Attitudes of donors and recipients to gamete donation

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An anonymous questionnaire was circulated at two gamete donation clinics to survey the attitudes of donor insemination patients (n = 71; 89% response rate), sperm donors (n = 52; 85% response rate) and ovum donors (n = 5; 63% response rate) to the release of medical records with non-identifying information, or with identifying information of the donor involved. The majority of established sperm donors agreed to the release of medical records with or without identifying information. In the subset of potential sperm donors 85% would not enter a sperm donation programme unless anonymity was maintained, but 60% would agree to the release of non-identifying medical records. Sixty per cent of recipients of donated spermatozoa would agree to the release of medical records with identifying information of the donor, but 85% stated that they would not tell their children of their genetic origin. There is a significant difference between the attitudes of potential sperm donor recruits to these questions and those of established donors and recipients of donated spermatozoa. In conclusion, the results of this survey show that although established sperm donors would continue to donate spermatozoa if their status of anonymity was withdrawn, recruitment of new donors would be significantly reduced. This would be to the detriment of gamete donation programmes and to the subfertile couples who request this form of treatment.

Key words: artificial insemination by donor/gamete donation/attitudes/spermatozoa

Introduction

There has been increasing interest in the legal status of gamete donors in the United Kingdom during the last decade. In 1984, the Warnock Committee Report carried out an inquiry into assisted methods of reproduction (Warnock, 1984). In 1990, the Human Fertilisation and Embryology Bill completed its passage through Parliament (HMSO, 1989). In the former, a central register of donors was suggested which would preserve the anonymity of donors. A similar structure currently exists in France (CECOS, 1989). In the latter, the donor’s status of anonymity has been reviewed. When the Bill was debated in the British Parliament in May 1990, 77% of the Members of Parliament thought anonymity should be conserved (HMSO, 1990).

It is a matter of concern that the introduction of access to medical records and a central register of gamete donors may significantly reduce both recruitment and the numbers of current donors in therapeutic gamete donation programmes (Braude et al., 1990). Any change in the status of anonymity of gamete donors would be of particular concern to practitioners.

A survey was carried out to establish the attitudes of both gamete donors and recipients to the potential effect of regulations governing gamete donation.

Materials and methods

A confidential questionnaire was circulated in two gamete donor clinics. Two questions were asked of gamete donors. Would they donate gametes (ova/spermatozoa) if offspring, once over the age of 18 years, had access to (i) medical records but not identity and (ii) medical records and identity? A supplementary question was asked of gamete recipients. Did they intend to tell any resulting children of the nature of their conception? (Copies of questionnaire are available on request.)

Questionnaires were completed and returned by 52 sperm donors (32 established donors and 20 new donors), five ovum donors and 71 recipients of donated spermatozoa. The 20 sperm donors who were new recruits, but had not yet been accepted by the programme, were analysed separately. Responses to questions by the different groups were compared using the Chi-square test.

Results

The results are presented in Table I. Responses from ovum donors were too few for conclusions to be drawn, but they tended to agree with the views of sperm donors. The results show that 97% of established donors would agree to the release of medical details without identifying information. Seventy-two per cent of these sperm donors would agree to the release of their identity to children resulting from gamete donation once over the age of 18 years. However, in the important group of potential sperm donors, 60% would agree to the release of non-identifying information but only 15% agreed that they would donate if their identity was available to resulting offspring. There was a significant difference between these two groups in their attitudes to both questions (P < 0.001 in both cases).

Eighty-five per cent of recipients of donated spermatozoa were
in favour of the release of medical details without identifying information and 59% were in favour of the release of identifying details. There were significant differences in the attitudes of recipients of donated spermatozoa and potential sperm donors to these questions ($P < 0.05$ in the case of non-identifying information and $P < 0.01$ in the case of identifying information). There was no significant difference in the attitudes of established sperm donors and recipients of donated spermatozoa to these questions. Interestingly 85% of sperm recipients stated that they did not intend to tell their children the nature of their genetic origin.

### Discussion

Previous research in Australia has shown that established sperm donors would be willing to provide identifying information to gamete recipients and their children. A survey of 23 current sperm donors showed that 86% would be willing to provide identifying information (Daniels, 1989). Another survey of 67 sperm donors revealed that 42% would continue to donate under these circumstances, with 6% remaining undecided (Rowland, 1983). In contradiction to these findings, experience in Sweden has demonstrated that the release of donor identity has dramatically reduced the availability of sperm donors (Bydgerman, 1989). In a recent leading article, Braude et al. (1990) suggest loss of anonymity will decrease the availability of sperm donors. The results of our survey help to explain the difference between these findings and views. This survey suggests that potential donors have significantly different attitudes to both established sperm donors and donated sperm recipients regarding the release of information about themselves. In particular, potential donor recruits are more concerned about the issue of anonymity than established donors. Most donation programmes have a high turnover of donors, recruitment is difficult, and potential donors are important to the continuation of treatment. Recruitment is essential as the Warnock Committee Report recommends that the use of each donor is limited to a total of 10 pregnancies. This survey would suggest a considerable drop in recruitment if the status of anonymity was withdrawn. Thus, while agreeing with survey findings of established donors in Australia, it would also predict the reduction in donor population experienced in Sweden.

It is interesting that while 59% of recipients of donor spermatozoa agreed to the release of identifying details about the donor, 85% stated that they would conceal the nature of their offspring’s conception. A previous survey in the United Kingdom found that only 5% of recipients thought that the child should be told of its origins (Walker, et al., 1987). One survey in Australia found that 64% of the general population thought that children of donor insemination conceptions should not be told of the nature of their conception (Rowland and Ruffin, 1983).

With the ability of recipients to control the release of information to their children, it is questionable whether government legislation is appropriate.

Although our numbers of ovum donors are too few for comment, Power et al. (1990) have shown that 87% of volunteer ovum donors would continue to donate if identifying information was available to the recipient. It is of note that only 40% of infertile patients who were undergoing treatment in an IVF programme and donating ova in that series would continue to donate under these conditions. In view of our findings in potential sperm donors, it would be interesting to survey potential ovum donors. In the United Kingdom the assurance of anonymity to ovum donors remains unchanged (Interim Licensing Authority, 1990).

When discussing this issue, there are other views to be considered apart from the attitudes of those participating in gamete donation programmes. Maintenance of the anonymity of the donor may be supported by the amount of unknown or misconstrued paternity in the general population (18% of putative fathers excluded as genetic fathers in one study (Weidinger et al., 1984)).

Furthermore, in therapeutic donor insemination programmes, there is a theoretical possibility of spontaneous conception during the treatment cycle. In Oxford in the last 13 years there have been eight spontaneous pregnancies in couples who have been gamete recipients (unpublished data). An important difference between gamete donation and adoption is the possibility of spontaneous conception such as occurred in these cases. It has been argued that there are similar practices and consequently gamete donation should follow the course of adoption and release identifying information (McWhinnie, 1986). However, in one survey 85% of the general population thought a child resulting from donor insemination should not be considered as adopted (Tyler et al., 1983).

With respect to gamete donation, loss of the status of donor anonymity, while in accordance with the views of the majority of established donors, may significantly reduce the recruitment of new gamete donors and the viability of some donor programmes. The views of the participants and of interested parties are complicated by theoretical considerations and the benefits of loss of anonymity may be outweighed by its negative impact.

### References


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