some respondents pointed out the separateness of the two as methods of achieving parenthood. Secondly, respondents emphasised the uniqueness of DI. They pointed out that DI allows women to conceive and bear their own children and that men are given the chance to experience, albeit vicariously, this biological experience of women. The issue of secrecy was also raised as an indicator of the slightly superior experience that DI offers over adoption. Nobody else need know that DI has been used and an appearance of family normalcy can be maintained for the outside world.

2. Selection Procedures

The second way in which respondents answered the questions about adoption was in terms of selection criteria for potential parents. Three broad themes emerged from the data. The first relates to criticisms of selection criteria used by adoption agencies. The second relates to the reasons given by respondents for the perceived strictness of selection criteria in adoption; and the third relates to criticisms of selection procedures per se. In general, respondents were very critical of the selection criteria they believed were applied to potential adopting parents in adoption. Whilst being critical, respondents implied that such selection criteria are inappropriate for use in DI and that they do not apply such criteria themselves.

a) Criticisms of Adoption Selection Procedures.

Just over two thirds of the respondents made criticisms of the selection procedures used by adoption agencies and, of these, eight made reference to an example of a group of people who might suffer as a result of specific criteria: poor people, Black people, people with disabilities, older people.

One respondent showed some awareness of the potential eugenic issues involved in the use of social screening in DI and adoption and implied that this is something which she wishes to avoid. She, like other respondents,

prefaces her criticisms of adoption criteria by saying they are not criteria she would use herself. With these respondents it transpired that the criteria of adoption agencies are not criticised because there exists a logical argument against their use, but because they are not of the sort respondents would use themselves. Their reliance on subjective evaluation of what constitutes good or suitable parenting is therefore revealed through their criticisms of adoption.

In his criticism of adoption agencies, another respondent also evaluates their selection procedures in relation to his own subjective ideas about suitability. His criticism of adoption agencies who want potential adopters to have tried every available medical method before they are accepted as genuine potential adopters is another example of the way in which respondents criticise adoption agencies for being unsympathetic to the needs of those who come to them for help:

- 08 I think the adoption people are really far too rough actually as I see it. I'm a little concerned about ... the way they are declining people for adoption. ... In fact one of the worrying things is that they want the woman to have done everything possible for her infertility treatment before they will take her on and that means, in fact, that they want them to have had a shot or two at IVF. Now that's not easy.

A fifth of the respondents singled out age-related criteria used in adoption to illustrate the harshness of their practice and their unsympathetic approach. The same respondent points this out while revealing her subjective criteria:

- 08 (pause) Well in a way it is similar, some aspect of it, but one of the things which I find a bit difficult to accept is the difficulties which a slightly more older couple are finding to be accepted for [adoption]. And when you think about it *they worked hard to achieve a stable environment and have a nice house maybe and a good position at work and then they are ready to start a family* but then they go and being refused.
(My emphasis)

These comments reveal the similarities that exist between the selection procedures of adoption agencies and DI practitioners, both those in the

medical literature and the respondents. The view taken by the majority of respondents, that adoption selection criteria are too harsh to be employed in DI, is therefore one which asks for an explanation. Why is it that the respondents perceive the criteria used in adoption to be much harsher than anything applied by doctors who offer DI? This is a basic misunderstanding of what goes on in adoption as compared with DI and I would argue that such a misunderstanding is functional for the respondents.

Even when respondents acknowledge that some similarities do exist between adoption and DI criteria, the latter are felt to be justified on medical grounds. For example:

- 11 I think that some of the age rules are not realistic. Thirty-five has been mentioned, over thirty-five. Now our rules for age are just because the treatment's unsuccessful at that stage. It's not because we don't think the parents could look after the children perfectly well.

Of course respondents may not be aware of the selection criteria used by other DI practitioners and therefore not realise that adoption-like criteria are used by them. Further, those respondents who believe that they do not decide about access to DI, and yet who will be shown in the next chapter to have criteria which they apply to potential recipients, also do not seem to realise the similarities that exist between the criteria they apply and those applied by the adoption agencies. They assume that adoption agencies are much harsher and stricter than anything they practice. The following is an example of a personal view or judgement which would be applied in making assessments but which is not acknowledged as such and is used to argue against what are believed to be the practices of adoption:

- 12 You could say should one do a full social report on these people having donor insemination? ... but would that be appropriate to do that? I think it is not appropriate ... just because you found that someone was in debt or someone had a criminal record would that prevent you doing donor insemination?... I think on the whole one wouldn't want to know their bank balance or whether or not there's some sociological,

severe sociological problem *unless it were a very major thing.*
(My emphasis)

This exemplifies the opinion of many respondents that in adoption, selection criteria are applied to every potential parent. In DI however, according to this respondent (and others), having a policy to blanket assess in this way is wholly unnecessary. It may be necessary in exceptional circumstances which would be defined as such by the respondent(s). The result both of arguing against the blanket application of selection procedures and the implication that such selection procedures are not employed by respondents, is that the question of intervention from other non-medical professionals in the DI process is countered. Another factor in this approach was to emphasise the ordinariness of the potential recipients of DI - who, but for an accident of nature, would have been having babies without anybody wanting to know why. The occasional potential recipient may require further assessment but the decision to make the referral will stay with the respondents and occur on their judgement.

b) Possible reasons for adoption criteria.

Half of the respondents believed that there are reasons why adoption agencies are compelled to apply the criteria they do to potential adopters. Both reasons given were specific to the nature of adoption as a method of achieving parenthood. Providing these rationales for the existence of harsh criteria reinforces the respondents' underlying argument that adoption and DI are separate methods requiring separate agencies for their provision. Most believed that selection criteria operate as a rationing device because of the dearth of babies available for adoption. A minority felt that the fact that adoption agencies have babies and children to place who are already born means that greater effort must be expended - through the selection procedures - to match their needs with potential adopters.

It is interesting that so many respondents believed that harsh selection criteria are related to market demands. Not only does this argument have implicit in it an unfavourable comparison with DI which has a theoretically limitless supply of babies, but it also acts to undermine the guiding principle

of adoption, which is also a statutory requirement: that the welfare of the child is of primary importance which requires adoption procedures to disregard the needs of the adopting parents in favour of finding the optimum environment for the child. Triseliotis (in Templeton and Triseliotis, 1983) refers to this development in adoption practice and also to the policy in 'better' adoption agencies where there has been a movement away from assessment of would-be adopters by adoption workers, and a move towards a process by which would-be adopters come to a decision themselves about whether they go on to the waiting list as approved adopting parents or not. However, the development of self-selection in adoption, one which many of the respondents described as operating in the DI process, seems to be unknown to respondents and adopting agencies are perceived as judgemental and in the main unsympathetic towards would-be adopting parents, not because there is any concern for either parenting skills or welfare of the child but because there are not enough babies to go around:

- 06 I mean the number of babies for adoption are very few, then the [adoption] societies start to take the very arrogant attitude of choosing the blue-race fathers and mothers if you want. You are looking for the best possible because you've got a lot of people who want them. But if it was the other way around, the amount of scrutiny [gone] through would be far less and therefore it's not the norm what is happening.

c) Selection Criteria *per se*

About half of the respondents responded to questions about adoption by criticising the use of selection criteria *per se*. A quarter stressed their belief that in DI 'ordinary' people are involved who, but for being infertile, would have had children without anyone attempting to impose restrictions on them. In criticising adoption procedures they attempted to illustrate how redundant they would be in the provision of DI. Another fifth questioned the use of selection criteria on the long term social success of adoption, arguing that using selection criteria was either unnecessary for success or that it militated against it. A minority argued that no selection criteria should be

used and instead, as they argued occurred in their own DI services, self-selection should take place.

3. The Medical Nature of DI.

A third specifically spoke about the medical nature of DI as a reason against it being provided by adoption-type agencies. For example:

10 No absolutely not. It has to involve a gynaecologist looking at the woman.

One respondent felt that the DI service provided by the non-profit-making, charitable sector was akin to an adoption-type service, but he did nevertheless emphasise the medical nature of DI and also the need to provide DI within the gamut of possible technological solutions for fertility problems so that if DI were to be unsuccessful women could be passed onto the next technique:

05 having it in the environment of a fertility service is actually quite useful for the parents to see that they're part of a larger problem and that there are other people with different problems but ultimately, although you're choosing one, one leads to another.

Only two respondents felt that DI could be provided outside the medical sphere. One argued that anyone could provide a DI service as long as "they know what to do and have got qualified according to what they're doing" (07). He still believed that someone with 'qualifications' - a professional - should be in charge of providing DI but had less allegiance to his own profession. The other respondent had a more radical response in terms of her lack of allegiance to any medical model of DI:

03 I think the idea of self-insemination works ... It really doesn't have to be as high-tech as all this anyway ... if you had some way of saying to people "this sperm is OK" ... why I mean ... it could be done anywhere...

This respondent's concern with sperm is with its status as a potential contaminator: people need to know that "this sperm is OK", not a

contaminator. This theme will be followed up in chapter six. The other respondents who felt that DI could not be run by adoption-type agencies concentrated their negative remarks around the selection procedures of adoption.

Those writing from a background in adoption argue first that DI and adoption are similar and, as such, the co-issues of telling the child and being open about the use of DI must be addressed and resolved. Second, these authors argue that, given the complexities of DI, potential recipients should be both counselled and assessed for suitability to parent. The respondents argue that, in the main, there are not enough similarities between the two as methods of achieving parenthood to warrant any wholesale transfer of skills from adoption. They also argue that the sorts of selection procedures that they believe are employed in adoption are both unnecessary for use in DI and are unnecessarily harsh. Thirdly, the respondents argue that DI is primarily a medical procedure which is properly situated in the medical sphere.

As I discussed earlier, there is in practice very little to choose from between the selection procedures which would be applied in adoption and those applied by medical authors about DI. In answer to the questions about adoption, respondents implied not only that selection procedures are inappropriate *per se* for DI but also that they did not apply them themselves. In the next chapter this will be shown not to be the case. It is interesting then that the respondents protested about selection procedures within the context of questions about adoption. In seeking to explain why this should be the case, I have argued that it is in the interests of the respondents to argue against the sort of selection procedures they believe are applied in adoption and would be applied if professionals from adoption were involved with the DI process. I have shown the way in which some respondents described how, if they defined a problem with potential recipients, they might refer on for an adoption-type assessment. It seems plausible then that respondents try to undermine the way in which they believe adoption professionals might problematise the social component of DI and apply blanket assessments for everybody.

Respondents' Views on other Non-Medical Professionals.

The majority of respondents stated that they do not refer potential recipients to psychologists, psychiatrists or medical social workers. A third of the respondents said that they had made referrals to one or more of these non-medical professionals, but only occasionally and when they felt it was necessary.

Three themes emerged in the answers given to the question although underlying all responses was the point that regular, blanket referrals to any of these non-medical professionals is inappropriate for DI. The first involved the reasons given for non-referral. The two most common were that, in the first place any necessary service was already provided by doctors, and in the second place the service was already provided at the clinic by, in the main, a counsellor or a nurse¹⁷.

The second theme was the respondents' perception of the reasons why any of these non-medical professionals might be referred to. Some respondents said that they might refer on if there was a problem and that the type of referral would depend on the respondent's judgement of the type of problem being exhibited. The third theme was the respondents' perception of the capacity in which these non-medical professionals might be asked to engage with potential recipients. This role - either evaluative or counselling - affected their response.

1. No Need to Refer On.

The first group under this heading includes half of the respondents who stated that any role non-medical professionals might perform is already performed by themselves or doctors in the referral chain:

¹⁷ The number of respondents who referred to the presence of counselling facilities on site in answer to this question does not reflect the total number of respondents whose DI unit provided a counselling service.

- 07 I don't wish to do that. I mean the purpose of the consultation, usually of course with the husband as well, is to see whether I have a stable person or persons in front of me who understand what it's all about and who understand what I agree to do for their fee.

The impression one gets is that there is no need for any outside intervention and it would appear that referral to non-medical professionals had never occurred to this respondent.

The following respondent appears to believe that a well-run referral system and luck have prevented the DI unit in which she works from receiving problematic potential recipients who might need such a referral. The impression given again is that such referrals are rare in comparison to the majority of unproblematic, ordinary potential recipients:

- 08 Well I think maybe we have been lucky. We've just felt that most of the couples coming to the clinic here, they've been assessed well before - they've been seen by their general practitioner or their consultant - they've been introduced to the programme and very few arrive not knowing what to do.

The second group included those who felt that any function non-medical professionals might perform is already performed by someone in the DI unit. A third of the respondents referred to the presence of staff at the DI unit whose presence refuted the need for systematic referral to any named non-medical professional.

- 19 I think everybody needs a bit of support and we're lucky in that our research sister L_____ is a very supportive, motherly, friendly sort of person and so really ... people can come in and have a cry and they can obviously come back to me and have a moan or whatever.

2. If There Was a Problem

Nearly half of the respondents said that they might refer on to the named non-medical professionals but only if it became apparent that there were specific problems. The problems respondents defined as possibly needing referral were those which they associated with the job description of non-medical professionals. For example:

- 16 I don't think a psychiatrist is an appropriate person to send these patients to in the first place unless there is some psychiatric illness.

Another respondent said that she would refer to a medical social worker if the couple needed to do some grief work about coming to terms with their infertility as a couple. A further respondent said that a social work report might be required if there seemed to be social problems; and three respondents said that a psychologist or psychiatrist might be used if there were psychological or psychiatric problems. These latter comments were made with specific emphasis on the job that psychologists and psychiatrists do rather than anything specifically to do with DI.

Two of those who made referrals because of problems arising mentioned independent counsellors as the people they would use. This suggests that counselling skills are the only extra skills potential recipients might benefit from, over and above the skills the respondents possess:

- 18 Good God! Ha Ha! (laughs) Well having worked in the field myself [of psychiatry] I wouldn't know who to send them to who would offer them a better deal. If somebody wants independent counselling, oh fine, that's their decision.

Referral to independent counsellors at the request of the potential recipients is presented as separate to what goes on in the respondent's consultation with them. There is no suggestion that the independent counsellor could participate in any decision-making the respondent might make about the suitability of the potential recipients for DI.

The next respondent emphasises two points with his remarks: that women who use DI are the biological mothers of their children, thereby raising the issue of whether selection or assessment is valid at all; and second, that psychologists and psychiatrists are not appropriate in the DI context because the respondent assumes that their role would be an evaluative, judgemental one. His comment reflects the job description of psychiatrists/psychologists and thus he implies that they have a specific role which is not appropriate to DI in general:

- 14 Yes if they're mad I'd refer them to a psychiatrist or if they had a psychological problem to a psychologist but I do not think that because a woman is a recipient, that the ordinary woman without any clinical disease, mental disease, should be referred to a psychiatrist any more than a chiroprapist.

3. The Function of Non-Medical Professionals

The last respondent's comment overlaps with this third category of responses in which is reflected the assumptions made by the respondents about the role psychologists, psychiatrists and social workers might play in the DI process. The majority of the respondents who made any assumption, ^(half) believed that these professionals would have an evaluative, judgemental role. Like their responses to the questions about adoption practice, their belief that non-medical professionals would attempt to impose an assessment procedure on potential recipients of DI meant that they both questioned the appropriateness of such selection criteria and implied that they did not apply such criteria. The following respondent assumed that non-medical professionals would have an evaluative role and reference is made again to the ordinariness of the people who use DI:

- 12 I don't think that because a man had mumps or viral illness and has got azoospermia but he's got a partner - I don't think it's necessary his wife goes or he goes to see a psychiatrist or a psychologist to make a decision - if he hadn't had that illness the chances are they would have had a child by normal procreation. So why is it necessary that we should - or we could ask the question as, should everybody who wishes to reproduce have an assessment before they do so?

Now there might be a case made out for that although I think there'd be a bloody great outcry if there was.

Similar to their attitude towards input from adoption professionals, respondents were resistant to intervention from medical social workers, psychologists and psychiatrists. And again the resistance is based mainly on the assumption that these non-medical professionals would make inappropriate, non-medical assessments of potential recipients and that such assessments would be blanket.

Two respondents who assumed that non-medical professionals would be evaluative wished to make it clear that they were not hostile to counselling. These remarks illustrate the ambiguity that surrounds both their perception of the role that these non-medical professionals might play and the place of counselling in DI:

- 01 Well I think that's going a bit far. I think it's all very well to counsel a couple that are not certain but I don't think we should use counselling as a screening process with those patients who have made up their minds, and [have] ... seen a registered medical practitioner with a bit of experience in the field or in clinical matters.

Of the three who assumed that the three non-medical professionals might counsel, one countered the point about using them by pointing out that potential recipients already had access to an independent counsellor if they wished a referral. This respondent said that, of those offered, only 10% ever took it up. The second respondent had known of referrals to a psychologist but this would happen only if there were specific problems and the potential recipients requested it. The third respondent, whilst making the assumption that the three would give counselling input, however, qualified his remarks by referring to the category 'we've already got someone':

- 05 I suppose in a ideal world I would, it would be sensible for them to sit with a third party, an interested third party and, and talk through AID at a non-medical level. I'm willing to concede that the questions one gets asked tend to be the medical questions and not very often the social issues so I think having a third person

- but I think that's what sister does but that's more when they ask for it rather than us saying "right and your next trip on the hurley burley is to go and see a counsellor".

Counselling

There was great variation in the definitions of counselling amongst respondents. Some apparently view counselling as being akin to a shoulder to cry on or an anonymous friend. Others felt that counselling may be needed by recipients who wanted to clarify their thoughts about using DI - and indeed to assist potential recipients' decision-making. This perception of counselling also coincided with a view that counsellors were separate from any counselling or decision-making process engaged in by respondents. According to these respondents, counsellors of this type are concerned with potential recipient-centred issues which may proceed either after the decision to offer DI had been taken by the respondents and accepted by potential recipients or after the decision to offer DI had been taken by the respondents and before the recipients had decided to accept.

Another view of counselling was that respondents felt it had a place in their decision-making process. These respondents - a minority - talked to counsellors about potential recipients and had reports from counsellors about them. Here the counsellors' role included an evaluative component which was incorporated into the (respondents') final decision-making.

A question was asked about what respondents felt about the suggestion in the White Paper (1987) that all potential recipients should have counselling to facilitate both the making of informed decisions and the exploration of the implications of having a child who would be the genetic offspring of only one parent. Depending on their response they were also asked what they thought about the further suggestion that the counselling should be independent of discussions with the doctor.

Most respondents felt that counselling has a place in the DI process. The discussion was mainly about who should provide it. Half believed that either they or nurses provided an adequate service. Six provided what they

believed to be supplementary counselling on request. Nearly a third felt that independent counselling should be an integral part of the DI process and of these four provided it. There is a difference between the respondents' attitudes to the use of counselling in the DI process and their attitudes to the use of social work or psychiatrist/psychologist skills. With the former, the majority of respondents agree that counselling is a necessary part of the DI process, although the majority consider that they (themselves or the DI unit) already provide the necessary counselling. With the latter, the respondents in the main rejected both the need for assessment on social and/or psychiatric/psychological grounds and imply that they do not undertake the sorts of assessments which they believe any of these non-medical professionals would.

The fact that the Report (1984), the White Paper (1987) and the Bill (1989) all refer to the use of counselling in the provision of fertility services, may provide a clue as to the rationale behind such differences of opinion. If provision of counselling is felt to be necessary, and that it should be made a legal requirement of licenced fertility services, then doctors who provide DI would need to accommodate this requirement. It is therefore functional for respondents to be in favour of the provision of counselling if they can then argue that they provide any that is necessary. In this regard it is interesting that the final Act made provision for "proper counselling" (1990:7) and not, as the White Paper had proposed, "somebody different, [from the doctor] preferably a qualified counsellor." (1987:13) so leaving the definition of who should carry out the counselling open to interpretation.

Conclusion

Writers with a background in adoption have sought to establish the similarities, as they see them, between adoption and DI as methods of achieving parenthood. To do this they have sought to emphasise the parallels they believe exist in the social consequences and implications of using DI and adoption. The two most important of these are firstly being open about the use of DI, especially to the children, and secondly the importance of assessing the suitability of potential recipients of DI to parent

and with regard to their coming to terms with their situation as potential parents.

Other non-medical professionals have also argued for their inclusion in the DI process. Their success in challenging the definition of DI as exclusively medical will depend on their ability to emphasise the extent to which the social component is problematised. Medical social workers have argued that there should be some social work input, in a similar way to that which adoption writers have proposed. And psychiatrists/psychologists have argued that there is a need to establish the emotional-mental stability of the potential recipients in order to ensure a socially and emotionally successful outcome for the users of DI. None of the above writers wish to redefine DI as primarily a social method of achieving conception and, indeed, do not question either the definition of DI as a medical procedure or its medical location. However these writers do wish to impress on medical practitioners involved in DI the usefulness their contribution could have for the DI process. This line of argument rarely leads to a direct challenge of the role of medical practitioners as ultimate decision-maker, but more often results in suggestions of either a team approach to DI practitioners' decision-making or a counselling role in the potential recipients' decision-making.

Respondents reject the idea that there are parallels between adoption and DI and argue this by pointing out the different nature of DI which, unlike adoption, *allows* for secrecy, and for women and men to experience biological parenthood. Respondents also argue that the sorts of selection procedures employed in adoption are unnecessarily harsh and are inappropriate for transference to the DI process. Many respondents also emphasised the medical nature of DI. In arguing against the use of selection procedures, respondents imply that they do not employ the sorts of selection procedures they believe are used in adoption. In the next chapter the selection procedures used by the respondents will be discussed and shown to be very similar to those they say are employed in adoption practice.

Almost all the respondents reject the idea that any other non-medical professionals could be usefully employed in the assessment stage of DI or in an on-going supportive capacity for the potential recipients. This leaves control of these aspects to respondents who may or may not decide to utilise the expertise of non-medical professionals on an irregular, exceptional basis. Further, it leaves doctors in a position, in theory, in which they can make any decisions they prefer about access to DI with no interprofessional monitoring and with little accountability. The way in which the Act (1990) will affect this situation will be ascertained in the conclusion.

The use of counsellors facilitates the maintenance of a medical monopoly in DI. Counsellors are used by some respondents and, in general, their employment was referred to in preference to any of the above named non-medical professionals. Apparently, counsellors are not viewed by the respondents as being likely to have or want any decision-making power, or to threaten respondents' decision-making authority. A few of the respondents spoke of the counsellors attached to their service as having some input in their (the respondents') decision-making process either by writing reports or having discussions with respondents about potential recipients. However, in the main, counsellors are perceived as being completely outside the application of DI as a medical procedure, but having value for potential recipients in an individualised, non-medical way. Further, their use undermines the idea that a social component exists which requires intervention from more powerful non-medical professionals who might threaten the DI practitioners' decision-making authority, since their work would be with potential recipients on issues arising from their involuntary childlessness rather than their suitability for parent. Their employment also reinforces the point, made by many of the respondents, that the decision to proceed with DI lies with the potential recipients themselves - who may be helped by discussions with counsellors.

The object of this chapter has been to outline the tension that exists between the professionals who feel that they have a legitimate role to play in the provision of DI. I have argued that the respondents have been able to establish both the primacy of the medical definition of DI and the authority

they require to make the final decisions about access. Counselling is the only profession that has made any serious entree into the DI process. Counselling occurs outside the main site of power in DI, that is, decision-making about potential recipients' suitability to parent, and takes the focus away from the social component of DI emphasised by the other non-medical professionals. In the next chapter there is a discussion of the way in which respondents deal with the social component of DI. Their approach, which has been discussed in this chapter and depends on the belief that all potential recipients are acceptable unless proven otherwise, is analysed. Although they do not problematise the social aspects of all potential recipients in the way the other non-medical professionals suggest, there is a sense in which respondents pathologise particular characteristics which, when identified in potential recipients, are cause for concern and rejection. These characteristics will be shown to be similar to those suggested by adoption professionals, medical social workers, psychiatrists and psychologists.

CHAPTER FIVE: SELECTING RECIPIENTS OF DI

The last two chapters have shown that DI practitioners - both respondents and those in the literature - are keen to emphasise the medical nature of DI and its proper location in the medical sphere. Part of their argument for this involves emphasising the technical aspects of using DI, but part also involves denying the importance of the social and/or psychiatric/psychological aspects of DI. To do the latter they deny that issues, such as who should use DI or whether recipients have counselling needs, require any extensive non-medical input. This denial leads many of them to accentuate the 'ordinariness' of the people who seek access to DI and, correspondingly, the injustice of treating these people in any way different to the rest of the population of fertile people who conceive and deliver babies and bring them up without any assessment of their ability to do so.

I have already indicated in chapter one that there is a well-established argument for making social assessments of potential recipients of DI. In this chapter I will demonstrate how the respondents apply the same sorts of criteria to potential recipients as do any of the non-medical professionals referred to previously. The first part of this chapter will examine how, despite all claims to the contrary, all respondents are engaged in making non-medical assessments of potential recipients. Three categories of ideological criteria are delineated: structural, environmental and eugenic. Their assessments, based as they are on social and/or psychiatric/psychological criteria, involve DI practitioners in making decisions about who is socially suitable to use DI, that is, who should parent. The respondents' approach to this non-medical decision-making falls into two categories. Those who apparently apply social/psychiatric/psychological criteria which are concomitant with their own personal views about what constitutes acceptable family settings and parenting; and those who, although uninterested in applying personal judgements, nevertheless show an allegiance to a particular family type because it is functional for them to do

so. These respondents refer to the dangers, as they see them, to DI services of falling out of step with what they perceive as public opinion.

In the second part, the decision-making process will be examined in an attempt to elucidate how most respondents can hold contradictory views simultaneously: that potential recipients are ordinary people in need of assistance not assessment and that they - the recipients - should make the final decision about whether or not they should use DI; and that certain people are not suitable for the use of DI and that they, the respondents, should retain decision-making authority.

Selection and Assessment of Potential Recipients

Haines (1990) has pointed out that, in the realm of reproductive technologies, doctors show a preference not only for a particular structural form of the family but an ideological and genetic one. The genetic aspect of these families will be addressed in the next chapter in relation to donors. In explanation of what she means by ideological, Haines poses these questions:

To what extent are the different family types produced by use of the new reproductive technologies supportive of a particular (that is, dominant) ideology of family life? That is to what extent do they reflect assumptions about the inherent worth of such families and the values they display?
(ibid:164)

Haines infers that ideological and structural forms of the family are separate concepts. She suggests that, ideologically, the notion of family implies "shared group characteristics of the 'wish to have a family' " (Haines, 1990:165). This, she says, stands in contradistinction to the perceived individualism of single women or lesbians whose position refers more to their right to a family than " 'familyness' " (Haines, 1990:165). However the perception that single women or lesbians are selfish or that they rely on an individualistic approach to argue for access to, and acceptance of, their parenting is itself ideological: the idea that people other

than heterosexual couples are not motivated by 'familyness' or the wish to 'have a family' is a product of heterosexism. This term has been coined to:

describe an attitude of mind that categorises and then unjustly dismisses as inferior a whole group of fellow citizens.
(Greater London Council [GLC] and GLC's Gay Working Party, undated:10)

In this case, only heterosexual couples are believed to have the right, and acceptable, motives for having children.

Haines (1990) also argues that the concept of motherhood is ideological and further distinguishes this dimension from the structural one. She illustrates her argument by discussing surrogacy which, she says, has been all but rejected as an alternative way to achieve parenthood because of the threat the surrogate poses to motherhood. She does acknowledge that the rejection is not wholesale and says that this indicates the "tension" that exists around the wish to have children and the concept of motherhood (Haines, 1990:166). However, the concept of motherhood is also inextricably connected to heterosexuality and a heterosexual context, and as such cannot be separated from the structural dimension. McIntyre (1976) demonstrates how, in medicine, the concept of motherhood is allied with heterosexual married couples; and lesbians have for a long time suffered the law's inability to separate motherhood from heterosexuality in custody cases, losing their children as a result (Hanscombe and Forster, 1982). Additionally, single heterosexual women have only comparatively recently been 'allowed' by the prevailing social mores to keep their children rather than give them up for adoption (e.g. Jones, 1987). Finally, the British Medical Association has recently argued that doctors should be involved in non-commercial surrogacy arrangements (1990).

Therefore I would argue that the existence of a preferred family structure is itself ideological and that the ideological notions of 'the family' are intricately woven around a preferred structure. To this extent the two are not separate but one is a subset of the other. I have identified three ways in which potential recipients are selected and assessed for suitability for DI, all of which are subsets under the umbrella of ideological ideas about the

family. The first appertains to the structure of the preferred family model; the second involves the eugenically motivated belief that certain women - and their male partners where relevant - should not reproduce; and the third layer, although often linked to the second, implicates an allegiance to a particular family environment rather than a genetic one.

Structural Allegiances

In her work with single women who were pregnant, Macintyre (1976) identified two sets of assumptions held both by clinicians and within society about married and single women - that marriage is equated with motherhood and non-marriage with non-motherhood. Of direct relevance to the present study are the assumptions that if a married couple are childless they should seek clinical diagnosis and treatment for infertility, and that it is clinically advisable on occasion to advise them to have a child; and that diagnosis or treatment for infertility is not clinically advisable, or even relevant, for single women and that to advise single women to become pregnant would be "inadvisable and inappropriate clinically" (ibid:160).

Although the two categories of either married or single women, excludes both women who may be in relationships with men *and* are not married, and lesbians, the point is well made that motherhood is perceived as appropriate only in the right context: heterosexual married couples. As Busfield (1974) said:

On the one hand it is expected and regarded as desirable that those who marry will have children; and on the other it is expected that those who want children will marry.
(ibid:14)

Other writers have pointed out how doctors, through their control of contraception and abortion, have demonstrated their allegiance to this perception of women. Thomas (1985) argues that it is easier for single women to get an abortion than married women although, as will be seen in the next section, other factors will also effect women's access. She also argues that the argument for giving unmarried women access to contraception was based on the undesirability of illegitimacy. However the

type of contraception offered is also dependent on women's potential fertility. For example, nulliparous women or women without children would not be offered the IUD thereby ensuring that, at the appropriate time - when they have married - their fertility would not be jeopardised. Walsh (1980) also argues, like Thomas (1985), that when contraception was first developed doctors restricted its use to married women to be employed to space and plan pregnancies. To offer contraception to single women was perceived as akin to encouraging promiscuity (Walsh, 1980).

In chapter one it was shown how single heterosexual women and lesbians are, in the main, rejected as potential recipients of DI. There is, however, also some literature devoted to the issue of access to DI for these women. The existence of such literature in itself, suggests some measure of recognition that DI is a procedure that can assist fertile women to conceive. The arguments presented against access to DI in this literature - like that in the medical literature - do not refer to medical discussions about fertility or infertility, but to the ethics of providing single women and lesbians with the means to become pregnant and their suitability as parents.

The preference for children to be brought up within heterosexual monogamous married households appears to stand without evidence that either these environments provide the best for children's needs, or that other family structures provide worse. With the emphasis being placed on the structure of the family rather than the actual existence of, or potential for, positive parent-child relationships it would appear that single women and lesbians are discriminated against solely because of their sexuality and lifestyle.

Eugenic Criteria

In chapter one I discussed the way in which eugenic issues are often raised in the context of reproductive decision-making, both in terms of preventing or facilitating birth. The eugenic theme is also visible within the context of DI. I have already described how DI has been mooted as an ideal eugenic tool for propagating preferred genes, although most of the proponents of

such a use refer to the propagation of preferred males' genes. This can be achieved both by providing DI to women when their male partners carry undesirable genes and by selecting preferred donors. However it was also indicated in the literature review that doctors also seek to prevent certain women from using DI and the examples given refer to women with disabilities which are believed to have genetic causes.

It is difficult to distinguish from my interview data whether motives to select out women are eugenically or environmentally driven. I have made a distinction between these two based on the respondents' stated preference for a certain environment for children rather than a stated belief that disfavoured environments are inherited genetically. However, I would argue that because eugenically motivated beliefs have existed historically within the medical profession and in relation to questions of reproduction, that it is not beyond all question that eugenic beliefs do influence the selection of potential recipients of DI.

Environmental Criteria.

Two types of environmental criteria were distinguished: those relating to the quality of the relationship between potential recipients; and preferred qualities in potential recipients. There is overlap between what are environmental preferences and what is eugenically motivated. It is possible that what I have categorised as environmental preferences are really the result of popular beliefs about positive eugenics based on social class allegiances. In other words, respondents identify with the familiar qualities they recognise in potential recipients and which they believe they themselves and others like them possess. This view is supported by the evidence produced in chapter one which shows that most recipients of DI come from the middle and higher social classes and that those who do not nevertheless demonstrate so-called middle class values and aspirations.

My data does not pick up a distinction between the two. However, regardless of motive, the respondents as a group had clear ideas about the sorts of environments children should *not* be brought up in. Most of the

respondents were actually very loathe to describe ideal qualities or environments which they felt would be the best for DI children. Their preferences in favour of particular settings and qualities in parents are inferred from their articulation of environments and qualities they felt children should not be brought up in or around.

The Respondents

Structural Preferences

In ideological terms, the composition of the family is crucial. Most of the respondents supported the view that heterosexual nuclear families constitute the preferred family structure. Furthermore, over a third stated their preference for *married* heterosexual couples. Marriage sets the seal on the structural commitment to heterosexual nuclear family values. Single heterosexual women and lesbians present a problem to those who prefer this ideal structure.

Single Women and Lesbians

Two thirds of the respondents said that they would not offer DI to single women. Two said that, although they had no personal opinion regarding single parenthood, they were bound by the 'guidelines'. These guidelines were those they perceived were held in the Report (1984) and by the RCOG. As I have explained in the introduction to this thesis, the Report does not include any guidelines about potential recipients and, equally, there were no ^{such} guidelines from the RCOG at the time of the interviews.

One respondent said that he had never come across single women seeking access to DI and explained this with reference to the fact that all referrals to the unit in which he worked were medical. This implies that only heterosexual couples would get a medical referral for DI. This perception of DI as a medical treatment for a male's fertility problem was replicated by other respondents. For example:

10 No we wouldn't treat single women.

Prompt: Why not?

10 Because this is a treatment for a couple. By definition infertility is a couple's problem.

Three quarters of the respondents said that they would not give access to lesbians although, of those who said they had no objection, one had never had lesbians consulting for DI. Two respondents said that they were unable to offer DI because of 'guidelines', one referring to the RCOG guidelines, the other to those of the academic department in which he worked. The latter had also never known of lesbians requesting DI at the DI unit and assumed that such requests and access would only occur in the private sector.

a) Personal Belief in Nuclear Families

Over half of the respondents refused access to single women on the grounds that they believed children should be brought up with two parents and that they thrive best within a heterosexual couple:

13 I think it's best for the children to be brought up in a family. Now, maybe (laughing) that's wrong but it's jolly difficult to know how you can prove it, and the real argument for doing that is I think one has the recipients - the husband and wife - and future child to consider ... In that it seems that families have been the traditional way that human beings have brought up children and so I personally will stay with that 'cause I'm not certain about what the alternatives hold for the child.

One of the respondents felt single women's use of DI too easily revealed the fact that DI had been used. In other words heterosexual couples can more easily conceal the fact that DI had been used and that such concealment is to be desired. Another respondent held misogynist views on single women seeking parenthood:

01 the patients I refuse for AID are single women. I think it's wrong ... I usually get very high nursing sisters who haven't been able to find a man. You get business

executives occasionally who can't find a man and my opinion is, you know, "look I don't want to be your consort. I believe that children should be brought up with a father and I'm not prepared to condone a single parent family and really if you are woman enough to get yourself pregnant, find yourself a man to do it. Have an illegitimate child properly, don't involve me" and I put it to them that way and I refuse.

Of those who said that they would offer DI to single women, several qualified their responses by saying that great care would be taken to ensure that these women genuinely could provide a suitable environment for children. Investigating their financial and emotional resources was stressed by those who, when asked if they made similar assessments of heterosexual couples, said they did not. One such respondent provided an indication of the grounds on which such assessments are made:

- 07 if I feel that I have somebody who potentially wants a child and potentially is healthy and potentially has a home and a background consistent with a normal parent, I wouldn't, say no.

When I asked whether this respondent's opinion was informed by his medical training he became very exasperated and said that his assessment resulted from being no different from the people who sat in front of, and consulted, him. His ability to recognise the sameness between him and his (private) 'patients' must influence his definition of what is 'normal'.

Three respondents who do give access to single women perceived the use of DI in a fundamentally different way to the rest of the respondents. These provided it on the basis that fertile women have the right to choose what to do with their fertility and choose parenthood. In the course of the interview it became clear that this approach did not preclude these respondents from applying some social criteria but their perspective remained clear that it is women's right to choose what they do with their fertility.

Over half of the respondents said they would refuse lesbians access to DI because of their beliefs about what sort of families children should be brought up in. Two respondents referred to their belief that lesbian

relationships are “more volatile” than heterosexual ones, and their concomitant concern for the resulting children. These two believed that lesbian relationships are based on heterosexual ones, with one playing the part of the “man” and the other playing the part of the “woman”.

- 09 I won't personally treat lesbians, not because I've any disapproval of a lesbian relationship, but you do have to think about the child you're creating and the statistical thing is that children with that in the environment have a much greater incidence of disturbance than a heterosexual environment. So I won't personally do lesbian couples, again because I think the relationship, basically, is often very unstable and you tend to get a dominant woman whose female partner is missing having a child and so the male [sic] partner says “all right then you can go and do it” and I don't think it's a good scenario.

This common belief that lesbians model their relationships on heterosexual ones is also associated with the belief that lesbians often want to be men. Another respondent, in answering the question about lesbian access, said that if one of the partnership had gone through a transsexual operation then there would be no bar to access because the woman had properly become a “man”.

The rest of the respondents in this group made reference to their belief that children need a stable heterosexual family in which there is a man and a woman providing appropriate parenting:

- 18 Because of my own gut feeling. I wouldn't be happy to do it because of the way I feel about that. I do think kids have got a right actually to start with a male dad and a female mum. And lesbian couples can't give that.

Those who accepted that there may well be evidence that lesbians bring up children as well as anybody else still felt that they should decide to override that evidence in favour of their own beliefs about families and parenting:

- 09 Well I don't think that kind of, we don't think that kind of relationship is best for the child although we have no evidence for that. There is no evidence. The evidence suggests that the children do all right but - it's anecdotal evidence really.

I asked two questions about the possibility of standardised criteria for potential recipients being set by the SLA and about the ethics of the government or themselves being in a position of being able to encourage or discourage certain groups from parenting. The majority worried that SLA-imposed criteria would mean an inflexible approach towards potential recipients. There was, however, also the feeling that such criteria imposed from outside would be akin to the intervention of non-medical professionals: that it would undermine the professional autonomy of respondents in coming to their own decisions regarding the suitability of potential recipients.

About a quarter of the respondents felt that some standardisation of approach towards potential recipients could be useful. Two felt that it would be beneficial for recipients to know that they would be managed in the same way at any clinic. Three felt that such guidelines would help enhance the reputation of the DI service by bringing everyone up to the same standards:

- 11 Yes I know that people will say this is interfering with clinical practice but I think in this field, in order to keep, you know, the thing a reasonable reputation - I mean in this method of helping people to have children there's a lot of cowboys in the field.

In regard to the question about the role of the government or themselves in encouraging or discouraging parenthood in different people, the majority of respondents stated that the government should have no say. After being prompted by the challenge that they *were* involved with this process especially through their refusal to allow single women and/or lesbians access to DI, nearly half said that they had to take into account the welfare of the child - or at least their conception of what constitutes the welfare of the child - and that this meant refusal of access to such groups. One felt very

strongly that she should be allowed to continue to exercise her professional autonomy:

Prompt: If you had guidelines imposed do you think it would be a good thing if all clinics had the same criteria?

18 I can't imagine that they wouldn't be criteria to which I already adhere. So if big brother was to tell me to inseminate lesbians big brother could go take a running jump. So it depends on what you mean by the criteria.

About a quarter were anxious to stress that any decision-making they were involved with was guided by the welfare of the child:

01 Well whatever criteria you use you should look at the welfare of the offspring. You see that's the only criteria ... they're doing it because they want a child. ... So, provided there are two parents I think that's 90% of the problem solved and I think 10% is probably the economic circumstances of those parents because I mean you have got a lot at stake and you really could get into trouble if the processes are incomplete.

In response to questions asked specifically about their refusal to allow single women and lesbians access to DI, nearly a quarter pointed out that these women could sleep with someone in order to achieve conception and had no need to involve them in a situation they felt was an ethical anathema:

21 If they want to be parents they can pick up a fellow somewhere. Or they can arrange for their own semen. Nobody is stopping them from doing that. But I am not going to aid them ... because I believe this leaves itself open to other difficulties or potential difficulties.

The majority of respondents show a personal allegiance to a particular structure of the family: they refuse access to women who are not in heterosexual partnerships. Although the structure is a high priority at the outset, it is also the case that the potential structure is taken into account. This is evidenced by the slightly greater numbers of those willing to give

access to single women. The respondents reasons for rejecting requests from lesbians and single women involved references to ideas about the constitution of the family, their preferences for heterosexuality and their assumptions about the stability of heterosexual relationships. Very little mention was made of the actual parenting skills women from either of these groups may have. Decisions are made as a result of respondents' personal conviction.

b) Functional Allegiance to the Ideological Family

One of the respondents described an event that had occurred in the NHS DI unit which was under the same consultant for whom she worked in the private sector, and which led to the formation of a written ethical policy concerning access to all ACTs. A woman had given birth to twins after using IVF but had been unable to return home with them because the home was not adequately heated. This situation had been picked up by the local media and the unit had come under heavy criticism for allowing the woman to conceive when it was felt that she did not possess adequate resources to parent. Since that time the clinics have an ethical policy which states that all potential recipients of the fertility services should have an adequate roof over their heads. However, the respondent said that, in fact, the policy was rarely, if ever, referred to if the potential recipients came from the private sector.

Those offering any of the ACTs might be susceptible to the public's reaction to their work. In this study, a further six respondents articulated their concern that there is more at stake than making a wrong decision about access or in not recognising women's ability to decide for themselves whether they wish to parent. In rejecting the idea that lesbians and single women should have equal access to DI, four felt that they had to take into account what they felt society would want them to do or where they felt society would stand on the issue:

- 06 If they come tomorrow and say you must have somebody sitting here counselling everyone then I will do it. At the end of the day I debate my opinion but I do not believe that I should all of a sudden decide to ignore what society agrees upon - not because I want

to be a part of the herd. It's simply because if you go far beyond what society wants, you may actually jeopardize the whole thing.

These respondents stated that they had no personal stand on whether single women and lesbians either should use DI or whether they would make suitable parents. What they felt was that they could not afford to jeopardise the DI service by letting women from these groups have access.

For a third of the respondents, all of whom work in large fertility units with the whole range of reproductive techniques on offer and research projects in progress, being seen to be sensitive to the public's anxieties about who is getting access to DI is functional. If they can gain general support for the way in which they administer DI then they will have demonstrated their trustworthiness and may then be trusted in their administration of the other more technically sophisticated reproductive techniques and also fertility and genetic research. The result of these respondents' functional allegiance to the heterosexual nuclear family is the same as those who have a personal allegiance to it: those who do not conform are rejected.

Eugenic and Environmental Criteria

In addition to most respondents' rejection of any structures except the heterosexual nuclear one, they applied further selection criteria to assess the suitability of heterosexual couples. Although the consequence of such scrutiny is that respondents are seeking suitable parents with whom to place babies - not withstanding the fact that it is the women's own babies - in actual practice very few refer to any attempt to assess potential recipients as prospective parents, and none discussed any attempt to scrutinise the existence of any parenting skills or the appropriateness of potential adult-child relationships that might ensue.¹⁸ What respondents did do was to reveal how they make decisions based on eugenic or environmental considerations with regard to the sorts of families in which they felt DI children should or should not be brought up in.

¹⁸ The only exception to this rule was those remarks made in the context of secrecy surrounding the DI conception of children and the anonymity of donors ie. that potential recipients should show that they could cope with this secrecy.

1. Eugenic Considerations

a) Race

Respondents were not asked questions about how or whether potential recipients from different ethnic groups are treated or assessed differently from white people. Instead they were asked whether they found recruiting donors from different ethnic groups difficult. Responses are included here because if the recruitment of appropriate donors is difficult this will affect the access of potential recipients from different ethnic groups.

Two respondents said that they offer DI only to white people. They said that they found it too difficult to recruit donors from different ethnic groups and that the storage of sperm made the process too complicated. One of these respondents is working in an area which has one of the three oldest populations of Afro-Caribbean people in Britain. A further six respondents had at some point been unable to offer DI to people from different ethnic groups because of the lack of appropriate sperm.

Other respondents argued that there is no excuse now for not having appropriate sperm available, both because of the network of sperm banks that now exists and because of the geographical spread the banks have, which allows for the transportation of sperm to anywhere in the country. If some respondents said they have never had problems recruiting donors or supplying sperm and others had developed ways to resolve any problems they had encountered, why have all DI units not developed, and/or cooperated with, strategies to counter any difficulties in the provision of appropriate sperm. The result of such uneven provision of DI to Black people is that in some areas these people do not have the same access to DI as do white people. In just over a third of the DI services in this sample Black potential recipients might not be able to use the DI service. This means that Black people have differential access both to services and the opportunity to become parents. For this reason I have included this data under the sub-heading of eugenics: because Black people are not being facilitated to use DI in the same way as white people are.

b) Genetic conditions.

All respondents were asked whether they would give access to women carrying an 'undesirable' genetic condition. Most of them held negatively eugenic views which made them unwilling to assist in the reproduction of children who express such conditions. That DI is utilised for the purpose of reproducing perfect babies is best illustrated by one respondent's response to the question:

- 10 This is a wrong question. You should re-phrase this. If the woman has a genetic disease then AID is not a treatment for her.

Only rarely did respondents state what genetic conditions they would find undesirable. The purpose of the question was not to compile lists of unacceptable genetic conditions but to gauge, to some extent, respondents' views on the access to DI of women expressing them. Because the medical literature abounds with references to the importance of preventing men with undesirable genetic conditions from donating sperm, I wished to ascertain whether the same conditions applied to women receiving DI. The screening process applied to donors does not apply to women. Half of the respondents said that the decision about access would depend on what the genetic condition was and the risk of it being transmitted. Access then is dependent on there not being a high risk of transmission, rather than, as with donors, *no* risk of transmission:

- 04 I mean (pause) some genetic diseases are not compatible with life so obviously, if the woman knows about it, knows about the implications and from the medical point of view, you know - for example if somebody had sickle cell disease, something like that, that's not compatible with life. Or I can't think of anything - it depends, it has to be something that you believe is incompatible with life or that will cause a severe handicap. That is when we would discuss it.

Only rarely did respondents mention actual genetic conditions they would find unacceptable. The emphasis, in the main, was on the risk of transmission:

- 02 Genetic disease depends on one, what type of genetic disease, two whether it is recurrent, whether it is seen in the family, ... whether it is a type that is serious or not, whether it is easily passed on or not, what are the consequences for the infant ... So again I will normally, in these circumstances, seek the advice of a genetic counsellor and if they say that this woman can go ahead and get pregnant then we take their advice and document it and go ahead.

In order to screen out particular genetic conditions, respondents should have some knowledge about heritability. As will be seen in chapter six, this knowledge was not considered important in relation to donors because any perceived risk of transmission of an undesirable condition is considered unacceptable. With women however, half of the respondents stated that they would seek advice from a genetic counsellor or geneticist to assist the decision-making:

- 07 Well it would depend on the disease but in that case I would have to depend on specialist advice concerning her. I might accept them providing I know what I'm doing is the right thing to do. If I'm uncertain I shall get professional advice.

Most respondents were not happy with the idea of being involved with the reproduction of a baby carrying an undesirable genetic condition. Half of the respondents felt that if potential recipients were prepared to undertake pre-natal diagnostic tests such as amniocentesis, they would feel better about them using DI:

- 05 I don't see that as a reason not to, provided she accepts that in terms of pre-natal diagnosis she's going to undergo the same sorts of tests that she would have done if he had been the father.

Implicit in the qualification that women should undergo pre-natal tests is the belief that action would be taken to abort the foetus if the tests proved the presence of an undesired genetic condition. One respondent was explicit about this preferred course of action:

- 18 I wouldn't turn her down if she was wanting to take the risk. I think that would be her decision but I would be very keen on pregnancy testing and selective termination if it was an affected child. So I don't know if I would be very happy to treat somebody who had a strong likelihood of transmitting something genetically, who wasn't willing to have an abortion if it proved to be a handicapped child.

Just over a third of the respondents said they would not let women with undesirable genetic conditions use DI if they, the respondents felt that the risk was too high and they felt an imperfect baby would be born:

- 13 Now that's a difficult one because clearly if there are high risks to a child then, you know, that's bad for the child and it depends - if it was 100% risk to the child of a major abnormality I might actually say no. But I've never had to encounter that one yet so it's a bit sort of theoretical.

There is some evidence that women are not routinely screened for their genetic inheritance due to the fact that a quarter of the respondents said that they had never had a woman with genetic conditions come to them for DI or by saying that DI is not for these women. It is more likely that the majority of respondents made an assumption about the sorts of genetic conditions women might have: that women would know they were or think they might be carriers or that they expressed a genetic condition.

A quarter of the respondents suggested another method of preventing the birth of imperfect babies: the use of more technically sophisticated reproductive technologies. Egg donation was suggested as one way of bypassing women's genetic condition and IVF with embryo screening another, to prevent undesirable embryos being implanted. Less than a quarter were prepared to allow potential recipients to make up their own mind about whether they would go ahead and use DI.

c) Women with Disabilities

In the main, respondents seemed more positive about women with disabilities using DI, with half saying that a physical disability should make no difference to women's use of DI or their ability to parent. For example:

- 06 I see no reason - we had two patients who are pregnant who are paraplegic. We have no problem in that, ... I mean we are not creating a brave new race you see. We are assisting a normal process.

However, a quarter - including some from the above group - showed some concern that the disability should not be a genetic condition. This attitude is consistent with the eugenically motivated belief that women carrying genetic conditions should not reproduce unless there is low risk of transmission:

- 07 (pause) Let me just think. No that would make no difference at all. Women with physical disabilities get pregnant. Again if there was a genetic problem I would seek advice. Never had such a patient.

In addition, about half of the respondents expressed some concern about the ability or fitness of women with disabilities to parent. The range of issues arising from this general concern included whether pregnancy might inadvertently affect women's health, and whether people with disabilities are able to parent in social terms.

Some of those who talked about whether a woman might actually be able to carry a pregnancy, pointed out that she would have been referred by a medical colleague, thus implying that if the referring doctor was of the opinion that a woman was suitable then they would be happy to accept the referral:

- 08 If it is something which is just accidental and if on medical - look she's been assessed by her consultant that she should be able to carry a pregnancy without adding any risk to her health then we accept them. But if it is genetic then we require some genetic counselling before going ahead

One respondent said that if a woman could not walk she would have to think about the 'wisdom' of pregnancy. This view was not substantiated by the several other respondents who had offered DI to women in wheelchairs.

Other respondents referred to the long term implications of women's disabilities, saying, for example, that if the woman had a degenerative disease, they would think twice about assisting her to conceive a child through use of DI. Some respondents also referred to the ability of women with disabilities to provide suitable parenting for children and said that an assessment would be made on these grounds:

- 11 It's not just strictly medical but you've learnt to assess people, whether they're likely to be able to look after the child properly. The judgement really is whether the woman is likely to be able to look after the child properly or not because that's in the interests of the child and if she has to get somebody else to look after it then that's not really the kind of person I think that you want.

d) Social Class

A third group of questions were asked which attempted to establish whether access is a function of social class. Indicators of social class were taken to be income, the material and living conditions of potential recipients and their paid employment. The responses to this set of questions are included under this section for two reasons. First, because there exists a history and tradition of the influence of negative eugenics on the relations between doctors involved in reproductive decisions and women from working class backgrounds. Second, because the result of such exclusions is that certain groups of women and men are considered unfit to reproduce and are encouraged not to whilst, at the same time, certain other groups, who are perceived to provide better environments for children, are assisted to reproduce.

Two thirds of the respondents - including all from the private and non-profit-making charitable sectors - identified at least one of these factors as being important in assessing suitability. Most concern was shown about the financial resources of potential recipients and whether they were in paid

employment. Most of those charging a fee implied that being able to meet the cost of DI was indicative of the satisfactory resources of potential recipients. Others, who also wished to illustrate their sensitivity to the issue, explained that they might not directly ask about money or income but would ask about potential recipients' occupation or, as the following respondent did, their residence:

- 11 Well yes to a certain extent, I mean if patients came from [part of city] there's a good chance that we would not want to go ahead if we thought the child was going to suffer. But actually most of the people that come are, you know, reasonably motivated and have reasonable accommodation. Few actually real poor people come for donor insemination.

Some others were more explicit about their belief that people without adequate resources should not have children:

- 04 Generally speaking, I mean as a charity we are able to help in situations of financial hardship. More often than not that doesn't seep into AID service, it's kept for other areas of our service because really if people can't afford our fees then they can't afford to have children.

The fees in question here were £110 per month. On being prompted about the minimum income they thought necessary respondents showed ambivalence and said that each situation had to be assessed individually.

The lack of paid employment signified inadequate financial resources for those who felt that this criteria was important. Some of those who charged for DI felt that people should be in paid employment, because of the risk of running into debt over paying for 'treatment'. Others held quite moral views about paid employment believing unemployment to be associated with a particular undesirable personality, like the following respondent working from private consulting rooms:

- 09 Obviously you do quiz around what their prospects are. I don't think you would want to add to the State's total support. But on the other hand if you're fairly *selective*, the doctors send[ing] them through, you're possibly not going to see so many in that position. ... If they're chronically unemployables, in other words, you see a lot of infertile couples, often not married and living together. Personally I am very reluctant to get involved in it, but you don't see them a lot in - you're more likely to see them in hospital out-patients and it's a matter [of] whether they're referred for either private AID or to a hospital clinic. In certain areas you see a lot of couples where there's no likelihood of them getting work or trying to get work, or in fact, getting married.

This respondent also illustrates the dependence some respondents have on the referral doctors in selecting out unsuitable potential recipients so that the respondents do not have to consult with them. This will be discussed later in this chapter.

There was much less concern with the material and living conditions of potential recipients with some saying that assumptions could be made based on the financial resources of potential recipients. Two said that they would contact GPs and social workers if they identified a cause for concern. Only one respondent acknowledged the total cost of using DI which, including the inseminations, can involve one or more trips per month to DI clinics, time taken off work and possibly overnight accommodation. Most clinics charged for DI or asked for donations towards its cost. Some of those working in the NHS said that if it became clear that the suggested donation was prohibitive they would waive it rather than see people refused access on financial grounds. The biggest reason given for charging in the NHS, was that there is no budget for a DI service within the NHS so making it necessary for it to be self-funding. In general, the charge made in the NHS was per cycle, regardless of the number of inseminations, and ranged from £50 for a package of eight cycles to £40 per cycle.

If the initial consultation fee, the extra charge for reviews, other treatments, further consultations and so on are excluded, the cost of DI within the private and non-profit-making charitable sector per cycle ranged from £30

(plus an initial donor fee of £25) to £315. The latter price included ovulation monitoring and, if this was done elsewhere the charge came down to £60 per insemination (one or two as recipients wanted). Some respondents offered a reduced charge for a second insemination in order to encourage more than one insemination per month. One offered reduced rates for those using DI for genetic reasons.

Such costs must act as a barrier to those on low or no incomes and who are working class. This sort of exclusion occurs in a way such that it can be reinterpreted as lack of motivation on the part of potential recipients or as the result of self-selection if women drop out of inseminations or never start them. Additionally, these costs would explain the numerous accounts of DI being favoured by recipients from middle class backgrounds.

Clearly there is some level of screening according to social class. This can take place in three ways. First, by charging for DI, respondents can assume that only adequately resourced potential recipients will be referred. Second, by asking indirect questions about occupations, accommodation and addresses, assumptions can be made about the resources of the potential recipients. A third way in which such screening can take place is in the reliance on referring doctors to have made a sound judgement about their referrals. This aspect of the screening has relevance for all criteria applied by respondents and will be taken up later.

e) Behavioural Traits.

Over half of the respondents also referred to what I have called behavioural traits in giving examples of reasons which would make them feel unhappy about giving potential recipients access to DI. I have called them behavioural traits to distinguish them from traits identifiable as physiological in nature; and to emphasise that these are factors that respondents would be seeking to identify and label and which would not necessarily be substantiated as such by potential recipients or other professionals. The most mentioned factor was emotional or mental instability. Half of all respondents referred to this. The comments ranged from vague generalisations like emotional and mental 'instability' to named mental

health problems like schizophrenia. Often the severity of the mental health problem was emphasised:

- 04 We've had one or two very difficult to deal with, of women who we felt were mentally unstable, whatever that means, when they actually approached us and that was part of what was explored in the counselling and as a result of counselling we felt unable to offer - it happens rarely but it does happen.

A quarter referred to people who have addictions either to drugs or alcohol as people they would not offer DI to; three said that a history of child abuse would be a contraindication; two "social problems"; one, "severe epilepsy"; and two that disease in potential recipients might indicate rejection because of the possibility of early death of a parent.

2. Environmental Criteria

Another group of criteria emerged from responses given to questions asking what respondents were both looking for, and seeking to avoid, in potential recipients. These criteria were related to the environment in which resulting DI children would be brought up, and more especially the environment created by the relationship that exists between the potential recipient couples. Three quarters of the respondents referred to the perceived quality of the relationship existing between potential recipients. Three key issues emerged which all relate to some aspect of the relationship: its quality in terms of the ways in which potential recipients actually behave and respond towards each other in front of the respondent; the stability of the relationship which is assessed by questions asking about its length and which is also inferred from its perceived quality; and the perceived motive for having a baby.

a) Quality

Half of the respondents described how they attempt to assess how potential recipients relate to each other both in general and in relation to their using DI. Three quarters of these made special mention of the male partner's position and response to the potential use of DI. All of these respondents

referred to their attempt to pick up verbal and non-verbal cues in the demeanour of potential recipients during their consultation. For example, the following describes the more general cues picked up as warning signs:

- 20 Well couples who seem in some hurry about the treatment ... you usually find that there's something needs exploring there, all is not entirely right in the relationship ... Maybe one partner's pushing a little bit more, the other one's being dragged along a little bit. So that type of approach we would deliberately slow down and try and help the couple to be absolutely certain that they were taking the right decision.

It becomes apparent that it is the respondents' judgement about potential recipients which may lead to the latter not using DI or to the process being 'slowed down' in order to give potential recipients time to reflect. Yet the respondent above was quite adamant that potential recipients make their own decisions about their use of DI.

The following respondent illustrates those who attempt to pick up verbal and non-verbal cues from the potential recipients:

- 19 Most couples who've decided that they want donor sperm are apparently happily together; they seem together when they sit with you; their experience of infertility seems to have drawn them together. There are some couples where you sense that there's an underlying bickering and perhaps they move the chairs (laughing) further apart as they sit down; perhaps where the husband is always just a little bit busy to come along.

This respondent also exemplifies the sort of double-sided comment given in response to questions about potential recipients. The first part of her answer describes what she judges to be preferable in terms of a suitable relationship between potential recipients. She also implies that such relationships are the norm because potential recipients are normal/ordinary people. The second part of her answer describes what she judges to be rare and undesirable in potential recipients. Those who present the normal desirable relationships come through the assessment process and

themselves take the decision about whether they want to use DI. Those who present undesirable traits are slowed down, talked to, persuaded that they need more time or that they need to re-think and perhaps not use DI: the respondent's judgements are translated into the decisions of potential recipients.

Three-quarters of the respondents who assessed the quality of relationship emphasised the role of men:

- 11 it needs support from both of them for each other to cope with - and particularly for the husband who is the one who is not able to give his wife a child. ... I've heard a wife saying "my husband's not a real man". So that sort of thing would put me off, if I felt or thought that mutual support was not forthcoming.

b) Stability

Half of the respondents made reference to "stability" as another indicator of the quality of the relationship. Those who mentioned stability were asked either what they meant by stability or whether stability referred only to the length of time together - depending on what they had said. Most agreed that time was the relevant factor in determining stability and this was especially the case where potential recipients were not married. Time together was equated in the respondents' responses with commitment to the relationship:

- 20 Well a couple who had been together for a number of years is the best indication, and who are prepared to obviously indicate that they have a commitment to each other. I mean many will choose not to be married just for their own reasons - that's not felt to be a contraindication - but if there are reasons why they aren't getting married we would want to explore it to find out where there are problems in the relationship that could be discussed usefully.

Some underlined the fact that potential recipients of DI would have already demonstrated their commitment to the relationship because of the time spent waiting to go through fertility investigations and for their turn at DI. Others referred to their ability to 'encourage' people to wait to decide

whether DI is the right option for them. Both of these comments were made in the context of stability being a criteria for the successful use of DI:

- 18 couples who've only recently set up I usually suggest that they give themselves time to become a couple before they start on this sort of thing.

Here again it is the judgement of the respondents which is the determining factor in deciding whether potential recipients will use DI and when they will use it. Often respondents like the one above would deny that they make the decisions for potential recipients but through delaying tactics such as the one above, respondents maintain control over access to DI.

c) Motive to Parent

Half of the respondents inferred it is important to make some assessment of what motivates potential recipients to become parents. The majority said that if they felt that potential recipients wanted children in order to save their relationship or marriage, this would be a cause for concern and even lead to them being rejected. The idea that people should not want children to save their relationship, has come to take on the status of medical fact. Regardless of whether there is any objective basis for the idea or whether it rests entirely on a sort of 'common sense' basis, it is presented as an accepted fact that this motive to parent is unacceptable and potentially harmful:

- 11 any indication that perhaps this was a way of trying to save a marriage. I've seen couples become divorced because they couldn't have children and one gets the feeling in discussion with them, you know, that their marriage would fall apart if they don't do this.

Others mentioned an attempt to assess whether the child is wanted for the 'right' reasons. Although these respondents did not always say what the right reasons would be, they alluded to the reasons they believe are wrong:

- 15 Well if it seems like the child is basically the whim of the parents then I would feel no. I suppose really we're looking for commitment to the children for their own sake.

Others saw the commitment to having a child as being capable of being measured in part by the length of time they had waited before getting access to DI. This commitment was deemed a sign of suitable motive for having children:

- 05 they've waited for 9 months or 18 months on my waiting list and if they're still there, then, they're motivated in my view.

d) The Baby

Over half of the respondents referred to the welfare of the child or their responsibility to the child in making decisions about the suitability of potential recipients. Some of these comments were made as rationales for excluding particular groups of women from access to DI, like lesbians, single women and so on. Most however referred to judging the best interests of the child in a more general way although they assumed they were only discussing heterosexual couples:

- 01 I usually go on guts, feelings and what I say is the best criterion is the child so, if I'm going to give this couple a child is the child going to have a mother and a father who isn't fit? Now if I can in my own heart say that's OK, that's fine.

Other respondents made specific references to the future of the child and to their attempt to ensure an on-going preferred environment for the child:

- 21 I'm looking for the ability of the couple to look after that child in whatever grade of society they happen to belong to. We don't try to differentiate that at all. That that child will be well cared for in the future, yeah. I wouldn't want to bring a child into a situation where obviously they're going to be under-nourished and so on.

Only one respondent acknowledged the difficulties involved in such an assessment; making an assessment on the basis of what people say whilst trying to be predictive. This respondent accommodates the difficulty by normalising most potential recipients and attempting to identify the most obviously problematic of them:

- 13 one can't pre-judge what's going to happen to children in marriages - in my view anyway - but if there are obvious problems one wants to try and avoid them.

A further respondent also illustrates how respondents accommodate the contradiction inherent in the statement that potential recipients of DI are ordinary people not in need of other non-medical intervention and assessment, yet that they do need to be assessed by respondents:

- 19 I think the most important thing really is that every child should be a wanted child into a family who can care properly for it and I think, providing we remember that basic ethic, then I don't think we can go wrong. But ... so many people who are clearly unsuitable ... can have children whenever they like it does seem rather unfair to impose controls on those who can't do it whenever they like.

This respondent worked at a clinic which had a written ethical policy governing access to any ACTs which included social assessments of potential recipients.

Decision-making strategies.

Most respondents showed evidence of adopting two approaches to decision-making which are pro-active and reactive. In the first, respondents actively seek to include certain potential recipients and in the second, they react only to what they discern as warning signs in potential recipients. Because most respondents show an allegiance to the heterosexual nuclear family model they demonstrate a pro-active approach both to include those potential recipients who conform to this model and to exclude those who do not. It is at the level of applying structural criteria that they make pro-active decisions.

In applying eugenic or environmental criteria all respondents make reactive decisions. With this, respondents assume that most potential recipients will be appropriate unless proven otherwise. In practice this means that respondents are not pro-actively seeking to select *in* particular ideal family situations. This is borne out by the almost total rejection of my question

asking whether respondents felt that an ideal family exists. What they are doing is reacting to what they see as indicators that mean some potential recipients might have to be selected *out*.

The result of adopting reactive decision-making is that respondents do not problematise the social component of DI. Unlike the medical component which they have problematised so that it has become the defining feature of DI, respondents seek, in the main, to 'normalise' those who use DI - once the structural criteria have been pro-actively applied. This strategy allows respondents to use their own judgement to identify and define a social problem without having to involve non-medical professionals to do a blanket assessment of potential recipients. The emphasis of the respondents is on the 'ordinariness' of all who use DI:

- 06 It's not our role to sit and say "oh the whole interview is to say how suitable these people are for parents" - unless I feel they are unsuitable. I'm not assessing the suitable unless they hit me as being *unsuitable*. In other words, you know, like the rule of law that you're innocent unless proved otherwise? They are all suitable parents unless proved otherwise.
(My emphasis)

This reactive approach allows a somewhat contradictory position to be taken by those respondents who insist that it is potential recipients themselves who make the decision about whether they will use DI or not. It seems that it is only if potential recipients do not present any contraindications to respondents, that they are then allowed to make a decision themselves about their use of DI. Contrary to their protestations, social criteria are applied and respondents decide that potential recipients are suitable and therefore able to make their own decision. It is not the intention to give the impression that the assessment is a long one. For some respondents in the private sector this would take place within the one and only consultation with potential recipients before inseminations begin.

Some respondents also try to maintain that their role is to facilitate the decision-making of potential recipients who are 'ordinary' people wishing to have children:

- 09 Mmmm I'm not a great one for this in-depth counselling thing. I like to think most couples have got enough common sense to sit and talk it over together and decide if it's their cup of tea or not. I'm only here to answer their medical anxieties, concerns, queries.

Five strategies were identified that respondents use to impose their decision about access on potential recipients:

- the use of waiting lists or a "long finger" to put people off, 'test' their motivation "give them time" to resolve any respondent-identified problem there may be within the relationship
- the use of talking or 'counselling' sessions to 'help them [the potential recipients] see' that the use of DI is the wrong decision for them
- the use of selection criteria by those who believe they have a responsibility to assess the suitability of potential recipients
- the use of the medical referral system to weed out unsuitable people so that they never actually arrive at the DI unit
- the use of diagnostic authority which allows respondents not to offer DI as an option as may happen when people are referred for fertility investigations in the first instance rather than for DI specifically.

The first three strategies are employed once respondents have reacted to what they perceive as warning signs. These strategies require some sort of assessment by respondents, using the criteria already outlined. The last two strategies involve methods by which potential recipients never actually present for DI. First, medical referring agents are relied upon to screen out unsuitable potential recipients. This may take place because referring doctors are cognisant of guidelines issued by the DI unit. It may also happen as a result of long-standing working relationships which result in more informal recognition of 'appropriate' criteria to apply. Second, that screening would take place during the time general fertility investigations were being carried out.

Waiting Lists or Other Delays

Waiting lists only exist in the public sector yet many respondents working there argued that putting people on waiting lists can be instrumental in 'encouraging' them either to sort out their respondent-defined and identified problem and/or to realise that DI is not appropriate for them. Other delays can be introduced during the DI process which all have the effect of making potential recipients wait until such a time as either they demonstrate their suitability after all, or they drop out of the process:

- 13 it's very easy to introduce a bit of a delaying tactic so that if I've felt that people are rushing into things and they haven't really sort of - we may get a couple where the husband has no sperm and our policy is always to tell everybody exactly what the score is. However, they may immediately then say "well look we want this", but not having really thought things through. And in that sort of instance I'd nearly always try to invoke some sort of delay by doing a few chromosome tests or something of this sort and at the same time giving some information and then bringing them back on another occasion.

This use of waiting times to influence people's relationship and their final decision regarding DI was talked about by respondents, some of whom were adamant that they had nothing to do with decision-making.

Talking or Counselling

An illustration of this sort of approach to facilitating people's decision-making is given below. This respondent not only illustrates the way in which delays can be introduced at any stage of the DI process by respondents, but also the way in which respondents believed that potential recipients make their own decisions - even though they are actually being encouraged to a particular decision which coincides with that of the respondent. This response was given to the question asking how people might be rejected:

- 09 I think often you can make them realise that they haven't thought it through ... you often feel you could push them into it whereas if you sort of say "well, there's a lot of things you want to think about. Come back and we'll go through some more again" you often find that they do do that. I think that's sometimes a wiser way than trying to sell it to them on the spot. They're open to enormous pressure, like all human beings.

This method of rejection whereby respondents persuade potential recipients that they do not want to use DI was quite prevalent and seemingly did not cause any problem for respondents. Indeed, facilitating potential recipients in coming to the right decision - especially if it coincided with the view of the respondents - was preferred over outright rejection of potential recipients:

- 18 more often I talk about things with people and let them turn themselves down

Making the Assessment

Respondents must also make the assessment about whether the people in front of them are suitable to parent. They may have an actual or mental check-list made up of their criteria, especially those which can be asked about relatively easily: addictions, family background, material conditions, employment, and so on. However, many of the criteria are not as easily verified. How do respondents ascertain the quality of the relationship that exists between potential recipients for example, or the motives to parent?

Respondents are dependent on potential recipients giving truthful, adequate information on which they can base their decisions. Many respondents were quick to point out that they could only act on what they were told and wished to stress that potential recipients 'could say anything' if they wanted to and they - the respondents - were not in a position to know the actual truth. Recognition that the role of decision-maker is based on such a vulnerable basis as this might be enough to question the actual effectiveness both of their attempts to apply criteria and their ability to

assess the trustworthiness of potential recipients. Yet, respondents are apparently quite satisfied with the selection procedures they employ.

One of the most oft-mentioned procedures was respondents' ability to 'just know' that the people in front of them were suitable. Half of the respondents said that they were able to "pick up vibes" or "just tell" about the potential recipients and their relationships:

- 01 I usually go on guts, feelings
- 08 just a special sort of chemistry which goes between the doctor who's interviewing the couple that he just feels whether they look suitable to be offered the service. You just sometimes feel that this particular couple they're not really ready for that sort of treatment and most of the time you are right.

This method of deciding whether potential recipients are suitable to parent provides more evidence for the idea that respondents are involved in recognising themselves in potential recipients. That is, they believe themselves - and people like them - to be suitable to parent and therefore identify with similarities between themselves and potential recipients. Thus they feel vindicated in 'feeling fine' about allowing these people to become parents.

I asked respondents whether their medical training informed their making of assessments. Only one said that all of her work with potential recipients was guided by her medical training and that none of her personal feelings were involved. A quarter said that they felt that their medical training was involved a lot with their decision-making and just over a third said that they thought there must be some involvement. However one of the skills which those in the latter group felt had come from their medical training - 'talking to people' - was identified as a skill not taught in medical schools by those who felt that their medical training played no part in their decision-making with potential recipients:

- 02 That's not something you learn in medical school. That's something you learn when you see patients in clinics ... you can't learn this in school.
- 21 I think medical training if it's any good at all will teach you to view people as they are and not what they seem to be.

Being able to talk to people and then make some assessment emerged as the most important skill identified, although there was disagreement as to how or where this skill was developed. Some felt that medical training had equipped them to do this, others that years of working in medicine and the practical experience of meeting people had given them the opportunity to develop this skill. Others felt that specifically working in fertility had enabled them to develop it:

- 11 the medical training is important but I think also, your general training in assessing people which is what you're doing actually, you know, whether they're telling the truth or whether they're genuinely complaining of these symptoms or whether really something else is bothering them. This is particularly so in the field of infertility, you may find there's some other problem like the marriage breakdown or something.

Half of the respondents also talked about influences other than their medical training which informed their decision making. Two felt that medical training was of little use to them next to common sense. These respondents emphasised the 'ordinariness' of potential recipients of DI and implied that any decision about suitability to parent would be based on a common, presumed to be shared, knowledge of what or who constitutes suitable parenting material:

- 01 (long pause) I honestly don't know. I think it's more common sense and experience in the field that I've picked up myself, not training. It's, field experience, it's street-wise rather than hospital-wise and I think it's probably using more of my GP brains in assessing the couple as appropriate for AID than I am as using my urological, or andrological or gynaecological brain.

Nearly a quarter acknowledged the influence of personal and life experiences. Two said that their background and education influenced them and one of these acknowledged his status as a white middle class male. Another talked about his own personal feeling guiding his decisions. None of the respondents talked about any training in, or special knowledge about, parenting or adult-child relationships. Their ability to make assessments seems to rest on their ability to talk to and get a feeling about people; and to be able to assimilate their experiences of meeting and talking to people in consulting rooms with their own personal experiences in the world in order to make sense of the potential recipients they meet.

- 05 (pause) I suspect there are people who are better at it than others and that's got nothing to do with medical training. (long pause) No I think, there are people who have a feel for - I mean I think it can be trained - to pick up the vibes but we certainly don't get very much training in that, in terms of being judgemental. I think that there are doctors who actually might find that process quite difficult deciding who should or who shouldn't have AID. But I think most people that work in the field don't have that problem - they get into it.

Conclusion

In this chapter I have identified the three sets of criteria respondents use to assess the suitability of potential recipients. All are ideological in character but are separately structural, eugenic and environmental criteria. Every respondent applied criteria from at least one set although their rationales for applying them might be different. In this respect I identified two rationales. The first and largest was the personal belief system of respondents who show an allegiance to a particular family over any others. The second, subscribed to by almost a third of respondents, was a functional allegiance to the same family type. These respondents felt that, in order to safeguard the provision of DI and the rest of the more technically sophisticated reproductive technologies, they should be seen to make decisions about access that are in line with what they perceive as public opinion.

Whatever their rationale, the end result of applying these criteria is the same for the majority of the respondents who seek to reproduce the heterosexual nuclear family. A third of the respondents also preferred heterosexual couples to be married. Over half showed some allegiance to middle class norms in relation to financial, living and material resources and paid employment. The result of their donor recruitment practices is that white people find it easier to attain access to parenthood through use of DI. Women with disabilities and genetic conditions will also find the question of their access comes under scrutiny because of beliefs that genetic conditions should not be propagated and that women with disabilities should be able to demonstrate a degree of physical fitness to parent and longevity.

I have also described the decision-making process which, for the majority of the respondents, is pro-active in applying structural criteria but reactive in applying eugenic and environmental criteria. In practice this means that in the first instance respondents wish to reproduce heterosexual family settings. Once this has been established, potential recipients are perceived as 'ordinary' people seeking assistance to have a child rather than, as the non-medical professionals in the last chapter would have it, all potentially problematic and in need of investigation. This approach to decision-making means that all potential recipients are viewed as appropriate unless respondents identify and define a problem. Because of this reactive approach, most respondents believe that it is potential recipients who decide to use DI. I have suggested that potential recipients are only allowed to make their decision after respondents have made theirs. The actual decision-making appears to rely on the respondents ability to talk to and get a feeling about the potential recipients and their suitability. There is no consensus about whether or where this skill has been taught.

In this chapter it is clear that respondents apply non-medical criteria to potential recipients of DI and make judgements about their suitability to parent. Most respondents rejected the idea that there is an ideal family type that could benefit from the use of DI. On the contrary, most respondents stressed how 'ordinary' most recipients are. However, the consensus about

the structural criteria and, in the broader sense, with the eugenic and environmental criteria, leads me to argue that 'ordinary' potential recipients of DI are in fact particular people who conform to respondents' notion of acceptability; and in this sense, these ordinary people *are* ideal. In the next chapter the way in which the ideal family is completed with the birth of ideal or perfect children is discussed.

CHAPTER SIX: THE DONORS, THEIR SPERM AND THEIR CHILDREN

The last chapter was concerned with the way respondents attempt to reproduce particular families through their application of ideological sets of criteria to potential recipients. In this chapter there is an analysis of the ways in which they also attempt to reproduce perfect DI babies through their selection of sperm donors.

The chapter has four sections. In the first section there is a discussion about three aspects of sperm: the genetic, the social, and as the embodiment of genetic fatherhood. In the second, there will be a review of the effectiveness of screening for both genetic conditions and sexually transmitted diseases (STDs)¹⁹ as presented in the medical literature. Then I will present the views of the respondents on the selection of donors and their methods of screening. This will include screening for genetic conditions and behavioural traits and continues the discussion about genetic fatherhood. There will then be a discussion about the decision-making process by which respondents recruit donors of sperm. In the final section, I will discuss the perception of most of the respondents that controlling sperm, both by screening donors and by deciding should receive it, is one of the most important roles they play and which offers the best justification for medical supervision of DI.

Sperm

There are three aspects of sperm which are discussed here. These are sperm as the carrier of men's genetic heritage; the fundamentally social aspect of sperm belonging to and expressing male sexuality; and the combination of the genetic and the social aspects of sperm as embodied in the phrase 'genetic father' and applied to sperm donors.

¹⁹ HIV and AIDS are included in this umbrella term

Sperm as Carrier of Genetic Heritage

In the last chapter I presented Haimes' (1990) framework which identifies three constituent elements of the family: the ideological, the structural and the genetic. Haimes' definition of the genetic component emphasises the biological relationships in DI families and the extent to which they replicate "normal families" (1990:64). For the purposes of the present study a further dimension to this genetic component is offered. This is the genetic inheritance of the child born of DI. Donors are selected by DI practitioners because their inheritance matches that of the male partner ^{and} it is assumed to be of intrinsic and objective value to the child, the family and society; or because of a mixture of both of these. As Snowden and Mitchell say:

The AID child is getting a calculated inheritance
(Snowden and Mitchell, 1981:77)

In chapter one I outlined the suggested use of DI as a positive eugenic tool by Brewer (1935), and Muller (1936). In America, Richard Graham has set up, what he calls, the Repository for Germinal Choice (in Brody, 1980). This sperm bank recruits donors from men who have been publicly recognised for their outstanding achievements: for example, nobel prize winners, olympic gold medalists. This attempt at genetic engineering has been at the centre of some controversy, yet a common remark made refers not to the morality of such engineering or to the question of whether it is possible but to the fact that such banks will not have very much genetic effect on the wider community (e.g. McLaren, 1973; Carter, 1983; Dowie, 1988). Rarely does the question of the effect of the environment of the children get mentioned (Teper and Symonds, 1983), and even more rarely the influence of the women's genes on the babies (Carter, 1983).

Carter (1983) argues that attempts to pass on the genetic endowment of preferred donors will be thwarted because their genetic constellation will be disassociated in the child, but then goes on to say that, even given these caveats, some DI children will be 'gifted' and others 'moderately gifted'. This may be problematic for the children, he says, because of their environmental experience. This issue of the 'dull' child in 'intellectual'

environments or the 'intellectual' child in 'dull' environments is one which has already been mentioned and recurs throughout the literature relating to DI (e.g. Dowie, 1988). But this is an important issue in the context of recruiting donors. The influence of both the environment and women's genes is somewhat reluctantly and rarely acknowledged, but provides an argument against the exclusivity of men's genetic inheritance. However, this is almost always retracted with allusions to the detrimental effect of mismatching 'bright' and 'dull' children and recipients and by concluding that the risk of reproducing 'bad' genes should be minimized in favour of 'good' genes. Carter suggests that:

there is a case on eugenic grounds for choosing donors who are above, but not greatly above, the parental level of intelligence.
(Carter, 1983:208)

The literature about the possible use of DI in positive eugenic programmes usually refers to the use of 'supermen' donors and the ideas of Brewer (1935), Muller (1936) and Graham (in Brody, 1980) which encourage such attempts at genetic engineering. Warnings about a 'brave new world' usually accompany such discussions but Motulsky (1975), for example, says the risk of such scenarios is reduced because doctors, rather than the state, are choosing donors in consultation with recipients. Carter (1983), agreeing with Graham, champions the individual's right to choose donors who have the sort of qualities they wish to see in the children they bring up. However, Snowden et al. (1983) report that the keenness of recipient couples to choose donors has been seen as a contraindication for DI by some doctors .

Sperm as a Social Facet of Male Sexuality

The anthropologist Douglas (1966), talks about societies' search for order which, she argues, underpins the development of rituals, magic and religious custom. She argues that, although disorder spoils the patterns in our social lives, it can also be a source of potential. Disorder, she says is a symbol of danger and power. In this context, donated sperm lies outside the known order of heterosexual intercourse and it could be that its potential for

danger or power is recognised by DI practitioners. Its danger lies in its separation from normative sexual relations and social contexts and its resultant potential to undermine these structures. Its power lies in its potential to either recreate normative family structures or create other family structures in which the position of men and their sperm is challenged and redefined.

Douglas refers to the work of Levy-Bruhl who describes how menstrual blood is perceived as a person who never was. This status of the potential child in a transitional state augurs danger:

simply because transition is neither one state nor the next, it is undefinable.
(Douglas, 1966:96)

In Western history sperm has been perceived as miniature men waiting to be implanted into the receptacle of women's wombs in order to grow there into a baby (Pfeffer, 1985). Again this idea that sperm is dangerous, especially sperm which is not contextualised within the expected order of things, is relevant to the way in which medical authors and geneticists talk about the need for sperm to be pure and controlled. Douglas goes on to argue that emissions from bodily orifices can also be a source of pollution and therefore danger. This she explains with reference to the larger issues of political and cultural unity of minority groups within wider social contexts. As an example Douglas discusses the Israelites who, an oppressed minority, have beliefs that all bodily emissions are polluting:

The threatened boundaries of their body politic would be well mirrored in their care for the integrity, unity and purity of the physical body.
(Douglas, 1966:124)

In DI the use of donated sperm outside normative social contexts represents a threat to the social order. This perspective helps to make sense of the way in which medical authors refer to sperm as if it were a potential contaminator. The control of sperm serves to impose a recognised social order on the potential disorder donated sperm represents and its screening,

together with the resultant pure sperm which is offered for donation, acts as a defence against its power to contaminate.

The Genetic Father

Yoxen (1986) points out that the verbs 'mothering' and 'fathering' have very different meanings. The former means primarily to nurture and care for someone and does not necessarily involve a genetic link or a pregnancy in its definition. Fathering on the other hand usually means begetting, making a genetic contribution to the resulting baby (ibid). This role of begetter is no less important in DI, but a third party, rather than the woman, chooses them. In the medical literature this third party is usually the DI practitioner. The word 'father' is clearly inadequate to describe the donor in DI. Certainly recipients deny the donor any emotional, familial, or obligatory role associated with the concept 'father'. The medical literature also plays down the role of the donor in the DI family - but only in so far as the familial, emotional or legal ties are concerned. The role of the donor as *genetic* father is perceived to be very important and some authors, through emphasising this role, imply that the genetic father's contribution is more important than that of women's. Potential donors are also screened for STDs and, in so doing, it becomes clear that an assessment of potential donors also takes place which is concerned with what sort of man the donor is and whether he might make a 'good' genetic *father*. Thus the term 'genetic father' includes the genetic aspects of donors but also a social aspect: an assessment is made of what sort of father he might make.

Effectiveness of Screening

The effectiveness of genetic screening can be challenged on three fronts. First, the nature of genetic conditions; second, the methods used to screen; and third, the heritability of conditions DI practitioners wish to screen out. Donors are also screened for STDs but donor recruitment apparently takes place on the grounds of group membership, in relation to screening for Human Immunodeficiency Virus (HIV) rather than the presence of any STDs.

The Nature of Genetic Conditions

Central to DI practitioners' procedures for recruiting and screening donors for DI is the belief that, by doing so, they can manipulate the genetic make up of DI children. In practice this means that they actively seek to both exclude undesirable genetic conditions in potential donors and include desirable ones. The belief on which this practice is based can be challenged on several grounds:

a) The necessary tests do not exist to identify all those conditions which may be carried or expressed in those who have reached an age to make reproductive decisions (Thomas, 1981; Schoysman-Deboek et al., 1988). Furthermore, Simpson (1981) argues that geneticists are rarely able to detect those couples who may be at risk of transmitting an unwanted condition; and that the presence of an unwanted heritable condition in a family does not mean that any baby will inherit that condition as this depends on its heritability.

b) Most genetic conditions express themselves *de novo* in babies with no warning signs in either parents' genetic history (Timmons, Rao, Sloan, Kirkman, Talbert, 1981; Simpson, 1981; Matthews, Ford, Peek, McEvoy, 1983).

c) To make genetic screening effective, women wanting to use DI would have to be screened as well and this does not take place systematically at present (Timmons et al, 1981; Simpson, 1981; Matthews et al., 1983; Selva, Leonard, Albert, Anger, and David, 1986) The use of DI to avoid genetic conditions in men is already established. These conditions are, in the main, dominant ones. However, Yoxen (1986) looks forward to the increased use of DI to sidestep recessive conditions as the diagnostic tests for such conditions are developed. Women would then have to be screened in order to match them more appropriately with donors. This increased emphasis on genetic screening, Yoxen argues, will necessarily entail more reliance on hospital-based DI services which, he argues, will lead to increased medical control and minimised access to DI (ibid:29)

The Screening Methods

The methods used to screen donors genetically are the taking of personal and family histories and performing karyotypes to assess the quality of donors' chromosomes. Sometimes both methods are adopted. Neither method is foolproof but the use of karyotyping is more highly questioned for its utility. A more recent study has suggested that the routine use of karyotyping is "not justified at present" (del Mar Perez, Marina, and Egozcue 1990:282). This study found that although karyotyping identified those who had abnormal chromosomes which were not picked up by family history taking, these men actually begat between one and thirteen "normal" children (ibid).

Timmons et al (1981) recommends not using karyotyping unless it is indicated by a family history of foetal wastage or first trimester spontaneous abortions. Schoysman-Deboek et al. (1988) argue that, on balance, karyotyping is too expensive for what are poor returns and the American Fertility Society (AFS) guidelines on the recruitment of donors say that karyotyping is "not an absolute requirement" provided proper family histories are taken and there is recognition of particular genetic risks for particular ethnic groups (AFS, 1988:829).

Taking family histories has its own problems which, some argue, warrant the inclusion of geneticists on DI programmes (Ackman and Rioux, 1980; Timmons et al., 1981). In one study (Timmons et al., 1981) recipients and donors self-assessed their genetic history and then geneticists assessed them. The results showed:

the majority of donors having a positive family history did not recognise the condition as being genetic, *even if the individual had had medical training.*
(Timmons et al, 1981:453, my emphasis)

Heritability of Conditions

The literature focussing specifically on the genetic screening of donors discusses the lack of uniformity in genetic screening programmes across DI

units (e.g. Ackman and Rioux, 1980). Some authors explain this with reference to the arbitrary nature of setting criteria and the subjectivity of DI practitioners who make the decisions about who and what conditions to reject (Timmons et al., 1981; Matthews, et al., 1983; Selva, et al., 1986).

Medical authors assume that many traits are inherited and can be included or excluded by screening. These traits may be physical or personality-related character traits such as intelligence. However it is not clear that all the traits DI doctors seek to manipulate are in fact genetically based. The fact that they act as if conditions are genetic indicates the extent to which they feel prepared to go to influence the inheritance of DI babies. It also indicates the extent to which they are able to impose on potential recipients of DI their subjective evaluations of particular traits within the context of a supposedly objective medical examination of donors.

Schoysman-Deboek et al. (1988) argue that because there are so many genetic conditions which cannot be identified, all donors must be rejected who have a questionable history. Selva et al. (1986) acknowledge that achieving no risk is the ideal but point out two obstacles to its attainment: information about genetic conditions received from donors depends both on the questions they are asked and the tests performed; and the fact that everyone carries some harmful genes means that all donors would be excluded. These authors suggest a grading of donors according to risk to arrive at a workable compromise (*ibid*). Simpson (1981) states that it is impossible to screen out all deleterious genes and that DI practitioners should concentrate on screening out those few potential donors who are at risk of fathering children with genetic conditions. Matthews et al. (1983) agree with this approach saying that doctors should detect transmissible conditions which have predictable inheritance patterns.

Apparently, no assurances can be given to recipients about the genetic health of their babies. As Simpson points out:

screening prior to natural insemination can do relatively little to decrease the over-all risk of anomalous offspring, and appreciably different results cannot be expected prior to artificial insemination.

(ibid, 1981:395)

The information booklets for recipients published by the RCOG (1987) carry a clause warning that the risk of miscarriage, ectopic pregnancy or genetic conditions remains the same as with ordinary conception and pregnancy. DI practitioners go to great lengths to eliminate any risk of any genetic condition yet their efforts do not decrease the actual risk of these conditions occurring.

Sexually Transmitted Diseases (STDs)

Potential donors are also screened for STDs. The dearth of literature on this issue is bemoaned by the two articles found focussing specifically on this aspect of DI (Mascola and Guinan, 1986; Monteiro, Spencer, Kinghorn, Barrat, Cooke and Cooke, 1987). Monteiro et al. (1987) present a study of thirty-six heterosexual potential donors (thirty-four of whom were single and thirty-three of whom were white) in Britain. Five said that they had had a STD yet only twelve were found to be without any history, signs or serological evidence of symptoms (Monteiro et al, 1987). Most semen is routinely screened for the HIV virus as set down in special guidelines by the RCOG in 1987, but Monteiro et al. conclude that:

at present ... other common sexually transmitted diseases pose a much greater risk from heterosexual donors.

(ibid:418)

Only screening for syphilis is recommended in the RCOG guidelines (1987). Monteiro et al. (1987) recommend routine screening for genital infection and repeat tests when donors change sexual partners.

Mascola and Guinan (1986) underlie the importance of screening donors who, they say, are majority white, unmarried and from a middle-class socioeconomic background. They say that there is no data on the sexual orientation or number of sexual partners of potential donors even though

they belong to the age group with the highest incidence of STDs in America. They warn of the dangers of using fresh semen, which is used more frequently in America than Britain, and recommend men who have only had one sexual partner in the previous year. Excluded groups they outline are men who have had male sexual partners; who have used intravenous drugs or whose partners have used them; who have visited a prostitute; who have had a blood transfusion in the previous year or whose partner has.

Both sets of authors exclude men who have or had male sexual partners because they are perceived to be at high risk for HIV. Mascola and Guinan describe seven groups of men who should be excluded by virtue of group membership. The safe sex practices of these men and their partners, the safe use of needles or the screening of blood is not relevant to these authors. This designation of men to groups which are high risk creates a sense of anxiety about the risks involved in not excluding such men. Individually any of these men may be no risk but all are excluded because of their assumed-to-be high risk behaviour which results in them being categorised as undesirable as genetic fathers.

If frozen semen is used, tests can be performed at the time of donation and later to confirm the status of the donated sperm both in terms of HIV and other STDs. Sometimes however, fresh semen is used (Schoysman-Deboek et al., 1988; AFS, 1988) and tests cannot be performed at the time of donation. In this case these authors recommend and stress the importance of building a trusting relationship with the donors (Schoysman-Deboek et al., 1988) so as to exclude high risk groups. It is doubtful whether the establishment of a trusting relationship with potential donors is a uniquely medical skill and neither is there any conclusive evidence that trust on its own guarantees there being no risk. As Monteiro et al. (1987) demonstrated, semen may be infected without donors necessarily knowing.

One of the results of screening donors is that DI practitioners believe they are able to manipulate the genetic inheritance of DI babies. Although most authors reject the extremity of positive eugenics as exemplified by

Graham's sperm banks, there is an assumption that both negative and a degree of positive eugenics is not only possible but desirable when selecting donors. This emphasis on, and prioritising of, negative and positive eugenics in the selection of donors implies both that the male genetic contribution is more important than the women's and is able to be manipulated. The goal of such manipulation is DI babies who do not express any genetic condition nor are carriers. Genetic conditions include personality related qualities, the heritability of which is not proven.

Another result of such screening procedures is not to relieve any anxieties in new parents about the health of their children - they cannot - but to create anxiety about *not* screening. That is, the risks that are taken by not subjecting donors to detailed examination, the fear of sperm which could contaminate. Outside DI clinics, people make reproductive decisions based on what information they ask for or are offered. Most of the time this will be none.

In an effort to eliminate all risk of contamination, groups of men have been identified as potential contaminators, through their assumed high risk behaviour with regard to transmitting the HIV virus, and excluded as donors by virtue of group membership. The risk of spontaneous abortion, still birth or the existence of genetic conditions remain the same in DI as in the population conceiving as a result of heterosexual intercourse. The usefulness of genetic screening has been neither conclusively validated nor proven effective. The criteria applied are arbitrary and the result of subjective decision-making about risk and the acceptability of genetic conditions. The introduction of geneticists or sophisticated techniques such as karyotyping into the DI process will not demonstrably assist in the reproduction of any more healthy, able-bodied or genetically pure children but may, as Yoxen observes, increase the medicalisation of DI. Screening becomes a sophisticated procedure which only professionals can undertake.

In the following section a presentation of respondents' views on the selection of donors serves to reinforce the argument about the existence of

the above points in the minds of DI practitioners; their self-consciousness that in DI uniquely:

the physician is responsible for the constitution of the biologic couple, a situation which involves genetic risks for the offspring. (Selva et al., 1986:389)

The Respondents

All of the respondents who recruit their own donors are involved in selecting men on the basis that they do not pose any threat to the genetic health of DI babies. In describing the sorts of criteria they apply, however, it became clear that the criteria applied have the purpose of screening out both undesirable physical conditions and behavioural characteristics. Neither group of genetic conditions or characteristics was screened using actual genetic knowledge. Rather the notion of risk is paramount in respondents' decision-making. Nevertheless, with regard to physical conditions, respondents made more play of the use of technical and genetic 'knowledge' in their screening.

In combination, these criteria create the impression that respondents are involved in selecting for 'good' genetic fathers to beget DI babies and evaluate potential donors' propensity for producing 'good' or 'bad' sperm. This is not, in the main, dependent on medical criteria, but on subjective assessments of donors and of the heritability of particular traits. These subjective assessments result in non-medical criteria being applied. The respondents' decision-making is also examined to gain an understanding of how these criteria are applied.

Genetic Screening of Physical Conditions

The three themes which emerged in responses given to questions about the genetic screening of donors were the screening methods and the variation across respondents in methods used; the extent to which respondents say they go in trying to ensure the birth of a perfect DI baby; and the matching that respondents say they do between donors and social fathers.

1. Screening Methods

Given the importance attached to the selection of donors and their screening by DI practitioners in the medical literature, it is perhaps surprising that a third of the sample did not recruit donors. In three, donors were recruited by other members of the DI teams and the other four bought sperm from sperm banks. Of these only two performed any post-thaw tests on the semen before it was used²⁰.

There were various methods used to establish the genetic status of potential donors. Of the fourteen who recruit their own donors six use karyotyping. Opinions on how effective these methods are also varied. Two respondents asserted that history-taking is the only effective way to eliminate the risk of genetic conditions. A further respondent referred to the impossibility of screening for most genetic conditions and said that although karyotypes were performed on potential donors this would only show 'gross abnormalities' and he primarily relied on the family history. Another respondent believed the best indicator of genetic health was a donor who had already 'fathered' two or three 'normal', that is, healthy children.

2. Extent of Screening

Most respondents, in response to questions regarding screening potential donors, referred to the lengths to which they go to ensure no genetic condition is passed on. The goal of screening out any possible risk is apparently unrelated to the nature of the genetic condition, its heritability or its status as a heritable factor. In short, anything respondents judge to be genetic and undesirable is excluded:

03 No. I mean there's no tests you can do that would

²⁰ The sister in one DI unit told me that in the year leading to December 1989 the clinic had had no pregnancies from DI and that they had decided that it must have been a 'bad' batch of sperm they had bought in. At the time of the interview they had changed their source of semen. Nevertheless they had never performed post-thaw tests on the sperm and had not recalled those recipients who had been unsuccessful to try again with the new batches of sperm.

accurately cover things but we err on the side of caution rather than on being abandoned about it. For instance, somebody who presented as a donor as one of nine children [and] one of his sisters has diabetes and although we asked around and the chances of him carrying diabetes is incredibly small we're not going to use him as a donor.

- 13 So one's responsibilities, when running a programme are, if you like [gesticulating with his arms drawing levels in the air with society on the top], society as a whole, there is the donor, there is clearly the recipient and there is the potential child. So all along the way you've got to consider these things. Now some of the questions you're asking at the moment are relevant to society as a whole and in general I think there are enough donors around that one doesn't have to perpetuate potential medical problems.

The last respondent indicates where he sees his responsibility lying. The aim is not just a child for people unable to achieve conception on their own, but for a perfect child who will neither be limited by any genetic condition herself nor pass on any condition to her children.

This respondent was one of the few to speak directly about the eugenic potential of DI. However, most respondents aimed to exclude any possibility of transmission of genetic conditions. The range of conditions qualifying for exclusion was enormous.²¹ Diabetes, epilepsy, heart conditions and cancer are among those named. The actual genetic status of the donor, that is, whether or not he actually carried an undesirable gene, or the actual risk of transmission of the condition were unimportant. The respondents stress eliminating risk as their goal and, conversely, they disclose their desire to reproduce babies who they hope will never succumb to illness and who will live long, healthy, able-bodied lives.

One of the respondents identified short-sightedness as an 'abnormality' he would avoid. Thereafter, each respondent was asked whether they too would eliminate short-sightedness in potential donors. Of the eleven who answered this question a further quarter gave qualified answers to this.

²¹ see appendix C for examples of checklists used by DI units in the sample

Some said yes they would if it were 'severe', others that they might depending on the extent of it, and one said she might not exclude it but would ask recipients how they felt about it.

The example of short-sightedness is a good one. Two of the respondents pointed out the prevalence of spectacle-wearing in the over forty age group, so questioning its status as an 'abnormality'. There was variation in the label applied to short-sightedness some calling it a "disability" or a "disorder". One respondent disagreed that short-sightedness is a disease calling it a "common variant", whilst another said that it was too common to be a "contraindication" and a third said that it was not "sufficiently serious" to warrant exclusion. This variation in opinion regarding the status of a genetic condition as acceptable or not is indicative of the lack of consensus among respondents and the subjective nature of decision-making by them in selecting donors. Only one respondent mentioned seeking advice from a geneticist, yet they all make genetic decisions.

3. Matching Donors with Recipients

All respondents said that they tried to match the physical characteristics of the social father with the donor. This matching is done on the assumption that such traits as skin colour, hair and eye colour, height, weight and general body build are genetic. Some respondents reflected that, because of the paucity of donors from different ethnic groups, matching was less well done. One of these said that in contrast, with caucasian donors and recipients, details such as the type of hair - wavy or straight - and type of skin - tans well or poorly - could be taken into account.

Other respondents said that although they attempted to match the above characteristics, they were not desperate to be too exact. Some made remarks about the limitations of attempts to match. One said that recipients are told that no guarantee can be made about the resulting baby and another said that, in reality, "racial group" is the only characteristic which can be matched whilst the rest is "in the melting pot". A third said that attempts are made by the sperm bank to match the photographs of donors

and male partners which he thought a “nice touch” but do not make any difference.

A minority take matching a stage further and in so doing disclose their perception of the donor as a genetic father and also the most influential contributor to resulting babies. One respondent said that they tried to match the personalities of the donor and the social father; another that they tried to match the “temperaments” and gave as examples those which are “scientific” and “artistic”. The third said that, at the end of the matching for physical characteristics, they might be able to match for things such as a “rugby player” if it were requested. The fourth said:

- 13 we simply take the husband and we say “which donor is near as possible to that person?”. And we have a ranking order of matching. We match by socioeconomic class as number one. ... And we match by physical characteristics as number two. Now why do we do that? The reason, I think, is because intelligence is partly hereditary. Now it’s unfashionable to say intelligence is hereditary but it jolly well is and everybody knows it. And if you look at university people’s children they’re much more likely to go to university than a manual labourer’s children.

This issue of matching for intelligence was asked as a separate question and is addressed in the next section.

Genetic Screening of Behavioural Characteristics.

There was evidence from the literature that, in recruiting donors, characteristics and traits that are behaviour and personality related are taken into account alongside the presence of physical conditions. These behavioural characteristics are by no means incontrovertibly genetic, *but* some are more controversial as to their genetic status than others. In order to assess the extent to which respondents take into account these characteristics and traits they were asked direct questions about particular traits, including intelligence, that had been identified in the literature as being taken into account in the recruitment of donors.

1. Named Characteristics

Respondents were asked whether six particular conditions were excluded and whether they believed them to be genetic: homosexuality, alcoholism, criminality, mental illness, greed and selfishness. In answering these questions the actual risk of heritability came second to respondents' perceptions of the attribute being asked about. Most did not think criminality or greed and selfishness were either genetic or identifiable, yet there were those who felt that, although they did not know whether they are genetic, they would be cautious if any potential donors expressed such attributes. There was an even split between those respondents who think alcoholism is genetic and those who said they did not know, yet most said they would not use such men because of their reduced quality of sperm. Furthermore, there were those who felt that 'alcoholism' is a sign of an undesirable personality in a donor. Most believed homosexuality not to be genetic although there were some who were unsure. Nevertheless, most said that gay men - like bisexual men and intravenous drug users would be excluded as donors in order to eliminate the risk of HIV. Similarly almost all respondents said they would not recruit men who had a personal or family history of mental illness because of the risk of transmission, although all of these believed the risk to be a genetic one.

A rationale emerged for their attitudes in relation to these attributes: the eradication of all risk. The risk may be genetic, either in that respondents believe traits to be hereditary as with mental illness, or where they are uncertain of the heritability. Those that showed ambivalence often also referred to other non-medical reasons for excluding such men as donors like their presumed lack of trustworthiness or their personality. These issues will be picked up in the third part discussing the 'genetic father'.

A further excluding criterion involves, not a genetic risk - although there is no consensus on this either - but the risk associated with group membership. This includes gay and bisexual men and intravenous drug users for the respondents. All semen is tested for the HIV virus. Exclusion based on group membership denies the reality of the risk from high risk

activity - something heterosexual donors may be involved with - and the existence of screening tests. Consequently groups of men are defined as having potentially contaminating sperm not because they have but because of their group membership. Although these two criteria seem distinct from each other - those where there is the possibility of genetic risk and those where the risk lies in group membership - they actually share the same criterion: they are perceived as potentially possessing contaminating semen.

2. Intelligence

Of the nineteen who were asked whether they matched donors and recipients for intelligence, eight dismissed the question out of hand. A further eight stated that they assumed that all their donors were intelligent by virtue of them being students, so revealing their belief that, in some way, this would be passed on to DI babies. Some of these felt that this created an issue because the resultant children would be more intelligent than their parents:

08 I think maybe we haven't really thought about it because we choose medical students so we just feel that - I don't know if we're right - that we're dealing with over-average intelligence and so it's not a problem. I don't know what we can do about matching (laughing) because you can't obviously guarantee [an] over average couple being accepted but we're frank and we normally tell them "look the donor[s] are mostly medical students" so if they don't wish to have an over-average intelligent [child] they have the right to refuse.

A further respondent argued her belief that intelligence is a result of nurture but then said that, as students are intelligent anyway, the problem of matching does not occur thus indicating her search for reassurance about the quality of sperm she uses. The rest argued that intelligence is at least partly hereditary. The following respondent is one of these and again the underlying anxiety about the quality of sperm as 'good' or 'bad' comes through:

- 03 one of the things that we have to cope with is that our donors are from a very much more mixed group in terms of what jobs they do and what their aspirations are and there is one donor who (hesitantly) I think I would be careful about putting in to a family where the intellectual aspirations were quite high - I feel a bit awful about saying that but I think (pause) I think there is just one that I would feel anxious about that.

Genetic Father

Most respondents alluded to particular elements about donors' personas which might lead them to recruit or reject them. These could be categorised loosely as referring to behavioural characteristics and personality traits and donors' motives to donate. Respondents did not necessarily believe a trait to be genetic to be influenced by it. What was important was the elimination of risk in relation to transmitting undesirable characteristics on to DI children and the choice of 'good' donors. This combination of genetics and socially acceptable traits in men illustrates the juxtaposition of 'genetic' with 'father' and respondents' wish to reproduce perfect DI children whose 'fathers' have given them a 'good' 'social' start in life.

1. Behavioural Characteristics and Personality Traits

In their rejection of men who display criminality, alcoholism and/or greed and selfishness, some respondents spoke of their dislike of irresponsible and undesirable behavioural characteristics:

- 02 If he's of criminal background I would say no.

Prompt: Is that because you think criminality is inherited?

- 02 No I didn't say it's inherited but, it's not suitable - some of the criminal tendencies could be - but we also have to look at other aspects ... It's just there are certain, not physical, not intelligence but certain aspects in the donor which we like to be suitable.

- 20 Yes I think - well I don't know if it's genetic - but we would avoid somebody who is an alcoholic because that's generally not regarded as being - all right some people might regard it as a disease - but it's regarded as not being a very responsible way of conducting your life and besides, severe alcoholism affects your fertility.

Conversely, there were those who answered in terms of dismissing the possibility of their donors displaying any of these tendencies, so demonstrating a preference for men who do not display them. The following said of men who might have alcohol problems:

- 03 Uhm well that would usually mess up the sperm count anyway (pause). I guess I wouldn't be terribly happy about that but I don't think our - again I doubt [in] our group, somebody would present in that situation.

Those who recruit their own donors were asked what criteria they used for so doing. Half included criteria which included donors' motives, background, intelligence, personalities and appearance:

- 09 We obviously like to be sure there's no psychiatric history. You don't want a bent donor or a funny man who might do something very funny like go and deliver a wrong coloured specimen or something, racially. That's happened - not to me. We obviously like to get the impression that they're reasonably intelligent, average intelligence. We like to know their other qualities, if they happen to be artistically talented, scientifically talented. Medical background and of course health at present and their (pause) and they have to have rigid blood screening, regularly.
- 16 I suppose one might say in appearance, what they look like, that's a screen. Their history, their motivation. Then there are various blood tests, for instance we screen them for blood group, we screen them for HIV and hepatitis B. We screen the semen for infection and quality. That's about it I think. Yes.

In answer to the question of whether they were influenced by the sort of father a donor might make a quarter said that they were to some extent. Two

referred to donors' intelligence and the other three to personality and/or good looks. Of those who referred to avoiding donors they did not like the appearance of, males referred to 'pronounced' facial characteristics, and females to the 'way they look':

- 08 you are not just assessing their general health but their fitness, personality, their look and we tend to be a bit diplomatic, you know, the look is very important and we tend to avoid accepting anyone with unusual features.

In answer to the question of whether they are influenced by the sort of children they believed the donors might have, a quarter said that they were in some way and most referred to their attempt to match donors with male partners as the reason for this. In answer to these direct questions then, there is some acknowledgement that, rather than being the dispensers of biological material - sperm - most respondents are engaged in assessing donors as social beings, as potential genetic fathers who will produce particular children. Their references to motive, personality, intelligence and so on are indicative of their subjectively evaluated perception of what sort of men should reproduce through DI and, consequently, what sort of children should be born.

The most essential criterion for potential donors to possess is fertility. Additionally, with the almost universal use of frozen sperm, post-thaw fertility is also very important. Without these the sperm is useless. In giving their criteria for recruiting donors, a quarter did not mention the quality of sperm. I also asked respondents whether they think an ideal donor exists. A minority rejected this idea. Half mentioned socially evaluated behavioural characteristics: intelligence, background, personality, motivation, honesty and physical appearance. In answer to this question under a third included the quality of sperm.

2. Motive

The motivation of men to become donors is perceived as being very important by most respondents. Most references to the preferred motive for

donating emerged in respondents' answers to the question asking what they thought about the ethics of payment for sperm. Again there was variation about the preferred motive. Some respondents felt that the best motive is the financial reward. Keeping the transaction purely financial, they believed, keeps emotions and moral problems at a distance:

- 07 For me the best reason that a donor comes forward, without any problems for me, is he wants the money. That's the best reason. There's no emotional nonsense, he wants to help society or all this nonsense. He just needs the money and then I know it's quite clear cut - when I've paid him I've satisfied him. Sometimes - if I get a donor who's too interested in my results I never use him again. If I get a donor asking me "did I make somebody pregnant?" I never use him again.

Others held the contradictory view that any payment or big payments can induce the 'wrong sort' to come forward:

- 03 Well the first issue is that (pause) donors who are paid are not really donors and we wanted to come more in line with the idea of the blood transfusion service in this country where you are using donors who are not paid. This becomes more of an issue with the worries about AIDS which is a very big worry for donor insemination banks and if in blood transfusion banks [in countries where donors are paid] it's been clearly shown that you run a higher risk of having people who might not be telling you the truth about their circumstances and might be carrying AIDS then that must be even more true for sperm banks.

Another respondent said that a willingness to help people was the first criterion he assessed in potential donors.

Respondents' attitudes towards, and opinions about, genetics are quite varied and, for some, confused. The main criterion for recruitment of donors appears to be two-dimensional about the issue of risk. Simultaneously donors must show no risk of contamination with any undesirable, believed-to-be genetic condition or behavioural trait, and they must have more than a good chance of being high quality both intellectually and behaviourally.

This double-sided criterion seems to be the guiding principle, regardless of the genetic or medical content of the condition being screened.

Decision-making

As the respondents answered the questions about selecting donors, it became apparent that their decision-making depended not so much on their ability to identify genetic conditions but their ability to make a good judgement of character: to assess whether potential donors are responsible and trustworthy enough to be honest for as long as they donate. The recruitment of such men may make the running of a DI clinic easier but making a judge of character is not a uniquely medical skill. Furthermore, the preference for 'nice' men was also connected with the wish to recruit nice genetic fathers - as if in some way this would bode well for resultant babies. Respondents were also asked whether they thought their medical training bore any influence on their decisions to accept men as donors.

1. Judging Character

Most of the information assimilated by respondents in the decision-making process about rejecting or accepting men as donors depends very much on what respondents are told by the men. Most respondents referred to their dependence on the honesty and sense of responsibility of the men. Two respondents listed honesty as a criterion for recruitment with one of these placing it first. Others referred to this somewhat defensively when answering other questions about screening donors:

Prompt: Would you screen out short-sightedness?

02 I don't think it's relevant how many of us wear glasses? People wear contact lenses they can tell me anything.[then quickly adds] The important thing is trust between the donor and the doctor and the trust has to be built. I have to take his word and it's very important.

12 Obviously we don't really want a highly promiscuous chap or we don't want homosexual people. Now I can't tell whether people are homosexual or not but we ask -

it's strange actually most homosexuals are quite responsible people and mostly wouldn't come forward for this sort of thing anyway, but if it did happen then often they wouldn't necessarily need to tell you why but they will in fact not just proceed with it.

Other respondents made the assumption that because they recruited from particular groups of men the information given was 'suitable':

Q.43a: Is it a deliberate policy to recruit from this group?

09 Yes because they've been vetted - vetted's the wrong word (laughs). ... their background checked by the ... Dean of the hospital. So they're not coming out of the blue and secondly they probably know the rule book ... or you like to think they do. And thirdly they can take an interest in it and if they've been a naughty boy they probably have enough sense to say "look I'm off your books for a bit" and you can finger them to find out where they've come from if one of them (pause) drops something awful (laughs) you can haul him up!

Some respondents who recruit mainly from student populations inferred suitability by referring to their attempts to advertise publicly for donors:

21 The vast majority are from students either in the university or the polytechnic. ... Deliberately yes.

Prompt: Why?

21 Because whenever we've had any publicity in the newspapers we've had such a load of cranks writing in and phoning in offering their semen, and I really do mean cranks, that I felt that at least in a student population I'm reasonably certain of the intelligence of the person concerned and I know perhaps a little more about their background than I would just picking a person out of the blue.

These respondents assume that male students will offer more reliable information, have more desirable motives and make better genetic fathers than the "cranks" who have answered publicity about the DI clinics. One of these had seen thirty men as a result of an advertisement for donors and

rejected all of them. On the other hand some respondents recruit men who have already 'fathered' children. One of these referred to the sort of men they were recruiting and again inferred the types of personalities she thinks make 'good' genetic fathers:

- 03 we land up with a group of people who are very caring and who very much enjoy children and so from that side of their nature I think it's coming across really nicely.

Subjectively evaluated behavioural traits are very important in the recruitment of donors. A combination of their motives, looks, personalities and sense of responsibility was mentioned more in responses to questions asked about recruitment and ideal donors than was the quality of sperm. This subjective evaluation of donors also applied to the genetic screening of physical conditions. That the decision rests on a *belief* that something is genetic is evidence enough of this, but the actual decision-making also depends on the ability of respondents to ask the right questions and the donors to give the right answers. Honesty, motivation and responsibility also therefore emerge as important qualities in donors²².

2. Medical Training

The responses to this question ranged from those who said it was a medical assessment to those who said that it was not at all medical, but influenced by their experience of life, other people's families and common sense:

- 07 Oh nothing to do with medical training! That was over thirty-five years ago. What's that got to do with it?
- Q51a: Are there any other influences?
- 07 Common sense!

²² Screening for genetic conditions also depends on the donor's knowledge of his own history and that of his extended family.

Some of those who lay between the two extremes said that their training was partially influential and partially based on an evaluation of the donors as likeable and/or trustworthy:

- 19 (long pause) Part of it is obviously because I'm looking at medical conditions and I examine them. (pause) Sometimes it's whether I like them or not I suppose (pause) but it is the fertility more importantly. It's the seminologists who really make the decisions. Before I see them.

Others said that their medical training had equipped them to observe and make judgements about potential donors. No mention here about medical or genetic assessments. The following respondent describes how her ability to 'just know' derives from her medical training:

- 16 Oh I think it is because you are trained to observe and there are things that you observe in the person's demeanour and so on that you would find difficult to say "that's it!" but you just know and - all right it's not infallible, I mean nobody's infallible. But I think you're trained to do it and you can just do the best you can. And as I say if you suspect things are not quite right (pause). You can but try.

The recruitment of donors then apparently depends on the ability of respondents to assess subjectively the personhood and potential fatherhood of potential donors. Their attempts to eliminate any hereditary risk to resulting children depends on their knowledge of what they think is inherited, how they think it is transmitted, and on their ability to glean reliable information from the men. Potential donors must also be reliable, honest, responsible, intelligent and have particular personality related qualities regardless of the heritability of these, but in the implied belief that they may be somehow passed on to the resultant children. Respondents attempt to identify the 'good' sperm of 'good' men. That seminologists actually carry out the crucial tests of semen quality was acknowledged by one respondent. Sperm is not just biological matter, but is capable of being either a contaminator or carrier of socially desirable, genetically healthy children.

Sperm

Respondents were asked whether they agreed that DI is a simple procedure and whether they thought its use should stay under medical supervision. As was shown in chapter three, all respondents agreed that DI is a simple procedure, although some had reservations, especially when their routine use of intracervical insemination led them to assume that women might attempt this method themselves. Nearly half of respondents conceded that nurses are able to and do perform inseminations but still these respondents argued for overall medical supervision. Over half of them argued that DI is a medical procedure.

However, the most remarks made in response to questions about medical supervision and self-insemination were about either control of sperm or the role of responsible person - which respondents assumed they played.²³ The issue of controlling sperm was couched in terms of preventing transmission of disease either through HIV or genetic inheritance. The most used expression in relation to the notion of self-insemination was 'where do they get the sperm from?'. The overall impression *received* was that unless it is controlled and its application supervised by responsible people - DI practitioners - sperm can be a contaminator.

- 13 Well before the days of AIDS that might have been acceptable in some ways but you really are now talking about - and it's a question of where do they get the samples from? ... The trouble with the sort of self-help approach is that scientific rigorousness is not always there and there's a bit more emotion sometimes and ... many people will be sorry later when things have gone badly wrong.

Respondents must realise that women and men have heterosexual intercourse either in order to conceive, or knowing the risk of pregnancy, all the time. Heterosexual partners take risks or not, according to their knowledge of their partner's genetic inheritance or STD status. Furthermore, in response to questions asking respondents their reasons for

²³ Four respondents had never heard of self-inseminating and could not answer the question.

refusing DI to lesbians and single heterosexual women, several respondents said that these women could sleep with men in order to have children without putting them, the doctor, in the position of refusing access. For these, heterosexual intercourse with perhaps an unknown and/or an unwanted sexual partner is preferable to using DI.

An explanation for this is that sperm becomes a potentially dangerous commodity when it is found outside its traditional social and biological context - heterosexual men engaged in heterosexual intercourse - and must therefore be medically supervised. Nearly half of the respondents referred to the responsibility involved in the proper application of DI: its appropriate use and provision of suitable screening mechanisms. By retaining a supervisory role, respondents can replicate normative family contexts by responsible use of DI:

- 20 I think you've got to decide who's going to take professional responsibility, as the medical profession have responsibility for other forms of infertility it seems to make [sense] I think that's important because - it must reflect the views of society at large and I think if you're going to have something that's going to be eventually accepted and this is in the interests of the children and the infertile couples particularly. All right there are other needs in terms of single, lesbian couples and so on but particularly in the context of infertile couples who are much more numerous, I think you have to have something that is seen to be accepted by the various sectors of society or else you take two steps forward, one step back.

Conclusion

In their attempts to reproduce perfect children - as they evaluate this - respondents attempt to screen out any trait which they believe could be genetic or which might in any way influence the DI child. Making decisions to screen out traits believed to be genetic which occur in potential donors' families also takes place regardless of their heritability, the type of genetic condition or the impact on the resulting babies' lives. The aim appears to be

the reproduction of genetically healthy, able-bodied children who also have desirable personalities and behavioural qualities and who are intelligent.

In attempting to recruit men who have such 'good' sperm, I have argued that respondents perceive potential donors as potential 'genetic fathers'. This means that, whilst they are anxious to screen out any condition or trait which they believe to be genetic and undesirable, they are also anxious to screen in desirable ones which, though they might not believe them to be genetic, they believe will bode well for the baby. The goal of utilising 'good' sperm has its antithesis in respondents' anxiety about uncontrolled 'bad' sperm. Unless sperm which is outside its ordinary social and biological context is controlled and supervised by the medical profession, sperm can become a potential contaminator of people.

Two reasons are given by respondents for medical control of DI. First, they can be 'responsible' for the proper handling of DI and secondly, they believe they offer the best means by which sperm can be controlled and supervised. The resultant image that emerges is that of sperm being a potential contaminator if uncontrolled - by DI practitioners - once it is separated from the traditional context of a heterosexual man engaged in heterosexual intercourse.

Although the application of DI has been medicalised and therefore becomes the preserve of DI practitioners, their actual role has not been clear. DI *is* a simple procedure which *is* performed by recipients' male partners, nurses or themselves. Although respondents protest at the intervention in the DI process of other non-medical professionals, especially at the stage of selecting recipients because, they say, potential recipients should not be assessed, they do in fact carry out quite extensive screening procedures of them and many respondents say that they also counsel potential respondents.

The result of this screening is the replication of a particular family type. Respondents believe that there is not an ideal family type, yet they know very clearly who they do not want to give access to. Their rationale for their

scrutiny and control of sperm offers an explanation for this. In order to satisfy their personal convictions or demonstrate their ability to be responsible in applying DI, particular family types are chosen. In the main, these family types replicate the traditional context in which sperm is used in heterosexual intercourse. They can therefore safely deliver the screened and purified sperm to safe family types, types that they know. Respondents become the arbiter of unknown men's sperm. In selecting donors, respondents seek men they like, 'good' men who will make 'good' genetic fathers. They attempt to make the semen as pure and safe as possible to be able to give assurances of their responsible attitude towards, and handling of, other men's life-giving sperm.

CONCLUSION

There are four sections to this chapter. In the first, I will discuss the methodology of the study in terms of its strengths and limitations and in relation to areas that emerged for further study. Second, I will discuss the results of the study in relation to the hypothesis and supplementary questions. There will then be an examination of the results in the light of the Human Fertilisation and Embryology Act (hereafter the Act, 1990) which passed through the Houses of Parliament during the time I conducted the fieldwork. This will include some discussion of how a study such as this can contribute to the study of social policy. In the fourth section the broader context in which DI practitioners provide DI is enlarged on and the decisions they make about access are placed within that context.

The Methodology

Strengths

This is the first study to be conducted in Britain that seeks to understand why DI practitioners provide the DI service they do and make the decisions they do about access of potential recipients and men as donors. The response rate of 67.7% was high and is perhaps explained by the fact that this was the first time the respondents had been asked to take part in a study of this sort.

In order to test the hypothesis and understand to some extent why DI doctors are in a position to make such non-medical decisions, a qualitative approach to data gathering was decided upon. This approach allowed me to ask respondents about their ideas and motives in a flexible and open-ended way whilst staying within the overall structure of the interview schedule. In general the interview was successful. It was perhaps too long for some respondents but most appeared happy to give full and comprehensive answers to most questions. In the absence of any qualitative data on the way DI is provided, the schedule allowed a lot of

meaningful and useful data to be collected about most aspects of the DI services offered by the sample.

Although the sample was not randomly selected, the great strength of the study is that the sampling framework was over half of the sampling universe. Given this, there is a case for arguing that the results of the study are relevant for understanding the way in which DI was provided in Britain between 1989 and 1990 and the way DI doctors make decisions about access to its use.

Limitations

In retrospect a number of weaknesses can be identified:

1. Respondents were not asked directly about their ideas about what families are. Indirect questions were used in an attempt to ascertain what sort of social criteria were applied by them and why, and respondents were asked whether they thought there was an 'ideal' family who would benefit from using DI. In the main, respondents reacted defensively to the latter question and, it could be argued, they did so in reaction to the assumed charge of creating a 'brave new world' nightmare scenario rather than to the actual purpose of the question. This was to attempt to reveal a particular type of family as ideal, that is, it was believed that they would discuss the traditional nuclear family. That respondents did not associate a traditional nuclear family with an ideal family is not surprising in light of the emphasis most of them placed on the 'normality' of those who actually use DI. It might therefore have been more fruitful to ask about their definitions or ideas about what, for them, constitutes a 'normal' family.

2. There is evidence in the data to suggest that, using my indicators of social class, there is some tendency to prefer potential recipients from middle and higher social classes. These indicators were those relating to financial resources. There were other attributes for which many respondents showed a preference which could be argued to be associated with the values and lifestyle of middle class people such as the respondents. However any attempt to make such an extrapolation has to be

extremely limited as these attributes were not included in a definition of social class. The interview schedule could have included questions asking respondents about their own definitions of class and, more importantly, whether they are influenced by their own value system in making assessments of people's suitability. They could also have been asked whether they felt that more middle class than working class people use DI and, if so, why they thought that was the case.

With both the above points the methodological issue lies in being too cautious and addressing issues in an indirect rather than a direct way.

3. In asking respondents about their role as final arbiter it was not expected that so many would be so resistant to the suggestion that they play this role and so insistent that potential recipients make the final decision. Because the medical literature is, in the main, quite categorical about DI doctors making assessments and selections about suitability, it was assumed that respondents would be in the same position. In actuality many would only admit to having any final responsibility in a theoretical sense as part of their professional discipline. What resulted was that a distinction emerged between the sorts of social criteria which might cause concern to respondents and the decision-making process which they resisted being a part of.

In analysing the data it became clear that most respondents adopt strategies to 'help' potential recipients make decisions which concur with their (the respondents') own, but the interview schedule did not include questions which asked specifically about this. Therefore the evidence of these strategies did not emerge in any consistent way, but was identified in an analysis of the data as a way of explaining the contradiction inherent in the respondents' stated position.

4. The explanation of how doctors have become sole arbiters of DI did not evolve fully into an analysis of the medicalisation process until halfway through the fieldwork. Questions were included about numbers and timing of inseminations and cycles and the use of medical referral systems and

success rates because of some recognition of the medical model which emphasises problematising individuals and their 'treatment'. However the argument that there are particular factors which exist in the medicalisation process which could be identified in the medical provision of DI did not come to fruition until the fieldwork was already begun and the data and literature being examined. As a result the interview schedule did not include questions about all the factors which were identified as being part of the medicalisation process, especially questions about how women's fertility status is established and whether this is necessary.

5. In retrospect it might have been useful to ask respondents why they would agree that the recruitment of donors could be standardised across clinics but disagree that assessment of potential recipients could be similarly organised. Most respondents argued that in their consultations with potential recipients they should be given the flexibility to respond to them individually. It could be that they saw standardised assessment procedures as a threat to their professional autonomy. However it may also have been that their view of donors and their sperm would have been clarified to some extent by a question asking why standardised screening in this situation could be permissible.

Emergent Issues for Further Consideration

1. The question of how DI doctors perceive sperm was not a focus for this study. The fact that their perceptions of sperm in terms of purity, danger and pollution emerged as an important factor in their rationale for the medical supervision of DI and their role as sperm screeners was unexpected. I was drawn to social anthropology in an attempt to disentangle this but a wide exploration of this issue was outwith the scope of the study. What emerged as a fascinating aspect of this study was both that sperm was perceived as a potential contaminator or purifier and that it would seem that sperm has not been a subject of study in the same way as, for example, menstruation has been.

2. There was also some indication that what or who constitutes as white is not a given. Some of the remarks made about matching donors and recipients with regard to ethnicity suggested that there is a category of British white which some respondents see as distinctive from any other nominally white country. Although there is little other data on this issue there was enough to suggest that there is a notion of Britishness that is not only constituted by skin colour but also culture and tradition which is believed to be inherited.

3. With regard to the decision-making process a future study might explore this aspect of the DI process with a view to enabling potential recipients to be more active in their decision-making.

The Results of the Study.

This study set out to test a hypothesis that DI practitioners make non-medical decisions about who should have access to DI and who should donate sperm, and that these decisions are based on an allegiance to an ideal family model. In order to test this, a supplementary question was also posed. How have doctors managed to establish that DI is primarily a medical technique and that, consequently, they should have professional authority and control over its use.

The majority of respondents perceived DI primarily as a medical procedure requiring medical supervision and control. The way in which the provision of DI has been medicalised was discussed and the combination of factors which result in medicalisation was delineated. During this medicalisation process women are pathologised and their fertility problematised so that, rather than being assumed to be fertile in the absence of any history to suggest otherwise, women are assumed to have problems which must be tested and screened for before they are deemed fertile. This means that the initial stages which precede the actual use of DI are heavily medicalised, with women undergoing fertility investigations and in some cases quite invasive exploratory procedures before being judged fit to use DI.

These medical interventions help to transform women from active and fertile actors seeking children into passive patients receiving DI 'treatment'. This asserts the medical authority of DI doctors who are required to declare women medically fertile. Thus diagnostic authority is assured. The application of DI itself has also been heavily medicalised and mystified in so far as both the literature and the respondents are concerned. The existence of quite different and contradictory protocols across the clinics in this study for the application of DI indicates the extent to which DI has been shrouded by ritual. Each individual DI practitioner has the opportunity to create their own ritual and this is reflected in the differences alluded to in chapter three. The fact that the differences sometimes amount to quite contradictory protocols being operated indicates to some extent the power of professional autonomy. DI doctors can quite legitimately offer a DI service the protocol of which other DI doctors might argue will produce the worst results. Any results of evaluative work that has been done are confined to the clinic where the work was undertaken. There is no obligation for others to take heed of the results and alter their provision.

The successful medicalisation process has had two major effects. The first is that the process by which women might choose donor insemination as a way of becoming parents has become defined by the technique - the insemination and use of strangers' sperm. Thus the assumed technical aspect of DI has been emphasised in its naming and reinforced by its ritualisation, for example, the number of inseminations, the fertility investigations that precede DI and so on. These aspects have been successfully subsumed into the medical sphere and the primarily medical definition accepted by other professions. The second effect follows on from this in that because it is the technical part of DI that defines it, and this has been accepted by non-medical professionals, the latter have been successfully excluded from any systematic input in the DI process. Their argument was rejected by the respondents that the social aspect of DI - the fact the women use it to achieve parenthood - demand their professional expertise in the areas of families, parenting, relationships and counselling. Most respondents rejected blanket referral and only a minority refer on an occasional basis for specific reasons as defined by themselves.

In arguing that there is no need for non-medical professionals to be included in any systematic way in the DI process most respondents affirm, on the one hand, the medical nature of DI and, on the other, the 'ordinariness' or 'normality' of those seeking access to DI. Most respondents undermine the social aspects of DI as a method of choosing parenthood to the extent that they do not systematically problematise the social circumstances of potential recipients. In contradistinction to the way in which women's fertility is problematised, respondents, as one succinctly put it, treat potential recipients as innocent until proven guilty: that is, they are assumed to be 'normal' or 'ordinary' people seeking children to complete their families, until respondents identify factors that would lead them to believe otherwise.

In this way respondents play down the need for a social and/or psychiatric/psychological screening of potential recipients. Yet in their responses about who they give access to and why it is obvious that they *are* engaged in socially screening potential recipients. It is in the idea of 'ordinariness' that an explanation for this lies. As a result of asking direct questions about specific groups of women as potential recipients and indirect questions about whom they would both be happy and unhappy about offering DI to, it became clear that the notion of ordinariness or normality is commensurate with a particular family model. Within the context of their agenda for happy family life respondents actually sought extraordinary people and to this extent they showed an allegiance to an ideal family model, which is the traditional heterosexual (preferably married) nuclear family model who are have neither genetic conditions nor disabilities which could be either transmitted to children or interfere with a lifetime of parenting; who are, in the main, white and imbued with attributes and resources that I have argued are associated with a middle class lifestyle and value system.

Relying on the medical referral system to refer appropriate potential recipients, most respondents expect to consult with these 'normal' people and it is this model with which they compare potential recipients, similarly to the way in which Porter (1990) argues that doctors relied on ideal types of

women against which they measured the actual women who consulted them. In chapter five, however, I argue that this comparison is part of a reactive decision-making process. I identify three sets of non-medical criteria, all ideological in nature, which respondents apply to potential recipients (every respondent applied criteria from at least one set): structural, environmental and eugenic. The first set is proactively applied, that is, respondents actively seek to include potential recipients who belong to the ideal family structure - heterosexual, preferably married couples - and exclude those who do not conform - lesbians, and single heterosexual women. After the structural criteria have been applied, reactive decision-making takes place. This means that, in the main, potential recipients are assumed to be 'normal' or 'ordinary', that is, ideal unless they indicate that they are not.

Eugenic and environmental criteria are applied in this way, with respondents reacting to cues they pick up in conversation and non verbally with potential recipients. As potential recipients reveal clues or signs which respondents see and/or hear and translate into pathology, so they exercise their power either to encourage potential recipients to go on and use DI or discourage them through use of the many devices described in chapter five. Some of these devices rely on potential recipients 'deciding' that DI is not for them. For example, respondents often argued that they might highlight problems they foresaw, either in general with regard to the use of DI, or specifically with regard to the potential recipients before them. They then might put people on waiting lists or 'counsel' them until they (the potential recipients) realise that they do not want to use DI.

The vast majority of DI practitioners were loathe to admit any non-medical professionals into the DI process to elicit signs and/or symptoms of potential recipients' status as suitable parents. Some conceded that nurses or independent counsellors could be useful for potential recipients in helping them make a decision about whether or not to use DI. Potential recipients' decisions not to choose DI - negative decision-making - is not a threat to the professional authority of respondents. The latter's power allows them not to

coerce people into doing what they do not want to do but to prevent them from doing what they might otherwise have done.

The result of applying these non-medical criteria is that respondents ensure that babies they feel responsible for are provided with ideal families in which to be brought up. Simultaneously however they also feel responsible to recipients of DI in that they feel obliged to ensure the birth of perfect babies. In order to do this they screen men who offer to donate - or, more accurately, sell their sperm (only two clinics gave no money to donors) - and to a lesser extent they are vigilant of women's genetic status. With women, most respondents only react to obvious genetic conditions brought to their attention. With men, the motivating principle is the elimination of any risk that anything undesirable - regardless of its status either as a genetic condition or its heritability - could be passed on, including STDs. Considering the importance attached to the recruitment of genetically desirable donors it is perhaps surprising that over a quarter are not personally involved in the recruitment and screening process.

The notion of 'genetic father' was used as a way of describing the way in which those who do recruit, screen for a combination of factors - genetic, behavioural, attitudinal, social, and personality-related. There is a sense in which, although respondents do not believe some traits to be actually genetic, they still exclude them and include others more socially desirable to them in the belief that this will benefit the child in some way. For a significant minority the inclusion of 'good' characteristics was prioritised over the fertility of men's sperm.

Both the literature and respondents revealed an enormous amount of variation in and rationales for particular screening protocols. There is no agreement about which method of screening is the most effective and all the evidence both about evaluation of methods and the nature of genetics suggests that genetic screening actually has little to offer in the form of guarantees about the quality of the resulting offspring. Most of the respondents made decisions based on judgements about whether donors were desirable or undesirable as genetic fathers and believed they could

manipulate the quality and characteristics of DI children as a result. To this extent, respondents are involved both in positive and negative eugenics at least in intent.

In constructing the sample some variables were identified that were felt could have some bearing on the provision of DI: the health sector context in which DI is offered; the sex of respondents; and the locale of the DI service. In general, the sex of respondents made no appreciable difference to the type of provision. However, of those who provide DI on the basis of a woman's right to choose, most were women. The medical model of DI provision was similar in both the NHS and private sector (excluding the non-profit-making, charitable sector). Variations occurred in the detail of the ritualisation surrounding the application of DI and some of the variations were contradictory in different clinics. All had their own ritualisation which undercut the medicalisation of DI and pathologisation of women's fertility. Only one respondent in the NHS provided DI on the basis that women should be able to decide whether or not they have children. DI was provided in the same way in both of the non-profit-making charitable clinics as a matter of policy.²⁴ The emphasis in these clinics was on the social aspect of DI, that is, fertile women seeking to use it are choosing to become mothers rather than patients seeking treatment.

Access to DI was influenced by the context in which it is provided in two ways. The value of waiting lists in precipitating self selection was identified by most respondents working in the public sector. Potential recipients who survived the waiting lists were identified as resilient in their resolve and well motivated to parent. Those who left the waiting list, regardless of their reason, were felt to have been wavering in resolve, not really motivated and therefore probably unsuited to DI. However, this valuable part of the DI process was not 'available' in the private or non-profit-making charitable sectors where there are no waiting lists and potential recipients may be

²⁴ The two clinics from the non-profit-making charitable sector are no longer in a position to offer DI on this basis because the service was withdrawn in June 1991 (The Observer, 9th June, 1991:2; The Guardian, 10th June, 1991:2)

offered DI at the end of one consultation and begin inseminating when the women next ovulate.

In both the private and non-profit-making sectors there was a heightened awareness of the social class of potential recipients and the latter are assessed on their financial, living and material resources by all respondents in these sectors. This will be discussed later, but it is an important difference that NHS DI practitioners were far less concerned with the financial resources of potential recipients and most were adamant that they would not ask about the availability of financial, living and material resources. This difference was sharply illustrated by those in the NHS who charged or asked for donations towards the cost of DI who said that if potential recipients could not take up DI because of the charge or donation this would be waived. Many respondents in the private sectors said that inability to pay indicated unsuitability to parent. Most clinics, regardless of health sector, charged or asked for donations towards the cost of DI, although the more expensive prices were found in the private sector.

The geographical locale of the DI service in general had no bearing on the provision of DI. However, those located in London were more in touch with the networks available for acquiring appropriate sperm and were less likely to say they had had to postpone inseminations due to lack of appropriate sperm.

DI practitioners, as represented by the respondents in this study, have successfully medicalised and mystified the application of DI and problematised women's fertility. In doing so they have also successfully fought off a challenge for authority in the DI domain by non-medical professionals. As a result they have acquired professional autonomy in the provision of DI. The hypothesis has been tested and shown to have validity in that, in having established that DI is a medical treatment requiring medical control, they make decisions about who should use DI and who should provide sperm by applying non-medical criteria which show an allegiance to an ideal family model.

The Study and the Human Fertilisation and Embryology Act 1990

This study and the interview schedule were informed by Government reports and legislative documents relating to Human Fertilisation and Embryology. During the latter part of my fieldwork the Bill of the same name was presented to the Houses of Parliament. It seems appropriate then, to make connections between the results of this study and the parliamentary and public debates which led to the Act (1990) because it defines policy in relation to the provision of DI; and because the issues which emerged during the passing of the Act reverberate with those which arose during the interview with respondents, especially in relation to access to DI.

The most important result of the passing of the Act (1990) was that it legitimated the medical definition of DI as primarily a medical treatment of infertility. Designating DI as an authentic treatment service, the Act (1990) ruled that its provision should be regulated by licences granted by the Human Fertilisation and Embryology Authority (HFEA) which was set up by the Act (1990) and which took the place of the Interim Licencing Authority, a voluntary, self-regulating organisation. The HFEA was instructed to establish a Code of Practice (hereafter, the Code, 1991) which would provide regulations governing the way in which licenced treatment services are to be provided.

The debates surrounding access to DI particularly had affect on the wording of the Act (1990) and this will be discussed below. The Act (1990) also made provision for the recruitment of donors and counselling for potential recipients of fertility services. These issues, together with the regulation regarding them published by the HFEA in the Code (1991), are also discussed.

Access of Potential Recipients to DI

The Human Fertilisation and Embryology Bill (the Bill, 1989) was published in November 1989 and began its parliamentary hearings in the House of

Lords. In October that year an Early Day Motion (EDM) was submitted to the House of Commons by Anne Winterton, Member of Parliament (MP) and supported by twenty other signatories, which expressed concern that fifty-five lesbian couples, three single lesbians and “2000 other unmarried women who are not infertile” (Winterton, 1989:1324) had been able to gain access to DI at the British Pregnancy Advisory Service (BPAS). Winterton’s use of the term “infertile” is interesting here. She could have been unaware of the nature of DI and the necessity that women using it must be fertile, but this seems improbable. What seems more likely is that Winterton understood exactly the nature of DI and wished to establish that “infertility” relates not to an individual’s reproductive incapacity but relates to a particular social relationship. She wishes to establish that the women she refers to were not infertile because they were not married to men with fertility problems. DI was not treating “infertility” but the women’s desire for a child. For Winterton and her supporters the dangers are all too obvious. They believed:

that such practices undermine the status of marriage, corrupt the family unit, and leave the ensuing children at grave risk of subsequent emotional harm:
(Winterton, 1989:1324)

During the Bill’s hearing many attempts were made to pass amendments which would restrict access to DI to married heterosexual couples. One such amendment which came very close to succeeding was proposed by Lady Soltoun of Abernathy and sought to prevent providers of licenced treatment services from placing an embryo in an unmarried woman (Soltoun, 1990:787). Although this actually would not have affected the provision of DI because no embryos are involved in the procedure²⁵, in her opening remarks Lady Soltoun stated:

²⁵ I wrote to ask her what she had hoped to achieve by this amendment but did not get a reply.

The object of the amendment is to prohibit the provision of AID to unmarried women, lesbian couples or unmarried couples
(ibid)

The amendment lost by one vote.

In response to the outcry by those worried by the threat to the family, the Government introduced a clause that directed that the welfare of the child should be taken into consideration before services were provided. David Wiltshire MP then succeeded in securing a further amendment to this welfare clause (Radford, 1991) which stated that account was to be taken

of the welfare of children who may be born as a result of treatment services (*including a child's need for a father*), and of other children who may be affected by such births.

(The Act, 1990: para 2 clause 5:14, my emphasis indicating Wiltshire's amendment)

The introduction of this clause places a legal requirement on doctors who offer any licenced fertility service, that is, DI practitioners, to make non-medical decisions about the suitability of potential recipients.

The application of social criteria which respondents in this study described have been legitimated in The Act. In the parliamentary debates there was a significant absence of any recognition about what the implications are of having policies governing access to fertility services, or of leaving doctors with diagnostic authority, that is, that doctors are being asked to decide who should have children. In accepting the definition of DI as a medical procedure requiring medical supervision Parliament effectively ducked these issues and left guidance of DI practitioners to the HFEA. The tenor of the debates which brought about Wiltshire's amendment and which is indicated by Winterton's EDM and Soltoun's amendment, reflects the concerns of respondents in this study, that is, that not just anybody should have children and that ideally children should have two parents, a mother and a father. There is no recognition that the screening of potential

recipients or donors will depend on the subjective assessments by DI practitioners.

Recruitment of Donors

The Act (1990) does not specifically mention how donors should be screened but the Code sets out guidelines for donor recruitment. These assume that the majority of criteria applied to potential donors will be medical and therefore objective and 'measurable'. There is a group of guidelines which fall under the heading "Scientific Tests". In a previous and more general list of criteria which are directed to be applied, the fertility of potential donors is given third place after their genetic background and, sequentially, risk of transmitting infection. Yet this study suggests that donor recruitment will involve subjective judgements being made about donors' genetic and personal health background based on what DI practitioners believe to be heritable and furthermore that recruiters are influenced by the sort of genetic father potential donors might make. The only overtly subjectively assessed criterion recommended to be applied to donors in the Code (1991) is their attitude to donating. There is no guidance on what is an acceptable or unacceptable attitude - just that this should be taken into account.

The Act (1990) in effect legislates in favour of the perspective of DI practitioners in relation to the provision of DI: DI is reinforced as primarily a medical technique requiring medical diagnostic authority and this, in relation to potential recipients, is to include a legal requirement to apply non-medical criteria which favour an ideal family structure²⁶, that is, the

²⁶ In their struggle to make sense of the statute and provide guidelines for clinics based on their interpretation of the law the SLA have created an hierarchy of concern about the welfare of the child which depends on where and what fertility services are undertaken. Those clinics offering fertility services which do not require a licence are not legally required to consider the welfare of the child. However, clinics offering fertility services which do necessitate a licence must also consider the welfare of the child when providing non-licenced services. In explanation the Code says;

However, the degree of consideration necessary will be greater if the treatment is required to be licenced under the Act and particularly if it involves the use of donated gametes.
(HFEA, 1991, para 3.11:iii)

heterosexual nuclear one. Similarly, in relation to donors, the Act (1990) legitimates the approach of respondents in applying whatever criteria they think best in order to eliminate any risk of producing less than perfect babies. The acceptance in legislation of the medical definition of DI serves also to underscore DI practitioners' victory in their professional territorial dispute over DI with other non-medical professionals.

Counselling

The only route by which non-medical professionals might gain access to the DI process is as providers of counselling for potential recipients. The question of what counselling will constitute was the subject of a separate Report commissioned by the HFEA (King's Fund Centre, 1991). In this there is some ambiguity about whether counselling is non-judgemental and non-directive or whether it will also involve an element of assessment of potential recipients. The Code (1991) does not completely resolve this ambiguity. In Part 6 of the Code, which refers specifically to counselling, paragraph 6.2c says that counselling should be distinguished from the process of assessment used to decide whether recipients will be accepted or not. However, paragraph 3.23, under the heading Multidisciplinary Assessment says that the views of all those at the centre who have had any contact with potential recipients should be taken into account in the decision about access. This will not affect counsellors who are independent of the clinic, but paragraph 1.10 under the heading Counselling Staff offers three options for licenced clinics to fulfil the counselling requirement:

- a. That one of the staff should first either have a social work or equivalent qualification
- b. That a member of staff be accredited by the British Association of Counsellors or be a chartered psychologist

It seems then that the welfare of children born using fertility services calls for differential assessments depending on what fertility services are utilised and where they are located.

c. That someone with either of the latter qualifications be on hand to provide advice for counselling staff or counselling for potential recipients as required.

This means that there is plenty of scope for counselling staff to be part of the multidisciplinary team asked to make a team decision about access, which allows for confusion about counselling and decision-making roles. Alternatively, if it is felt that doctors or nurses provide adequate counselling and they fulfil the recommendations of the Code then, in theory, assessment and counselling will be carried out by the same people. Of course in the clinics where independent counsellors are employed, that is, counsellors who are not employed as part of the fertility team, the assessment will be left entirely to the medical and nursing professionals involved.

DI Children's Right to Know

A further indication of the extent to which DI practitioners' position was consolidated with regard to their professional monopoly of DI is evidenced by the legislation giving DI children the right to know the way they were conceived and the identity of their genetic father. Parliament accepted the view that children have the right to know how they were born. This view was strongly argued for by adoption professionals and, in this study, was strongly rejected by respondents. However, the legislation falls short of identifying the donors. Furthermore, although clinics are instructed to discuss with recipients the importance of telling their children about their origins (the Code, 1991:3iv) there is no reference to the experience of adoption professionals which might be useful here. It is felt that the clinic which may or may not have non-medical professionals involved in the team will be sufficient to accommodate needs arising from these issues.

Social Policy Implications

With any piece of social policy there are gainers and losers. In the provision of DI the gainers are clearly DI practitioners and the profession of medicine. The former have had their role as arbiters of people's suitability to parent

not only affirmed but legally augmented. For the latter, the encroachment of medicine and medical control even further back in reproduction to the achievement of conception is an incident of successful medicalisation which, together with the successful seeing off of non-medical professionals, ensures a medical monopoly over DI provision.

Conversely, non-medical professionals are losers. Their arguments, which did not actually threaten the medical definition of DI but only identified the social aspects of DI as at least as important as the medical aspects and deserving of appropriate professional expertise, were lost. They may find a route into the DI process as counsellors but counselling as a quite separate profession with specialisms - for example fertility counselling - is emerging as the favoured group.

The other and perhaps more important losers as a result of this piece of social policy are fertile women who wish, for what ever reason, to become parents through the use of DI. All of them, with or without male partners, will be under scrutiny and encouraged to take counselling about their desire to become pregnant by using DI. Their fertility and their wish to become parents have been problematised, even pathologised, and all must 'prove' themselves worthy of children before they can use DI. A further sub-group of these women contains those who do not conform to the structural criteria applied by DI practitioners and required to be considered by the Act. For lesbians and single heterosexual women, what was difficult before the Act (1990), as evidenced in this study, can only become worse. The Act (1990) does not challenge DI practitioners' essential diagnostic authority or impose the nuclear family model as the only criterion for participation in DI. However, the ideological statement is clear, that one family model is preferred over any other and any DI practitioner who does not want to risk making a decision which they believe will jeopardise the fertility services as a whole, can rely on the Act (1990) to explain their decision.

It is in revealing the ideological motivations underlying the decision-making of DI practitioners that this sociological study can contribute to the social policy discipline. In analysing the ideas which influence DI practitioners

about both preferred and undesirable family models in relation to recipients of DI and donors of sperm, a clearer understanding can be gained about the contexts in which such decision-makers operate. DI practitioners are assumed to make decisions about 'treatment' which are objective to the extent that they rely on measurable or quantifiable observations about the physiology and anatomy of their 'patients'. There is much evidence that doctors do not rely on these observations alone in other areas of medicine which relate to women's reproductive capacity and this has been discussed in chapter three. However, DI is a unique technique. It involves the separation of heterosexual intercourse from procreation and affords women the chance to choose (sometimes autonomous) parenthood. The potential in DI to undermine the traditional heterosexual nuclear family has been recognised. For example, Snowden et al. (1983), in arguing that single women and lesbians were problematic recipients of DI, said there was:

the need for rules within which the service (of DI) is to be provided if the practice is not to change what many see as the basis of our social organisation, the family.

(Ibid: 14)

The furore that was evoked by the news that single women, lesbians and unmarried heterosexual couples not only could receive, but were receiving, access to DI²⁷ and further, to the news that women who were "virgins"²⁸ (e.g. The Guardian, 1991:1-2) were also receiving DI, gave legitimacy to the sorts of social criteria doctors in this study have been applying to potential recipients of DI long before such furores broke. In making some sense of the apparent resistance to the idea that just anyone should have access to DI - and therefore parenthood - it makes sense to think of the debate not in terms of access to DI, but access to a stranger's sperm. DI practitioners are acting not as gatekeepers to a medical treatment but to the potential to

²⁷ The Sunday Express from October 15th, 1989 and for three consecutive Sundays ran front page and inside stories about this issue; The Pink, November 4th, 1989.

²⁸ It was never clear what was meant by the term "virgin": whether it was women who had never had any sex at all; women who had never had any sex with men; or women who had never had any penetrative sex with men. However The Guardian, for example, devoted some of page one and most of page two to this issue (March 12th, 1991)

achieve parenthood without recourse to the traditional social-sexual relationship and, as such, act as protectors of the heterosexual traditional/ideal nuclear family. Their protection extends to the DI children who they believe should be born into ideal families; to recipients of DI who they believe should be provided with perfect babies; and society who they believe they should protect from the undermining influence of families who do not conform to the ideal.

The sociological nature of this study has allowed an exploration of the influence of the ideology of the family, which includes eugenicist ideas about who should be born and who should be encouraged or discouraged to reproduce, in an area of social policy hitherto unexamined in such a way. Of course DI practitioners are not only a product of their own upbringing, families, social circles and professional circles, but society itself. A brief discussion about the context of the broader society in which the Bill and the Act were debated and passed through Parliament, and in relation to the legal and medical control of DI, is also necessary to an understanding of how the particular perspective of DI practitioners on the provision of DI has been so resoundingly legitimated.

DI in the Broader Context of Society

During the 1980s and early 1990s the ideology of 'the family' has been a Party Political issue. One of the first big indications that the family was high on the Political agenda was the Conservative Party Family Think Tank policy document which was leaked to the Guardian in 1983 (Dean, 1983). Proposals included those to encourage women to stay at home to look after young people and dependent elderly and/or disabled people and people with learning difficulties. Although the emphasis in debates about the family lies on its structure, that is, that the heterosexual nuclear family is the 'natural' unit of social life, in fact many assumptions are made about other facets of this family. These characteristics are related to the roles people play in the family, for example, the think tank proposals relied on stereotyped sex roles to formulate policy: women doing unpaid work in the home.

This stereotype depends on the existence of other stereotypes to succeed, that is, someone else, the husband, providing an income to keep the household going and housing which can accommodate young adults, older relatives and/or people with disabilities (contingent as well, on the desire of these people to stay). In other words, sex role stereotypes of men as providers and women as unpaid housewives who provide the family's welfare services, depend on at least a certain level of financial, material and living resources. The non-medical criteria applied by respondents in this study strike a chord with the characteristics of this idealised heterosexual nuclear family which has come to dominate the Political agenda.

More recently two Acts of Parliament have been passed which have in effect served notice on those who do not conform to heterosexual nuclear families that they can not live with impunity. The first, the Local Government Act (1988) contains section 2(a) which makes it illegal for local authorities to intentionally promote homosexuality or for children in schools to be taught that lesbian and gay families are anything other than "pretend" family relationships (Colwin and Hawksley, 1989). Regardless of the powers of this Act,²⁹ its strength has been in its ideological power to create an environment in which a particular way of living is reinforced and even glorified and another devalued in law. The second piece of legislation is the Child Support Act (1991) which feeds on the popular belief that absent parents (who in the vast majority are men) should make financial provision for their children. This Act only targets single parents who receive state benefits and carries penalties for those women who do not wish to name their children's father. For some single heterosexual women and lesbians this law will have the effect of creating nuclear family structures in which they are forced to be financially dependent on men with whom they no longer have (or never had) a relationship and who were never 'fathers' in the social sense of the word; and sustains the idealised family stereotype that men should be providers.

²⁹ Sex education is governed by school governors who are not covered by the remit of this Act

In combination with other proposals for example, the impact of the Community Care Act (Griffiths, 1992a, 1992b), clear ideological statements are being made about the preferred nature, structure and value system of desirable families and, conversely, undesirable families are being identified, isolated and targeted with punitive social policy initiatives. It is within this milieu that the *Act (1990)* was debated and enacted. Most DI practitioners in this study, in showing an allegiance to the ideal family model, only coincide with the views of other powerful people in powerful institutions - for example politicians in Parliament and journalists in the media.

In DI the concept of an idealised heterosexual nuclear family is crucial to understanding the decision-making of DI practitioners. It is also crucial to understanding the central importance of the containment of sperm to respondents. The sperm of men who are strangers is controlled both by being protected and guarded against as the potential for purity in the birth of perfect DI babies, and potential contaminator, respectively. The former occurs by only placing purified sperm in appropriate family settings, the latter by only allowing pure genetic fathers to donate sperm.

In order to exercise this control, DI practitioners must exercise minute scrutiny of potential donors and effectively police women's sexuality. Women are the crucial actors here as it is they - as the fertile actors in the DI scenario and the ones who will carry the foetus to term - who threaten to 'run off' with the sperm of strangers and disrupt the order of society. Their resistance to this example of medical power, which has been legally enhanced in law, can be found in their recourse to self-insemination and by presenting 'acceptable' scenarios to DI practitioners. But the ideological message of medicalised DI is clear. Not everyone should have children and medicine has demonstrated satisfactorily that they can be trusted to protect the idealised heterosexual nuclear family by socially screening the suitability of those who seek to become parents through access to a stranger's sperm in the use of DI.

LIST OF ABBREVIATIONS

ACT	Assisted Conception Techniques
AFS	American Fertility Society
AID	Artificial Insemination by Donor
AIH	Artificial Insemination by Husband
BAAF	British <i>Agencies for</i> Adoption and Fostering
BASW	British Association of Social Workers
BBT	Basal Body Temperature
BMA	British Medical Association
BPAS	British Pregnancy Advisory Service
BWSG	Brighton Women in Science Group
DSS	Department of Social Security
DI	Donor Insemination
EDM	Early Day Motion
GIFT	Gamete Intrafallopian Transfer
GLC	Greater London Council
GP	General Practitioner
HFEA	Human Fertilisation and Embryology Authority
HSG	Hysterosalpingogram
IUD	Intrauterine Device
IVF	In Vitro Fertilisation
LH	Lutenising Hormone
MP	Member of Parliament
NHS	National Health Service
NPMC	Non-Profit-Making Charity
OWHAG	Oxford Women's Health Action Group
PAS	Pregnancy Advisory Service
RCOG	Royal College of Obstetricians and Gynaecologists
SLA	Statutory Licencing Authority
STD	Sexually Transmitted Disease

APPENDIX A: INTRODUCTORY LETTER TO DI CLINICS

Dear

I am a student reading for a PhD in the Department of Social Policy and Social Work at the University of Edinburgh. The subject of my research is the role of the medical practitioner in the provision of Artificial Insemination by Donor (AID). I am writing to ask whether you can help me by allowing me to come and interview you about the AID service you operate.

The questions I would like to ask fall into the following broad categories: the development and operation of the AID service you run; how decisions are made about selecting appropriate recipients; how you recruit appropriate donors; and some general questions relating to proposed Government Legislation, arising out of the Warnock Report, for example the suggested standardized guidelines for the selection of donors.

I hope that the interview can take place within the next two months. The interview itself will last about 45 minutes. With your permission I would like to tape-record the interview in order to make my task of collating data easier. When I write up my results I would like to reference remarks made with names, or with the localities of the AID clinics - whichever you give permission to. If neither of these options are to your liking I could reference your remarks with a number. We could discuss this before the interview.

I will telephone your clinic in the next two weeks with a view to making an appointment for an interview. I hope that you will be able to help me.

Yours sincerely

Catherine Donovan (Ms).

APPENDIX B: THE INTERVIEW SCHEDULE

My name is Catherine Donovan and I'm a post graduate student at Edinburgh University. I am doing research into how decisions are made about which potential recipients and which donors are appropriate for Artificial Insemination by Donor. The interview is divided roughly into four sections. In the first section I will ask questions about your own experience as an AID practitioner and about this AID service. In the second I will ask about how potential recipients of AID are assessed and accepted and then in the third how donors are recruited. In the final section there are some questions about the proposed Government legislation on the provision of AID.

Is it alright to use the tape recorder? We can turn it off at any point in the interview if you want to.

[All questions requiring yes/no answers or answers that ^{can} be categorised are marked with an * at the beginning]

* Respondent: male/female

1. How would you define Artificial Insemination by Donor?

*2. How long have you been involved in this clinic?

*3. How long have you been involved with AID?

*4. How long has this clinic been offering AID?

5. What is your role here?

6. AID has been surrounded by some controversy. Why do you feel you can offer it?

7. Does this clinic offer other fertility services?
what are they?

*8. Approximately how many people use this clinic every year with fertility problems?

*9. And of these how many would use AID?

*10. Do you charge for AID

10a. how much?

10b. what does the fee cover?

- *11. How many inseminations per cycle will recipients have?
- *12. Can people inseminate for as long as they want to?
- *13. Is there a waiting list for people to use AID?
- *14. Do they ever inseminate at home?
why/why not
- *15. What is the success rate?
- *16. Does this clinic serve a particular catchment area?
 - 16a. Are you happy with that?
 - 16b. Can recipients come from anywhere?
- 17. How are they referred?
- *18. Do you accept self-referrals?
 - 18a. Has this always been the case?
- *19. Do you have a policy governing who is eligible for using AID?
- *20. Do all the doctors who refer to you get a copy of the guidelines to aid their work?

CAN WE NOW TALK ABOUT POTENTIAL RECIPIENTS?

- 21. Can you tell me what the medical indications are for AID?
- 22. Is AID offered to all those with medical indications?
- 23. Do you think there is an ideal couple for whom AID is most suited?
- 24. Could you tell me for what sorts of reasons you might consider recipients to be unsuitable?
- 25. Can you say what you think the most important qualities are in people using AID?
- 26. To what extent would you say your assessments are influenced by your medical training?
- 27. Would you give AID to single women?
 - 27a. Why/ why not?

28. What about lesbians?

28a. Why/ why not?

29. Would women with genetic diseases be able to use AID?

29a. If she and her partner knew the risk involved and wanted to go ahead would they be able to use AID?

30. What about women with disabilities?

31. Could you describe the decision-making process?

31a. How many meetings do you have with potential recipients?

32. Who takes the final decision about the use of AID?

32a. Do potential recipients realise they are being assessed?

33. It has been reported that some AID practitioners refer potential recipients to psychiatrists, psychologists or medical social workers. Do you refer potential recipients to anybody like this?

33a. What do you think are the benefits/ drawbacks of using these professionals?

34. If you feel unable to give particular potential recipients access to AID how do you tell them about your decision?

34a. Could they come back at a later stage and try again?

35. Some writers have compared AID with adoption and said that they are so similar that AID practitioners like yourself could learn from the adoption experience in selecting recipients. What do you think about that?

36. Do you think that AID could be run by adoption agencies or similar agencies where people experienced with placing children for adoption would be dominant in the selection process?

37. Some adoption agencies assess the financial situation of potential adopting parents. Do you do this?

37a. IF YES:

Could you say what you think the minimum acceptable level of income would be?

38. Some adopting agencies would also assess the living and material conditions of potential adopters. Is this something you would do?

39. Would you expect both potential recipients to be in paid work? - the women and men?

COULD WE MOVE ON TO DONORS NOW?

40. Where do you get your supply of semen from?

IF FROM A SPERM BANK:

41. To what extent can you specify the sort of donor you want?

41a. What tests do they do on the sperm?

41b. Do you do any further tests on the sperm once it is here?

IF RECRUIT THEIR OWN:

42. Do you find it difficult to recruit donors?

43. Where do you recruit from?

43a. Do you recruit from this group deliberately?

44. Do you pay them?

44a. How much?

45. For some people the payment of donors is an ethical issue. What do you think about this?

46. Do you have a list of criteria by which you recruit donors?

47. What sort of screening do you do before you accept them?

47a. Are there particular genetic diseases you would screen out? - what are they?

48. Could you give me a sketch of the ideal donor you are hoping to recruit?

48a. What would you say are the most important qualities?

49. Do you think you are influenced by the sort of father you think he might make?

50. Do you think you are influenced by the sort of children you think he might have?

51. To what extent do you think your assessment is informed by your medical training?

51a. What other influences do you think there are?

ALL RESPONDENTS:

52. Do you try and match donors?

52a. What for?

53. It has been reported that recruiting donors from different ethnic groups is difficult. Have you found this to be the case?

54. How have you recruited them?

55. Some AID practitioners say that they try to match for intelligence. Is that something you would do?

56. Are there any characteristics you would try to avoid in donors?

57. I've got a list here of characteristics I have taken from the literature. Can I read them out to you and will you tell me whether you would screen for them and whether you think they are genetic?

alcoholism

mental illness

criminality

homosexuality

greed and selfishness

58. Do donors sign consent forms?

58a. What do they say

58b. Do recipients sign consent forms?

THIS IS NOW THE FINAL SECTION ABOUT THE PROPOSED GOVERNMENT LEGISLATION:

59. The White Paper on Human Fertilisation and Embryology says that potential recipients of AID should receive counselling to facilitate the making of informed decisions and to explore the implications of having a child which is the genetic offspring of only one parent. Is this something you would welcome?

60. The counselling outlined by the White Paper will have to be separate from discussions with the doctor about medical treatment and have to be carried out by someone else - a qualified counsellor. What do you think about this?

61. The White Paper also intends that donors should be counselled. What do you think about that?

62. The White Paper intends to make it a legal right of children born of AID to know of their origins at 18. Is this something you welcome?

63. The AID procedure is in itself a simple procedure. Do you feel that it should remain under medical supervision?
why/why not?

64. At the moment some women are self-inseminating. What do you think about this?

65. The White Paper would like to discourage this from happening. Do you agree?
why/why not?

66. The White Paper would require a statutory licencing authority to impose guidelines on the way donors are selected. Do you think it would be a good idea if all AID clinics recruited donors on the same basis?

67. One of the factors that would be taken into consideration in granting a licence would be the procedure for selection of recipients. Do you think that all AID practitioners should follow the same selection procedures?

68. To what extent do you think that you or the SLA or the government should be in a position to encourage or discourage certain groups of people to parent?

68a. And yet you refuse AID to lesbians/single women?

That's the end of the interview. Thank you very much for giving me your time.

APPENDIX C: EXAMPLES OF DONOR SCREENING SCHEDULES

DONOR HISTORY FORM 2

Medical History

	<u>Donor</u>	<u>Family</u>
Any history of: Epilepsy	_____	_____
Diabetes	_____	_____
Congenital Abnormality	_____	_____
Mental Illness	_____	_____
Any Major Disease	_____	_____
Any history of: STD	_____	
Genital Warts	_____	
Herpes	_____	
Urinary Infection	_____	

Have you ever had a homosexual relationship _____

Do you think that you may be at high risk of contracting HIV ?

No of Partners in the last 6 months _____

Do you smoke ? _____

Do you drink ? _____

Do you use any soft or hard drugs ? _____

DONOR HISTORY

Personal Details

Full Name: _____

Address: Home _____ Term _____

Tel No: _____ D.O.B. _____

Place of Birth: _____ Marital Status: _____

Occupation: _____ Nationality: _____

Physical Details

RACE: Caucasian/Negroid/Asian/Oriental/Mixed

SKIN COLOUR: Fair/Medium/Dark BUILD: Slim/Medium/Heavy

HAIR COLOUR: Black/Dk Brown/Mid Brown/Lt Brown/Fair/Red/Grey

EYE COLOUR: Blue/Brown/Green/Hazel/Grey

HEIGHT: _____ WEIGHT: _____

BLOOD GROUP: O/A/B/AB RHESUS GROUP +VE/-VE

Comments:-

Medical History

ANY HISTORY OF:-

	DONOR	FAMILY
Epilepsy	_____	_____
Diabetes	_____	_____
Cystic Fibrosis	_____	_____
Congenital Abnormality (e.g cleft palate)	_____	_____
Muscular Dystrophy	_____	_____
Mental Illness (e.g schizophrenia)	_____	_____
Breast Cancer	_____	_____
Cardiac Disease	_____	_____
Any other major disease	_____	_____
Any history of vaccination problems	_____	_____
Any history of STD or Urinary infection	_____	_____

PERSONAL MEDICAL HISTORY:

AGE:

ANY CURRENT ILLNESS: Y / N

IF YES, SPECIFY.....

ANY CURRENT LONG-TERM MEDICATION: Y / N

IF YES, SPECIFY.....

ANY PAST MEDICAL HISTORY: Y / N

IF YES, SPECIFY:

URETHRAL DISCHARGE IN LAST 12 MONTHS: Y / N

IF YES, SPECIFY DATE:

DIAGNOSIS:

ANY BLOOD TRANSFUSION: Y / N IF YES, WHERE:

ANY DRUG ABUSE IN THE PAST: Y / N

SPECIFIC QUESTIONNAIRE:

HAVE YOU OR ANY OF YOUR FAMILY HAD:

CONGENITAL HEART DISEASE Y / N

EPILEPSY Y / N

FITS Y / N

SCHIZOPHRENIA Y / N

MANIC DEPRESSION Y / N ANY OTHER PSYCHIATRIC DISORDER Y / N

ANY PHYSICAL DISABILITY Y / N

HEPATITIS Y / N

DIABETES Y / N AGE OF ONSET.... (<5) don't accept

HYPERTENSION Y / N AGE OF ONSET... (<40 don't accept)

BLOOD DISORDERS Y / N THALASSAEMIA Y / N

SICKLE CELL Y / N
ALLERGIES Y / N (information only)

BIBLIOGRAPHY

Ackman, C. F. D.; Rioux, J. E. (1980) "Artificial Insemination and the Genetic Defect Crisis: A review of quality control and crisis management" in *Human Artificial Insemination and Semen Preservation* George, D. and Price, W. S. (eds) New York: Plenum Press

Aitken-Swan, J. (1977) *Fertility Control and the Medical Profession* London: Croom Helm Ltd

Alder, E. (1984) "Psychological Aspects of AID" in *Psychological Aspects of Genetic Counselling* Emery A. E. H.; Pullen, I. (eds) London: Academic Press

American Fertility Society (1988) "New Guidelines for the Use of Semen Donor Insemination: 1986" in *Progress in Infertility* Behrman, S. J.; Kistner, R. W.; Patton, G. W. (eds) Boston/Toronto: Little Brown and Company

Antonis, B. (1981) "Motherhood and Mothering" in *Women and Society: Interdisciplinary Essays* The Cambridge Women's Studies Group (eds) London: Virago Press

Arditti, R.; Klein, R. D.; Minden, S. (eds) (1984) *Test-Tube Women. What Future for Motherhood* London: Pandora Press

Arnold, J. M.; Joyce, D. N. (1982) "Artificial insemination by donor (AID)" in *The Practitioner* Vol 226 (2) pp. 1324-1330

Barton, M. (undated) "A.I.D. an alternative option" first appeared in 1972 and now collected in *Child Adoption. A selection of articles on adoption theory and practice* The Association of British Adoption and Fostering Agencies

Barton, M.; Walker K.; Weisner, B.P. (1945) "Artificial Insemination" in *British Medical Journal* Vol 1 13th January pp.40-43.

Beck, W. W. (1976) "A Critical Look at the Legal, Ethical and Technical Aspects of Artificial Insemination" in *Fertility and Sterility* Vol 27(1) pp. 1-8

Behrman, S.J. (1959) "Artificial Insemination" in *Fertility and Sterility* Vol 10(3) pp. 248-258

Behrman, S. J. (1979) "Artificial Insemination" in *Clinical Obstetrics and Gynaecology* Vol 22(1) pp. 245-253

Behrman, S. J. (1979) "Artificial Insemination and Public Policy" in *New England Journal of Medicine* Vol 300(11) pp. 619-620

Bergquist, C.; Rock, J.; Miller, J.; Guzik, D.; Wentz, A.; Jones, G. (1982) "Artificial Insemination with Fresh Donor Semen Using the Cervical Cap Technique: A Review of 278 Cases" in *Obstetrics and Gynaecology* Vol 60(2) pp. 195-199

Bloom, P. (1957) "Artificial Insemination (Donor)" in *The Eugenics Review* Vol 48 pp. 205-207

Bogdan, R.; Taylor, S. T. (1975) *Introduction to Qualitative Research Methods. A Phenomenological Approach to the Social Sciences* 2nd Edition USA: John Wiley and Sons Inc.

Brandon, J. (1979) "Telling the A.I.D. Child" in *Adoption and Fostering* Vol 95(1) pp. 13-14

Brandon, J.; Warner, J. (1977) "A.I.D. and Adoption: Some Comparisons" in *British Journal of Social Work* Vol 7(3) pp. 335-341

Breen, D. (1978) "The Mother and the Hospital" in *Tearing the Veil. Essays on Femininity* Lipshitz, S. (ed) London: Routledge Kegan Paul Ltd.

Brewaeys, A.; Olbrechts, H.; Devroey, P.; Steirteghem, A.C. (1989) "Counselling and Selection of Homosexual Couples in Fertility Treatment" in *Human Reproduction* Vol 4(7) pp. 850-853

Brewer, H. (1935) "Eutelegensis" in *Eugenics Review* Vol 27(2) pp.121-126

Brighton Women in Science Group (1980) "Technology in the Lying-in Room" in *Alice Through the Microscope* Birke, L.; Falkner, W.; Best, S.; Janson-Smith, D.; Overfield, K. (eds) London: Virago Press

British Association of Adoption and Fostering (BAAF) Medical Group A.I.D. Working Party (1984) "Evidence submitted to the Government Inquiry into Human Fertilisation and Embryology" in *AID and After. Papers from BAAF, BASW and the Scottish Working Party* Britain: BAAF

British Medical Association (BMA) (1990) *Surrogacy: Ethical Considerations. Report of the Working Party on Human Infertility Services* BMA Occasional Paper - Ethics No. 1

British Association of Social Workers' Sexuality Special Interest Group (1984) in *AID and After. Papers from BAAF, BASW and the Scottish Working Party* Britain: BAAF

Brody, E. B. (1987) "Reproduction Without Sex - But With a Doctor" in *Law, Medicine and Health Care* Vol 15(3) pp. 152-155

Bromwich, P.; Kilpatrick, M.; Newton, J. R. (1978) "Artificial Insemination with Frozen Stored Donor Semen" in *British Journal of Obstetrics and Gynaecology* Vol 85(9) pp. 641-644

Bryan, B.; Dadzie, S.; Scafe, S. (1985) *The Heart of the Race. Black Women's Lives in Britain* London Virago Press

Bunkle (1984) "Calling the shots? The international politics of depo provera" in *Test Tube Women* Arditti et al. (eds) *op cit.*

Busfield, J. (1974) "Ideologies and Reproduction" in *Integration of the Child into a Social World* Richards, D. (ed) Cambridge: Cambridge University Press

Carruthers, G. B. (1977) "Andrological Aspects of Sexual Medicine: Artificial Insemination by Donor" in *British Journal of Sexual Medicine* Feb. pp.11-18

Carruthers G. B.(1981) "Management of the Infertile Male" in *Infertility* Philipp, E. E.; Carruthers, G. B. (eds) London: William Heineman Medical Books Ltd

Carter, C. O. (1983) "Eugenic Implications of New Techniques" in *Developments in Human Reproduction. Eugenic and Ethical Implications* Carter, C. O. (ed) London: Academic Press

Cary, W. H. (1948) "Results of Artificial Insemination with an Extramarital Specimen (Semi-Adoption): Report on 89 Cases." in *Americal Journal of Obstetrics and Gynaecology* Vol 56(4) pp. 727-732

Case Conference (1978) "Lesbian Couples: should help extend to A.I.D.?" in *Journal of Medical Ethics* Vol.4(2) pp. 91-95

Child Support Act (1991) London: HMSO

Chong, A.; Taymor, M. L. (1975) "Sixteen Years Experience with Therapeutic Donor Insemination." in *Fertility and Sterility* Vol 26(8) pp.791-795

Clayton, C.; Kovacs, G. (1980) "A.I.D. - A Pretreatment Social Assessment" in *Australian and New Zealand Obstetrics and Gynaecology* Vol 20 pp. 208-210

Colwin, M.; Hawksley, J. (1989) *Section 28: A practical guide to the law and its implications* Britain: National Council for Civil Liberties

Corea, G.; Hanmer, J.; Klein, R. D.; Raymond, J. G.; Rowland, R. (1987) "Prologue" in *Made to Order. The Myth of Reproductive and Genetic Progress* Spallone, P; Steinberg, D.L.(eds) Oxford: Pergamon Press

Curie-Cohen, M.; Luttrell, L.; Shapiro, S. "Current Practice of Artificial Insemination by Donor in the United States" in *The New England Journal of Medicine* Vol 300(11) pp. 585-590

Daniels, K. R. (1986) "New Birth Technologies: A Social Work Approach to Researching Psychological Factors" in *Social Work in Health Care* Vol 11(4) pp. 49-60

David, A.; Avidan, D.; (1976) "Artificial Insemination Donor: Clinical and Psychological Aspects" in *Fertility and Sterility* Vol 27(5) pp. 528-532

Dean, M. (1983) "Ministers rethink welfare state" in *The Guardian* p.1 17th Feb

Denzin, N. K. (1970) *The Research Act in Sociology. A Theoretical Introduction to Sociological Methods* London: Butterworth

Department of Health and Social Security (1986) *Legislation on Human Infertility Services and Embryo Research. A Consultation Paper* Cm 46 London: Her Majesty's Stationary Office (HMSO)

Department of Health and Social Security (1987) *Human Fertilisation and Embryology: A Framework for Legislation*. Cmnd 257 London: HMSO

Diamond, I.; Quinby, L. (eds) (1988) "Introduction" in *Feminism and Foucault. Reflections on Resistance* Boston: Northern University Press

Dixon, B. R.; Bouma, G. D.; Atkinson, G. B. (1987) *A Handbook of Social Science Research* Oxford: Oxford University Press

Dixon, R.; Buttram, V.C. (1976) "Artificial Insemination using Donor Semen: a Review of 171 Cases" in *Fertility and Sterility* Vol 27(2) pp.130-134

Douglas, M. (1966) *Purity and Danger* London: Routledge and Kegan Paul Ltd

Dowie, S. (1988) *Baby Making. The Technology and Ethics* London: The Bodley Head Ltd

Duelli Klein R. (1984) "Doing it Ourselves" in *Test-Tube Women* Arditti et al., (eds) *op cit*.

Edwards, J.H. (1976) "Discussion Opener to Recruitment, Selection and Matching Donors" in *Artificial Insemination Proceedings of the Fourth Study Group of the Royal College of Obstetricians and Gynaecologists* Brudenell, M.; McLaren, A.; Short, R.; Symonds, M. (eds) London: Royal College of Obstetricians and Gynaecologists

Ehrenreich, B.; English, D. (1973a) *Complaints and Disorders. The Sexual Politics of Sickness* N.Y.: Writers and Readers Publishers Cooperative

Ehrenreich, B.; English, D. (1973b) *Witches, Midwives and Nurses. A History of Women Healers* New York: Writers and Readers Publishers Cooperative

Ehrenreich, B.; English, D. (1979) *For Her Own Good. 150 Years of the Experts' Advice to Women* London: Pluto Press Ltd

Evans, F. (1985) "Managers and labourers: women's attitudes to reproductive technology" in *Smothered by Invention* Falkner, W.; Arnold, E. (eds) London: Pluto Press Ltd

Falkner, W. (1985) "Medical Technology and the Right to Heal" in *Smothered by Invention* Falkner and Arnold, (eds) London: Pluto Press Ltd

Finger A. (1990) *Past Due. A Story of Disability, Pregnancy and Birth* Washington: Seal Press

Fish, S. A. (1965) "Continuing Problems of Artificial Insemination" in *Postgraduate Medicine* Vol 38 pp. 415-420

Foote Whyte, W. (1982) *Field Research. A Sourcebook and Field Manual*

Foss, G. L. (1982) "Artificial Insemination by Donor: A Review of 12 years Experience" in *Journal of Biosocial Science* Vol 14 pp. 253-262

Friedson, E. (1970) *Profession of Medicine. The Study of the Sociology of Applied Knowledge* Dodd, Mead and Company

Glezerman, M. (1981) "Two Hundred and Seventy Cases of Artificial Donor Insemination: Management and results" in *Fertility and Sterility* Vol 35(2) pp.180-187

Golombok, S.; Spencer, A.; Rutter, M. (1983) "Children in Lesbian and Single-Parent Households: Psychosexual and Psychiatric Appraisal" in *Journal of Child Psychology and Psychiatry* Vol 24(4) pp. 557-572

Golombok, S.; Rust, J. (1986) "The Warnock Report and Single Women: What about the Children?" in *Journal of Medical Ethics* Vol 12 pp. 182-186

Goss, D. A. (1975) "Current Status of Artificial Insemination with Donor Semen" in *British Journal of Obstetrics and Gynaecology* Vol 122(2) pp. 246-252

Greater London Council (GLC) in Cooperation with the GLC Gay Working Party (undated) *Changing the World A London Charter for Gay and Lesbian Rights* London: GLC

Greenwood, K.; King, L. (1981) "Contraception and Abortion" in *Women in Society. Interdisciplinary Essays* The Cambridge Women's Studies Group (eds) London: Virago Press

Gregoire, A. T.; Mayer, R. C. (1965) "The Impregnators" in *Fertility and Sterility* Vol 16(1) pp. 130-134

Griffiths, R. (1992a) "With the Past Behind Us" in *Community Care* 16th January:18-21

Griffiths, R. (1992b) "Making it Happen" in *Community Care* 23rd January:20-22

The Guardian (1991) (untitled) 10 June 1991 p 2

Guttmacher, A. F.; Haman, J. O.; Macloed, J (1950) "The Use of Donors for Artificial Insemination. A Survey of Current Practices" in *Fertility and Sterility* Vol 1(3) pp. 264-270

Guttmacher, A. F. (1960) "The Role of Artificial Insemination in the Treatment of Sterility" in *Obstetrical and Gynaecological Survey* Vol 15 pp. 767-785

Haines, E. (1990) "Recreating the Family? Policy Considerations Relating to the New Reproductive Technologies" in *The New Reproductive Technologies* McNeil, M.; Varcoe, I.; Yearley, S. (eds) London: Macmillan Press Ltd.

Hakim, C. (1987) *Research Design. Strategies and Choices in the Design of Social Research* London: Allen and Unwin

Haman, J. O. (1954) "Results in Artificial Insemination" in *The Journal of Urology* Vol 72(3) pp. 557-563

Haman, J. O. (1959) "Therapeutic Donor Insemination. A Review of 440 Cases" in *California Medicine* Vol 90(2) pp. 130-33

Hanmer, J.; Allen, P. (1980) "Reproductive Engineering: The Final Solution?" in *Alice Through The Microscope. The Power of Science over Women's Lives* Birke, L.; Faulkner, W.; Best, S.; Janson-Smith, D.; Overfield, K. (eds) London: Virago Press

Hanscombe, G.; Forster, J. (1982) *Rocking the Cradle: Lesbian Mothers A challenge in family living* London: Sheba Feminist Publishers

Hanscombe, G. (1983) "The Right to Lesbian Parenthood" in *Journal of Medical Ethics* Vol 9(3) pp. 133-135

Hargreave, T. B. (1985) "Artificial insemination by donor" in *British Medical Journal* Vol 291 pp. 613-614

Heiman, M.; Kleegman, S. J. (1966) "Insemination: A Psychoanalytic and Infertility Study" in *Fertility and Sterility* Vol 17(1) pp. 117-125

Holbrook, S. (1990) "Adoption, Infertility and the New Reproductive Technologies: Problems and Prospects for Social Work and Welfare Policy" in *Social Work* Vol 35(4) July pp. 333-337

Hornstein, F. (1984) "Children by Donor Insemination: A New Choice for Lesbians" in *Test Tube Women* Arditti et al. (eds) *op cit*.

Houghton, P.; Houghton, D. (1987) *Coping With Childlessness* London: Unwin Paperbacks

House of Lords (1989) *Human Fertilisation and Embryology Bill* HMSO

Human Fertilisation and Embryology Act (1990) London: HMSO

Human Fertilisation and Embryology Authority (1991) *Code of Practice* Human Fertilisation and Embryology Authority

Humphrey, M.; Humphrey, H. (1986) "A fresh look at genealogical bewilderment" in *British Journal of Medical Psychology* Vol 59 pp. 133-140

Humphrey, M.; Humphrey, H. (1987) "Marital Relationships in Couples Seeking Donor Insemination" in *Journal Biosociological Science* Vol 19 pp. 209-219

Humphrey, M.; Humphrey, H.; Ainsworth-Smith, I (1991) "Screening Couples for Parenthood by Donor Insemination" in *Social Science and Medicine* Vol 32(3) pp. 273-278

Jabbari, D. (1990) "The Role of the Law in Reproductive Medicine: a New Approach" in *Journal of Medical Ethics* Vol 16(1) pp. 35-40

Jackson, M. (1957) "Artificial Insemination (Donor)" in *The Eugenics Review* Vol 48 pp.203-205

Jackson, M.; Richardson, D.W. (1977) "The Use of Fresh and Frozen Semen in Human Artificial Insemination" in *Journal of Biosocial Science* Vol 9 pp.251-262

James, W. H. (19484) "Artificial insemination by donor: A review of 12 years experience" in *Journal of Biosocial Science* Vol 16 pp. 153-154

Joint Working Party Representing Family Care, The Scottish Council for Single Parents, British Agencies for Adoption and Fostering (Scottish Centre) and National Association for the Childless (South-East Scotland Branch) (1984) in *AID and After. Papers from BAAF, BASW and a Scottish Working Party BAAF*

Jones, M. (1987) *Everything You Need to Know About Adoption* London: Sheldon Press

Joyce, D. N. (1976) "Recruitment, Selection and Matching of Donors" in *Artificial Insemination. Proceedings of the Fourth Study Group of the Royal College of Obstetricians and Gynaecologists* Brudenell, M.; McLaren, A.; Short, R.; Symonds, M. (eds) London: Royal College of Obstetricians and Gynaecologists

Joyce, D. N. (1984) "The implications of greater openness concerning AID" in *AID and After. Papers from BAAF, BASW and a Scottish Working Party BAAF*

Kelves, D. (1985) *In The Name of Eugenics* New York: Alfred A Knopf

Kennedy, I. (1978) "Case Conference. Lesbian Couples: should help extend to AID?" in *Journal of Medical Ethics* Vol 4(2) pp. 91-95

Kerr, M. G.; Rogers, C. (1975) "Donor Insemination" in *Journal of Medical Ethics* Vol 1(1) pp. 30-33

Kerr, M.; Templeton, A. (1976) "Selection and Counselling of Recipients" in *Artificial Insemination. Proceedings of the Royal College of Obstetricians and Gynaecologists* Brudenell, M.; McLaren, A.; Short, R.; Symonds, M. (eds) London: Royal College of Obstetricians and Gynaecologists

King, M.; Pattison, P. (1991) "Homosexuality and Parenthood" in *British Medical Journal* Vol 303 August pp. 295-297

Kings Fund Centre Counselling Committee (1991) *Counselling for Regulated Infertility Treatments. The Report of the King's Fund Centre Counselling Committee* King's Fund Centre

Kleegman, S. J. (1954) "Therapeutic Donor Insemination" in *Fertility and Sterility* Vol 5(1) pp. 7-31

Klein, R. D. (1984) "Doing it ourselves: self-insemination" in *Test-Tube Women* Arditti et al. (eds) *op cit*.

Kovacs, G. T. ; Lording, D. W. (1980) "Artificial Insemination with Donor Semen. Review of 252 Patients" in *The Medical Journal of Australia* Vol 2(11) pp. 609-613

Kramarae, C.; Treichler, P. A. (1985) *A Feminist Dictionary* London: Pandora Press

Labovitz, S.; Hagedorn, R. (1971) *Introduction to Social Research USA*: McGraw-Hill Inc

Lamson, H. D.; Pinard, W. J.; Meaker S. R. (1951) "Sociologic and psychological aspects of artificial insemination with donor semen" in *Journal of the American Medical Association* Vol 145(2) pp. 1062-64

Langer, G ; Lemberg, E.; Sharf, M. (1969) "Artificial Insemination. A Study of 156 Successful Cases" in *International Journal of Fertility* Vol 14(3) pp. 232-240

Ledward, R. S.; Crich, J.; Sharp, P.; Cotton, R. E.; Symonds, E. M. (1976) "The Establishment of a programme of Artificial Insemination by Donor Semen within the National Health Service" in *British Journal of Obstetrics and Gynaecology* Vol 83 pp. 917-920

Ledward, R. S.; Crawford, L.; Symonds, E. M. (1979) "Social Factors in Patients for Artificial Insemination by Donor (AID)" in *Journal of Biosocial Science* Vol 11 pp. 473-479

Leeson, J.; Gray, J. (1978) *Women in Medicine* GB: Tavistock Publications Ltd

Levie, L. H. ⁽¹⁹⁷²⁾ "Donor Insemination in Holland" in *World Medical Journal* Vol 19(5) pp. 90-91

Lewis, J.; Cannell, F. (1986) "The Politics of Motherhood in the 1980's. Warnock, Gillick and Feminists" in *Journal of Law and Society* Vol 13(3) Autumn pp. 321-342

Soltoun, Lady (1990) "Human Fertilisation and Embryology Bill" 6th February Lords Hansard

Mahmood, T. A. (1988) "Experience in the Establishment and Running of a Clinic for Artificial Insemination by Donor in the Scottish Highlands" in *Public Health* Vol 102(3) pp. 281-285

del Mar Perez, M.; Marina, S.; Egozcue, J. (1990) "Karyotype screening of potential sperm donors for artificial insemination" in *Human Reproduction* Vol 5(3) pp. 282-285

Mascola, L. ; Guinan, M. E. (1986) "Screening to Reduce Transmission of Sexually Transmitted Diseases in Semen Used for Artificial Insemination" in *The New England Journal of Medicine* Vol 314(21) pp. 1354-1359

Matthews, C. D. (1980) "Artificial Insemination by Donor and Husband" in *The Infertile Couple* Pepperelle, R. J.; Hudson, B.; Wood, C. (eds) Edinburgh: Longman Group

Matthews, C. D. ; Broom, T. J. ; Crawshaw, K. M. ; Hopkins, R. E. ; Kevin, J. F. P.; Svigos, J. M. (1979) "The Influence of Insemination Timing and Semen Characteristics on the Efficiency of a Donor Insemination Program" in *Fertility and Sterility* Vol 31(1) pp. 45-47

Matthews, C. D.; Ford, J.; Peek, J.; McEvoy, M. (1983) "Screening of karyotype and semen quality in an artificial insemination program: acceptance and rejection criteria" in *Fertility and Sterility* Vol 40(5) pp. 648-654

Monteiro, E. F.; Spencer, R.; Kinghorn, G.; Barrat, C.; Cooke, S.; Cooke, I. (1987) "Sexually transmitted disease in potential semen donors" in *British Medical Journal* Vol 295 p 418

Motulsky, G. (1975) "Brave New World?" in *Science* Vol 185(4152) pp. 653-663

Muller, H. J. (1936) *Out of the Night* London: Victor Gollancz Ltd

Murphy, D. P.; Torrano, E. (1966) "Donor Insemination. A Study of 112 Women" in *Fertility and Sterility* Vol 17(2) pp. 273-277

McCartney, C. (1985) "Decision by Single Women to Conceive by Artificial Donor Insemination" in *Journal of Psychosomatic Obstetrics and Gynaecology* Vol 4 pp. 321-328

McDaniel, S. A. (1989) "A New Stork Rising? Women's Roles and Reproductive Changes" in *Society-Societe* Vol 13(1) February pp. 6-14

McGuire, M.; Alexander, N. T. (1985) "Artificial Insemination of Single Women" in *Fertility and Sterility* Vol 43(1) pp. 182-184

McIntyre, S. (1976) "Who Wants Babies? The Social Construction of 'Instincts'" in *Sexual Divisions and Society: Process and Change* Barker, D.; Allen, S. (eds) London: Tavistock Publications

McLaren, A. (1984) *Reproductive Rituals* Methuen and Co. Ltd.

McLaughlin, E.; Bromwich, P. D.; Macken, A. M.; Walker, A. P.; Newton, J. R. (1983) "Use of home insemination in programmes of artificial insemination with donor semen" in *British Medical Journal* Vol 287 pp. 1110

McWhinnie, A. "Who Am I?" (undated) a paper given in 1969 and published in *Child Adoption. A Selection of Articles of Adoption Theory and Practice*. British Association of Fostering and Adoption

McWhinnie, A. (1984) "The Case for Greater Openness Concerning A.I.D." in *A.I.D. and After. Papers from BAAF, BASW and a Scottish Working Party* BAAF

McWhinnie, A. (1986a) "Test-Tube Babies ... the Child, the Family and Society" in *In Vitro Fertilisation. Past, Present, Future* Fishel, S.; Symonds, E. M. (eds) IRL Press Ltd

McWhinnie, A. (1986b) "A.I.D. and Infertility" in *Adoption and Fostering* Vol 10(1) pp. 16-17

Newill, R. (1976) "A.I.D. - A Review of 200 Cases" in *British Journal of Urology* Vol 48 pp. 139-144

Newton, J. R. (1981) "The Present Status of AID in the United Kingdom" in *Changing Patterns of Conception. Proceedings of the 16th Annual Symposium of the Eugenics Society London* Roberts, D. F.; Chester, R (eds) London: Academic Press

Oakley, A. (1975) "The Trap of Medicalised Motherhood" in *New Society* Vol 34 Dec 18th pp. 639-641

Oakley, A. (1986) *The Captured Womb. A History of the Medical Care of Pregnant Women* Basil Blackwell Ltd.

O'Brien, M. (1981) *The Politics of Reproduction* London: Routledge and Kegan Paul

O'Brien Steinfeld, M. (1983) "A.I.D. and the Single Welfare Mother" in *The Hastings Center Report* Vol 13(1) February pp. 22-23

The Observer (1991) "Virgin births service to be cut" 9 June 1991 p. 2

Oxford Women's Health Action Group: Propper, C.; Saffron, L.; Turner, S.; Walter, K.; Woodcock, H. (1984) *Whose Choice. What women have to say about contraception* London: Oxford Women's Health Action Group

Pennington, G. W.; Naik, S. (1977) "Donor Insemination: report of a two year study" in *British Medical Journal* Vol 1 pp. 1327-1330

Perkoff, G. T. (1985) "Artificial Insemination in a Lesbian. A Case Analysis" in *Archive of Internal Medicine* Vol 145 March pp. 537-531

Pfeffer, N. (1987) "Artificial Insemination, In Vitro Fertilisation and the Stigma of Infertility" in *Reproductive Technologies, Gender, Motherhood and Medicine* Stanworth, M. (Ed) Polity Press

Pfeffer, N.; Woollett, A. (1983) *The Experience of Infertility* London: Virago Press

Philipp, E. (1984) *Overcoming Childlessness. Its Causes and What to do About Them* London: Hamlyn Paperbacks

Pommerenke, W. T. (1957) "Artificial Insemination: Genetic and Legal Implications" in *Obstetrics and Gynaecology* Vol 9(2) pp. 189-197

Porter, M. (1990) "Professional-Client Relationships and Women's Reproductive Health Care" in *Readings in Medical Sociology* Cunningham Burley, S. and McKeganey, N. (eds) London: Routledge

Poyen, B.; Penochet, J-C.; Mattei, A.; Choux, M. (1980) "Is There a Right to A.I.D.?" in *Human Artificial Insemination and Semen Preservation* David, G.; Price, W. (eds) N. Y.: Plenum Press

Prince, G. (1978) in "Case Conference. Lesbian Couples: should help extend to AID?" in *Journal of Medical Ethics* Vol 4(2) pp. 91-95

Quinlaven, W. L. (1979) "Therapeutic Donor Insemination: Results and Causes of Non Fertilisation" in *Fertility and Sterility* Vol 32(2) pp. 157-160

Rabosh, J.; Tomasek, Z. D. (1967) "Therapeutic Donor Insemination - Results" in *Journal of Reproduction and Fertility* Vol 14(3) pp. 421-425

Radford, J. (1991) "Immaculate Conceptions" in *Trouble and Strife* Vol 21 Summer pp. 8-12

Richardson, D. W. (1975) "Artificial Insemination in the Human" in *Modern Trends in Human Genetics* 2nd Edition Butterworth and Son

Richardson, D. (1980) "Organisation of Sperm Banks on a National Basis" in *Human Insemination and Semen Preservation* David, G.; Price, W. (eds) London: Plenum Press.

Richardson, J. W. (1987) "The Role of a Psychiatric Consultant to an Insemination by Donor Program" in *Psychiatric Annals* Vol 17(2) pp. 101-105

Rosenkvist, H. (1981) "Donor Insemination" in *Danish Medical Bulletin* Vol 28(4) pp. 133-148

Royal College of Obstetricians and Gynaecologists (RCOG) Fertility Sub-Committee (1987a) *Recommendations for Centres Planning to set up a Donor Insemination Service* RCOG

Royal College of Obstetricians and Gynaecologists (1987b) *Donor Insemination Patient Information Booklet* RCOG

Rowland, R. (1984) in *Test-Tube Women* Arditti et al. (eds) *op cit*

Rowland, R. (1985) "The Social and Psychological Consequences of Secrecy in Artificial Insemination by Donor (A.I.D.) Programmes" in *Social Science and Medicine* Vol 21(4) pp. 391-396

Rubin, B. (1965) "Psychological Aspects of Human Artificial Insemination" in *Archives of General Psychiatry* Vol 13 August pp. 121-132

Saffron, L. (1987) *Getting Pregnant Our Own Way. A guide to alternative insemination* 2nd Ed. London: Women's Health Information Centre .

Sandler, B. (1972) "Donor Insemination in England" in *World Medical Journal* Vol 19(5) pp. 87-89

Sandler, B. (1979) "Adoption and Artificial Insemination by Donor (AID)" in *Medical Aspects of Adoption and Foster Care* Wolkind, S. (ed) London: William Heinemann Medical Books

Sants, H.J. (undated) "Genealogical bewilderment in children with substitute parents" first appeared in 1964, and now collected in *Child Adoption. A selection of articles on adoption theory and practice* The Association of Adoption and Fostering Agencies

Schoysman, R. (1975) "Problems of selecting donors of artificial insemination" in *Journal of Medical Ethics* Vol 1(1) pp. 34-35

Schoysman-Deboek, A.; Van Roosendaal, E.; Schoysman, R. (1988) "Artificial Insemination: AID" in *Progress in Infertility* Behrman, S. J.; Kistner, R. W.; Patton, G. W. (eds) Boston/Toronto: Little Brown and Company

Scully, D.; Bart, P. (1973) "A Funny Thing Happened on the Way to the Orifice: Women in Gynaecology Textbooks" in *American Journal of Sociology* Vol 78(4) pp. 1045-9

Selva, J.; Leonard, C.; Albert, M.; Anger, J.; David, G. (1986) "Genetic Screening for Artificial Insemination by Donor (A.I. D.)" in *Clinical Genetics* Vol 29 pp. 389-396

Seymour, F. I.; Koerner, A. (1936) "Artificial Insemination" in *Journal of the American Medical Association* Vol 107 pp.1531-1534

Shapiro R. (1987) *Contraception. A Practical and Political Guide* London: Virago Press

Shields, F. (1950) "Artificial Insemination as Related to the Female" in *Fertility and Sterility* Vol 3 pp. 271-280

Simmons, F. A. (1957) "Role of the Husband in Therapeutic Donor Insemination" in *Fertility and Sterility* Vol 8(6) pp. 547-550

Simms, M. (1974) "Abortion Law and Medical Freedom" in *British Journal of Criminology* Vol 14(2) pp. 118-131

Simms, M. (1985) "Legal Abortion in Great Britain" in *The Sexual Politics of Reproduction* Homans, H (ed) Gower Publishing Group

Simpson, J. L. (1981) "Genetic Screening for Donors in Artificial Insemination" in *Fertility and Sterility* Vol 35(6) pp. 395-396

Singer, P.; Wells, D. (1984) *The Reproduction Revolution. New Ways of Making Babies* Oxford: Oxford University Press

Smart, C. (1987) " 'There is of course the distinction dictated by nature': Law and the problem of paternity" in *Reproductive Technologies. Gender, Motherhood and medicine* Stanworth, M. (ed) U.K.: Polity Press in association with Basil Blackwell Ltd

Snowden, R.; Mitchell, G. D. (1981) *The Artificial Family* London: George Allen and Unwin Ltd.

Snowden, R.; Mitchell, G. D.; Snowden E. M. (1983) *Artificial Reproduction: A Social Investigation* London: George Allen and Unwin Ltd

Sorenson, J.; Swazey, J.; Scotch, N. (1981) *Reproductive Pasts. Reproductive Futures. Genetic Counselling and its Effectiveness* New York: Alan R. Liss

Spallone, P. (1987) "Reproductive Technology and the State: The Warnock Report and its Clones" in *Made to Order. The Myth of Reproductive and Genetic Progress* Spallone, P.; Steinberg, D. I. (eds) Oxford: Pergamon Press

Stanway, A. (1980) *Why Us? A Common Sense Guide for the Childless* London: Granada Publishing Ltd

Stanworth, M. (1987) "Reproductive Technologies and the Deconstruction of Motherhood" in *Reproductive Technologies* Stanworth, M. (ed) Cambridge: Polity Press in association with Basil Blackwell Ltd

Steinberg, D.L. (1987) "Selective Breeding and Social Engineering: Discriminatory Policies of Access to Artificial Insemination by Donor in Great Britain" in *Made to Order* Spallone, P.; Steinberg, D.L. (eds) Oxford: Pergamon Press

Steinberg, D. L. (1990) "The Depersonalisation of Women Through the Administration of In Vitro Fertilisation" in *New Reproductive Technologies* McNeil, M. ; Varcoe, I. ; Yearly, S. (eds) London: Macmillan Press Ltd

Stewart, C. R.; Daniels, K. R.; Boulnois, J. D. H. (1982) "The Development of a Psychosocial Approach to Artificial Insemination of Donor Semen" in *New Zealand Medical Journal* Vol 95 pp. 853-6

Stone, S. C. (1980) "Complications and Pitfalls of Artificial Insemination" in *Clinical Obstetrics and Gynaecology* Vol 23(3) pp. 667-682

Strauss, A. L. (1987) *Qualitative Analysis for Social Scientists* Cambridge: Cambridge University Press

Strickler, R.; Keller, D. W.; Warren, J. C. (1975) "Artificial Insemination with Fresh Donor Semen" in *The New England Journal of Medicine* October pp. 848-853

Strong, C.; Schinfeld, J. S. (1984) "The Single Woman and Artificial Insemination by Donor" in *The Journal of Reproductive Medicine* Vol 29(5) May pp. 293-299

Sudman, S.; Bradburn, N. M. (1982) *Asking Questions* London: Jossey-Bass Publishers

Tesch, R. (1990) *Qualitative Research Analysis Types and Software Tools* U.K.: The Falmer Press

Templeton, A. A.; Triseliotis, J (1983) "AID and Adoption" in *Male Infertility* Hargreave, T.B. (ed) Springer Verlag

Teper, S.; Symonds, E. M. (1983) "Artificial Insemination by Donor: Problems and Perspectives" in *Developments in Human Reproduction and their Eugenic, Ethical Implications*. Carter, C. O. (ed) London: Academic Press

Thomas, H. (1985) "The Medical Construction of the Reproductive Career" in *The Sexual Politics of Reproduction* Homans, H. (ed) Gower Publishing House

Thomas, S. (1986) *Genetic Risk* London: Penguin Books

Timmons, M. C ; Rao, K.; Sloan, C.; Kirkman, H. N.; Talbert, L. M. (1981) "Genetic Screening of Donors for Artificial Insemination" in *Fertility and Sterility* Vol 35(4) pp. 451-456

Traub, A. I.; Boyle, D. D.; Thompson, W. (1979) "The Establishment of an AID Clinic in Northern Ireland" in *Ulster Medical Journal* Vol 48 pp. 137-141

Triseliotis, J. (1973) *In Search of Origins* London: Routledge and Kegan Paul Ltd

Trounson, A.; Matthews, C. D.; Kovacs, G. T.; Spiers, A.; Steigrad, S. J.; Saunders, D. M.; Jones, W. R.; Fuller, S. (1981) "Artificial insemination by frozen donor semen: results of multicentre Australian experience" in *International Journal of Andrology* Vol 4 pp. 227-234

Vere, M. F. ; Joyce, D. N. (1979) "Luteal function in patients seeking AID" in *British Medical Journal* Vol 2 p. 100

Walsh, V. (1980) "Contraception: The Growth of a Technology" in *Alice Through the Microscope* Birke, L.; Falkner, W.: Best, S.; Jansom-Smith, D.; Overfield, K. (eds) London: Virago Press

Warner, M. P. (1974) "Artificial Insemination. Review after thirty-two years" in *New York State Journal of Medicine* December pp. 2358-2361

Warnock Committee (1984) *Report of the Committee of Inquiry into Human Fertilization and Emryology* Cmnd 9314 London: HMSO

Wasoff, F.; Dobash, R. E. (1992) "Simulated Clients in 'Natural' Settings: Constructing a Client To Study Professional Practice" in *Sociology* Vol 26(2) pp. 339-349

Watters, W. W.; Souza-Poza, J. (1966) "Psychiatric Aspects of Artificial Insemination (Donor)" in *Canadian Medical Association Journal* Vol 95 July pp. 106-113

Winterton, A. (1989) "Impregnation of Lesbian Women" Early Day Motion 1324 House of Commons

Yoxen, E. (1986) *Unnatural Selection? Coming to Terms with the New Genetics* London: Heinemann

Zola, I. (1972) "Medicine as an Institution of Social Control" in *Sociological Review* Vol 2(4) pp. 487-504