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# Anonymous Semen Donation: Medical Treatment or Medical Kinship?

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*Abstract: Opinion in European countries has been divided over whether people conceived with donated gametes (semen, eggs and embryos) should be able to obtain identifying information about their genetic (donor) parents. Despite the increasing number of countries whose laws now permit access to such information, many in the infertility treatment business remain opposed to or anxious about this change of legislation. Based on ethnographic fieldwork on social aspects of anonymous semen donation, including unstructured interviews with doctors in the UK who had donated between the late 1960s and early 1980s and with doctors currently in clinical practice in several European countries, I show in this article how although anonymous semen donation is used to circumvent childlessness caused by male infertility, it is also a way for doctors to wield influence in the domain of kinship and family formation.*

*Keywords: semen donation, donor anonymity, kinship, family formation*

## Introduction

The use of donated human semen to avoid childlessness caused by male infertility has become widespread in European countries in the period since donor insemination was developed in the late 1930s.<sup>1</sup> In some countries, the infertility specialists who pioneered and developed the practice insisted that the identity of the donor must be kept from the donor offspring and their parents. In other countries, anonymity was mandated by law. Since the 1980s, an increasing number of countries have passed laws or regulations to prohibit donor anonymity, and to provide for donor conceived people, as adults, to obtain identifying information about their donor (Blyth 2009). Often these legal changes have been controversial because of the anxieties or even hostility of many infertility specialists, most-

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ly medical doctors. This has been revealed in a number of ways such as refusal to co-operate with the changes, and accusations that supporters of the changes are unsympathetic to the plight of childless couples because infertility specialists usually assume that the removal of anonymity will make donor recruitment more difficult.

A number of ethnographies have focussed on assisted reproductive technology (ART) in which the main exploratory and analytical areas are *in vitro* fertilisation (IVF), human egg donation and the perceptions of women upon whose bodies the technologies are used (e.g. Franklin 1997, Kahn 2000, Konrad 2005). The social aspects of semen donation have been much less researched within social anthropology and the contrast with ova donation is striking and remarkable. The association of semen donation with human male infertility may be significant given the more serious stigma attached to male infertility in comparison to female infertility (Lasker 1998: 25, Inhorn 2004), and the 'elision between potency and genetic reproduction for men' (Thompson 2005: 121). Helene Goldberg goes as far as to assert that there is a 'severe silence' surrounding male infertility, in Israel and in general, and that 'men had been crudely overlooked in studies of reproduction' (Goldberg 2010: 84). Sidelined to some extent have been the male partners in couples seeking infertility treatment, as well as the men providing semen for use in donor insemination (DI).

Also of lesser significance in anthropological research have been the infertility specialists themselves. They tend to be in the shadows, outside of the main ethnographic frame. Doctors and clinical scientists reveal their presence obliquely, as field site gatekeepers, ethical arbiters, policy makers and ambitious entrepreneurs, as well as strategists deeply concerned about involuntary childlessness and strongly motivated to alleviate it by means of co-creation (Bonaccorso 2004, Simpson 2004). I suggest that, in fact, infertility specialists' efforts to treat male infertility gave to them, and in some countries continues to give them, a powerful role in how families are formed. Medical treatment becomes kinship creation of a particular kind: a family in which the biological origins of the child are anonymous to the child and parents, and the record of the identity of the genetic father is kept secret or, as happened in the past in the UK, was destroyed by clinics.

This article is a brief description of how this happened in the UK and how the role of the infertility specialists in co-creating families formed on the basis of the anonymity of the genetic father is affected increasingly now by national, cross-border and international actions. I conclude by noting differences between the UK and the Czech Republic which, I hope, will encourage further research in both countries. The article is based on ethnographic research carried out mostly 'at home' in the UK between 2001 and 2007. The research originated partly in my curiosity that self-appointed advocates, especially in the medical profession, were making claims that semen donors of the past would never have donated if

they had not been promised anonymity. The voices of the donors had rarely been heard and there was no anthropological research into the long term implications, if any, for them and their families that they had donated anonymously, and often for financial rewards, when they were young. My research was multi-sited (Marcus 1995, Franklin 1997, Rapp 2000) in order to capture as much as possible of the diversity and complexity of the field. It included unstructured interviews and discussions with fertility specialists and other health professionals currently or formerly working in clinics providing DI services in the UK, as well as with men who had donated semen between the 1960s and early 1980s mostly when they were medical students. Participant observation was carried out at conferences and other meetings of personal and professional stakeholders in infertility treatment services in Austria, Czech Republic, Denmark, England, Northern Ireland, Scotland and Sweden. Further information about attitudes to anonymity and family formation was gathered in a survey of UK infertility clinics' policies about using semen from donors known personally to recipients, and from the non-confidential written responses to a public consultation on what information on donors, if any, should be accessible for donor offspring.

The research aimed to understand how semen donors of the past were experiencing the culture of secrecy surrounding anonymous donation and the fact that they were consigned to obscurity by the clinics after donating. The research itself provided at times uncomfortable challenges, because of what I often experienced as having to comply with secrecy (Speirs 2007b). Social anthropologists bring their own cultural perceptions to ethnographic fields, giving the work of self-reflexivity an especial importance, and keeping secrets, pretending for example that I did not know that a well-known infertility specialist had been a semen donor, made participant observation a highly dynamic process. We make choices in our own personal and professional lives which reflect or are driven by our own traditions, moral views and beliefs, and our own ideologies of kinship can influence our choice of ethnographic field. Anthropology 'at home' therefore becomes more than making the local 'exotic' (Jackson 1987: 8): it can be a test of how far we are prepared to objectify our own culture. Aleksander *Bošković* notes the emergence of a form of anthropology which consists of an anthropology of 'one's own tribe' (2008: 14) in which the local is not exotic or other, but normalised. In other words, the local is an appropriate research site. As László Kürti and Peter Skalník assert,

We are not searching for remote locations, faraway tribes, strange and exotic rituals just for the sake of carrying an anthropological badge, even though some of us have conducted research outside Europe; for many of us there are now, we must stress here, pressing issues present in our very own backyards deserving of attention (2009: 8).

Although not a new concept, anthropology at home particularly in the areas of infertility, secrecy and family formation, raises important considerations about the personal beliefs of domestic anthropologists and how we manage the theoretical and methodological challenges that emerge when exploring sensitive local issues.

### **The development of anonymous DI**

The passing of the Human Fertilisation and Embryology Act 1990 in the UK introduced the first legislation anywhere in the world to regulate reproductive technology and to introduce a licensing system for infertility clinics. It also included provisions for regulating DI services and it defined who were to be treated in law as the parents of a donor-conceived child. Until then, the practice of semen donation in the UK had not been considered unlawful, but rather to be legally ambiguous. There was also public concern that DI was immoral because it seemed like adultery and therefore an undermining of marriage and a stigmatising of donor-conceived children. There was considerable concern about the secrecy inherent in the practice and that this could not be in the best interests of the children.

This public concern in the UK about DI led to several official enquiries. A Commission was appointed by the Archbishop of Canterbury in 1945 (Church of England 1948) and a government-appointed Feversham committee was set up in 1958 with the following terms of reference:

To enquire into the existing practice of human artificial insemination and its legal consequences and to consider whether, taking account of the interests of individuals involved and of society as a whole, any change in the law is necessary or desirable. (Feversham 1960: 1)

The Feversham report noted that, apparently, 'human artificial insemination has been practised in the United States on a considerable scale for over thirty years' and that according to estimates perhaps over 10,000 children had been born there since the practice began. It was also practised in Australia, South Africa, France, Germany, Scandinavia, Belgium and the Netherlands. In proportion to population, the country with the second most frequent use of donor insemination was thought to be Israel. In several of these countries, government committees had recommended that the practice should be regulated or criminalized, but in no country had legislation been introduced.

Secrecy was strongly encouraged by infertility specialists. This was for the protection of those involved from accusations of adultery, and because there was thought to be no necessity for the identity of the donor to be known to the parents or children. The parents were advised by clinics not to tell their donor-conceived children about the nature of their conception, clinic records were not always retained, and information about donors was kept from the recipients

(Church of England 1948, Feversham Report 1960). Infertility specialists also insisted that DI should be anonymous partly as a protection for themselves against legal liability if anything went wrong (British Medical Journal 1973), and also to protect patients' marriages from the perceived stigma of male infertility, and children from the stigma of illegitimacy. Donor anonymity and secrecy about the use of DI was thought to be best for the family, and also to be a protection of the donor from accusations of adultery and from claims for financial support of the child.

Despite the public concerns about DI, a reluctance to legislate on the part of successive UK governments is clearly evident: forty-five years elapsed between the publication of an article which described the use of anonymous semen donation and thus brought the practice to public attention in the UK (Barton, et al. 1945) and the passage of the Human Fertilisation and Embryology Act in 1990. The medical profession itself appears not to have taken steps to lobby for legislation even though many doctors, including infertility specialists, were concerned about the safety aspects of DI. Donor Insemination only became subject to regulation in the UK as a result of the introduction of legislation to deal with the technologically more complex and risky practice of *In Vitro* Fertilisation, not because of the longstanding concerns about the legal status of donor offspring.

### Defending anonymity

In June 1990, at a crucial stage of the parliamentary process of the Human Fertilisation and Embryology Bill, the highly regarded British Medical Journal (BMJ) published a commentary on the matter. The Bill provided for information about gamete donors to be passed to the proposed new regulatory authority, the Human Fertilisation and Embryology Authority (HFEA), partly so that donor conceived people might seek non-identifying information about their genetic origins on reaching the age of 18. The authors of the commentary note: 'opinions are polarised as to whether this new lack of guaranteed anonymity for donors is a good or a bad thing' (BMJ 1990a: 1410). They give several reasons for it not being a good thing and assert that 'finally and most importantly, if donor anonymity is lost men will be inhibited from coming forward as sperm donors... the loss of anonymity is likely further to reduce the availability of men who are willing to be donors. This has already occurred in Sweden, where the law was changed to allow donors to be named. The donor population has been reduced dramatically...' (1990a, 1411). This allegation was based on a report that the law in Sweden had indeed changed to allow children, when they were considered mature enough, to obtain identifying information about donors. However, the BMJ authors omitted to mention that the number of donors had then recovered, except in clinics where, as social science research later uncovered, some clinicians were so against the new law that

they tried to sabotage it by encouraging their patients to travel to other countries for anonymous DI (Daniels and Lalos 1995).

The BMJ commentary failed to mention research from an Australian clinic in the 1980s which showed that 73% of donors would still be prepared to donate even if it were possible for the donor offspring to obtain identifying information at the age of 18 (Daniels 1989: 121). The research studies in various countries by Daniels, a social work academic in Aotearoa/New Zealand, helped to shift semen donors from a position of obscurity and of definition as a 'non-person' to one of acknowledgement, at least in the social sciences. He has published extensively in social, ethical and medical journals, and is cited by sociologists and social workers, but seldom by practitioners in reproductive medicine in the UK. They give the impression of being averse to his research findings, by ignoring them. During my research, at an annual conference of the HFEA I reminded the audience of Daniel's research findings about the willingness of many sperm donors to be identified to their donor offspring. Thereafter I was referred to by several fertility specialists in the audience who did not know me as 'our colleague from New Zealand', a neat but transparent way of insinuating that Daniels' findings were irrelevant to the UK since they came from a different 'culture'.

### **Removing anonymity**

Debate about amending the 1990 legislation in order to remove donor anonymity increased throughout the 1990s. As a result of lobbying especially by social workers and NGOs working with children and families, public consultation on the matter was promised in 1995, during the parliamentary debate in the House of Lords on the Children (Scotland) Bill, but was postponed due to a change of government shortly afterwards. Finally, regulations were passed which provided for gamete donors to be identifiable to any of their adult donor offspring who were born after 2006 (Department of Health 2004). These donor conceived adults can access identifying information about their donor, if they so wish, at the age of 18 years, or earlier if marriage to a named individual is planned before then. The regulations, which are not retrospective, were introduced after a public consultation which showed a clear majority of respondents in favour of donor conceived people having access to information about the donors (Department of Health 2003). The impetus for the consultation was a court case of a donor conceived person in which the court's decision was that Article 8 of the European Convention on Human Rights could be interpreted to include the right of a donor-conceived person to identifying information about her or his identity (cited in Blyth and Frith 2009: 176)

However, the principle of allowing such access to identifying information for donor-conceived people was not accepted by a number of infertility specialists

who remained resistant to the new regulations even after they had been introduced. There were claims that the government had made a big mistake and that the new regulations should be replaced by the pre-existing system of anonymity, because it was essential that donors' identities should be kept secret from their offspring.

Further, during the public consultation and after the regulations were introduced, many infertility specialists stated their belief that the system of anonymity in DI had worked well and therefore that there was no need to change it: donors remaining unidentifiable to donor offspring had not caused problems. They also pointed out that research showed that very few parents had told their donor-conceived children about their origins, thus implying that keeping secret the fact of donor insemination, as well as the identity of the donor himself, was not having adverse effects. However, they failed to mention the research studies which have found that a large number of parents have told someone else even if they have not told the child (Back and Snowden 1988; Lycett, Daniels, Curson and Golombok 2005). Back and Snowden suggested that for parents, keeping the fact of DI a secret from everyone was stressful. A study by Lalos, Gottlieb and Lalos (2007) of couples who had conceived a child after DI found that 61% of the parents had told all of their children about the DI, but 89% had told one or more persons outside of the family. One woman and three men told the researchers that they were sure that no one apart from their partner knew of the DI, but the researchers found that two of these men had wives who had told a close friend about it, without their husband's knowledge. This study was carried out in Sweden, where the legislation introduced in 1985 provides for donor-conceived children to obtain identifying information about gamete donors, but of note here is the researchers' finding that the attitude of healthcare staff was important to parents' decision-making. The parents reported that infertility clinic staff had not always encouraged them to be honest with their children. One of the reasons given by parents for deciding nevertheless to tell their children was that they wanted to avoid the possibility of the children discovering the truth by accident, and also to avoid the burden which keeping the secret was placing on the parents' marriages.

In addition to the view that the system of anonymity in donor insemination had worked well, it was also asserted by infertility specialists in my research that there was no evidence that it had not worked well. This argument had to rely on disregarding the accounts of an increasing number of donor conceived people asking for the law to be changed. None of the infertility specialists claimed to speak on behalf of donor conceived people as to what they wanted, rather, there were claims about what donor conceived people 'should' want. A good example of this occurred in 2002, during the period of the public consultation on donor information, when a young female doctor had an article published anonymously in the 'personal view' section of the *BMJ* (British Medical Journal 2002) in which she described her feelings about being donor conceived and why she would like

to know something about the semen donor who gave her ‘the opportunity of life.’ She pointed out that, although the issues about donor insemination had been debated over the years, “what are lacking are the views of the children created”. She pointed out that the studies carried out about people like her ‘have only used parental interpretations of our emotional state.....No one has questioned us....We have no voice.’

There were five responses to the article: two from mothers of donor conceived children, one from a professor of social work, and two from doctors. One of the doctors gave an address in Canada and the other an address in India. The response from Canada commented on the importance of knowing about family medical history and made suggestions for minimising any difficulties caused by a donor conceived ‘child’ receiving information about the donor. The other doctor commented:

Thrilled to know your feelings as a child of DI. But what I personally feel what is the need of knowing your DI father, because once you come to know your DI father you will be interested in knowing other brother and sisters of your DI father and on and on....So better to stop here. Content yourself with being the son of your present parents.

There were no comments on the article from any other doctors and I never heard it mentioned except by social workers, and by parents and donor conceived people. It is possible to speculate that few doctors would actually read the article due to its length and its obvious message from the beginning. Even the reader in India got the gender of the author wrong, as though the reading had been rushed. Perhaps readers agreed with the comment from India, which followed a noticeable pattern of telling donor conceived people not just what they should be doing, but also of what they should be feeling about their origins and the way that their families had been formed. Some infertility specialists have accused donor-conceived people of being ‘selfish’ for wanting to find out about their origins.

Acknowledgement by infertility specialists that they do not have sufficient professional knowledge to talk about what is in the best interests of donor conceived people is rare, but was readily admitted by several whom I interviewed, who were senior doctors clearly respected in their profession. They described to me how haphazard had been the development of an anonymous donor insemination service in the past, and how the need for patient confidentiality had been the major concern at that time. One of them told me that he did not have any research evidence about the welfare of donor conceived people and that his knowledge came from meeting with parents when they returned to his clinic requesting donor insemination in the hope of achieving a second pregnancy:

EH, we don’t know, you know, I’ve never been involved in long term follow up studies of the well-being of these children, nor have I been in a position to com-

pare them with the long term follow up of the well-being of children from any other point of view. My impression's always been that, many of these parents who come back for a second baby seem to be very happy with the way things are going.

Another retired doctor admitted to me that 'there may be problems of which I am unaware', but he had never heard of any. He said that he had relied greatly on informal feedback from the clinic's nursing and administrative staff who would be speaking informally with patients when they returned to visit the clinic. He had managed to obtain resources in the 1980s for a small follow-up study of married couples who had a donor-conceived child, but the results were never published and he believed that the data had been destroyed in order to preserve the anonymity of the couples.

### **European aspects of DI**

Legislation and regulations have had a profound impact on the ways in which DI services have developed in the UK, even if some of the infertility specialists have resisted what they view as interference with their professional expertise and knowledge. However, no medical infertility treatment in any European country can be performed in isolation. Changes to medical and laboratory practices as a result of European Union laws have had an impact in all member states, especially the European Union Tissues and Cells Directives (EUTCD 2004) which, through common safety and quality standards, mandates the traceability of donated body parts and tissues including gametes, and the safe keeping of records. The transnationalism of medical practices and ideologies has been noted by a number of social anthropologists from various field sites. Adriana Petryna describes how the clinical trials industry has grown into a 'largely uncharted field of global experimental activity' (Petryna 2007) and Bob Simpson notes from research in Sri Lanka how western medicine carries its ethical systems with it as it takes over in the spread of new reproductive technology (Simpson 2004).

Conferences and professional journals play a key role in the exchange and dissemination of information and ideas about clinical assessment, diagnosis and treatment in infertility treatment. The annual conference of The European Society of Human Reproduction and Embryology (ESHRE) has attracted over seven thousand participants in each of the last four years from all over Europe, as well as from other continents, and journals such as *Fertility and Sterility*, *Human Fertility* and *Human Reproduction*, have worldwide readership. Guidelines produced by ESHRE cross state borders but, unlike EU directives, take care to avoid being prescriptive. Thus guidelines on gamete donation (Barratt, et al 1998) noted that European countries each may have different experiences and practices but should adhere to minimum standards in order to ensure safety and good practice for pa-

tients and donors. The guidelines contain some statements which are considered mandatory for clinic professionals, but otherwise they respect 'autonomy on ethical aspects' in each country, meaning that the guidelines avoid making recommendations about donor anonymity. They focus on technical procedures such as semen analysis, relying on professionally-accepted scientific evidence and omitting any review of the social implications of donor anonymity.

At an international level, the United Nations Convention on the Rights of the Child (UNCRC) sets out the human rights to which all children are entitled, including non-discrimination and respect for their views. Article 7 (the right to know one's parents) and Article 8 (the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference) have both been used to support the removal of donor anonymity, but the application of these articles to donor conceived children has been contentious. Importantly, whilst arguments have tended to be framed around the right of donor offspring children to access identifying information about gamete donors, the continuing pressure for access to information has come from donor-conceived adults, who have asserted that being denied access to information about their origins is discriminatory and even degrading treatment. However, The Council of Europe has stated that 'It is not possible - at the present moment - to draw decisive arguments from the Convention for the Protection of Human Rights and Fundamental Freedoms either in favour or against the anonymity of donors' (cited in Frith 2007).

A European phenomenon which has gained considerable publicity in recent years is reproductive tourism or, as it is often called, cross-border reproductive care (CBRC), particularly involving Americans, Israelis and western Europeans seeking fertility treatment in 'the 'white' post-Soviet Bloc of Eastern Europe including Russia, Slovenia, Romania and the Czech Republic (Inhorn 2011, Nahman 2008). Often this search is prompted by long waiting lists or prohibited use in the country of origin for donated gametes. However, research in the UK by Culley et al. (2011) has shown that reasons for travelling abroad are complex and include lower costs of treatment and higher success rates abroad, treatment in a less stressful environment, and dissatisfaction with UK treatment. People travelled to 13 different countries, the most popular being Spain and the Czech Republic.

There are considerable financial transactions involved in CBRC which are economically important for the destination countries. Ventruba et al. (2007) note that infertility treatment services involving gamete and embryo donation in countries with liberal laws have become lucrative business and therefore a major ethical issue and asserts that 'Nowadays, describing the situation in Czech Republic, we can speak about an embryo and semen banking "industry"'. Amy Speier describes how 'reproductive travellers' seek infertility treatment in the Czech Republic, most often for IVF treatment with donated eggs (Speier 2012 forthcoming) due to the

short or non-existent waiting lists there and the considerably lower treatment costs in comparison to clinics in the travellers' countries of origin. She notes that this tourism is an important source of revenue for the Czech economy. Egg donors at a particular clinic that Speier studied were mostly university students or young mothers on maternity leave. According to the clinic's webpages, the clinic also provides donor insemination but does not explain how the donors are recruited and what compensation they receive. Donors may be as young as 18 and must have no problems in their family medical history<sup>2</sup> However, there have been concerns about the vulnerability of young egg donors in the Czech Republic to economic, emotional and physical exploitation, and strong calls for more social science research (Whittaker and Speier 2010: 376). Michal Nahman (2008) asserts on the basis of her research in Romania that women recruited to donate eggs there were not donors but sellers. Anecdotal evidence from infertility counsellors in the UK is that the possibility of inducement of gamete donors tends to be glossed over by UK clinics, leaving patients ignorant about donors' motivations. Unsurprisingly, counsellors have wondered what financial rewards, if any, accrue to the clinics and individual doctors for referring patients for CBRC.

In European countries, semen donor anonymity is associated not only with keeping the fact of DI secret from donor offspring, but also with the active support of state authorities in preventing access to records. This resembles the system of closed adoptions which is still operating in some jurisdictions, notably France, where birth mothers can legally abandon their babies. For post-Soviet societies of Eastern Europe, secrecy has an additional layer, a legacy of the management of information (Verdery 2002) and the operation of state surveillance which relied on secret police collaborators. Writing of the opening up of the files of the Stasi, the Ministry for State Security in the former East Germany, Tyler Marshall describes how the system involved 'ordinary citizens – lawyers, doctors, writers, schoolchildren, friends, neighbours, even spouses' supplying information about people's activities, conversations and diary contents (Marshall 1992). The files were opened up to the public in 1992, 'exposing a web of betrayals' in reports on 'friends, family, colleagues or lovers' (Marsh 2009). These essential secrets of the past have become the frustrations of the present, as individuals seek to discover the truth about the manipulations of their past identities. Secrecy in such situations is not only a matter of privacy, the value much emphasised by UK fertility specialists who support donor anonymity, but also of concealment of past behaviour. In the UK, medical practices in DI have been revealed which perhaps seemed right at the time to those involved, but are not so today: one example being the extensive use of semen donations from just a few donors. However, anecdotal evidence from countries in Eastern Europe suggests that if such practices were publicly known, they

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2 <http://www.crmzlin.cz/en/page/1749.sperm-donation/>

might raise fears about unwitting incest having occurred. Better that they should not be revealed, it is suggested, in order to avoid unnecessary distress and anger, and to prevent any threat to continuing public trust in the medical profession. For infertility specialists, such public trust may be at risk if past practices are revealed which call into question the integrity of the profession.

### **Czech Republic and UK contrasts**

I have suggested that arguments in the UK about anonymity in DI are indicative of how some people, especially some infertility specialists, think about family formation. What might the apparent absence of argument in Czech Republic mean? Does the silence signify agreement, or a preoccupation with other matters felt to be more important? As an outsider I can only surmise that it is significant, but that it will need ethnographic research by Czech speakers to discover and analyse what the causes might be. Not surprisingly, there are some significant silences in the UK which also need to be explored. These include the extent of infertility specialists' undeclared conflict of interest because they themselves were semen donors when they were young men, and the financial profits which some specialists, mostly medical practitioners, are said to be making at the expense of people who are unwillingly childless and are seeking infertility treatment.

In his introductory article on postsocialisms, Douglas Rogers suggests that comparison, especially if it is properly situated and contextualised, can work to create new insights, but notes that social anthropologists have had reason to be wary of comparative techniques, especially because they are far from being 'politically neutral' (Rogers 2010:9). In this concluding section I wish simply to draw some preliminary contrasts in the hope of providing further insights.

The clearest obvious distinction between the UK and CR lies in the legislation currently operating in each state. Donor anonymity is compulsory in CR and that extends to the exclusion of using donations of gametes from a person known to the recipient. In the UK, anonymous gamete donation is illegal and donation from donors known to recipients is allowed. The use of known donors transfers control from doctors to patients in the process of donor selection. Known donation between male relatives and friends is much less common than between female relatives and friends, but is preferred by some patients (Speirs 2007c). In both countries, the legislation provides for access to information about the donor for health reasons, although in CR the access is mediated by doctors which can be interpreted as emphasising the donor as a provider of reproductive material and not as a person whose health over the life course might be of great interest to donor offspring.

In countries without regulation of infertility treatment, there is the seldom mentioned concern about the number of donor offspring created from the donations of each donor. Before the regulation of DI, there was no legal limit in the UK to

the number of pregnancies which could be created. This is public knowledge in the UK where there are several large groups of people conceived in the 1940s and 50s from the donations of a few men (Blyth 2012), but even so, revelation of past practices reinforces public concern about unwitting incest between donor offspring and even between donor offspring and their (anonymous) donor. The risk of unwitting incest between two individuals who do not know that they are genetically related through a mutual gamete donor, either because they do not know that they were donor conceived or because they do not know that they share the same donor, has been noted as a concern amongst the public in the UK (Edwards 1999, Edwards 2004). In my own fieldwork, the possibility of unwitting incest when gamete donation is anonymous was always played down by infertility specialists because the statistical possibility of it was considered very remote. However, it was viewed as a public policy issue and potential cause of personal tragedy by individual lay people. In this respect there is a contrast between the policies of the UK and the CR, given that people conceived by donor in the UK can apply to the HFEA for information which would help to identify their donor and any half-siblings.

There may be a point of similarity between the policy makers and infertility specialists of the CR, and those in the UK who argue for donor anonymity, which is that keeping apart people who have no legal connection seems to be a response to the fear of the fluid and non-traditional relationships which non-anonymity might introduce. Anonymity cuts off new relationship possibilities and keeps category relationships tidy, provided that everyone involved keeps up the pretence that the social relationships map on to the genetic ones, and of course that the parents can keep secrets. In reality, social relationships can shift over the lifecourse, are strategically manoeuvred, and as the mother of two donor-conceived young people said to me, can be 'messy'. Social anthropologists know this, but for infertility specialists with no continuing contact with families created by donor conception and also with little knowledge of how increasing numbers of adopted people are searching for their birth relatives, anonymity in donor insemination provides structural security. As Bob Simpson describes in Sri Lanka, medico-legal constructs of relationality 'arrive pre-packaged with ARTs' (Simpson, forthcoming).

Finally, from the perspective in this article of an insider/outsider, an intriguing difference between the CR and the UK is the amount of public 'noise' about donor anonymity. In the UK there continues to be considerable argument, activism and media publicity. At conferences, in the press and in online newsletters such as BioNews, social workers argue with doctors and lawyers, doctors argue with each other, and support groups for donor conception families publicise leaflets and workshops about how to tell their children of their origins. The media frequently report news items about donor offspring finding half siblings or looking for their donor, and about illegal sperm donor provision, donor recruitment

issues, and reproductive tourism. Above all, there is on-going lobbying by donor conceived adults to have the form of birth certificates amended so that the name of the donor is recorded as well as the name of the legal parents. Whereas the historical development of semen, egg and embryo donation provision in the UK has been punctuated by government enquiries, public consultations, legal changes and consistent media interest, the situation in CR seems to be very quiet. The anthropological interest then is for future exploration into whether this is so, and why.

We can ask equally why the UK is so 'noisy.' Perhaps it is relevant that many people in the UK are curious about their ancestry and, in a land that has been spared civil war and invasion for several centuries, have access to rich sources of historical documents. There is a widespread interest in genealogy in the UK, and the Scottish Government in particular has promoted 'roots tourism.' News stories of reunions between siblings separated in childhood by adoption or other circumstances, such as child migration, are given wide publicity in the media. Genealogical research has been described as the next most popular pastime after gardening in the UK, and indeed searching for relatives and roots was described by a semen donor who I met as 'the new gardening.' His point was made in support of the removal of donor anonymity and as an admonishment to doctors complaining about it. In such a context, information about one's genetic parents can be seen not as a sign of 'genetic essentialism,' but rather as an enriched sociality.

However, I found in many of the professionals working in infertility clinics a belief that the nurturing (social) father of a donor-conceived child must be treated 'as if' he is the biological father because 'you cannot have two fathers.' Sally Sheldon (2005) suggests in her analysis of ART regulation that 'the search must be for the candidate (and for one candidate) who will best fit the role of 'real father'' (2005: 546). I suggest that the belief that there cannot be two fathers signifies the fear not only that two men would be in competition for the one role of 'real father', but also that genes are so strong a basis for connection that they will exert more influence than social connection. Frequently during my research, in written texts and in discussions, I encountered the view that donor conceived children might leave their social father in preference for the donor, the genetic father. The presumed power of genetic fatherhood also led to anxiety about whether to allow DI where the donor and recipient are known personally to each other. For some doctors, this brings the practice of DI into an acceptable kinship frame, but for others it confuses family boundaries: there 'might be' fantasies between donor and recipient, and the genetic father 'might interfere' with the donor-conceived child's upbringing. Thus, the insistence that there is still a need to maintain anonymity is based not on empirical evidence, but on deeply held beliefs about kinship and how it ought to work, on a confidence that parent-child relationships will not be harmed by deceit, and that it is possible and correct to keep secrets from children even into adulthood if that serves to protect the parents' status as infertile from being revealed.

In conclusion, I suggest that Jeanette Edwards' research into how lay people approach the question of connections in donor-assisted conception elegantly suggests a framework for the further exploration of views on donor anonymity. Edwards' informants in Alltown in the north of England 'drew on their own experiences of family relationships and on their cultural understanding of the reproduction of persons' when discussing sperm donation (Edwards 1998:168). How we as social anthropologists understand how infertility specialists conceptualise anonymity is related to their understandings of 'identity and belonging, the reproduction of class and gender, and the maintenance and creation of social relationships' (ibid). Beliefs about anonymity and secrecy in donor insemination reveal what people think about connectedness and relatedness in general.

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