As soon as the material is used, it loses its replaceability. The actual use of his material by a specific recipient, which happened with his free and informed consent, cuts off the way back for the donor. The recipient's right to have children by the same donor overrides the donor's right to withdraw his consent. This is the case for paid as well as unpaid donors. For all other material, no such cut-off point exists because there is no party to make a specific and privileged claim on his material. Consequently, the donor can only withdraw the material that is not reserved for second or third pregnancies and thus can only prevent new women or couples from conceiving with his material.

Donor’s attitudes about the use of their donation

Pennings raises some interesting issues relating to ‘ownership’ of donated material, suggesting, for example, that a person might change their mind about their donation should the sperm bank modify the categories of recipients who can apply for treatment. Daniels (1991) and Daniels et al. (1996b) note that donor’s have differing views about recipients. There are those who favour the stability of the family and those who feel it is right of any female to have a child provided they are able to provide it with appropriate support. In Daniels’ (1991) study, all his respondents were happy with the idea of married couples using their semen while they were generally less happy with the idea of single, divorced or widowed women or couples using then semen while they were generally less happy with the idea of single, divorced or widowed women or couples using their semen. Unfortunately, whether the latter were more likely than the former to subsequently change their mind about use of their donation was not investigated in this study.

In general then, donors are a varied group who have a number of, often altruistically related, motives for wishing to donate and who would frequently continue to do so in the absence of financial remuneration. In spite of Pennings’ caution, those who change their mind are likely to be the exception rather than the rule although there is no available research on this issue. If a change in life circumstances is more likely to promote a desire to withdraw one’s semen donation then it would seem reasonable to assume that older, married donors with families will be less prone to such concerns. Thus, one issue which future research might usefully explore is whether age, marital status and experience of parenthood is predictive of future acceptance or regret in relation to semen donation.

Psychological factors relating to semen donation: a comment

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In his debate article, Pennings (1996) argues that a sperm donor should have the right to withdraw at any time all the genetic material that belongs to him on the condition that it has not been used. Reasons he suggests for a donor wishing to stop the use of his gametes include: an alteration in the donor’s personal circumstances, the sperm bank modifying the categories of recipients who can apply for treatment and changes in laws relating to anonymity. He further suggests that it would be ‘cruel’ not to return semen to those donating for altruistic rather than financial reasons. The points noted by Pennings not only give rise to a number of moral and legal concerns but also raise a number of psychological issues. These relate in particular to the underlying rationale for an individual donating semen, donor’s attitudes about the use of their donation and the provision of appropriate counselling.

The rationale for donating semen

Pennings noton that people might change their mind about their donation due to a change in life circumstance, such as having children and getting married, suggests that donors are of a particular ‘type’, i.e. young, single and childless and requiring remuneration to donate. A number of studies have evaluated characteristics of semen donors and factors influencing them in their decision to donate semen (e.g. Daniels, 1987; Cook and Golombok, 1995; Daniels et al., 1996). The general finding from this research is that semen donors tend to be <30 years of age and in technical or professional occupations. The prime factors motivating the decision to donate include knowing infertile people, helping infertile couples and evaluating their own fertility. Financial remuneration may also play a role although many donors assert that they would continue to donate in the absence of payment. The fact that there is not one donor ‘type’ is illustrated in a study by Daniels et al. (1996a) who found marked differences between the two clinics they studied. In one, the typical donor was a 41 year old man with two children who probably did not intend having further children, while in the second clinic the typical donor was a 23 year old male who may or may not have been in a steady relationship. Unfortunately, whether the latter were more likely than the former to subsequently change their mind about use of their donation was not investigated in this study.

In general then, donors are a varied group who have a number of, often altruistically related, motives for wishing to donate and who would frequently continue to do so in the absence of financial remuneration. In spite of Pennings’ caution, those who change their mind are likely to be the exception rather than the rule although there is no available research on this issue. If a change in life circumstances is more likely to promote a desire to withdraw one’s semen donation then it would seem reasonable to assume that older, married donors with families will be less prone to such concerns. Thus, one issue which future research might usefully explore is whether age, marital status and experience of parenthood is predictive of future acceptance or regret in relation to semen donation.

References


women and lesbians using their semen. One of the less favourably disposed respondents felt that donors should decide who was a ‘suitable’ recipient. One would assume that clinics are not going to shape their decisions on the basis of donors’ preferences. The donation is for the clinic to use in its treatment programme and not for use only with recipients favoured by the donor.

Within this general rubric, however, the donor clearly donates with the treatment programme or clinic regulations in mind. An issue raised by Pennings is whether changes in regulations, for example with regard to changes in the law and hence changes in a clinic’s own rulings relating to anonymity of donors, would provide the donor with a valid reason for withdrawing his consent. In the UK, in spite of Human Fertilisation and Embryology Authority (HFEA) guidelines and Code of Practice Requirements, the information provided to donors is likely to vary considerably between clinics. Information and consent forms relating to donor material derived from the HFEA guidelines do not refer to the issue of anonymity and such information may or may not be provided verbally or in the clinic’s own consent form. Currently donors are likely to donate under conditions of assured anonymity and, while there is evidence that many donors would continue to donate even if their identity were to be made available to any resultant children, it would seem inappropriate for changes to be applied retrospectively. Indeed, current discussions seem to indicate that any change in the anonymity issue would not be applied retrospectively. However, one could envisage a situation where those who are aware of their origins as donor offspring and who were conceived long before any changes in the law relating to anonymity had occurred would then apply pressure for changes to be made retrospectively. Rather than placing a donor in a position where he would seek to withdraw his donation it would seem more appropriate to provide them with all the details relating to the above issues in order to enable them to make an informed choice to donate. This relates to the provision of counselling discussed in the following section.

**The provision of appropriate counselling**

A number of authors have noted that the semen donor is often seen ‘as a means to an end’ with little regard paid to their thoughts and feelings (Daniels, 1991). Yet many men would welcome the opportunity to discuss in greater detail their involvement in DI programmes (Kovacs et al., 1983) and the Warnock Report (1984) recommended that counselling should be available for donors. Unfortunately, availability of counselling varies greatly between clinics and rarely is it seen as an essential part of all phases of infertility treatment which would include donors. At the very least donors should be provided with adequate information and an opportunity to discuss the implications of their involvement. As noted above, much of the information provided is likely to be given verbally rather than in writing and consent forms may not have information relating to either the issue of anonymity or whether the donor can withdraw their donation. This is in spite of the fact that the HFEA Code of Practice states that donors should be made aware that they are free to withdraw their consent to use of donated material at any time prior to its use in treatment. The HFEA consent form allows donors to state whether or not they agree to their semen being stored for up to a period of 10 years but does not indicate that they would be able to change their decision subsequently. A similar position is taken in many clinics’ own consent forms. These are clearly issues which adequate counselling should address, facilitating the donor’s informed choice to donate so that the question of whether the donor would wish to subsequently withdraw his donation would be far less likely to arise.

**Concluding comment**

The idea that semen donors should request the return of unused donations seems inherently wrong if this is motivated by a change in the clinic’s profile of couples seeking donor insemination. With adequate counselling the possibility that donors will subsequently change their mind or express regrets is likely to be limited. However, both information available to donors and counselling provided varies greatly between clinics and many donors may not be told enough to enable them to make an informed decision to donate.

**References**


