

## **Personal semen donors**

Report of a survey of UK clinics' provision of donor-assisted conception treatment to patients using own known donors.

Author: Jennifer Speirs, ESRC Innogen Centre, University of Edinburgh, Scotland

### **Introduction**

In 2004 a small survey of UK clinics was carried out for the National Gamete Donation Trust (NGDT) into the current provision of treatment to patients using semen donors known personally to the patients. The NGDT and its advisory council decided that such a survey might shed light on perceived variations in the provision of such a service at a time when clinics were reporting contradictory effects on levels of gamete donor recruitment following the UK Department of Health consultation on donor anonymity.

### **Method**

The researcher, Jennifer Speirs, was at the time a member of the NGDT advisory council and a doctoral candidate at the ESRC Innogen centre at Edinburgh University. The centre provided access to a confidential telephone line by which 29 clinics were contacted and a short questionnaire completed with a member of staff identified in the past to the NGDT as a contact person for that clinic. Respondents were advised that the researcher was a doctoral student carrying out the survey as part of her own research as well as on behalf of the NGDT. Respondents were assured that their responses and their identities would be non-attributed and would remain confidential to the researcher.

Responses were obtained from clinics located in all four UK nations and included both National Health Service and private clinics. Due to resource and time constraints, the survey focussed only on semen donation and therefore a comparison with egg donation was not possible. One clinic declined to participate, on the grounds that it was not currently providing any DI treatment due to shortage of staff.

### **Findings**

22 of the 28 respondents (75%) reported that their clinics provided a service for patients wishing to use the help of their own known semen donor but six of them qualified their reply by stating that the practice was rare and mostly confined to treatment for patients originating from the Asian subcontinent. Only 2 of these 22 respondents stated that it was clear in the clinic information leaflets provided to new patients that they could ask to use the help of an own known donor. The usual practice was to wait for patients to suggest the idea themselves and to assume that if they did not ask then they did not want the service. Of the 6 clinics where the service was never provided, and patients could not use an own known donor, only one had made a formal policy to that effect.

All but one of the respondents accepted the invitation to make comments about the subject and some were obviously very much interested in doing so. From these comments it was apparent that clinics, as represented by these respondents, appeared to vary widely in the extent to which cultural variations in human reproduction were identified, understood and discussed amongst clinic staff. Often the matters were

viewed rather as being ethical in character. They included beliefs about child and family development and uncertain or no knowledge about current practice and psycho-social research in adoptive and step-parent families. In addition, relationships between donors, recipients and donor conceived people were thought in some cases to be potentially problematic due to a belief about a permanent tension between 'the social' and 'the genetic'. However some respondents noted that such relationships did not need to be problematic and that they required negotiation, just like other relationships.

No respondent provided formal evidence which would contra-indicate the use of donations from own known semen donors. However a number of respondents believed that such a service was more costly for clinics than using anonymised donors, due to the perceived need for more counselling and for additional resources for screening, quarantining and cryopreservation.

A number of respondents stated their belief that the matter needed to be discussed as a policy issue in their clinics, and they noted that there might be differences in their own and colleagues' views about known semen donation and known egg donation.

### **Conclusion**

This small telephone survey suggested that the provision, or not, of an own known semen donor service depends on the personal beliefs and values of clinic staff and especially of the clinicians in charge rather than on policies based on other kinds of evidence. Clinic practices at the time of the survey appeared to be reducing the choices for patients as well as the number of potential semen donors. However the number of clinics where treatment for patients using the help of an own known donor had ever been provided was higher than the NGDT had anticipated, and informal evidence suggests that the number may have increased since the survey was undertaken.

For further information, contact may be made with Jennifer Speirs by email [J.M.Speirs@ed.ac.uk](mailto:J.M.Speirs@ed.ac.uk)